

Mental health calls cont.

Mental health issues related to current crisis

Both Indigenous and non-Indigenous mental health calls showed similar trends in terms of the features of their situation related to their current crisis. 'Aloneness' and 'relationship/family' were the most prominent in both groups. However, both these variables were more prominent in the Indigenous group.

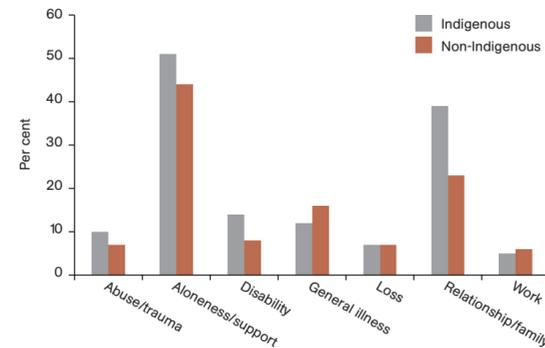
Although 'loneliness' did not emerge as a prominent 'specific issue' in the Indigenous group, when mental health calls are separated out, 'aloneness' becomes significant (51%). This suggests that 'aloneness' is specific to the Indigenous mental health group.

This data also suggests that in an Indigenous context, as in non-Indigenous, social support networks are functional in helping prevent mental ill health.

Western society is strongly individualistic, while Aboriginal society emphasises membership of a group and the obligations and responsibilities of individuals to meet the expectations of others (Bourke & Edwards, 1994). For Aboriginal people the family and community are of central significance and group interests and needs are a fundamental part of an individual's identity and self-fulfilment (Lynn, Thorpe & Miles, 1998). Personal identity is expressed in extended family and places of belonging, not in individualistic concepts (Quinn, 2000). Traditional Aboriginal society functioned by means of kinship networks, which formed the basis of social relationships and maintained social order (Healy, Hassan & McKenna, 1985).

Reser (1991, pp. 257–258) refers to the 'relatedness' for the Aboriginal individual that comes from such kinship networks, stating "...there has been little discussion of what these networks mean in terms of emotional well-being, or of how they function in terms of social support, experienced connectedness and identity, and with respect to coping and adjustment".

Graph 8: Mental health issues related to current crisis



Suicidal behaviour related to specific issue

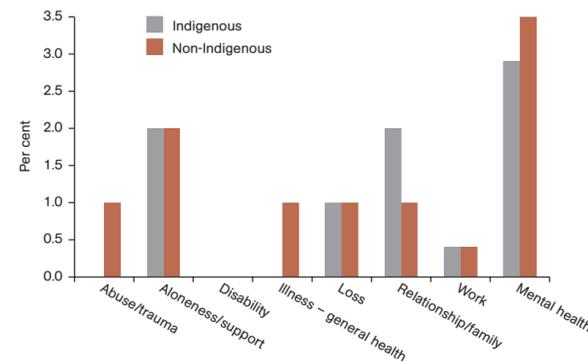
These data should be interpreted with caution as there were very few entries (as can be seen by the low percentages). A trend may be suggested that 'mental health', 'aloneness' and 'relationship/family' are the most influential factors. The latter appears to be more prominent in the Indigenous caller population (2%).

These findings certainly resonate with the available literature on Aboriginal suicide. Tatz (2001) proposes that Aboriginal suicidality is not always the domain of mental health, finding little evidence of clinical depression or any other diagnosable mental illness in cases of Aboriginal suicides he

studied in NSW. Depression, anxiety and stress have ranked highly in several surveys of Aboriginal suicide attempters (Radford, Brice, Harris, Van Der Byl et al 1999; Deemal, 2001); however, there has been little reference to the cultural context and meanings of such behaviours (Reser, 1991).

In his studies in the Kimberley, Hunter (1993) found that excessive alcohol use was moderately associated with suicide ideation, yet powerfully associated with acting on such thoughts. Hunter (1993) deduced that binge drinking functioned more in an enabling than causative role in terms of suicide and self-harm behaviour. Both Tatz (2001) and Hunter,

Graph 9: Caller's situation when thoughts of suicide present



Suicidal behaviour related to specific issue cont.

