Chapter 4

Culturally competent services

> A culturally safe health system is as important as a clinically safe health system. As evidence shows, when people experience culturally unsafe health care encounters they will not use health services or they will discontinue treatment, even when this maybe life threatening.[1]

4.1 The focus of this inquiry, the accessibility and quality of mental health services in rural and remote Australia, is of particular importance to Aboriginal and Torres Strait Islander peoples. As noted in Chapter 3, Aboriginal and Torres Strait Islander peoples are much more likely to live in these areas than non-Indigenous Australians.

4.2 The health outcomes for Aboriginal and Torres Strait Islander peoples is far poorer compared to non-Indigenous people and addressing this health disparity is the goal of many close-the-gap programs. Aboriginal and Torres Strait Islander peoples are have disproportionately low outcomes on almost every scale of social, health and wellbeing.[2] Of relevance to the health focus of this inquiry, the rate of admissions to specialised psychiatric care for Aboriginal and Torres Strait Islander peoples is double that of non-Indigenous Australians.[3]

4.3 The previous chapter outlined key barriers to the accessibility and quality of mental health services in remote communities of Australia. These included 'tyranny of distance' issues, workforce shortfalls and a lack of appropriate support services, among others.

4.4 For Aboriginal and Torres Strait Islander peoples, there is the added need for those services to be culturally competent in order to provide an appropriate, and adequate, service that does not re-traumatise people through the denial of their cultural needs. An overwhelming body of evidence presented to this inquiry shows that the lack of culturally competent and safe mental health services results in significantly lower rates of Aboriginal and Torres Strait Islander peoples accessing the mental health services they need.[4]

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1 Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), *Submission 74*, p. 5.

2 National Aboriginal Community Controlled Health Organisation (NACCHO), *Submission 128*, p. 2.

3 NACCHO, *Submission 128*, p. 2.

4 NACCHO, *Submission 128*, pp. 2–3. Other submitters who argued that a lack of cultural competency in mental health services is a key factor in lower use of mental health services by Aboriginal and Torres Strait Islander peoples include: Aboriginal and Torres Strait Islander Healing Foundation (Healing Foundation), *Submission 39*, p. 7, NACCHO, *Submission 128*, p. 2, Aboriginal Medical Services Alliance Northern Territory (AMSANT), *Submission 129*, pp. 4–5, CATSINaM, *Submission 74*, p. 3.

4.5 This chapter will outline the frameworks of culturally competent mental health service delivery in rural and remote locations, discusses the improved health outcomes when services are culturally competent, and explores the barriers to culturally competent service delivery. Although services which target alcohol and other drugs (AOD) services are often co-located with mental health services, this chapter will focus on clinical mental health services and social and emotional wellbeing (SEWB) programs, as well as suicide prevention strategies.

Service contexts

4.6 An overwhelming majority of submitters and witnesses cited the causes of mental health problems for Aboriginal and Torres Strait Islander peoples as being significantly different to non-Indigenous Australians, in that the causes are primarily poor social determinants of health[5] which leave families and whole communities in crisis, combined with the trauma caused by historical factors. A wide body of research has found that these historical factors include intergenerational trauma, racism, social exclusion, and loss of land and culture.[6]

4.7 The Aboriginal Health and Medical Research Council of NSW (AHMRC) submitted that the compounding impact of removal from families, racism and loss of culture through past assimilation policies left communities with high levels of disadvantage and ill health.[7]

4.8 A General Practitioner from Kununurra discussed the range of causative factors leading to mental health problems that she encounters as being intergenerational trauma, sexual abuse and 'a whole breakdown of cultural values, cultural connections, that we see; it's all absolutely contributing to that.'[8]

4.9 The National Aboriginal Community Controlled Health Organisation (NACCHO) submitted that:

> [I]t is not possible to consider best practice mental health models of service for Indigenous people without considering culture, including an understanding of the multi-faceted impact that intergenerational trauma has on Indigenous people and its inextricable link to mental health, and social and emotional wellbeing.[9]

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5 The World Health Organization defines the social determinants of health as …*the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.* See: https://www.who.int/social_determinants/sdh_definition/en/ (accessed 13 November 2018).

6 NACCHO, *Submission 128*, p. 2.

7 Aboriginal Health and Medical Research Council of NSW (AHMRC), *Submission 99*, p. 4.

8 Dr Stephanie Karen Trust, Principal GP, Kununurra Medical, *Committee Hansard*, Kununurra, 5 July 2018, p. 11.

9 NACCHO, *Submission 128*, p. 4.

4.10 Prior to discussing the cultural competence of mental health service delivery, it is important to outline the context in which those services are being delivered. The following sections outline key service delivery factors within Aboriginal and Torres Strait Islander communities.

Dispossession and colonisation

4.11 Evidence to this inquiry from a range of organisations noted that the colonisation of Australia involved the disruption and severing of many of the connections that are at the heart of social and emotional wellbeing and good mental health for Aboriginal people.

4.12 Witnesses noted that these impacts are still felt in Aboriginal and Torres Strait Islander communities today. The Aboriginal Medical Services Alliance Northern Territory (AMSANT) noted that the current delivery of mental health, SEWB and AOD services, generally without local input and governance, replicates some of the harmful aspects of colonisation and has significant implications for accessibility of services.[10]

4.13 The Medical Director of Wurli-Wurlinjang Health Service made a similar observation:

> The wellbeing of the community is affected by dispossession, by poverty, by all these other things, by lack of respect from the Australian government …which has disempowered and continues to do that on a fairly spectacular basis.[11]

4.14 Miss Nawoola Newry, a local advocate, pointed out that the direct outcomes of colonisation occurred in Kununurra in living memory, which meant the trauma was still fresh within that community.[12]

Collective and intergenerational trauma

4.15 The Aboriginal and Torres Strait Islander Healing Foundation (Healing Foundation) submitted that intergenerational trauma, where the impacts of trauma continue down through multiple generations, is complex in its impacts as it is both collective and cumulative. It is collectively experienced across communities, it is cumulative over a life-span and can be passed from one generation to the next.[13]

4.16 The Healing Foundation further submitted that the impacts of collective trauma can be devastating, as it can cause whole community breakdown and a loss of connection to community. This emphasises the need to provide collective healing responses, as individual treatment interventions alone cannot address this collective factor. The failure thus far to tailor healing efforts at a community level means

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10 AMSANT, *Submission 129*, pp. 4–5.

11 Dr Peter Fitzpatrick, Wurli-Wurlinjang Health Service, *Committee Hansard*, Katherine, 9 July 2018, p. 14.

12 Miss Nawoola Selina Newry, *Committee Hansard*, Kununurra, 5 July 2018, p. 27.

13 Healing Foundation, *Submission 39*, p. 3.

families continue to live in vulnerability without the strength of a community to assist them to heal.[14]

4.17 The Central Australian Rural Practitioners Association told the committee that the collective trauma of the stolen generation continues to impact decisions to access mental health services, as 'there is a very strong fear now still alive for Aboriginal people that welfare will be involved in your family and you might lose your children. That does have an effect.'[15]

4.18 The committee also heard of the build-up of collective grief, where communities were dealing with multiple instances of crisis and loss. A psychologist for the Ord Valley Aboriginal Health Service described this as:

> …people being in a constant state of grief and loss. They have relatives dying consistently. We are talking about people attending a funeral every week. They are almost in a cycle of grief and loss continuously.[16]

4.19 AMSANT submitted that the combination of these historical and present day experiences of trauma result in the disconnections in aspects of life that keep people well and strong and underlie the complex mental health, SEWB and AOD issues that impact Aboriginal and Torres Strait Islander communities.[17]

Social determinants of health

4.20 Many submitters and witness argued that the provision of mental health services will not alone address the mental health gap between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians, as many of the causes of poor mental health and wellbeing for Aboriginal and Torres Strait Islander peoples are the social determinants of health, such as housing access, adequate food and educational and job opportunities.[18]

4.21 The Manager of the Social Emotional Wellbeing Unit for Yura Yungi Medical Service told the committee that housing was a significant factor in stress-related mental health issues:

> There's an extensive waiting list on the housing commission, up to four to eight years. What we find is that this builds frustration. I honestly think it

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14 Healing Foundation, *Submission 39*, p. 4.

15 Mrs Lynette Byers, Secretary, Central Australian Rural Practitioners Association, *Committee Hansard*, Alice Springs, 10 July 2018, p. 26.

16 Mr Simon Dann, Senior Medical Health Worker (Psychologist) and Alcohol and Drug Coordinator, Ord Valley Aboriginal Health Service, *Committee Hansard*, Kununurra, 5 July 2018, p. 1.

17 AMSANT, *Submission 129*, p. 4.

18 Yura Yungi Medical Service Aboriginal Corporation, *Submission 70*, p. 1. Multiple organisations argued that many mental health issues in Aboriginal and Torres Strait Islander peoples were caused by social determinants of health including: Central Australian Aboriginal Congress, Central Australian Rural Practitioners Association, Danila Dilba Health Service, Kimberley Aboriginal Medical Services, Shire of Halls Creek and Wurli-Wurlinjang Health Service among others.

> has sometimes led to suicide, because people are frustrated, they can't get out of it and there are arguments and things like that within families.[19]

4.22 Townsville Aboriginal and Islanders Health Services told the committee that many instances of clients with depression or anxiety are found to have external stressor causes:

> When the doctor talks to them, or even the health worker, in their yarning they usually find out that it's more of a social thing. It might be overcrowded at home or dad's not working—he's unemployed—or Billy might be running off all the time and not going to school.[20]

4.23 The Social and Emotional Wellbeing support worker from the Kununurra Waringarri Aboriginal Corporation discussed the levels of crisis that individuals deal with on a regular basis, which leads to feelings of being overwhelmed, such as dealing with 'housing, Centrelink, the courts, juvenile justice and all that kind of stuff. A lot of them find it quite daunting and hard to deal with.'[21]

4.24 The AHMRC argued that mainstream mental health services are not capable of addressing the social determinants of wellbeing.[22] Mrs Gillian Yearsley, the Executive Director of Clinical Governance and Performance with the Northern Queensland Primary Health Network (PHN) affirmed this view and told the committee that:

> Current mental health service models are based upon models of care which are culturally inappropriate and which do not target the underlying systemic issues within those communities. This impacts upon the health and wellbeing of all community members, such as housing, employment, education, access to healthy food and the areas which link to the social determinants of health.[23]

4.25 The AHMRC pointed to the need for 'equitable funding and resource allocation towards the determinants of health and wellbeing such as safe and affordable housing, access to affordable nutritious food, and vocational and educational opportunities.'[24]

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19 Ms Cheryle Ann Kaesler, Manager, Social Emotional Wellbeing Unit, Yura Yungi Medical Service, *Committee Hansard*, Halls Creek, 5 July 2018, p. 1.

