

Brief communications

The National Report of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC): findings relating to Aboriginal and Torres Strait Islander health¹

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Introduction

The Royal Commission into Aboriginal Deaths in Custody (RCIADIC) was appointed in 1987 and submitted its report in April 1991.²

The purpose of the Commission was to enquire into the deaths of Aboriginal and Torres Strait Islander people that occurred in custody during the period 1 January 1980 to 31 May 1989. Ninety-nine such deaths met these criteria, and they were the subject of exhaustive enquiries by the Commissioners.

The Royal Commission was led until April 1989 by Commissioner James Muirhead, and from that point until its conclusion by Commissioner Elliott Johnston. Three other Royal Commissioners, Commissioner Daniel O'Dea, Commissioner Hal Wootten and Commissioner Lewis Wyvill, were appointed with the primary responsibility of investigating the deaths that occurred in particular States, as well as the underlying issues associated with the deaths in those States. In June 1989, Commissioner Pat Dodson was appointed to enquire into the underlying issues in Western Australia.

The Royal Commission's National Report is in five volumes. A number of state reports are also available. The report reflects the style of operation of the Royal Commission: it pays detailed attention to both the deaths that occurred and the immediate reasons for the deaths, on the one hand, and the underlying social, cultural and legal issues that had a bearing on the deaths, on the other.

Health and illness is a theme that runs throughout the report. The poor health status of Aboriginal and Torres Strait islander people in the community is reflected in the poor health status of people in custody. The two chapters of the report directly concerned with health (Chapters 23 and 31) are summarised later in this paper.

1. Many people contributed to the Commissions' understanding of Aboriginal health issues. They include those who gave evidence and provided submissions to the Royal Commission, as well as the staff of the Royal Commission and contract researchers, particularly Jane Bathgate, Deborah Fyfe, David McDonald, Suzanne O'Neill, Joseph Reser and Neil Thomson.

2. The Royal Commission into Aboriginal Deaths in Custody's national report, in five volumes, and the State reports, are published by the Australian Government Publishing Service, Canberra, and are available through Australian Government Bookshops in each capital city, and in major libraries, including that of the AIATSIS.

Interested readers may wish to follow up other chapters which also focus on health issues, including:

- Chapter 3—The findings of the Commissioners as to the deaths
- Chapter 15—The harmful use of alcohol and other drugs
- Chapter 24—Custodial health and safety
- Chapter 32—Coping with alcohol and other drugs.

The deaths

Of the 99 Aboriginal deaths examined in detail by the Royal Commission, 88 were males and 11 were females. Their ages ranged from 14 to 62 years, with a mean of 32 years. The majority of the deaths occurred in police custody (63 deaths), with 33 occurring in prison custody, and three in juvenile centres.

The manner of death varied. The largest category was 'natural causes' (37 deaths), with hanging (30 deaths) being the next most frequent category. The other categories were head injuries (12 deaths), gunshot wounds (4), other external trauma (7), drug use (4) and acute alcohol use (5).

The Royal Commission found that none of the deaths had been caused by foul play. Illness and self-inflicted hangings accounted for most of the deaths. The Commissioners did find, however, that in a number of cases the custodial death would not, or may not, have occurred if the person had been dealt with more appropriately.

The vulnerabilities of those in custody (Chapter 23)

It was apparent that health was a key vulnerability facing those Aboriginal people who died in custody. The deaths occurring in custody highlight the great health risks to which many Aboriginal people are exposed, in and out of custody.

The pattern of Aboriginal deaths occurring in custody (with the exception of the self-inflicted deaths) resulted from an unusual combination of causes associated with material disadvantage and of causes previously thought to be associated with affluence, such as heart disease and stroke. The self-inflicted deaths, occurring at much the same rate as among non-Aboriginal people in custody, appeared to reflect an increasing tendency for some Aboriginal people to behave in self-harming ways. For most of the people whose deaths were examined by the Commission, the hazardous use of alcohol was a major factor contributing to their deaths.

The diseases and injuries which caused many of the deaths in custody reflect the overall health status of the Aboriginal population. Aboriginal people have an expectation of life at birth which is markedly lower than that of other Australians and poor even by international standards. Despite a rapid decline in recent years, the Aboriginal infant mortality rate is still three times higher than that of other Australians. Hospitals statistics confirm the relatively poor health status of Aboriginal people, both in terms of the rate of hospitalisation and the length of stay in hospital. Many of the diseases which are still common among Aboriginal people are very uncommon among the non-Aboriginal population: malnutrition, diarrhoeal disease, meningitis, tuberculosis and leprosy, for example. Aboriginal people also suffer increasingly from the so-called lifestyle diseases, including diabetes, hypertension and ischemic heart disease.

