

Culture, custom, modernity and health: a nexus of factors in the status Aboriginal children

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I acknowledge the Larrakia traditional owners, their elders and ancestors.

You who are our best trained healers will work, in the main, amongst the world's healthiest people. While some of you will work in developing countries and regions, those of you who work in Australia will be in the lucky country. Your duties will be bound up with the diseases of wealth and high standards of living and consumption, such as obesity. But Aboriginal people are the unlucky Australians, people who have been failed by history and by our system of governance and economic management. For those few of you who will work amongst Aboriginal people, it is important to understand the present circumstances of the least healthy and least fortunate Australians. Their disease and morbidity status is the result of generations of marginalisation, poverty and underdevelopment, although this varies greatly across the nation.

Here in Darwin, the children of the Larrakia are in a more fortunate situation than many other Aboriginal children. In this beautiful tropical town, the income disparity is between those who are accumulating wealth from the resources and energy sector and those who are dependent on social security incomes and it is

plain to see. When one leaves the modern, clean environment of the central business district, the more extreme disparities become evident.

The most vulnerable citizens of the Northern Territory are Aboriginal babies. Unable to feed themselves and given insufficient nutrition for normal growth, at the very beginning of their lives they suffer hunger and they are unable to develop normally.

They are the victims of a health crisis with economic, social, historical and cultural dimensions. Other manifestations of this crisis are the subject of the hotly contested Northern Territory Emergency Intervention, involving quarantined social security income payments, restrictions on alcohol sales, special land leases in the declared 73 communities, and a wide range of programs, including child medical examinations by special teams and child nutrition programs. David Brewster and Andrew White¹ have documented this problem of malnutrition in Aboriginal children and growth failure. They write:

It is well recognised that Aboriginal children in the Northern Territory have a higher burden of disease, with higher admission rates and longer lengths of hospital stay than other children in the Territory.’ There is an estimated minimum prevalence of malnutrition of 20%² ‘in children 0–2 years of age living in the Darwin rural region, with microcephaly very commonly accompanying malnutrition.

1 Prof David Brewster (RDH); Dr Andrew White (Central Australian paediatrician), Growth and Malnutrition (Failure to Thrive), accessed 20 May, 2011:

http://www.carpa.org.au/Ref%20Manual%204th%20Ed/Child%20Health/Growth_malnutritionFTT.pdf

2 Weight/height or height/age >2 standard deviations below the NCHS standard.

They also note that, according to WHO/FAO criteria for developing countries, 'a community nutritional intervention is warranted when the prevalence of acute malnutrition in children under five years is greater than 10%, or 5 to 9% with aggravating factors.' Growth failure or growth faltering is the principal manifestation of malnutrition in children and it is attributed to insufficient weaning foods provided to infants. Their recommendations for community-based interventions to overcome infant under nutrition are urgently required.

These babies are caught between two tides of history: on the one hand, they have been swept up by the tide of the past. Their parents and ancestors were the victims of such a disruption of normal life brought about by colonisation, enforced segregation in managed reserves and missions, removal of children from families, extreme exclusion from the economy and poverty, that they were deprived of the knowledge or commonsense of parenting duties and responsibilities, from feeding weaning babies to basic hygiene. These skills of parenting, taken for granted in normal family life in most of Australia, are severely compromised among Aboriginal people whose lot is the isolated community under government administration. On the other hand, they will be swept along by an ill tide into an unhappy future. Already biophysically affected by undernourishment and growth faltering, their capacity to take up opportunities for a happy, productive life, will be limited. They are very sick children with an uncertain future.

Their experience is one of suffering from birth to adulthood, and if they make it beyond adulthood, there on their lives are similarly blighted.

The work of the medical researchers I cite here is some of the most important and urgent work –including research and practical measures – taking place in indigenous Australia. It is making a difference. There are some important factors to understand in the indigenous health field, some of them introduced by Aboriginal leaders, such as Noel Pearson, some anthropologists, and some by medical researchers. This is increasingly an interdisciplinary task because of the complexity.