20 Mrs Erica Buttigieg, Social and Emotional Wellbeing Program Manager, Townsville Aboriginal and Islanders Health Services, *Committee Hansard*, Townsville, 30 August 2018, p. 25.

21 Mr Brendan Morrison, Social and Emotional Wellbeing, Kununurra Waringarri Aboriginal Corporation, *Committee Hansard*, Kununurra, 5 July 2018, p. 2.

22 AHMRC, *Submission 99*, p. 5.

23 Mrs Gillian Yearsley, Executive Director, Clinical Governance and Performance, Northern Queensland Primary Health Network, *Committee Hansard*, Townsville, 30 August 2018, p. 8.

24 AHMRC, *Submission 99*, p. 4.

Impacts of trauma on child development

4.26 The committee heard a range of evidence that showed the social and historical determinants of health for Aboriginal and Torres Strait Islander peoples often has a more sharply felt negative impact on children.

4.27 The Healing Foundation submitted that the impact of trauma on children can effect emotional regulation, attachment, aggressive behaviour and developmental competencies.[25] This can be compounded by other risk factors experienced by Aboriginal and Torres Strait Islander children, such as family disruption, family violence, economic disadvantage, poor living standards, disengagement from school and overcrowded housing.[26]

4.28 The Healing Foundation further submitted that medical research has also shown that trauma interferes with childhood neurobiological development, impacts responses to stress and increases a child's later engagement in correctional, social and mental health services.[27]

4.29 The Youth Program Manager for the Shire of Halls Creek outlined that there is higher than average presentation of youth with neurodevelopmental disorders in that region which is generally undiagnosed until after they have engaged youth justice services and these children 'are more likely than their peers to have other mental disorders, such as anxiety, depression and antisocial behaviour.'[28] The youth worker went on to detail other findings from diagnostic tools used on this youth cohort:

> Young people in the Olabud Doogethu program consistently present with low baseline scores when tested against the Rosenberg self-esteem scale, the Oxford happiness questionnaire, the social identification scale, which relates to belongingness, and the Kessler psychological distress scale. This indicates that clients have very little to no resilience skills.[29]

4.30 The Senior Medical Officer for the Nganampa Health Council told the committee that the experiences of poverty, malnutrition, chronic stress and exposure to violence damage the vulnerable minds and brains for children and that this could cause physical changes:

> The stresses are an ongoing thing. The high cortisol levels not only change how your body works and ages more quickly from a cardiovascular point of view but also the way the brain develops.[30]

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25 Healing Foundation, *Submission 39*, p. 12.

26 Healing Foundation, *Submission 39*, p. 13.

27 Healing Foundation, *Submission 39*, p. 1.

28 Mr Jake Hay, Regional Program Manager Youth, Shire of Halls Creek, *Committee Hansard*, Halls Creek, 5 July 2018, p. 12.

29 Mr Jake Hay, Shire of Halls Creek, *Committee Hansard*, Halls Creek, 5 July 2018, p. 11.

30 Dr Martin Kelly, Senior Medical Officer, Nganampa Health Council, *Committee Hansard*, Alice Springs, 10 July 2018, p. 12.

4.31 A psychologist for the Ord Valley Aboriginal Health Service bluntly told the committee that 'we've got kids who probably have the same circulating stress hormones as people living in a combat zone—and that's what they're going back home to.'[31] He further informed the committee that many of these children, some as young as 10 years old, self-medicate with cannabis to deal with their stress.[32]

4.32 The Mental Health Coordinator of the Ngaanyatjarra Health Service, a mental health nurse, told the committee of child behaviour cases he sees, with a range of possible causes such as 'alcohol, drugs, genes, genetics and in utero stuff' and further told the committee it was things he had 'never seen before within a city setting, the behaviours. A lot of it could be learnt behaviours as well, plus the beginning of mental health behaviours.'[33]

4.33 One of the traumas experienced by Aboriginal and Torres Strait Islander children in higher rates than non-Indigenous children is sexual assault. The committee was told this can be caused in part by one of the social determinants of health, overcrowded housing, which leads to children to being more vulnerable to sexual assault because the 'protective factors of family being able to provide safety are compromised.'[34]

4.34 A psychologist working for the Ord Valley Aboriginal Health Service told the committee of the high rates of sexual abuse encountered among their client population, which can be children as young as five to eight years of age:

> Also, regarding seeing clients who are survivors of child sexual abuse, I've never seen so many as in the Kimberley. I might have three sessions a day sometimes that are survivors of childhood sexual abuse. So I know we definitely need the services and skilled clinicians to help people recover from that devastating history.[35]

4.35 The psychologist further stated that generally the presentation he sees is an older female adolescent who is dealing with past trauma, who goes on to being a long-term therapy client.[36]

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31 Mr Simon Dann, Ord Valley Aboriginal Health Service, *Committee Hansard*, Kununurra, 5 July 2018, p. 7.

32 Mr Simon Dann, Ord Valley Aboriginal Health Service, *Committee Hansard*, Kununurra, 5 July 2018, p. 7.

33 Mr Nicholas Newman, Mental Health Coordinator, Ngaanyatjarra Health Service, *Committee Hansard*, Alice Springs, 10 July 2018, pp. 20–21.

34 Ms Brenda King, Sexual Assault Counsellor, Anglicare WA, *Committee Hansard*, Kununurra, 5 July 2018, p. 20.

35 Mr Simon Dann, Ord Valley Aboriginal Health Service, *Committee Hansard*, Kununurra, 5 July 2018, pp. 2 and 8.

36 Mr Simon Dann, Ord Valley Aboriginal Health Service, *Committee Hansard*, Kununurra, 5 July 2018, p. 9.

4.36 The Sexual Assault Counsellor for Anglicare WA told the committee of the impacts that child sexual assault can have on development:

> Child sexual abuse can have a very significant impact on a person's mental health both as a child and later on when they become an adult. Child sexual abuse is often a factor in people experiencing mental illness. It is identified as a factor in suicide and often results in personality disorders.[37]

4.37 The Sexual Assault Counsellor for Anglicare WA further discussed the lack of cultural competency in services to address issues of disclosure, including training for local Aboriginal Health Workers:

> There is a strong taboo against, and shame for, victims speaking about sexual abuse, and this is especially the case for Aboriginal people. There is a need for culturally appropriate education and resources to be rolled out by people who are adequately trained. It is my opinion that we need staff from both Aboriginal and non-Aboriginal backgrounds engaged in this work. Aboriginal workers may require training and mentoring to overcome the taboo associated with talking about sexual abuse.[38]

4.38 AMSANT told the committee that the only child and adolescent mental health services in the Northern Territory are in Darwin and Alice Springs and said that children are only receiving psychiatric care at crisis point from mainstream services that are not culturally safe for them.[39] Jesuit Social Services pointed out that this is compounded in the Northern Territory, where clinical psychologists used to be provided in schools but that service is no longer funded.[40]

Drug and alcohol issues

4.39 Aboriginal and Torres Strait Islander communities often have high rates of drug and alcohol use, which compounds and increases the complexity of mental health service delivery. The Ord Valley Aboriginal Health Service told the committee that the use of cannabis was 'linked to psychosis' but that clients reported they used cannabis as a coping strategy:

> What we see also is people almost in a perpetual state of grief and loss, continuously, with many of their relatives passing. So I believe that, quite often, alcohol and drug use is self-medication for underlying mental health disorders and psychological distress.[41]

4.40 A local advocate in Kununurra also raised the issue of self-medication, often to deal with undiagnosed mental health issues:

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37 Ms Brenda King, Anglicare WA, *Committee Hansard*, Kununurra, 5 July 2018, p. 19.

38 Ms Brenda King, Anglicare WA, *Committee Hansard*, Kununurra, 5 July 2018, p. 19.

39 Mrs Danielle Dyall, Team Leader Trauma Informed Care and Social Emotional Wellbeing, AMSANT, *Committee Hansard*, Darwin, 9 July 2018, p. 7.

40 Mr John Adams, General Manager, Central Australia, Jesuit Social Services, *Committee Hansard*, Alice Springs, 10 July 2018, p. 35.

41 Mr Simon Dann, Ord Valley Aboriginal Health Service, *Committee Hansard*, Kununurra, 5 July 2018, p. 1.

> Because so many [in the] community have these illnesses that are undiagnosed they turn to alcohol and drugs to mask their issues. When people are self-medicating on such a level in town it creates all these extra issues out in community. There can be violent outbursts and everything, which the family have to deal with, and then that can create further dysfunction in the family, trying to deal with that as well.[42]

Kinship and family structures

4.41 The different notions of kinship held by Aboriginal and Torres Strait Islander peoples, alongside the increased cultural obligations to family, was raised as an important service delivery context that was often overlooked by non-Indigenous service providers. The Provisional Psychologist for the Derby Aboriginal Health Service outlined that carer duties can impact on a client's ability to attend appointments:

> An Aboriginal person might book an appointment with me for 10 o'clock, but they don't rock up because Nan has said to them, 'I need to go to Woolies at 10 o'clock.' I'm not prioritised. And why aren't I prioritised? I'm not prioritised because they don't have to live the rest of their life with me; they're going to live it with Nan, and Nan won't forget that they didn't take her to Woolies at 10 o'clock when she needed to go…funders have difficulty getting their heads around it.[43]

4.42 The committee was also told that Aboriginal families tended to be larger, and for Aboriginal women with many children they found it difficult to attend appointments while caring for their children.[44]

4.43 The committee was also told that the different family structures found within Aboriginal communities can result in older Aboriginal women running informal safe houses for children with limited resources, often funded by a pension and under great stress:

> These safe houses, which they run and organise and where they've given their heart and their soul to the preservation of their children, are really where the duty of care, in my view, shines…These are receiving places within their community, built on a strong cultural base and on strong relationships, either personal or otherwise….That's where the rubber hits the road in this context. You asked the question: what are the cultural solutions? There is one.[45]

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42 Miss Nawoola Selina Newry, *Committee Hansard*, Kununurra, 5 July 2018, p. 25.

43 Ms Maureen Robertson, Social and Emotional Wellbeing Unit Manager, Provisional Psychologist, Derby Aboriginal Health Service, *Committee Hansard*, Derby, 6 July 2018, p. 3.