On the basis of the deaths examined, it appeared that the greatest specific risk for Aboriginal people in custody was self-harmful behaviour, which the Commis-

sion recognised could be precipitated by acute situational factors, as well as any underlying mental disorder or distress.

A number of factors were identified as contributing to mental health problems. These include socio-historical and socioeconomic stress, the effects of rapid cultural transition, implications of alcohol use, and experiences of racism. Other factors increasing the risk of self-harmful behaviour included intoxication, anger and emotional distress, age and sex (younger adult males appeared to be most vulnerable).

For Aboriginal people, higher proportions of self-harm occurred in police rather than in prison custody, and alcohol figured significantly in the incidents of self-harm. In noting that self-destructive behaviour was not uncommon in Aboriginal communities, nor in custodial situations, the Commission concluded that it is best understood in its social context, as the interaction of life experiences and immediate stresses.

In its consideration of the mental health context of the self-inflicted deaths, the Commission noted two particular factors: the presence of psychotic conditions, and of alcohol-induced states of mental disturbance. Five cases of self-inflicted death examined by the Commission appear to have involved a classified mental disorder. A number of the cases also involved alcohol induced states of mental disturbance, including those associated with withdrawal from alcohol use.

The Commission noted that conventional models of mental health may not necessarily provide the most appropriate context in which to analyse and treat the mental distress experienced by Aboriginal people. It recognised that to comprehend fully the nature of this distress, psychiatric assessments of Aboriginal people must be balanced by the social and cultural insights provided by social science perspectives of mental health.

In terms of underlying factors, the most frequent element of risk for Aboriginal people in custody (particularly police custody) was alcohol use, seen in conditions associated with acute alcohol intoxication and in diseases associated with the long-term effects of alcohol use. The effects of alcohol misuse were also seen in more general ways, such as in the general debility of Aboriginal people in custody. Alcohol also contributed to the masking of life-threatening conditions and, in some cases, was a cause of sleep apnoea, the cessation of breathing caused by a blockage of the airway during sleep.

In 20 of the cases examined by the Commission, the deaths were caused directly by diseases of the circulatory system. Autopsies also revealed significant heart disease in a number of other cases. It is likely that the emergence of significant ischemic heart disease among Aboriginal people is a relatively recent health phenomenon, but it appears that its impact is particularly lethal. The Commission noted that the extent of premature mortality caused by circulatory system diseases warrants urgent attention from all responsible authorities.

Towards better health (Chapter 31)

Since so many Aboriginal people experience serious sickness and injury as part of their everyday lives, the Commission was not surprised to find that many coming into the custodial situation had a relatively poor health status. Although no clear and direct relationship was established, it was felt that the provision of health services could undoubtedly impact significantly on Aboriginal health. It was also felt that a mismatch existed between national health services resources, and their appli-

cation to meeting the needs of particularly vulnerable groups within Australian society.

The Commission noted that health services were provided to Aboriginal people by a combination of Commonwealth, State, Territory and local governments. This diversity of responsibility impacts significantly on the coordination of services provided. A major issue in access to health care for Aboriginal people was the relative inaccessibility of many mainstream health care services. In recent years, Commonwealth funding of State-run programs has decreased steadily with funds being redirected to Aboriginal community-controlled health services. Some States have also provided funds to these health services. The Commission recognised that Aboriginal health services had improved both the accessibility and the cultural sensitivity of health care delivery to Aboriginal people.

A primary principle underlying the way in which Aboriginal health services operate is the commitment to a broad definition of health, taking into account the cultural, social and economic circumstances of Aboriginal people. The Commission recommended that they should be adequately resourced to maintain this focus (Recommendation 259). In addition, it was noted that mainstream health services have much to learn from the experiences of Aboriginal community-controlled health services (Recommendation 248). Aboriginal health workers were seen as an important component in the effectiveness of Aboriginal health services, and the Northern Territory example of the training and career structures developed for Aboriginal health workers was seen as a model for their better incorporation into health care institutional structures (Recommendation 262).