Reser, Baird and Reser (2001) detail the link between the impulsivity of Aboriginal suicide and alcohol use.

There is a general consensus that Aboriginal suicide is the "...product of a complex set of individual, situational and sociocultural factors" (Hunter et al, 2001, p. 8). Based on his research into Aboriginal suicide in NSW, Tatz (2001) proposed a list of eight factors in the causation of Aboriginal suicide: a lack of a sense of purpose in life; a lack

of publicly recognised and local role models and mentors; the disintegration of the family resulting in a lack of meaningful support networks within the community; sexual abuse; alcohol and drug use; animosity and jealousy within the community which interferes with socio-economic progress; the perpetual cycle of grief and high exposure to death; and illiteracy, which leads to unemployment, frustration, alienation, low coping skills and violence.

Conclusion

Overall the findings from the Lifeline statistics showed many similarities between Indigenous and non-Indigenous callers. However, Indigenous callers are more likely to be from rural areas, be unemployed and call about 'alcohol and drug issues' than non-Indigenous callers. There is also consistency and synergy between data collected by Lifeline, ABS Statistics and academic research on Aboriginal and Torres Strait Islanders.

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Lifeline Calls

Indigenous Lifeline Caller Statistics

PROFILE/05 | MAY 2008

Introduction

For 45 years Lifeline has provided access to mental health support services that connect people with care.

Lifeline's 24 hour telephone counselling service - 13 11 14 - operates nationally from 60 locations, answering over 1300 calls daily.

The purpose of this profile is to provide an insight into the profile of Indigenous callers who use the Lifeline telephone counselling service.

The Lifeline call data collected and analysed below represents a national focus excluding Melbourne Victoria. Classification of data relating to callers was made by Lifeline telephone counsellors using a mixture of questions and assumptions made from the information freely given during the call. Data comparisons are between Indigenous callers and non-Indigenous callers.

The information is drawn from 121,668 calls to Lifeline telephone counselling Centres across Australia during the period January to June 2006. However, this number dropped to 63,008 once calls where demographic information was categorised as 'unable to collect' were removed. Calls from Aboriginal and Torres Strait Islanders made up 1.7% of this sample, that is: 3,708 calls. Aboriginal and Torres Strait Islander peoples comprise approximately 2.4% of the Australian population according to the Australian Social Trends 2002 report by the Australian Bureau of Statistics (ABS 2002).

Call profile

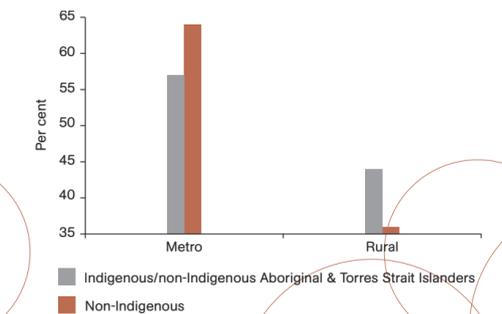
No significant differences were found in the sex or age distribution of Indigenous callers when compared with the general Lifeline caller profile. Most callers to Lifeline are aged 31-60. Significantly fewer Indigenous calls came from people living alone (40%) when compared with non-Indigenous calls (50%).

Rural/metro profile

44% of Indigenous calls were from rural areas. This is higher than in the non-Indigenous population (36%). This is reversed in metro areas where 64% of calls were non-Indigenous, while 56% of Indigenous calls were from metro areas.

According to ABS 2002 data, over half of the Indigenous population in Australia live in either NSW (29%) or Queensland (27%). Indigenous people make up nearly one third of the total Northern Territory population, the highest proportion for any Australian state or territory. Approximately one in four Indigenous Australians live in remote areas of Australia compared with around one in 50 non-Indigenous Australians.

Graph 1: Metro/rural calls



Call profile cont.

It is interesting to note that both Indigenous and non-Indigenous callers display the same trend of more callers being located in metro than rural locations. However, when comparing Indigenous and non-Indigenous call rates, there are fewer Indigenous metro calls, but more Indigenous rural calls. This may in part be explained by the population distribution of Indigenous people; however it is also likely to be explained by Indigenous help-seeking patterns and preferences.