44 Mr Brendan Morrison, Kununurra Waringarri Aboriginal Corporation, *Committee Hansard*, Kununurra, 5 July 2018, p. 5.

45 Mr Wayne Barker, Festival and Cultural Events Coordinator, Kimberley Aboriginal Law and Cultural Centre (KALACC), *Committee Hansard*, Broome, 6 July 2018, p. 8.

Committee view

4.44 It is clear that the mental health service contexts for rural and remote Aboriginal and Torres Strait Islander communities are greatly different to those for predominantly non-Indigenous communities. These differing contexts include both the causes of mental illness, as well as barriers to the service delivery itself.

4.45 The committee heard compelling evidence directly from rural and remote Aboriginal and Torres Strait Islander people of the environments in which they live, work and raise families and the impacts these environments have on social and emotional wellbeing. Aboriginal and Torres Strait Islander communities are often operating in crisis mode, dealing with the continuing impacts of past traumas such as colonial dispossession and the stolen generation, compounded by ongoing traumas caused by high suicide rates and extremely poor social determinants of health.

4.46 The committee also heard from a range of experts that those social determinants of health have a far greater impact on individual mental health outcomes for Aboriginal and Torres Strait Islander peoples than that felt in non-Indigenous communities.

4.47 It is clear to the committee that health and mental health services which do not reflect these contexts are not only destined to fail, in the worst cases these services traumatise and retraumatise the very people for whom they are supposed to provide therapeutic treatment.

Culturally competent services

4.48 The Implementation Plan for the *National Aboriginal and Torres Strait Islander Health Plan 2013–2023* outlines the importance of health services being culturally competent.[46] The Implementation Plan states an intention that 'mainstream health services are supported to provide clinically competent, culturally safe, accessible, accountable and responsive services to Aboriginal and Torres Strait Islander peoples in a health system that is free of racism and inequality.'[47]

4.49 The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) submitted that for Aboriginal and Torres Strait Islander peoples, cultural wellbeing is inextricably linked to health outcomes, and pointed to the National Aboriginal Health strategy definition of health:

> Health is not just the physical wellbeing of the individual, but the social, emotional and cultural wellbeing of the whole community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total wellbeing of their community.[48]

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46 Cultural competence is often also described as cultural safety, cultural awareness, cultural sensitivity, cultural security and culturally appropriate.

47 *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023, Strategy 1B*, quoted in CATSINaM, *Submission 74*, p. 5.

48 National Aboriginal Health Strategy Working Party, quoted in CATSINaM, *Submission 74*, p. 4.

4.50 NACCHO also discussed the importance of culturally competent health services and submitted that this competency directly impacts the health outcomes of Aboriginal and Torres Strait Islander peoples accessing those services:

> Aboriginal people identify culture as key to mental wellbeing and evidence highlights that programs and services which provide culturally safe early intervention and prevention are the most effective in reducing the likelihood of poor mental health and suicide.'[49]

4.51 However, NACCHO submitted that access to culturally secure mental health services, particularly in rural and remote locations, is inconsistent and in many cases is non-existent.[50]

What is cultural competence?

4.52 Before evaluating the cultural competence of mental health service provision, it is useful to outline what cultural competence is and the impact that cultural competence can have on the clinical outcomes of mental health services for Aboriginal and Torres Strait islander peoples.

4.53 The Centre for Cultural Competence provides a definition of cultural competence in an operational context as 'the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes.'[51]

4.54 The Tangentyere Council provided a commonly used definition of cultural safety as:

> An environment that is spiritually, socially and emotionally safe, as well as physically safe for people, where there is no assault, challenge or denial of their identity, of who they are and what they need.[52]

4.55 The committee was told that culturally competent service provision is fundamental to the mental health outcomes of Aboriginal and Torres Strait peoples. NACCHO submitted that the lack of culturally competent services is a major barrier to Aboriginal people seeking the mental health care they need, and that in 2012–13 seven per cent of Aboriginal and Torres Strait Islander peoples reported avoiding seeking health care because they had been treated unfairly by medical staff.[53]

4.56 It was also acknowledged to the committee that cultural competence in the Aboriginal and Torres Strait Islander service setting is not a one size fits all solution.

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49 NACCHO, *Submission 128*, p. 3.

50 NACCHO, *Submission 128*, p. 2.

51 Centre for Cultural Competence, *Information Pack: Imagine a culturally competent Australia*, p. 4, https://www.ccca.com.au/Frontend/Content/Course/InfoPack/ c25a38a984eb4feba8314953e3581ca8.pdf (accessed 18 September 2018).

52 Ms Maree Corbo, Program Manager, Tangentyere Family Violence Prevention Program, Tangentyere Council, *Committee Hansard*, Alice Springs, 10 July 2018, p. 33.

53 NACCHO, *Submission 128*, p. 3.

Each community will have different needs and a different cultural context and traditions.[54]

Trauma informed and strengths based care

4.57 The interrelated nature of trauma informed care and culturally competent care was raised by submitters and witnesses across a number of contexts. It was contended that without cultural competency, services for Aboriginal and Torres Strait Islander communities could not be considered trauma informed, as they often inflicted additional trauma on the very people using the service.

4.58 AMSANT submitted that the mainstream models of trauma informed care, considered best practice in non-Indigenous settings, could not be considered best practice for Aboriginal and Torres Strait Islander peoples. AMSANT argued it can in fact be harmful, because of the differences between non-Indigenous and Aboriginal and Torre Strait Islander communities' belief systems and historical experiences of colonisation.[55] AMSANT pointed to Culturally Responsive Trauma Informed Care as an approach of best practice, which requires the service approach to be contextually tailored and localised to the nuances of each location.[56]

4.59 The Healing Foundation contended that many mental health staff lack education about the nature and impact of trauma on the mental health of Aboriginal and Torres Strait Islander peoples. The Healing Foundation submitted that despite an increasing awareness of trauma informed care in mainstream health services, there is a significant gap in the accessibility of genuinely trauma-informed mental health services for Aboriginal and Torres Strait Islander peoples.

4.60 The use of fly-in, fly-out (FIFO) services can be particularly problematic if people are encouraged to talk about traumatic life events, and then the service is unavailable for over a month leaving the community to manage the distress of the individual, and in some case suicide attempts.[57]

4.61 The issue of FIFO services was raised by many other witnesses. The Kununurra Waringarri Aboriginal Corporation told the committee that many people will not engage with a FIFO service because the periodic nature of the service raises trauma and then leaves it unresolved:

> They're thinking: 'What's the point of going and speaking to someone who's only to be [here] for a week? We're not going to see them again.'…If they're supporting a person who's going to be permanently based here in town and they can put a face to a name and know that that person is going to be here

54 Dr Denise Riordan, Chief Psychiatrist, Northern Territory Department of Health, *Committee Hansard*, Darwin, 9 July 2018, p. 1.

55 AMSANT, *Submission 129*, p. 5.

56 AMSANT, *Submission 129*, p. 5.

57 Healing Foundation, *Submission 39*, p. 6.

> for good, I think it will encourage them to come out and really speak about our story and talk about what issues they might be facing.[58]

4.62 The Consultant Psychiatrist with the Kimberley Mental Health and Drug Service described other health services which are standard for non-Indigenous patients but can be traumatising to Aboriginal and Torres Strait Islander peoples:

> If there is a compelling health reason to keep someone in hospital, then yes, of course we will do that. That's our duty of care and it's our ethical, personal and professional obligation…However, a hospital is an institution. It's a conventional western institution that's a traumatising place…that will often make things worse.[59]

4.63 The Consultant Psychiatrist also described how the usual approach to therapeutic questioning can also be traumatising for an Aboriginal and Torres Strait Islander patient:

> When I take a step back in the consulting room, rather than me driving that and rather than me being a top-heavy, medical-down practitioner, if I've asked a local person who can build a bridge between me and the distressed person rather than me inadvertently retraumatising that person by grilling them with interrogative questions, the person who's there building the bridge, the Aboriginal person, makes it a safe interaction and allows that person and their family to buy in to the strategies that will most likely make a more meaningful and enduring difference.[60]

4.64 CATSINaM pointed to strengths-based approaches being linked to wellbeing in Aboriginal and Torres Strait Islander health, as they assist in changing perspectives of Aboriginal and Torres Strait Islander health and provide alternative ways to approach social and emotional wellbeing.[61]

4.65 AMSANT pointed to a review conducted for the Closing the Gap Clearinghouse, which found that programs that show positive results for Aboriginal and Torres Strait Islander peoples' social and emotional wellbeing are those that are strengths-based, in that they 'encourage self-determination and community governance, reconnection and community life, and restoration and community resilience.'[62]

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58 Mr Brendan Morrison, Kununurra Waringarri Aboriginal Corporation, *Committee Hansard*, Kununurra, 5 July 2018, p. 4.

59 Dr Huu Duy Tran, Consultant Psychiatrist, Kimberley Mental Health and Drug Service, *Committee Hansard*, Broome, 6 July 2018, p. 23.

60 Dr Huu Duy Tran, Kimberley Mental Health and Drug Service, *Committee Hansard*, Broome, 6 July 2018, p. 23.

61 CATSINaM, *Submission 74*, p. 5.

62 P Dudgeon and C Holland, 'Recent developments in suicide prevention among the Indigenous peoples of Australia', *Australasian Psychiatry*, vol. 26, no. 2, 2018, pp. 166–169, quoted in AMSANT, *Submission 129*, p. 3.

Cultural competency in non-Indigenous services

4.66 As outlined above, a key concern raised regarding the cultural competency of non-Indigenous service providers is the prevalence of the FIFO model used to service remote communities.

4.67 The Regional Youth Program Manager for the Shire of Halls Creek discussed how this model is incompatible for Aboriginal and Torres Strait Islander adolescent mental health, which favours a drop-in model. The FIFO model means that '[r]apport building with clientele is difficult, and intensive therapeutical intervention is almost impossible.'[63]

4.68 AMSANT said that FIFO services often do not have access to community members who do not show up for an appointment–as discussed early in this chapter this can often be for competing family duty issues. Services run by local community members with relationships on the ground can have staff drive around and find those people and then conduct a meeting in a safe environment.[64]

4.69 The Acting Chief Executive Officer (CEO) of Jungarni-Jutiya Indigenous Corporation gave a similar example, where a non-Indigenous service refused to find a young man in need of mental health intervention, requiring him to visit the service or attend hospital:

> They waited four weeks until he went off his head. The system doesn't work for people here because there's no real prevention on the ground. They're all in these flash offices with the air conditioning and everything else, but they're not on the ground out there where people can see them just having a yarn with people. Mental health doesn't have to be that bad. If you just go and have a yarn with somebody, you could stop those people from being what they are in some cases.[65]

4.70 The Healing Foundation further submitted that government-funded services need to reframe their thinking to recognise that service delivery failures are due to a failure to build trust and safety with clients, rather than viewing Aboriginal and Torres Strait Islander clients as being 'hard to reach.'[66]

4.71 Mr Nathan Storey, the chair of the Kununurra Region Economic Aboriginal Corporation, told the committee that a lack of cultural awareness was also felt in children's counselling services, where children did not engage because the services were delivered 'in a little sterile room.' Mr Storey outlined how a culturally competent children's service should engage with Aboriginal and Torres Strait Islander children:

> Take them out bush to hunt a kangaroo. Everyone will cook the kangaroo and sit around eating damper and even marshmallows, if you want. We will

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63 Mr Jake Hay, Shire of Halls Creek, *Committee Hansard*, Halls Creek, 5 July 2018, p. 11.