A picture of Australia's children 2009 is a comprehensive report on the status of children, providing the most comprehensive and reliable data yet available on this population and the subpopulations, using 16 indicators. This report provides the following statistics:

Aboriginal and Torres Strait Islander children are over-represented in the child protection system. Indigenous 0–12 year olds were the subject of a substantiation of a notification received in 2007–08 at 8 times the rate of other children, and were also on care and protection orders at 8 times the rate of other children.³

The demographic charts in this report show an overwhelmingly young Aboriginal population. Along with the crisis of poor outcomes in Aboriginal health, education and ability to participate in the Australian, the demographic picture of the future of Aboriginal children demonstrates that the indigenous Australians population has crossed the Rubicon, and the other side of the river is not a good place to be.

³ Australian Institute of Health and Welfare, 2009. *A Picture of Australia's Children*, see especially, Chapter 34 Child abuse and neglect, p. 111.

The future for young indigenous people will be one of accelerating poverty and exclusion.

Only a small minority continue to be bound up in the lifestyle of their ancestors, and even this minority is largely dependent on welfare and state subsidies for everyday survival. The others are attracted to the consumer economy, but they are excluded from it, and hence the extraordinary rates of juvenile detention. It should also be clear that the extraordinary rates of notification for care and protection point to the inability or failure of their carers to provide safe, healthy home environments for them.

High mobility and extended visits for cultural reasons often extend far beyond the requirements of observing culture, and become unproductive and often destructive forms of social pleasure and demand-sharing. The fate of the children in these circumstances is failure to attend school and, far too often, poor health.

These factors are exacerbated by the 'rivers of grog' that have flowed into Aboriginal communities, deliberately targeted by the purveyors of alcohol as a vulnerable and lucrative market. The result is foetal alcohol spectrum disorder, the numerous adverse effects on a developing foetus caused by consumption of alcohol by the pregnant woman.¹³ Children at the most severe end of this spectrum who display the complete phenotype of characteristic facial anomalies, growth retardation and developmental abnormalities of the central nervous system are defined as having foetal alcohol syndrome. While this is the most readily clinically recognised, there are other categories: 'partial foetal alcohol syndrome, alcohol-related birth defects and alcohol-related neuro-developmental disorder'.

The prevalence of youth suicide, attempted suicide and self harm tell us that something is going very wrong in Aboriginal family life. The Mental Health Council of Australia has emphasised that Indigenous youth are the most 'at-risk' group in Australia for suicide.⁴ The sparse literature on this topic indicates that far too many Aboriginal children are choosing not to live by committing suicide because the prospect of continuing life is unbearable. Despite the absence of consistent public reporting on this matter, it is possible to see a picture emerging.⁵ Aboriginal communities are responding with a sense of great urgency to this problem. In 2008, in Western Australia, Coroner Hope handed down a 212-page report into the deaths of 22 Kimberley men and women including the death by suicide of an 11 year old boy. The Billard Aboriginal community led by Stephen Victor Sr responded with the Blank Page Summit aimed at innovative thinking to tackle this plague of youth suicides. In the small remote community of Oombulgurri there were five deaths of young people by suicide or misadventure between 2005 and 2006 among those prompting a Coroner's Inquiry, which was completed in 2008.⁶ This scourge is being tackled by the Gelganyem Youth and Community Well Being Program.⁷

⁴ See: http://www.aph.gov.au/senate/committee/clac_ctte/suicide/report/report.pdf

⁵ See: http://www.aph.gov.au/senate/committee/clac_ctte/suicide/report/report.pdf

⁶ Western Australian Coroners Act, Ref No: 13/08, 2008 as cited in The Gelganyem Youth and Community Well Being Program, accessed 20 May, 2011, <http://www.ichr.uwa.edu.au/files/user5/Chapter18.pdf>

⁷ See: <http://www.ichr.uwa.edu.au/files/user5/Chapter18.pdf>

It is undeniable, as I have said, that a proportion of today's Aboriginal parents, especially in remote areas, have not learnt the basics of home economics, nutrition and hygiene and the minimum daily food intake required for children to perform normally and to grow. The family life practices of the hunter gatherer society were rendered largely untenable many decades ago. Only a limited range of traditions and the knowledge necessary for living in precolonial Australian environments survive. Hunting and gathering persists, but usually to supplement the store-bought foods purchased with social security income and some other income. Demand sharing of traditional times has been perverted by poverty and the high proportion of income spent on alcohol, gambling, vehicles and the much increased rates of mobility involved in attending funerals.

