



Unknown family at the taxi stand

Dennis McDermott

The summer before last, two members of my family died. For an extended Aboriginal family, the fact that they died within 6 weeks of one another wasn't unusual — no less hurtful, but not out of experience. Blackfellas, unfortunately, bury often. Both deaths were unexpected: my mother's, from postoperative complications, and my never-met, distant in-law's, from violence. My mother's was unusual (she'd made it to 87), my unknown relative's less so: shocking, distressing to all connected to her, but not unheard of for black women, or men, in their twenties. It was unclear whether the violence was self- or other-inflicted — the stories of the male relative who found her and the cops differed ("there was a piece of rope"/"there was no rope to be seen"). What was not in dispute was the fact that two young boys, who had accompanied the relative to the woman's front door, now carried the picture of her legs protruding from a door frame down the hall.

This is a difficult essay to write, even to justify: it's personal — involving current and possible future pain for people I'm close to and care about — yet it relates to concerns that I research and talk about professionally all the time. As a Koori psychologist who has worked for some years teaching Indigenous health to medical students and registrars and Indigenous wellbeing to mental health professionals, it's undertaken in the belief that narrative can carry a complexity that epidemiology lays out as so many bones. Coolly useful as data are, when statistics have real human faces there's a chance that a lost emotional resonance might return. For Gubbas (non-Indigenous Australians) to come to grips with what's happening in Indigenous health in this country doesn't require a bleeding heart. It does require new means to "de-Other" Indigenous Australians — to situate us, and our experiences, inside the national consciousness. Blackfella health won't change until we are no longer the exotics of our own land.

My Aboriginal country is in New South Wales, west of the divide.* The day I was due to fly to New Zealand, to spend a few days with my Wellington-based partner before she headed to Europe to give a paper, my mother's condition worsened. I grabbed a flight to my old home town instead. My mother died the next day. After a few days, out-of-town relatives arrived for the funeral. My partner crossed the Tasman and brought my daughter and granddaughter up with her from Sydney. On our way from stocking up on groceries at the local ShoppingWorld, we noticed a public phone by the exit. We thought a quick call or two might help sort out our travel mess, but were there for the next hour. While my partner worked through the complexities of rescheduling a later departure for her conference in winter-dark Copenhagen, I watched people in sun-dresses, shorts and thongs drift out of the glass doors into the dry, inland heat of the car park. Hearing the sound of running feet, I turned to see two small girls in vividly coloured tutus coming down the last avenue of shops. Once through the exit, they took off for the taxi stand, ballet slippers in hand, some way ahead of their mother, who followed with stroller and shopping bags.

There was a momentary halt inside the taxi shelter while slippers were pulled over bare feet and ribbon wound around calves, then they were out and dancing. One tutu, a full-on orange, glowed in the late-afternoon light like a fiery variety of gum blossom. The younger one's was a complementary wattle. Both were fluorescent against deep-brown limbs. While their mother bent to the small figure in the stroller, the girls pirouetted behind the shelter, arms curved against the blue sky, calling out to each other as they turned. A few minutes later a taxi turned up and off they went to their lesson.

A few weeks after the burial, I thought I was done with the visceral jolt of sudden death, at least for a while. Grief was a different beast, to be grappled with in the coming months. When my partner returned from Europe, I flew with her to New Zealand to begin a 6-month sabbatical term looking at Indigenous mental health internationally. But my private and professional life kept overlapping. My thoughts kept coming back to my mother. Just a year before, my sister and I had battled to have my mother taken off antidepressants. After caring for her terminally-ill second husband for some years, she'd developed a reactive depression. There had been no consultation with family before she'd been prescribed SSRIs (selective serotonin reuptake inhibitors), nor when she was maintained on them for some years after her husband's death. Maintained, but not monitored. The family was left to puzzle the restless, even manic, energy and the apparent lack of empathy in a normally loving woman — the SSRI stimulant effect at work. After professional weight was used to have these concerns taken seriously, she was taken off her medication, abruptly (without her knowledge and, again, without family consultation), enduring a roller-coaster of withdrawal emotionality until we twigged what was happening. And there I was, in Aotearoa (New Zealand) and soon off to Canada to look for pointers, to ponder the central puzzle: does the fact that we do mental health badly in Australia fully explain how we get blackfella mental health so comprehensively wrong?

Once in a while, when I became too sombre, I'd conjure up the pure joy of that scene in the ShoppingWorld car park. I had no idea who the young Aboriginal family I'd seen at the taxi stand were, and, seemingly, they had no particular connection to me. I described them to my sister and found an unexpected one. The mother of the young girls and the child in the stroller was, in fact, the sister of a particular in-law: they were unknown family. The vibrancy and sense of possibility emanating from the tutu sisters seemed a hopeful sign. Professionally, in my teaching, I found it easy to point to Aboriginal resilience and give example after example of positive programs that were being piloted. Yet the shut-down of serious reconciliation in Australia and the decade-long growth of historical revisionism — the refusal to consider Indigenous/settler history and contemporary Indigenous health on the same page — had made it increasingly hard to maintain that hope. Creating a positive future for the current generation of Aboriginal children had felt, more and more, a hard ask. I didn't know whether to feel quaint or subversive, giving seminars on the inescapable nexus —

* The Great Dividing Range.

even in the clinical setting — between politics and Indigenous health outcomes. But I became increasingly convinced that, along with conceptual freshness, a sophisticated political boldness was vital, particularly in relation to turning around Indigenous mental distress.