64 Mrs Danielle Dyall, AMSANT, *Committee Hansard*, Darwin, 9 July 2018, p. 10.

65 Mrs Sharon Bambling, Acting Chief Executive Officer, Jungarni-Jutiya Indigenous Corporation, *Committee Hansard*, Halls Creek, 5 July 2018, p. 1.

66 Healing Foundation, *Submission 39*, p. 12.

> all sit, dance and sing. We will go to sleep and when we wake up we will go fishing. We will come back. Eventually you'll get those kids opening up.[67]

4.72 The Youth Program Manager of the Shire of Halls Creek described how external service providers continue to win service contracts, despite a low success rate:

> Services like this are not successful, and have not been able to mobilise community buy-in; however, they continue to be funded. CAMHS—Child and Adolescent Mental Health Services—have closed open cases on multiple occasions due to little or no engagement with the client. So they've had a referral, but when they come to Halls Creek every two to three weeks, they can't find the client or the client does not want to engage, making rapport building extremely difficult.[68]

4.73 The Healing Foundation contended that successful non-Indigenous service models not only acknowledge Aboriginal and Torres Strait Islander culture, but value it as a fundamental cornerstone.[69] This issue was raised by many witnesses, who argue that a lack of service co-design with local communities resulted in poor services which were not utilised by the local community:

> Little consultation occurs with our communities with regard to identifying the level of need and service design. Decisions about operating models are often focused on budget constraints rather than the number requiring access to the service.[70]

4.74 The CEO of Aarnja Ltd, pointed out that too many service decisions impacting Aboriginal and Torres Strait Islander peoples are made by non-Indigenous people:

> So when you look at, for example, some of our decision-making in the Kimberley—no disrespect to the organisations or departments here—when we sit in discussions on Aboriginal people, it's predominantly non-Aboriginal managers who sit in that space. They're getting direction and some information from their Aboriginal staff, but the Aboriginal staff aren't at that decision-making table. That needs to be changed if we're going to get any traction within the current system.[71]

4.75 Submitters and witnesses argued that not only are many mainstream services in remote locations not culturally competent or responsive, they do not appear to take action to address this issue. Many services do not provide cultural awareness

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67 Mr Nathan Storey, Chair, Kununurra Region Economic Aboriginal Corporation, *Committee Hansard*, Kununurra, 5 July 2018, p. 31.

68 Mr Jake Hay, Shire of Halls Creek, *Committee Hansard*, Halls Creek, 5 July 2018, p. 12.

69 Healing Foundation, *Submission 39*, p. 8.

70 Mr Jake Hay, Shire of Halls Creek, *Committee Hansard*, Halls Creek, 5 July 2018, p. 12.

71 Ms Maureen O'Meara, Chief Executive Officer, Aarnja Ltd, *Committee Hansard*, Broome, 6 July 2018, p. 4.

training.[72] Where it is provided, it is insufficient, ad-hoc and relies on online training modules.[73]

4.76 The CEO of Aboriginal Interpreting WA told the committee that addressing intergenerational and vicarious trauma will not happen 'if it's continually attempted in high English without regard for traditional Aboriginal languages.' The CEO informed the committee that English is not the first language for many Aboriginal people in Western Australia and many are missing out on services where no interpretation is offered.[74]

4.77 The Tangentyere Council pointed out that mental health services also include phone counselling services, such as Lifeline and beyondblue, which 'are frequently not appropriate for people where English is a second or third language or where the people on the end of the phone do not understand the cultural context of the people they are speaking to.'[75]

4.78 The Healing Foundation recommended that cultural competency should be tested with agreed criteria and standards, and that local community input should be required, with measurable outcomes relating to the client's experience used as the primary indicator of success.[76]

4.79 The Royal Flying Doctor Service (RFDS) told the committee that their model of ensuring they are culturally competent is based on building relationships with community controlled organisations:

> We visit and work in community controlled organisations only at the invitation of them. Over many years, those dynamics have developed such that, for many nurse-led outposts, we provide the medical backup over the phone and the emergency retrieval as required at the invitation of the community controlled organisation. That will continue as we expand our mental health service.[77]

4.80 The RFDS went on to say that the working model went beyond being invited to a community, but included:

> …the establishment of the service in response to local need…I can flag that, as part of that very long established dialogue with community controlled organisations, we'd only work where we're invited to do so with

72 Miss Nawoola Selina Newry, *Committee Hansard*, Kununurra, 5 July 2018, p. 25.

73 Healing Foundation, *Submission 39*, p. 6.

74 Ms Deanne Lightfoot, Chief Executive Officer, Aboriginal Interpreting WA, *Committee Hansard*, Broome, 6 July 2018, p. 4.

75 Ms Maree Corbo, Tangentyere Council, *Committee Hansard*, Alice Springs, 10 July 2018, p. 34.

76 Healing Foundation, *Submission 39*, p. 6.

77 Dr Martin Laverty, Chief Executive, Royal Flying Doctor Service (RFDS), *Committee Hansard*, Townsville, 30 August 2018, pp. 6–7.

> Aboriginal communities and in the manner in which those communities want us to operate.[78]

4.81 Cyrenian House cited a similar approach, where that organisation provides a monthly written report to the community councils outlining its recent activities and seeking feedback from communities.[79]

Aboriginal community controlled services

4.82 The committee heard evidence from a range of organisations that the Aboriginal Community Controlled Health Service (ACCHS) model of comprehensive primary health care delivers better outcomes for Aboriginal people.[80]

> Without exception, where Aboriginal people and communities lead, define, design, control and deliver services and programs to their communities, they achieve improved outcomes.[81]

4.83 The AHMRC submitted that for the majority of Aboriginal people, their local ACCHS is their first point of contact with the health system and is their preferred provider of primary care services. The AHMRC argued that Aboriginal communities consider their ACCHS as integral to the wellbeing of the community, and provides a gathering place where families can safely attend to their physical and mental health needs.[82]

4.84 NACCHO also pointed to ACCHSs as best placed to deliver mental health services to Aboriginal communities, as the community-based model of care involves a sense of empowerment for Aboriginal people with mental illness.[83] Dr Denise Riordan, the Chief Psychiatrist of the Northern Territory, noted that ACCHSs are also particularly good at delivering SEWB services.[84]

4.85 In some cases, to improve the cultural competency of external mental health specific diagnostic tools, ACCHSs have rewritten the standard mental health screening tools to adapt to local culture. This included ensuring that the diagnostics were undertaken by health workers of the same gender as the client, as required under local cultural tradition.[85]

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78 Dr Martin Laverty, RFDS, *Committee Hansard*, Townsville, 30 August 2018, p. 7.

79 Ms Sally Ann Malone, Manager, Cyrenian House, Milliya Rumurra Outreach Team, *Committee Hansard*, Broome, 6 July 2018, p. 14.

80 See, for example: NACCHO, *Submission 128*, p. 1; Community Mental Health Australia, *Submission 16*, pp. 4–5; Central Australian Aboriginal Congress, *Submission 55*, p. 1.

81 NACCHO, *Submission 128*, p. 1.

82 AHMRC, *Submission 99*, pp. 1–2.

83 NACCHO, *Submission 128*, p. 3.

84 Dr Denise Riordan, Northern Territory Department of Health, *Committee Hansard*, Darwin, 9 July 2018, p. 3.

85 Ms Cheryle Ann Kaesler, Yura Yungi Medical Service, *Committee Hansard*, Halls Creek, 5 July 2018, p. 7.

4.86 In direct comparison to the clinical-setting services provided by many non-Indigenous providers, the Derby Aboriginal Health Service outlined the informal engagement methods they used to build rapport and trust with people needing mental health support:

> We have a community engagement model where a number of our workers—our youth worker, our perinatal worker and our Aboriginal mental health worker—actually spend a lot of time out in the community. So it's a more relaxed approach…Ash, our male Aboriginal health worker, may go footy training out of work hours and he may lean on the fence and have a yarn with someone. It's in a very relaxed environment where the client or the patient feels comfortable, but there's a consultation going on here. So we're reaching out.[86]

4.87 The Derby Aboriginal Health Service outlined that many Aboriginal people will not attend state mental health services because of the history of institutions for Aboriginal people.[87] The Danila Dilba Health Service made a similar observation, and pointed out that the co-location of mental health services in ACCHSs meant that people who are comfortable with their health service are more likely to access mental health services located within the same facility.[88]

4.88 The Tangentyere Family Violence Prevention Program described the informal environment they created to make clients feel safe:

> We are surrounded by Aboriginal artwork, and the atmosphere is welcoming and physically and emotionally safe. We understand that conducting outreach to people's homes assists them to feel more in control. Many conversations regarding challenging topics happen in the car.[89]

4.89 Dr Peter Fitzpatrick from the Wurli-Wurlinjang Health Service pointed out to the committee that federal funding which used to resource the ACCHS sector is now being diverted to fund PHNs, who then tender out services:

> NGOs are all putting in tenders for chunks of money that previously went to ACCHOs to provide services to Indigenous people, and that's a concern for us. We've seen that here in Katherine. We've seen NGOs applying for funding and winning the tender because they have access to great tender-writers because they're multinational companies.[90]

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86 Ms Maureen Robertson, Derby Aboriginal Health Service, *Committee Hansard*, Derby, 6 July 2018, p. 4.

87 Dr Lynette Henderson-Yates, Chief Executive Officer, Derby Aboriginal Health Service, *Committee Hansard*, Derby, 6 July 2018, p. 5.

88 Mr Malcolm Darling, Acting Chief Executive Officer, Danila Dilba Health Service, *Committee Hansard*, Darwin, 9 July 2018, p.26.