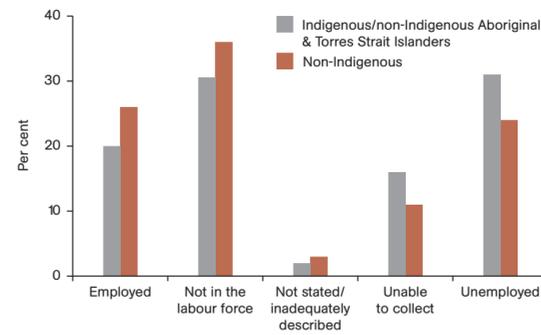
In metro locations, Indigenous people have greater choice of access to a wide variety of both mainstream and Indigenous-specific services and it could be surmised that Indigenous people in metro locations are more likely to access these services for their problems. However, in rural locations, such choice is often more limited, and the close-knit nature of such Indigenous communities would place a greater emphasis on the need for confidentiality. This may explain the propensity for Indigenous people in rural locations to access the Lifeline service at rates greater than those displayed by non-Indigenous people.

Employment profile

According to information provided during calls, more Indigenous callers are unemployed (31%) whilst more non-Indigenous callers are either employed (26%) or not in the workforce (36%).

This is in keeping with national data regarding employment and unemployment. The ABS (2002) reports that Indigenous people aged 18 years or over were less likely to be employed than non-Indigenous people, with more than three out of five non-Indigenous people (64%) employed compared with around two out of five Indigenous people (43%). When the effects of age differences were removed, the unemployment rate for Indigenous people stood at more than twice the rate for non-Indigenous people. It should be noted that according to the 2001 Census, approximately one in six of all Indigenous people classified as employed were actually engaged in

Graph 2: Employment situation



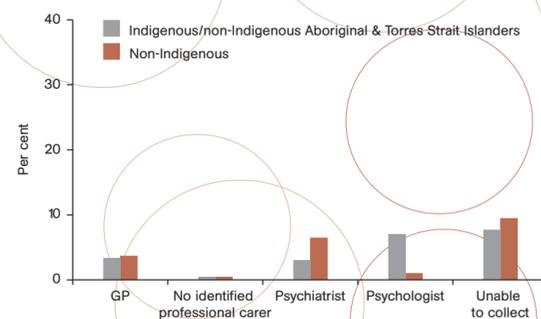
Community Development Employment Projects (CDEP), a program whereby participants work for their social security payment whilst also receiving training (Aboriginal & Torres Strait Islander Social Justice Commissioner, 2005).

Under the care of a Health Professional

A very low percentage of Indigenous calls were noted as under the care of a health professional. Compared with non-Indigenous callers, less Indigenous callers were seeing a psychiatrist and more were seeing a psychologist.

In terms of a lower rate of Indigenous access to psychiatrists, this is in keeping with recent findings that Indigenous people do not access

Graph 3: Under care of a Health Professional



mental health services at rates commensurate with estimated need (Westerman, 2004). In some locations this is related to a lack of available services (Reser, 1991). It can also be related to reluctance within Aboriginal communities to access mental health services because of negative historical experiences, stigma, perceived and experienced racism, cultural inappropriateness of service provision, and the perception of the individual regarding whether or not the issue at hand is in fact a mental health issue.

The higher rate of Indigenous calls noted as being under the care of a psychologist may also be due to the availability of psychological and counselling care at many Aboriginal Medical Services across Australia.

Call issues

Although 'family and relationships' and 'self and community' were prominent issues identified for the Indigenous group, they called proportionately less about these issues than non-Indigenous callers. The Indigenous group called more about 'trauma', 'behaviour problems' and 'practical help' than the non-Indigenous group.

The representation of these issues in the data has backing in statistics and literature. According to the ABS (2002), eight in ten Aboriginal and Torres Strait Islander people had experienced at least one stressor in the year prior to being surveyed (82% compared with 57% for non-Indigenous). As shown in Graph 5, taken from the ABS (2002), the most common stressor reported by Indigenous people living in remote and non-remote areas was the death of a family member or close friend (46%). In remote areas, the next most common stressors were overcrowding at home (42%), and alcohol and drug-related issues (37%). In non-remote areas the next most common reported stressors were serious illness or disability (31%) and unemployment (27%).