It is important to understand the cultural and social factors that contribute in a primary way to this worsening historical situation. I love and enjoy Aboriginal culture as often as possible. This can happen anywhere in Australia, and it happens often. But the usual form of Aboriginal culture that I or even you might enjoy is most often the stylized, sometimes classical, sometimes modern or even hypermodern culture possible where the disadvantages are overcome by the sheer will of the performance or artist or the resources of a well run arts organisation.

When I hear naive outsiders talk about the need to restore Aboriginal cultural practices as a remedy for the Aboriginal health crisis, I wonder how it might be possible to explain just how fanciful and unrealistic this romantic goal is. While kinship and marriage customs continue, and in some areas continue much as they did in precolonial times, other features of Aboriginal culture have become

exacerbated to the point where they become a threat to life. Good friends and colleagues with whom I have discussed this issue say that it is possible to resolve these problems of the clash of culture with modernity by being respectful and discussing the issues intelligently. This should be a starting point, I say, but it is much more complicated and intractable than this optimistic view paints the picture, I believe. This problem has been most intelligently discussed by Peter Sutton in his book, *The Politics of Suffering*. A few other anthropologists, such as myself, as well as Francesca Merlan and Diane Austin-Broos and a handful of others, have also tackled the complex issues involved, such as agency, dependency, the scale of the problems faced in the transition to modernity. There are many happy Aboriginal families whose lives are improving and who are taking the opportunities available to other Australians. But for those left behind, the problems are often difficult to understand and analyse.

One of the dangers in the present debates is that the status of childhood is treated as if it were a universal experience. There is an assumption lurking in the discourse that the lives of children are best in a nuclear family. Many involved in the debate seem blithely unaware that childhood consists of widely varying experiences from society to society. In some, children must learn to kill things from the time that they can walk, even if hunting economies are on the wane with the introduction of cash economies and food sold in stores. The notion of a universal childhood has its origins in the twentieth century, and in the colonisation of lounge rooms by American television where childhood has been deviously shaped as a lucrative market for a range of commodities.

In traditional Aboriginal society, if a child survived infancy and grew into a toddler, it was given a name, but not before that. Children were more often cared for by older female siblings or young mothers's sisters, rather than their immediate mothers, while the mother engaged in various economic activities, working hard harvesting and preparing food. There was little discipline or punishment. Children lived for large parts of the day in a cohort of children with little adult interference. At the end of childhood, life suddenly changed when boys were sent to initiation camps and the betrothed husbands girls came to collect their new wives. Some of these old practices as documented many years ago by anthropologists Annette Hamilton and Diane Smith (formerly von Sturmer) can be glimpsed through the social hurley burley in present day communities. The transition to modernity has not dealt a good hand for Aboriginal children. These precontact ways of raising children are not suited to the closed, sedentary, low income communities which sprung up across Australia from the late nineteenth century at the end of the frontier wars.

It is in these places that physical violence, verbal abuse and lateral violence are manifested. Those most at risk of violence are family members, and in the main, the most vulnerable members of the family: old people, women and children. Especially the children.

Lateral violence is also a threat to children. Lateral violence has many detrimental impacts, and leads to heightened levels of mental illness. Just as sudden – and indeed, constant – death results in a state of permanent grief in some communities, so too the constant bullying and 'humberging' result in a social malaise akin to grief. Mood swings and disorientation, fear and a poor level

of response to ordinary events are typical of the low-level but persistent post-traumatic stress disorder that manifests in these milieux of constant bullying, aggression and humiliation.

Together, intentional and unintentional injuries are the third leading broad cause of Indigenous Australian disease burden (healthy years of life lost due to deaths and disability). Suicide, road traffic accidents, and homicide and violence contributed to more than two-thirds of the Indigenous Australian injury burden. Suicides contributed to one-third of the disease burden.

There is an important qualification that needs to be made about developing cultural continuity. It is that *healthy* cultural continuity, rather than *unhealthy* cultural continuity will improve the socio-economic and health status of indigenous Australians. The isolation of community members from the outside world is a serious problem. Too many young people conclude that the only place they can live is in an Aboriginal community. Most indigenous people appear to consider their lives normal because of their lack of exposure to life in other families and places, and their general lack of education. In addition, many communities are divided between those who are politically connected and those who are not. The major difference is reflected in access to resources and opportunities, a difference that extends to the lives of children at school. Families of the first group enjoy preferences for work and other pay-offs. There is no equity, democracy or valuing of education and training.