89 Ms Maree Corbo, Tangentyere Council, *Committee Hansard*, Alice Springs, 10 July 2018, p. 33.

90 Dr Peter Fitzpatrick, Wurli-Wurlinjang Health Service, *Committee Hansard*, Katherine, 9 July 2018, p. 8.

4.90 Dr Fitzpatrick went on to state that ACCHSs have developed over time to be highly effective health service delivery organisations:

> There are 130-odd across Australia. They're a highly evolved structure. We're general practice accredited. We're ISO accredited. We get ticked off by ORIC and every other—we're, really, very organised organisations. We've got state bodies and national bodies. And we're all paid for by the Australian taxpayer, so use it. Use the structure that you've created instead of bypassing it.[91]

Improved outcomes when services are competent

4.91 The AHMRC pointed to the low numbers of Aboriginal people accessing non-Indigenous mental health services, resulting in crisis presentation at Accident and Emergency, resulting in admission for treatment and subsequent community follow-up after discharge, at a cost of $19 728 per person. The AHMRC submitted that evidence shows that better allocation of resources to the ACCHS sector would result in a redaction of hospital admissions and associated costs, because ACCHSs have made significant impact on the burden of illness in Aboriginal communities and provide good value for money.[92]

4.92 NACCHO agreed with this view, noting that the ACCHSs sector was able to deliver lower cost community-based mental health services and that these services were closer to where people live, which assists in keeping people healthy in the community and prevents hospital admissions.[93]

4.93 The AHMRC further submitted that although ACCHSs are making referrals to funded non-government organisations (NGOs) and mainstream mental health services, Aboriginal people are not presenting for those appointments, usually as a result of inflexible and culturally unsafe practices in the organisations.[94] NACCHO agreed with this view and submitted that mainstream services are unable to provide holistic and culturally competent care to Aboriginal people, particularly those living in rural, remote and very remote locations.[95]

4.94 The Townsville Aboriginal and Islanders Health Services put forward a similar view and told the committee:

> We do have clients that still go out to the hospital, but they don't ever return out there because of the way that they feel they're treated. There's not a lot of Indigenous staff to support them when they're out there, which, I

91 Dr Peter Fitzpatrick, Wurli-Wurlinjang Health Service, *Committee Hansard*, Katherine, 9 July 2018, p. 16.

92 AHMRC, *Submission 99*, pp. 2 and 4.

93 NACCHO, *Submission 128*, p. 3.

94 AHMRC, *Submission 99*, p. 5.

95 NACCHO, *Submission 128*, p. 3.

> suppose, comes back to resourcing and having enough staff to help people.[96]

4.95 The Healing Foundation submitted that 'the most successful service models to address trauma, healing and indeed mental health balance best practice western methodologies with Aboriginal and Torres Strait Islander cultural and spiritual healing practices.'[97]

4.96 The Townsville Aboriginal and Islanders Health Services told the committee of the successful services they delivered using this model, where Queensland Health are co-located at their clinic. This enabled the services to establish trust before making a mental health referral, as they 'sometimes go through another channel instead of going straight to mental health.'[98]

4.97 The Executive Director of medical services at the Wurli-Wurlinjang Health Service agreed with this view and told the committee that:

> …the experts in Indigenous mental health are Indigenous people. They're not psychiatrists, they're not mental health nurses, they're not GPs, and we don't recognise that—we don't pay for it and we don't engage with that group. Those other groups come in and value-add to it but they can't actually resolve it.[99]

4.98 The CEO of Kimberley Aboriginal Medical Services (KAMS) provided the committee with an overview of all the positive outcomes that can be achieved when services are culturally competent, which go far beyond improved service delivery for individuals:

> It will build local Aboriginal community capacity and resilience through workers [being] trained and people feeling much more comfortable in dealing with their own community. It will improve access and coordination of care by having one-stop shops, so people don't have to try and navigate this complex system. It'll help increase cultural awareness and cultural safety of mainstream programs, because these workers can work with the mainstream services to make sure that their programs and services are appropriate. And it'll reduce costs of service delivery at the acute end if we can keep people healthy and out of the expensive hospital system.[100]

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96 Mrs Erica Buttigieg, Townsville Aboriginal and Islanders Health Services, *Committee Hansard*, Townsville, 30 August 2018, p. 25.

97 Healing Foundation, *Submission 39*, p. 7.

98 Mrs Erica Buttigieg, Townsville Aboriginal and Islanders Health Services, *Committee Hansard*, Townsville, 30 August 2018, p. 25.

99 Dr Peter Fitzpatrick, Wurli-Wurlinjang Health Service, *Committee Hansard*, Katherine, 9 July 2018, p. 14.

100 Mr Robert McPhee, Chief Executive Officer, Kimberley Aboriginal Medical Services (KAMS), *Committee Hansard*, Broome, 6 July 2018, pp. 13–14.

4.99 Submitters and witnesses strongly argued that a culturally competent workforce is the foundation to delivering culturally competent services. These workforce challenges are discussed in detail in the following chapter.

Committee view

4.100 It is an accepted fact within various national health strategies and implementation plans that health services must be culturally competent in order to be effective. Cultural competency is not an optional extra. It is not a gold-standard. Cultural competency is a basic benchmark that health services must reach in order to meet the needs of the communities they serve, be they urban, remote, non-Indigenous or a predominantly Aboriginal and Torres Strait Islander client base.

4.101 The committee has heard overwhelming evidence that in rural and remote locations, mental health services lack the cultural competency and safety required to meet the most fundamental principle of medicine: *first, do no harm.*

4.102 The committee has also heard that the experts in cultural competency, the local communities, have very little input into service design or scope of practice. Clearly, until communities have greater say in what services are funded and how those services will operate, mental health services for Aboriginal and Torres Strait Islander peoples in rural and remote locations will continue to fail their patients.

Social and emotional wellbeing programs

4.103 The committee heard from many submitters and witnesses that SEWB programs are fundamental to improving the overall mental health of Aboriginal and Torres Strait Islander communities, both on an individual and a collective level.

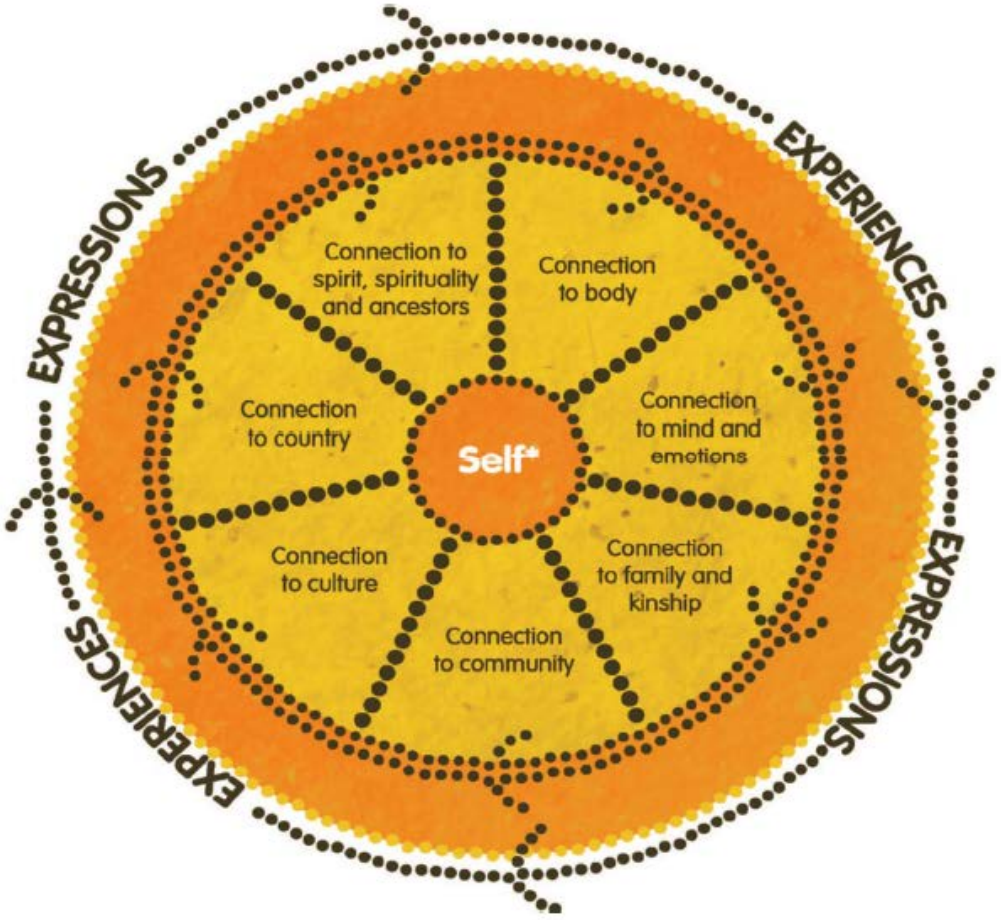
4.104 The Social Health Reference Group, responsible for developing the *National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2004–2009*, concluded that:

> The concept of mental health comes more from an illness or clinical perspective and its focus is more on the individual and their level of functioning in their environment.
>
> The social and emotional wellbeing concept is broader than this and recognises the importance of connection to land, culture, spirituality, ancestry, family and community, and how these affect the individual.[101]

101 See: Department of Health, National Aboriginal and Torres Strait Islander Suicide Prevention Strategy, '*Social and emotional wellbeing*', http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-natsisps-strat-toc~mental-natsisps-strat-1~mental-natsisps-strat-1-soc (accessed 29 November 2018).