The Commission recognised that the evaluation of Aboriginal health services is a difficult area, as it is for all community based health services, but that the development of appropriate and sensitive indicators could contribute to the building of skills and self-confidence in managers and service delivery personnel. This should contribute to the development of services, and not simply be a tool for determining levels of funding (Recommendation 260). The Commission concluded that Aboriginal organisations should increasingly be recognised as the appropriate vehicle for delivering, coordinating and evaluating Aboriginal health services, and that existing models which involve the contracting of Aboriginal community-controlled organisations to provide health services on behalf of government departments should be considered (Recommendation 258). It was also seen as vital that effective mechanisms of communication between Aboriginal health services and mainstream health services be developed (Recommendation 250).

The experience of being a patient in mainstream health services was noted as being uncomfortable and bewildering for many Aboriginal people. The Commission concluded that there was much room for improvement in the better training of health professionals at all levels, particularly in aspects of Aboriginal culture, society and economic circumstances, as well as in the skills of cross-cultural communication. In addition, the distinctive morbidity patterns of Aboriginal people need to be understood by health professionals (Recommendations 247 and 249), as does the effect of negative stereotypes, both of Aboriginal people and of people with drinking problems (Recommendation 255). The design and procedures of health services which service Aboriginal people should be reviewed to reduce the likelihood of ineffective diagnosis and to better attune the physical design of, and methods of oper-

ating, health care facilities to the needs of intended patients (Recommendations 251–253, 267).

The involvement of Aboriginal people at all levels in the operation of the health care system was seen as a critical factor in improving the quality of mainstream health care delivery. This should range from inclusion of Aboriginal people on hospital boards (Recommendation 254), to the increased employment of Aboriginal people at all levels of mainstream health care delivery (Recommendations 254 and 256). The appointment of Aboriginal liaison officers in hospitals, and their recognition as a part of the therapeutic team, was endorsed, as was the encouragement of Aboriginal doctors (Recommendations 257 and 261). To ensure that the contribution of Aboriginal staff is effective, it was important to recognise the potential for role conflict, and to develop strategies to minimise it (Recommendation 256).

The Commission noted substantial deficiencies in the delivery of mental health care services to Aboriginal people, but felt that these deficiencies could be ameliorated through better training of non-Aboriginal health professionals and the development of a cadre of Aboriginal health workers with appropriate mental health training (Recommendation 265). It was felt particularly important that mental health services should be linked and integrated with local health and other support services (Recommendation 266).

The major current policy thrust in the area of Aboriginal health in the implementation of a National Aboriginal Health Strategy was recognised. It was noted that the Working Party which was responsible for developing the strategy comprised leading members of the Aboriginal community, who undertook an exhaustive process of consultation with Aboriginal people and others. As such, it embodied a perhaps unprecedented direct involvement of Aboriginal people in the formulation of Aboriginal health policy.

The National Aboriginal Health Strategy Working Party recognised the need for research into a wide variety of Aboriginal health issues. It recommended that funds be set aside for research projects conducted by, and specific to, Aboriginal communities and Aboriginal community-controlled organisations. In noting that Aboriginal people are particularly sensitive to intrusive research, the Commission recommended that they should be involved at all stages of the development and implementation of research and statistical data collection (Recommendations 268–270).

The Commission noted that, despite acceptance by Commonwealth and State Ministers, current funding allocations appear inadequate to facilitate the full implementation of the Strategy. The recently announced allocation of \$232 million over a five year period is less than one-fifth of that estimated as being needed by the government officials responsible for recommending on implementation. Around three-quarters of the \$232 million will go to improvements in housing, water, waste disposal, roads, power and communication facilities, with a further one-fifth being allocated to the establishment of new Aboriginal community-controlled health services, and to improving the facilities of existing services. The Commission recommended that funds should be made available urgently to allow the strategy to be implemented fully (Recommendation 271).

Conclusion

The Royal Commission's National Report was tabled in the Commonwealth Parliament on 9 May 1991. At a Joint Ministerial Forum held on 8 July, Ministers from the Commonwealth, the States and the Territories agreed to develop a coordinated national response to the report by March 1992.

In the 1991-92 Commonwealth budget, a small appropriation (approximately \$3 million) was made based on the Commission's recommendations. During the second half of 1991, however, the main activity has been for governments to develop their responses to the report. It is to be hoped that Aboriginal and Torres Strait Islander people will be actively involved in the process of developing and implementing the far-reaching changes which the Royal Commission's report recommends.