It need not be the case that every aspect of Aboriginal tradition is defended as worth retaining, in a Manichean struggle with racist ideology. It is crucially important for the future of the children, and future generations, to cast a cold,

objective eye over Aboriginal society. We should be able to rationally and calmly consider the potential benefits that might flow from shortening the funeral 'sorry camp' periods of confinement, or limiting the impact of traditions such as 'house-cursing', and both respect traditions and provide a path to a safe and secure life.

There are communities where a hard-headed approach to neglect and abuse of children is being adopted and is beginning to bear fruit. One of the most important developments I have observed is the way that leaders in Cape York have dealt with the problem of child neglect. In 2007, I chaired a meeting of Cape York community leaders who were keen to discuss ways families and communities could ensure that children are not neglected or abused. The idea of commissions in each community made up of Aboriginal elders and community people, along with retired judges and others with expertise, was developed by the Cape York Institute for Policy and Leadership at the behest of community leaders. The hearings consider children at risk and design a response that involves the family group and the community in ensuring safety and care for each child. Noel Pearson, Anne Creek, Alan Creek and other leaders proposed the Families Responsibilities Commission as a means of ensuring family and community responsibility through a local court designed to hear cases of child neglect and abuse, and provide remedies. This work required legislative change and political support, and is now operating as the Families Responsibility Commission. This framework has the capacity to undermine both the vertical and lateral forms of violence that have done so much damage. This is a sophisticated response that avoids the dangers of entrenching passivity and dependency. Other interventions are less successful because they do not change the behavior of the individuals

involved, but rather encourage health diminishing or life threatening behavior. A range of researchers in the health social sciences are identifying this risk. MacDonald and others writing in the *Medical Journal of Australia*⁸ have noted that

Community-based nutrition education/counselling and multifaceted interventions involving carers, community health workers and community representatives, designed to meet program best-practice requirements and address the underlying causes of growth faltering, may be effective in preventing growth faltering. Other interventions, such as food distribution programs, growth monitoring, micronutrient supplementation and deworming should only be considered in the context of broader primary health care programs and/or when there is an identified local need.

For remote Indigenous communities, development and implementation of programs should involve a consideration of the evidence for potential impact, strength of community support and local feasibility. Given the lack of strong evidence supporting programs, any new or existing programs require ongoing evaluation and refinement.

Health supplements are essential for the at-risk babies; health and growth monitoring is also essential. However, MacDonald and her co-authors concluded that community feeding programs should only be implemented in situations in

⁸ Elizabeth L McDonald, Ross S Bailie, Alice R Rumbold, Peter S Morris and Barbara A Paterson, Preventing growth faltering among Australian Indigenous children: implications for policy and practice, *In MJA* 2008; 188 (8 Suppl): S84-S86, accessed 20 May, 2011: http://www.mja.com.au/public/issues/188_08_210408/mcd11068_fm.html

which food insecurity is a major problem and in which feeding programs are supported by the local community. Such programs should only be seen as a relatively short-term solution.

And this is the nub of the policy problem in general: how to intervene to improve measurable, identified problems without entrenching passivity and dependency and worsening the situation, or making these expensive interventions permanent. As the Northern Territory Intervention policies are revised to enter a second phase, it is ever more important to follow the lead of the forward thinking Aboriginal leaders in Cape York and the Kimberley who are addressing the problems of babies, children and youth by developing strong community responses to their suffering. They are incorporating the best resources of their own culture and adopting innovative practices from elsewhere. The agency and sense of responsibility of community members is a vital ingredient in their success. The critical question is: How do involve family and community members in health interventions so that they are taking responsibility for their own health and that of their children? This is far more likely to succeed than the growth in the number of public servants entering the indigenous administration field. It is important to have the best researchers monitoring these developments and continuing to recommend strategies that have not been available to these isolated communities. The sustainability of Aboriginal society and communities will rest on the success of these interventions. Some important improvements are being seen. Understanding the need for them is of the first order of priority. Thus I have tried to bring my own thinking to these difficult problems, not to discourage you but to show you that our best medical researchers can make a

difference. I hope that some of you will join them. I wish you the very best for your future.

Thank you.