4.105 AMSANT stressed the importance of SEWB programs in Aboriginal and Torres Strait Islander cultures (see Figure 4.1) and submitted that 'First Nations Peoples of Australia maintained health and mental health through beliefs, practices and ways of life that supported their social and emotional wellbeing across generations and thousands of years'.[102]

Figure 4.1—Social and Emotional Wellbeing from an Aboriginal and Torres Strait Islanders' perspective



Source: AMSANT.[103]

4.106 The National Mental Health Commission's 2015 *Review of Mental Health Programmes and Services* concluded that mainstream mental health services had largely let down Aboriginal communities and recommended that integrated mental health and SEWB teams should be established in all ACCHSs.[104] The AHMRC made

102 AMSANT, *Submission 129*, p. 2.

103 Model developed by the Australian Indigenous Psychologists Association. In: AMSANT, *Submission 129*, p. 3.

104 National Mental Health Commission, *Review of Mental Health Programmes and Services*, 16 April 2015, quoted in AMSANT, *Submission 129*, p. 3.

a similar recommendation to this inquiry, that all ACCHSs are funded to build and establish SEWB teams including Residential Rehabilitation and Healing Services.[105]

4.107 AMSANT recommended that integrating SEWB, mental health and AOD programs into primary health care services is the most cost-effective approach to the delivery of metal health services in rural locations. AMSANT stressed that this requires funding for multidisciplinary, culturally and trauma informed teams.[106]

4.108 AMSANT told the committee of a SEWB model developed by a working group of the Northern Territory Aboriginal Health Forum, based on a combination of a community based Aboriginal workforce and a mental health professional workforce. AMSANT told the committee this model includes both a clinical and community development prevention component and is particularly suited to remote communities. It provides access to therapy in a culturally safe environment, noting that the provision of cultural and social support is a crucial part of mental health care.[107]

4.109 The Healing Foundation cited research which indicates that healing programs are best delivered on country by people from the same cultural group as participants.[108]

4.110 The Queensland Alliance for Mental Health discussed the importance of early intervention SEWB programs in providing people with supports in the early stages of mental illness, resulting in the diversion of those people from more expensive hospitalisation or long term National Disability Insurance Scheme funding. The organisation went on to say that in rural and remote areas, one of the most effective interventions is community capacity building via informal programs in local communities.[109]

4.111 The Chief Psychiatrist of the Northern Territory stressed to the committee the need for a broad approach to mental health, and that while clinical mental health services are important components in addressing mental health related conditions, 'the promotion and maintenance of mental health in the community is influenced by many complex social factors and really is the responsibility of the whole of the government and the whole of the community.'[110]

Committee view

4.112 As outlined earlier in this chapter, the committee heard that the social determinants of health in rural and remote Aboriginal and Torres Strait Islander

105 AHMRC, *Submission 99*, p. 2.

106 AMSANT, *Submission 129*, p. 3.

107 Mrs Danielle Dyall, AMSANT, *Committee Hansard*, Darwin, 9 July 2018, p. 7.

108 Healing Foundation, *Submission 39*, p. 15.

109 Mr Jeremy Audas, Member, Queensland Alliance for Mental Health, *Committee Hansard*, Townsville, 30 August 2018, p. 49.

110 Dr Denise Riordan, Northern Territory Department of Health, *Committee Hansard*, Darwin, 9 July 2018, p. 1.

communities are not being adequately addressed and that these communities are often operating in a continual cycle of crisis. The committee also received evidence that the collective social and emotional health of the community is vital to individual mental health outcomes for Aboriginal and Torres Strait Islander peoples.

4.113 These service contexts, however, are not being taken into account in funding decisions and social and emotional wellbeing programs are not being delivered to the extent needed in remote communities. It is clear to the committee that increased focus on this form of early intervention would have a significantly beneficial therapeutic impact to entire Aboriginal and Torres Strait Islander communities.

Suicide prevention

4.114 Suicide is a major cause of Aboriginal and Torres Strait Islander peoples' premature mortality and is a contributor to the overall Aboriginal and Torres Strait Islander peoples' health and life expectancy gap. In 2014 suicide was the fifth leading cause of death among Aboriginal and Torres Strait Islander peoples, with the rate double that of non-Indigenous people.[111] In the 15–34 years age bracket, suicide is the leading cause of death[112] and those aged 15–24 are over five times more likely to commit suicide than their non-Indigenous peers.[113] The Healing Foundation submitted that gender should also be considered as a factor, as males represent a significant majority of completed Aboriginal and Torres Strait Islander suicides.[114]

4.115 NACCHO noted that while the prevalence of mental disorders is similar throughout Australia, the rates of suicide and self-harm are higher in rural and remote areas, and these rates get higher as areas become more remote.[115] Again, this is more relevant for Aboriginal and Torres Strait Islander peoples, as the majority of suicides among Aboriginal and Torres Strait Islander peoples occurred outside of capital cities.[116]

4.116 AMSANT discussed the findings of a review of suicide prevention strategies for Aboriginal and Torres Strait Islander peoples, which found:

> High Indigenous suicide rates arise from a complex web of interacting personal, social, political and historical circumstances. While some of the causes and risk factors associated with Indigenous suicide cases can be the same as those seen among non-Indigenous Australians, the prevalence and

111 NACCHO, *Submission 128,* p. 4.

112 AHMRC, *Submission 99*, pp. 4–5.

113 NACCHO, *Submission 128,* p. 4.

114 Healing Foundation, *Submission 39,* p. 9.

115 NACCHO, *Submission 128,* p. 4.

116 NACCHO, *Submission 128,* p. 4.

> interrelationships of these factors differ due to different historical, political and social contexts.[117]

4.117 AMSANT further noted that this review found that one of the quality indicators of suicide prevention services is culturally safe services and that such services were optimally provided by ACCHSs.[118]

4.118 The Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council agreed with this view of the non-mental health causes of suicide and told the committee of their internal suicide register, which shows that half of all suicides and attempted suicides have a clear link with domestic and family violence.[119]

4.119 The Chief Executive Officer of the Northern Territory PHN noted that culturally appropriate suicide prevention strategies need to be developed for each community:

> A prevention strategy that works on one community may have very little impact on another. Culturally appropriate services need to be developed, and community consultation and engagement is essential to this. Those approaches need to be community led.[120]

4.120 NACCHO submitted that efforts to reduce suicide in Aboriginal and Torres Strait Islander communities must do more than address social and economic disadvantage and health gaps, and must also promote healing and building the resilience of individuals, families and the whole community.[121] The Kimberley Aboriginal Law and Cultural Centre (KALACC) concurred with this view and quoted an expert in indigenous suicide, Professor Michael Chandler:

> [I]f suicide prevention is our serious goal, then the evidence in hand recommends investing new moneys, not in the hiring of still more counsellors, but in organized efforts to preserve Indigenous languages, to promote the resurgence of ritual and cultural practices, and to facilitate communities in recouping some measure of community control over their own lives.[122]

4.121 KALACC cited the Western Australia (WA) Parliamentary report into Aboriginal youth suicide, which found the need to focus more on a holistic approach

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117 P Dudgeon and C Holland, 'Recent developments in suicide prevention among the Indigenous peoples of Australia', *Australasian Psychiatry*, vol. 26, no. 2, 2018, pp. 166–169, quoted in AMSANT, *Submission 129*, p. 5.

118 AMSANT, *Submission 129*, p. 5.

119 Miss Christine Williamson, Manager, Youth Program, Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council, *Committee Hansard*, Alice Springs, 10 July 2018, p. 14.

120 Mrs Nicola Anne Herriot, Chief Executive Officer, Northern Territory PHN, *Committee Hansard*, Darwin, 9 July 2018, p. 6.

121 NACCHO, *Submission 128*, p. 4.

122 KALAAC, *Submission 59*, p. 1.

than a simple clinical approach[123] and recommended restoring culture and a sense of identity as a key protective factor against Aboriginal and Torres Strait Islander suicide.[124] The CEO of KAMS also recommended that this report 'had a suite of recommendations that we need to start to act upon.'[125]

4.122 The AHMRC submitted that evidence shows that programs and services which provide culturally safe early intervention and prevention have proved to be the most effective in addressing suicide.[126]

4.123 The National Suicide Prevention Trial, outlined in Chapter 2, involves a number of trial sites, one of which is the Kimberley region of Western Australia and targets Aboriginal and Torres Strait Islander peoples. This trial is discussed below.

Kimberley suicide prevention trial

4.124 A decade-long audit quantified the suicide rate in the Kimberley among Aboriginal and Torres Strait Islander peoples as among the highest rates in the world.[127] The CEO of KAMS told the committee 'this means is that Aboriginal family members in the Kimberley are losing loved ones at rates that are among the highest in the world.'[128]

4.125 The trigger factors for suicide in the Kimberley region include alcohol and other drug use, relationship difficulties, family conflict or a previous suicide attempt, as well as other causal issues, including intergenerational trauma, loss of culture and other social determinants, such as employment, education, and housing.[129] KALACC argued that Aboriginal suicide in the Kimberley has very little to do with clinical mental health.[130]

4.126 A Consultant Psychiatrist with the Kimberley Mental Health and Drug Service concurred with this view and listed the causes of Aboriginal and Torres Strait Islander peoples suicide as the 'upstream factors' which also cause substance use, poverty, children in custody and incarceration, stating that 'suicide is almost never due to a mental illness. So it's is not due to something that we can diagnose and treat within a conventional Western model, within a Western framework of how our hospitals and our clinics are set up.' He went on to recommend that increased funding for clinical services was not the answer:

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123 WA Parliament Standing Committee on Health and Education, *Learnings from the message stick: The report of the Inquiry into Aboriginal youth suicide in remote areas*, November 2016, quoted in KALACC, *Briefing Paper submitted to the Kimberley Suicide Prevention Regional Trial Working Group*, additional information received 28 September 2018, [p. 2].

124 KALAAC, *Submission 59*, p. 4.

125 Mr Robert McPhee, KAMS, *Committee Hansard*, Broome, 6 July 2018, p. 14.

126 AHMRC, *Submission 99*, p. 5.

127 ConnectGroups Support Groups Association WA Inc., *Submission 3*, [p. 3].

128 Mr Robert McPhee, KAMS, *Committee Hansard*, Broome, 6 July 2018, p. 13.

129 Mr Robert McPhee, KAMS, *Committee Hansard*, Broome, 6 July 2018, p. 13.

130 Mr Wayne Barker, KALACC, *Committee Hansard*, Broome, 6 July 2018, p. 1.

> People who are at risk of or complete suicide have drowned at the end of the stream. If you give us more resources to catch more people with nets before they drown, then of course we will catch more people before they drown. However, that doesn't address the upstream factors.[131]

4.127 The committee was told that the National Suicide Prevention Trial was not culturally competent to factors in the Kimberley region. The CEO of KAMS told the committee that the National Suicide Prevention Trial needed to be more responsive to the local factors, and that the trial is 'looking at evidence from Europe, which senses depression as the centre of why people take their lives, and all of the evidence in Aboriginal suicides says that it's not depression; it's often all of the other crap that you're dealing with every day.'[132]

4.128 Both KALACC and Aarnja sit on the National Suicide Prevention Trial Kimberley community reference group. Both organisations discussed their frustration with the project, citing a lack of progress and a lack of community involvement in designing solutions:

> All we get, as the community reference panel—they said, 'We'll set the strategic plan and we'll bring it back to you.' What did we get? Two meetings in 12 months. No action. At the last meeting they came back and said, 'We'll just give the money out.' As community organisation we thought we were going to be consulted and involved in the establishment of the trial. It's just gone to a fixed interest group. I will be blunt about it, because that's what it is.[133]

4.129 Aarnja was so frustrated with the lack of progress and cultural competence of the National Suicide Prevention Trial, they designed their own suicide program, which is a family empowerment project for extended, rather than nuclear, families and based is on Bardi and Jawi cultural frameworks.[134]

Inuit suicide prevention program

4.130 The high rate of suicide among Aboriginal and Torres Strait Islander peoples is also found in other Indigenous peoples throughout the world.[135] The Canadian Inuit peoples' experience of colonisation is relatively comparable to that of Aboriginal and Torres Strait Islander peoples, both historically and also in the continued impacts of that colonisation in the form of collective and intergenerational trauma and the destruction of the protective factors of culture and a sense of identity.[136]

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131 Dr Huu Duy Tran, Kimberley Mental Health and Drug Service, *Committee Hansard*, Broome, 6 July 2018, p. 21.