A few weeks after I'd commenced my sabbatical, my sister called. My newly-found relative was dead. The picture was confused: she was estranged from the children's father, he was out of jail, there'd been disturbances, she was found on the floor of her house. What was indisputable was that she hadn't made 30, that the dancers and a younger child were motherless and that the two little boys at the door had seen too much. Investigations take time: I still don't know what really occurred, but, regardless of what actually happened on the day, I could sense what might have happened on all the prior days.

While I'd been working on a research project in south-west Sydney, it was put to me that the most commonly used instrument to pick up postnatal depression (PND) in Aboriginal mothers, the Edinburgh Scale, couldn't be relied on to sift out Aboriginal mothers at risk. The community nurses and infant mental health workers reported too much background "noise" to pick up a clear PND "signal": the women were routinely carrying such an accumulated load of mental distress that it was hard to sort out birth-related changes. Whether it's the NSW Chief Health Officer reporting on levels of east-coast Aboriginal mental distress, or Western Australian studies on the everyday stress levels and burden of negative life events borne by Nyoongah kids, a similar picture emerges. The greatest difficulty in improving Indigenous mental health is not finding data, but finding mechanisms to convince governments — ultimately, the program funders, workforce developers and agenda-setters — and, in particular, the current federal government, that to connect the unresolved trauma of dispossession, child removal, missionisation, racism and over-incarceration to contemporary distress is not adopting a "black armband view of history".

The dots are on the page. There is a lack of political will to join them up. When you make the connection between psychoneurobiological research, historical data and Aboriginal testimony, what emerge are the processes by which the long, slow legacy of colonisation and the human consequences of "virtual" apartheid are enacted: the physiologically and psychologically corrosive stress of having to deal, daily, with racist acts; the multiplier effect of the actions of each paedophile nun or unchecked abusive lay children's home worker; the undischarged body memory of beatings at Cootamundra Girls' Home, Kinchela Boys' Home or Beagle Bay; the brutality of Grafton Gaol or the Palm Island lock-up; the lack of both identity and hope when your comings and goings, your bank account, your ability to marry — your life — are controlled by the mission manager. When eyes aren't averted, these processes become clear.

Let's take just one process: a check of major newspapers for the summer of 2005–06 would show a number of current Australian governments denying even the *existence* of entrenched racism in this country, let alone the cumulative effects of its operation. Unless you're the one on the receiving end, the one on the performing end makes sure it's difficult for

anyone else to perceive the racist act. Even more rarely do we connect racism, and constant discrimination, to physical and mental health consequences. Racism takes an invisible toll. When you're the last one served in the sandwich shop, when you're on the corner waiting for the lights to change and the abuse from a wound-down car window slaps you in the face, or when you're young and brown and profiled by the cops as you perform your bravado shuffle down Glebe Point Road, it piles up in your head and chest.

In December 2005, as I walk home from the Coogee shops to my flat, I pass a sooty smear on Arden Street, the residue of a recently fire-bombed van. Across the road are the gas barbecues behind the beach, where every night an easygoing smorgasbord of UNSW[†] students cook up their diverse fancy. Both events are the real Australia: we are both a tolerant and a racist society. The bogey-man is currently "of Middle Eastern appearance", although he shape-shifts: when I was growing up, he looked aggressively out from May Gibbs' books, the bushy-eyebrowed, spindly-legged and nulla nulla-clutching Big Bad Banksia Man. Maybe Jung was right when he said that part of really growing up is reclaiming our own projections.

Yet all the Australian Prime Minister's 2006 Australia Day address can offer is racism as a "behavioural problem". The solution, as ever in our country, is more "punishment". But a century of research on behavioural change tells us that punishment doesn't change behaviour. At best, it temporarily amends it, drives it underground, ahead of a later, volcanic re-emergence.

In 2006, health professionals must work in a climate reductive of complexity. There is certainly no will to explore the reality of Australian racism, let alone its hard-to-pin-down, but profound, impact on physical health and what blackfellas prefer to call social, spiritual and emotional wellbeing. If we health professionals are to genuinely care for our patients and clients, the times call for informed, professional boldness. Not only is the "political" an everyday element in our funding and workforce shortfalls, but in our governments' data-denying intellectual shortfall. Reversing Indigenous mental distress requires awareness that new mechanisms of consensus building, beyond mere lobbying, need developing before we can effectively discharge our duty of care. In 2006, the political is the clinical.

We need — sorely need — a bridge between Western ways of approaching mental health and a body of Indigenous knowledge on maintaining, or recovering, wellbeing. We need to reconceive what actually underlies Indigenous mental distress before we can reconceptualise our praxis and develop the infrastructure to support a renaissance of wellbeing. Understanding is insufficient: the task requires recognising and incorporating the complex transgenerational effects of colonisation on blackfellas. The final step — no mean feat — would be the "de-Othering" of Indigenous Australia. You've got relatives out there.

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