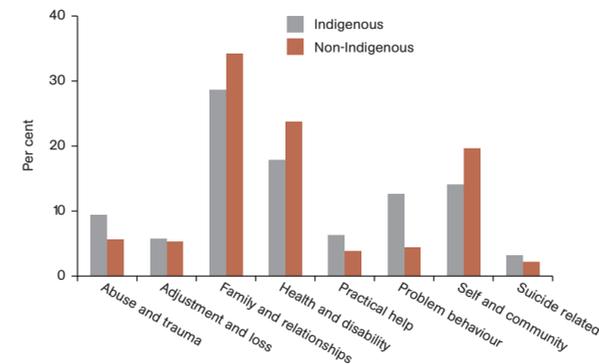
Indigenous callers were more likely to call for practical help than their non-Indigenous counterparts. This may be indicative of the potential value of Lifeline to be used as a referral and information service as well as a counselling service.

Specific issues

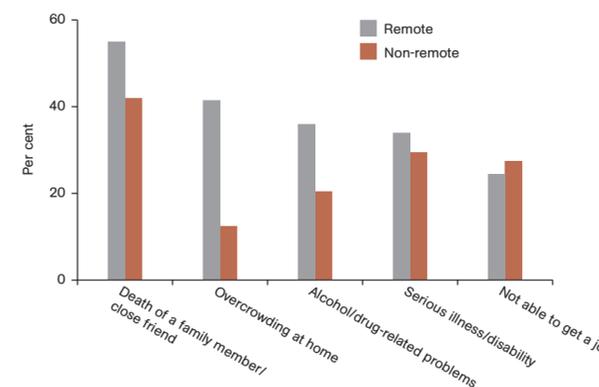
Significant specific issues can be seen in Graph 6. 'Mental health' and 'family/partner challenges' were the most prominent specific issues for both groups. 'Relationship breakdown' was also equally represented across groups.

Interesting trends emerge: In the Indigenous group the prevalence of 'alcohol and drug issues' are much greater. Loneliness, a prominent issue in the general Lifeline caller population, is not prominent in the Indigenous group.

Graph 4: Call issues

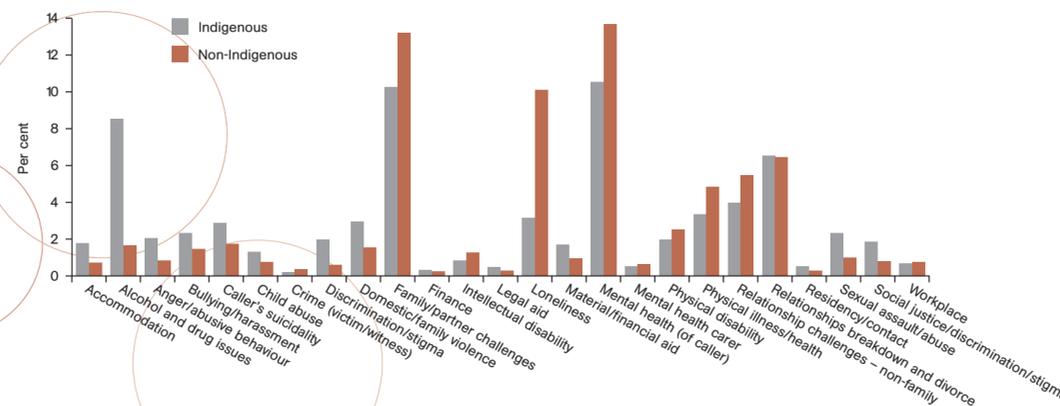


Graph 5: Selected reported stressors (a) in the past 12 months, Indigenous persons aged 15 years or over



(a) Respondents may have reported more than one type of stressor. Source: (ABS, 2002, p. 7)

Graph 6: Significant specific issues



Mental health calls

The following analysis relates to calls from Indigenous people that were identified by a telephone counsellor as being about mental health issues.