132 Mr Robert McPhee, KAMS, *Committee Hansard*, Broome, 6 July 2018, p. 15.

133 Mr Martin Sibosado, Chairperson, Aarnja Ltd, *Committee Hansard*, Broome, 6 July 2018, p. 7.

134 Mr Martin Sibosado, Aarnja Ltd, *Committee Hansard*, Broome, 6 July 2018, p. 7.

135 AMSANT, *Submission 129*, p. 5.

136 Inuit Tapiriit Kanatami, *National Inuit Suicide Prevention Strategy*, 2016. https://www.itk.ca/national-inuit-suicide-prevention-strategy/ (accessed 27 November 2018).

4.131 The following case study is of a suicide prevention strategy developed for the Inuit Nunangat (homeland) regions in Canada by Inuit Tapiriit Kanatami, the national representational organisation of Inuit in Canada.

Case study: National Inuit Suicide Prevention Strategy

The National Inuit Suicide Prevention Strategy (NISPS) envisions suicide prevention as a shared national, regional, and community-wide effort that engages individuals, families, and communities. The NISPS is a tool for assisting community service providers, policymakers, and governments in working together to reduce the rate of suicide among Inuit to a rate that is equal to or below the rate for Canada as a whole.

The NISPS will promote the dissemination of best practices in suicide prevention, provide tools for the evaluation of approaches, contribute to ongoing Inuit-led research, provide leadership and collaboration in the development of policy that supports suicide prevention, and focus on the healthy development of children and youth as the basis for a healthy society.

Risk factors for suicide

The NISPS identifies the key risk factors for Inuit suicide as:

Historical Trauma: from the social and cultural upheavals tied to Canada's colonization of Inuit Nunangat, experienced by an entire group as a result of a cumulative and psychological wounding over a lifespan and across generations.

Social Inequity: Poverty and other indicators of social inequity translate into stress and adversity for families, disparities in health status and increased risk of suicide.

Intergenerational trauma: Unresolved symptoms of trauma can make it difficult for caregivers to provide a sense of safety and security to their children.

Childhood adversity: is linked to negative outcomes that are associated with suicidal behaviour, such as poor mental health, substance abuse, and poverty.

Mental Distress: there are greater rates of depression, personality disorder and substance misuse in Inuit who died by suicide.

Acute Stress: Mental health disorders or developmental adversity impair an individual's ability to cope with or adapt to life stress or change.

Strategy

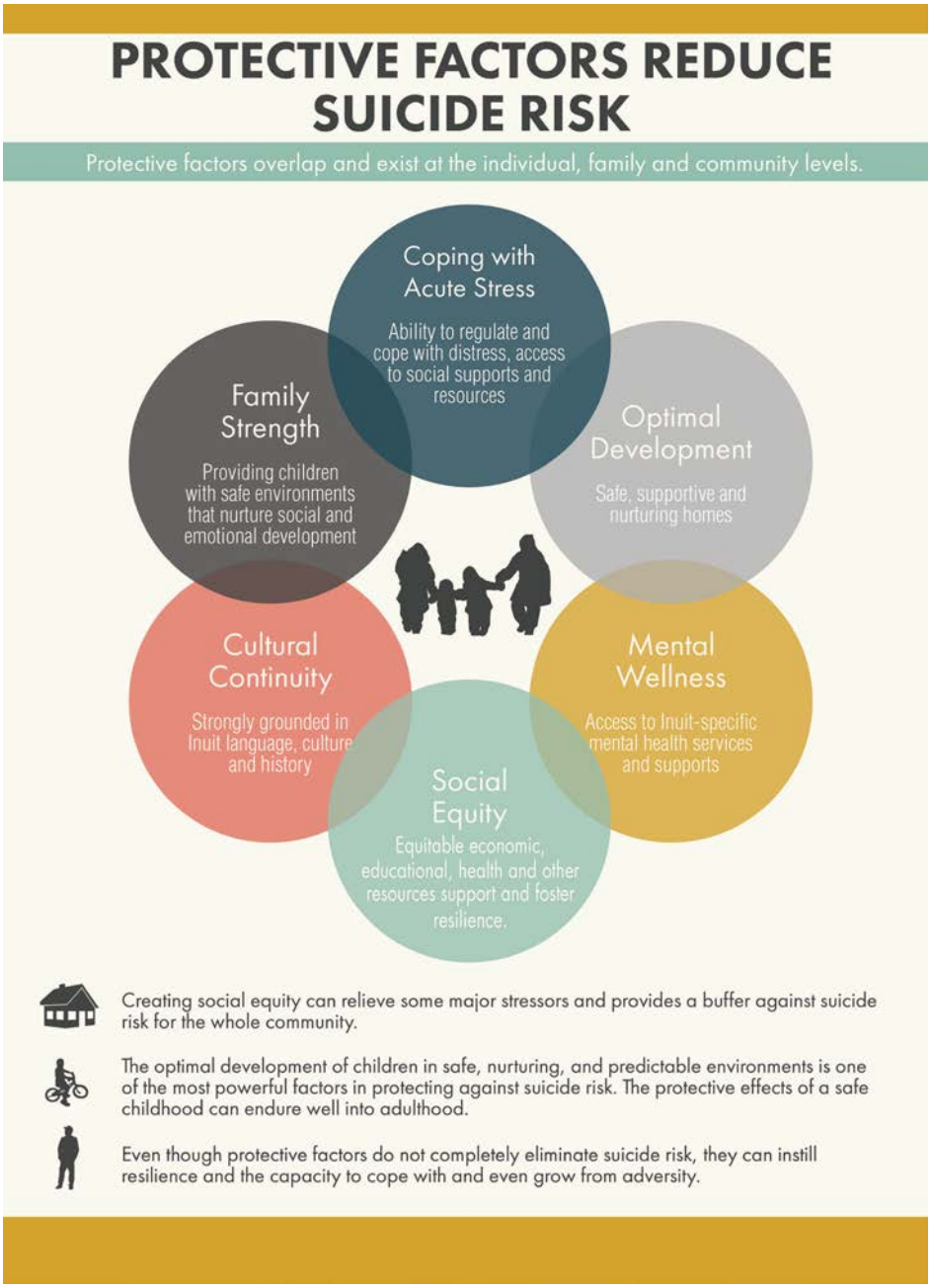
The NISPS promotes an evidence-based, Inuit-specific approach to suicide prevention by identifying priority areas for intervention that would be most impactful in preventing suicide.

These priority areas are as follows: (1) creating social equity, (2) creating cultural continuity, (3) nurturing healthy Inuit children from birth, (4) ensuring access to a continuum of mental wellness services for Inuit, (5) healing unresolved trauma and grief, and (6) mobilizing Inuit knowledge for resilience and suicide prevention (see Figure 4.2).

The Strategy's evidence-based approach to suicide prevention considers the entire lifespan of the individual, as well as what can be done to provide support for families

and individuals in the wake of adverse experiences that we know increase suicide risk. Focusing our resources and efforts on supporting families and nurturing healthy Inuit children is the most impactful way to ensure that people never reach the point where they consider suicide.

Figure 4.2—Protective factors identified by the Inuit suicide prevention strategy



Evaluation

One of the implementation tasks will be to finalize an evaluation framework for the NISPS, by identifying key indicators for each action item, and processes for collecting necessary data in an ongoing way. Progress will be evaluated in two-year increments.

Source: Inuit Tapiriit Kanatami, *National Inuit Suicide Prevention Strategy*, 2016.

Committee view

4.132 The committee heard evidence from organisations and communities that suicide, both attempted and completed, has long since reached a crisis level in rural and remote Aboriginal and Torres Strait Islander communities. That this has been allowed to continue unchecked for so long is to Australia's shame.

4.133 The committee heard overwhelming evidence from mental health experts that in too many cases, the causes of suicide for Aboriginal and Torres Strait Islander peoples is not mental illness, but despair caused by the history of dispossession combined with the social and economic conditions in which Aboriginal and Torres Strait Islander peoples live.

4.134 The committee strongly recognises the Australian and international evidence that demonstrates the most effective suicide prevention strategies for Aboriginal and Torres Strait Islander peoples will be to restore strong, resilient communities who are able to raise children with the inherent protective factors that arise from safe homes, safe communities and strong culture.

National strategic framework

4.135 The Australian Minister's Health Advisory Council endorsed the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023* (Aboriginal Mental Health Framework) in February 2017.[137]

4.136 The stated purpose of the Aboriginal Mental Health Framework is to 'to guide and inform Aboriginal and Torres Strait Islander mental health and wellbeing reforms' and to 'to respond to the high incidence of social and emotional wellbeing problems and mental ill-health [of Aboriginal and Torres Strait Islander peoples]'. The purpose also declares that ' the Australian Government has committed to continue to seek advice from Aboriginal and Torres Strait Islander mental health and related areas leaders and stakeholders to shape reform at the national level.' [138]

4.137 The Aboriginal Mental Health Framework contains 5 key action areas, each with three outcomes. Of particular relevance to discussions of culturally competent mental health service delivery is the following action areas and associated outcomes:

> ACTION AREA 1: Strengthen the Foundations
>
> Outcome 1.1: An effective and empowered mental health and social and emotional wellbeing workforce.

137 Commonwealth of Australia, *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023*, October 2017 (Aboriginal Mental Health Framework), [p. 4], https://pmc.gov.au/resource-centre/indigenous-affairs/national-strategic-framework-mental-health-social-emotional-wellbeing-2017-23 (accessed 21 November 2018).

138 Aboriginal Mental Health Framework, p. 2.

> Outcome 1.2: A strong evidence base, including a social and emotional wellbeing and mental health research agenda, under Aboriginal and Torres Strait Islander leadership.
>
> Outcome 1.3: Effective partnerships between Primary Health Networks and Aboriginal Community Controlled Health Services.