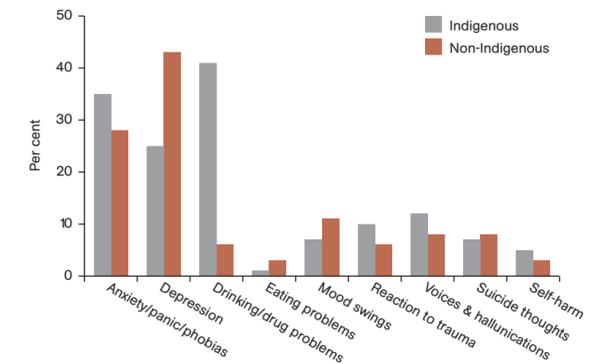
Presenting symptoms

To date, very little information is available regarding the mental health of Aboriginal people, including the extent and nature of mental health problems (ATSISJC, 2006). What information there is has come from crisis situations, when the mental health issue results in hospitalisation, and such data is collected from the perspective of mental illness as opposed to wellbeing (ABS 2002 & Australian Institute of Health and Welfare, 1999), based on western views of mental illness and aetiology (Kahn, 1987, cited in Reser, 1991). Indigenous and non-Indigenous conceptions of mental health differ, and numerous attempts to define Indigenous mental health concepts appear to produce a common theme – "...that Indigenous mental health needs to consider the holistic nature of health and wellbeing" (Vicary & Westerman, 2004, p. 3).

Western culture is generally 'internal' in its attribution of cause, viewing the individual as in a position of control over life events. However, Aboriginal cultures are generally 'external' in attribution of cause, viewing external causes, forces, supernatural agents, and impaired relationships, all of which are outside of the control of the individual, as causative factors in mental illness (Reser, 1991).

It has been estimated that certain forms of mental illness, such as anxiety and depression, are experienced in disproportionately higher rates, and often remain largely undiagnosed and untreated in Indigenous communities (Reser, 1991). It is interesting to note that while issues regarding anxiety were more prominent, issues regarding depression were less prominent amongst Indigenous callers than their non-Indigenous counterparts. This raises concerns regarding the level of awareness in Indigenous communities of mental health issues, and the access to appropriate resources, in terms of information and services.

Graph 7: Mental health themes for calls



It also raises the issue of possible relationships between mental illness and disadvantage. Hunter and Harvey (2002, p. 17) highlight the difficulty in distinguishing between what could be a mental disorder and what could be termed a "...understandable reaction to unremitting adversity". The evidence in the Lifeline data of callers experiencing multiple problems certainly suggests a relationship between reported mental health issues and other issues that could be described as resulting from socioeconomic disadvantage.

Drinking/drug problems (41%) emerge as a particular mental health issue for the Indigenous group. These callers also identified more symptoms of 'anxiety', 'voices' and 'reaction to trauma'. Interestingly, treatment for depression was less commonly disclosed in the Indigenous caller profile.

Drug and alcohol issues are reported by various sources in the literature as a current concern for the majority of Australian Indigenous communities, and it is therefore of little surprise that it featured so strongly in the Lifeline data. The ABS (2002) found that one in six (15%) Indigenous people reported drinking risky or high amounts of alcohol in the previous year. Overall, males (17%) were more likely than females (13%) to consume alcohol in excess. According to ABS (2002), approximately one quarter (24%) of

Indigenous people living in non-remote areas reported using drugs for non-medical reasons (most commonly cannabis) in the previous year.

Alcohol and drug use is often described as a maladaptive coping mechanism. However, aside from the risks of health problems, violence, reckless behaviour, suicide and self-harm risks, alcohol or drug dependence as a coping mechanism has the disadvantage of interfering with, and even preventing, the learning of more effective, adaptive, functional and suitable long-term coping strategies.

Reporting of 'voices and hallucinations' was more prominent amongst Indigenous callers. There are many incidences of Indigenous individuals reporting 'spirits' in connection with suicide and self-harm behaviour. These spirits are both in visual and auditory form, often recognised as deceased friends and family members, particularly those that had died as a result of suicide, and of malevolent, frightening spirits (Hunter, 1993, Hunter, Reser, Baird & Reser, 2001). These incidences commonly involve the spirit enticing the individual to suicide. Many of these incidences occur in the context of alcohol and cannabis use. Similar accounts are noted in the context of Canadian Aboriginal suicide and self-harm, with spirits commonly described as encouraging the individual to kill themselves, or to come and join them (Wilkie, Macdonald & Hildahl, 1998).