4.138 The Aboriginal Mental Health Framework notes that a monitoring plan would need to be prepared, and noted it 'should be developed under the leadership of, and in partnership with, Aboriginal and Torres Strait Islander leadership bodies.'[139]

4.139 CATSINaM recommended that all planning and development of mental health services should follow the recommendations made in the Aboriginal Mental Health Framework and the *National Aboriginal and Torres Strait Islander Health Plan 2013–2023*, both of which 'were for and about Aboriginal and Torres Strait Islander peoples and demonstrated best practice in policy development.' CATSINaM noted however, that the Aboriginal Mental Health Framework did not yet have an implementation plan and required associated funding investment.[140]

4.140 The following discussion outlines some continued policy and funding concerns presented to the committee, which appear to show some inconsistency in the early implementation of the Aboriginal Mental Health Framework.

Framework failures

4.141 A consistent theme appeared in the evidence presented to the committee, that the lack of culturally competent mental health services for Aboriginal and Torres Strait Islander communities was due in part to the fragmentation of policy advice and funding arrangements across multiple jurisdictions. The funding framework for mental health services was discussed in detail in chapter two, including details on how the ACHHS sector is funded. This following section will focus on certain policy and funding issues that continue to impact the cultural competency of mental health services.

Policy fragmentation

4.142 The committee heard from a range of organisations that policy fragmentation, across different geographical regions and different levels of government, was a contributing factor to poor cultural competency of mental health service delivery for rural and remote Aboriginal and Torres Strait Islander peoples.

4.143 NACCHO submitted that policy fragmentation is also felt in how services operate, citing that a lack of coordination between government and non-government services impacts mental health service provision, particularly in addressing needs in a 'culturally appropriate and holistic way.'[141]

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139 Aboriginal Mental Health Framework, p. 33.

140 CATSINaM, *Submission 74*, p. 4.

141 NACCHO, *Submission 128*, p. 5.

4.144 The Danila Dilba Health Service made an overarching recommendation that all levels of government, as well as non-government service providers, should adopt a policy to move services to the Aboriginal community-controlled sector, starting with capacity building of the sector. This could be done by funding for services to Aboriginal communities including a requirement for non-Indigenous providers to develop an exit strategy and show progress in implementing that strategy. Danila Dilba Health Service cited the Jesuit Social Services in Victoria, who partnered with the Victorian Aboriginal Child Care Agency (VACCA) and managed a successful transition in the roles where VACCA is now the led agency in the partnership.[142]

4.145 When asked about this program, Jesuit Social Services told the committee that organisations must be prepared to allocate enough time within the program framework 'to enable Aboriginal and Torres Strait Islander people to strengthen their capacity so that in the long term they may develop the autonomy and skills required to manage these services.' Jesuit Social Services discussed a similar approach they took to service delivery in Santa Teresa, and noted that 'Business-wise, that work is difficult because, when you're continually operating to put yourself out of business, you have to work out how you stay in business too.'[143]

4.146 CATSINaM submitted that many areas of policy, such as economic and environmental policy, use impact assessments to predict and assess the consequences of a proposed policy, to assist in creating better outcomes. CATSINaM recommended that future policy decisions for mental health should include a social impact assessment to study the consequences on Aboriginal and Torres Strait Islander peoples and all peoples in rural and remote Australia. CATSINaM pointed to this being of particular importance for rural and remote Australia, as the emphasis on market driven solutions for human services has resulted in market failure in mental health services delivery in rural and remote locations.[144]

Funding implications for cultural competency

4.147 The committee was told that the complexity in funding arrangements for Aboriginal and Torres Strait Islander-specific health and wellbeing services impacts on the quality of those services.

4.148 NACCHO argued that the continual underfunding of ACCHSs to deliver mental health and SEWB services limits the capacity of ACCHSs to improve the mental health outcomes for Aboriginal people, leading to increases in hospital admissions for complex and chronic conditions.[145]

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142 Ms Joy McLaughlin, Senior Officer, Strategy, Research and Policy, Danila Dilba Health Service, *Committee Hansard*, Darwin, 9 July 2018, p.27.

143 Mr John Adams, Jesuit Social Services, *Committee Hansard*, Alice Springs, 10 July 2018, pp. 35 and 37.

144 CATSINaM, *Submission 74*, p. 5.

145 NACCHO, *Submission 128*, p. 6.

4.149 Organisations from the ACCHS sector told the committee there was a significant reduction in overall funding to the ACCHS sector after policy oversight of Aboriginal-specific health and wellbeing funding was transferred in 2013 from the Department of Health's Office of Aboriginal and Torres Strait Islander Health to the Department of the Prime Minister and Cabinet.[146]

4.150 The committee was also told this transfer has resulted in increasing the already confusing array of funding sources, which now includes the Department of Prime Minister and Cabinet, Commonwealth health funding disbursed by PHNs, as well as State and Territory funding. AMSANT recommended that at a Commonwealth level, SEWB, mental health and AOD program funding be placed back into the Indigenous Health Division of the Health Department, with input and advice on funding decisions from jurisdictional forums such as the Northern Territory Aboriginal Health Forum.[147]

4.151 The Northern Queensland PHN raised similar concerns, telling the committee that multiple funding streams, not just in the health portfolio, could be better coordinated to achieve improved outcomes with the same level of resources.[148]

4.152 Danila Dilba Health Service commented that the fragmentation of funding meant that an organisation could apply for capital works to build a facility, but they did not guarantee funding would be supplied from different areas of government to actually operate the service.[149] Danila Dilba Health Service also told the committee it takes a full time role to apply for funding and then complete funding reporting requirements and they had the capacity to do this only because they are a larger organisation.[150]

4.153 The Wurli-Wurlinjang Health Service noted that the funding fragmentation of Aboriginal and Torres Strait Islander health and wellbeing programs sometimes led to the duplication of services. It also noted that this ever-changing funding environment also meant that organisations have 'no real foundation in regard to infrastructure to work from. There's no stability; you're constantly on the move because it's so funding dependent.'[151]

4.154 AMSANT submitted that the small amount of overall funding available for health and wellbeing services to Aboriginal and Torres Strait Islander peoples often goes to large NGOs who lack local and cultural expertise. This leads to mental health

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146 AHMRC, *Submission 99*, p. 1 and NACCHO, *Submission 128*, p. 6.

147 AMSANT, *Submission 129*, p. 4.

148 Mrs Gillian Yearsley, Northern Queensland Primary Health Network, *Committee Hansard*, Townsville, 30 August 2018, p. 11.

149 Mr Malcolm Darling, Danila Dilba Health Service, *Committee Hansard*, Darwin, 9 July 2018, p.27.

150 Ms Joy McLaughlin, Senior Officer, Strategy, Research and Policy, Danila Dilba Health Service, *Committee Hansard*, Darwin, 9 July 2018, pp. 24–25.

151 Miss Mary Maloney, Wellbeing Manager and Registered Mental Health Nurse, Wurli-Wurlinjang Health Service, *Committee Hansard*, Katherine, 9 July 2018, pp. 8–9.

services designed and delivered without local Aboriginal input, which are usually ineffective and inappropriate for Aboriginal communities and results in people not accessing these services.[152] AMSANT noted that the Northern Territory PHN had prioritised funding of ACCHSs, but in other PHN areas this did not occur.[153]

4.155 The AHMRC raised a similar concern and submitted that current funding landscapes, which include commissioning models and competitive tendering, have resulted in a fragmentation of services where external NGOs are allocated funding to work with Aboriginal communities, whose preference is to seek services through their local ACCHS.[154]

4.156 The AHMRC pointed to recommendations from bodies such as the AMA and the National Aboriginal and Torres Strait Islander Leadership in Mental Health, which have recommended long term investment in the ACCHS sector by governments.[155]

4.157 The AHMRC submitted this could be implemented through a model where ACCHSs work with Local Health Districts to develop integrated models of care. The AHMRC argued that such partnership agreements would provide the framework to develop better referral pathways, pre-discharge planning and care coordination. This would also provide mainstream mental health workforces with the exposure to Aboriginal culture needed to work in a culturally safe manner with Aboriginal communities The AHMRC made further recommendations for reinvestment in community mental health services to provide clinical services in thin markets where specialist psychiatric services are scarce, such as child and adolescent services. [156]

4.158 Neami National raised concerns that funding is not provided up-front for service design, to ensure that organisations are 'working with people on the ground in co-designing what that service might look like.'[157]

4.159 KALAAC pointed to the lack of funding overall for any form of cultural programs, despite the findings on the important role of Aboriginal culture as a protective factor against suicide. KALAAC cited Productivity Commission statistics, that at present 0.74 per cent of Commonwealth and State Government funding for Aboriginal Affairs in Western Australia are allocated to culturally based programs.[158]

4.160 The Social and Emotional Wellbeing Manager for Aboriginal Interpreting WA told the committee that investment in Aboriginal-designed programs was the overarching solution:

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152 AMSANT, *Submission 129*, pp. 4–5.

153 Mrs Danielle Dyall, AMSANT, *Committee Hansard*, Darwin, 9 July 2018, p. 7.

154 AHMRC, *Submission 99*, p. 5.

155 AHMRC, *Submission 99*, p. 2.

156 AHMRC, *Submission 99*, pp. 6–7.

157 Ms Karen Thomas, Queensland State Manager, Neami National, *Committee Hansard*, Townsville, 30 August 2018, p.11.

158 KALAAC, *Submission 59*, p. 5.

> There should be investment and building of the solutions for our people. It's quite simple. We can have an overarching framework to sit with our community and talk about our own intergenerational cycles, hold our own people to accountability, create healing and be responsive and reflective of our own people's needs. A right delayed is a right denied. The investment and the solutions are before the government and before the decision-makers and the influencers who have that power. So, there should be no inquiry and there should be no royal commission; there should only be investment in the solutions for a better way.[159]

Concluding committee view

4.161 The committee recognises that the mental health service needs of Aboriginal and Torres Strait Islander peoples are different to those of non-Indigenous Australians. This is because the causes of mental illness and disorders are often very different, and the cultural framework for effective therapeutic outcomes is also very different.

4.162 What was made clear in the evidence presented to the committee is that those different health services needs are not being met, to devastating outcomes for whole communities.

4.163 What was also made clear from experts in mental health and the Aboriginal Community Controlled Health sector, is that the solutions are there, but are not being recognised, funded and supported to grow. The committee is strongly of the view that Aboriginal and Torres Strait Islander peoples mental health service challenges in remote communities will only be solved when Aboriginal and Torres Strait Islander peoples are given better opportunity to address them.

159 Mr William Hayward, Social and Emotional Wellbeing Manager, Aboriginal Interpreting WA, *Committee Hansard*, Broome, 6 July 2018, p. 9.