Inquiry into the Needs of Urban Dwelling Aboriginal and Torres Strait Islander Peoples

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FOREWORD

The Mental Health Council of Australia is the peak, national non-Government organisation representing and promoting the interests of the Australian mental health sector. The MHCA has eight membership groups including consumers, carers, clinical service providers, private mental health service providers, non-government organisations, State/Territory peak bodies, Aboriginal and Torres Strait Islander groups, and special needs groups. Through its constituents, the MHCA seeks to promote the mental health of all Australians, including Aboriginal and Torres Strait Islander people.

The MHCA was established under the *National Mental Health Strategy,* and through that the *Second National Mental Health Plan* (1998). The Plan, endorsed by all Australian Health Ministers, aims to provide a clear national framework to improve the treatment, care and quality of life for people with mental illness of all age groups through to the year 2003. The Plan acknowledges that while priority must be given to people experiencing the most serious and disabling mental illnesses, the needs of other people with mental illness, many of whom are not gaining access to appropriate services, must be addressed. The Plan identifies Aboriginal and Torres Strait Islander people as one group warranting particular attention.

> "Aboriginal and Torres Strait Islander people, particularly those removed as children from their families, are a core group whose vulnerability has been identified in the Human Rights and Equal Opportunity Commission report into the separation of Aboriginal and Torres Strait Islander children from their families entitled *Bringing Them Home*. Responses for these groups that lessen the risk of developing mental illnesses, especially depression, need further development, refinement and evaluation" (p.13).

The Plan also acknowledges the importance of Aboriginal and Torres Strait Islander people participating in developing partnerships for service reform. Priority partnerships for Indigenous mental health services are most likely to include general health and primary care services, Indigenous networks and organisations, rural and remote health services, adult and juvenile justice systems, and drug and alcohol services.

> "The report of the National Consultancy on Aboriginal and Torres Strait Islander Mental Health entitled *Ways Forward* documents the policy framework for Indigenous mental health. An essential principle in achieving progress for Indigenous people is to ensure that they play a central role in determining acceptable partnerships for service reform. At the national level, an Action Plan has been developed and there is now a need for each State and Territory to develop a mental health policy and strategic plan which identifies priorities for action at a local level" (p.17).

Social, environmental and economic factors have significant and lasting effects on psychological wellbeing and research suggests such factors often precede the onset of psychosis. The *New South Wales Aboriginal Mental Health Report* (1991) found that present disadvantages experienced by Indigenous people leads to increased vulnerability to the development of particular mental illnesses. Furthermore, the likelihood of an individual developing a mental illness is pronounced when a history of childhood separation from biological parents, neglect or institutionalisation exists. This makes Indigenous people particularly vulnerable.

The effects on an individual's mental health and psychological well being following their removal as a child from their family, social and cultural settings are numerous. For instance, loss, trauma and grief, reduced parenting skills, child and youth behavioural problems, and youth suicide are recognised effects impacting on the quality of an individual's life (*Ways Forward*, 1995). Such effects have been identified as current issues confronting Indigenous communities. Youth suicide, in particular, is a major issue confronting Indigenous communities. Victims of suicide are often the children of the generation of people who were forcibly removed from their families and suffered extreme social and economic discrimination (Burdekin, 1993). Such experiences have long-term psychological impact. Recent sociological research confirms the importance of family and other 'connectedness' as a major factor in resilience for young people. Dis-connectedness has major long-term effects on both the family and the young person.

Colonisation disrupted Indigenous traditional customs and life cycles, resulting in grief, loss, anger, hate, frustration, depression and alienation that is still felt today by Indigenous communities, as a result of the re-telling and passing of such stories through the generations, and the current economic and social disadvantage of Indigenous people. Burdekin (1993) suggests:

> "The underlying causes of Aboriginal mental ill health flow from generations of cultural genocide, a dislocation and destruction of Aboriginal cultural ways of survival and a denial of the right to self-determination. This has its psychological [consequences]...Aboriginal people are subjected to blatant and subtle racism, and inevitably this racism is internalised and people feel bad about themselves and each other" (p.693).

1. The nature of existing programs and services available to urban dwelling indigenous Australians, including ways to more effectively deliver services conM:\INQUIRY\urban dwelling\Submissions\internetsubs\sub33.docM:\INQUIRY\urban dwelling\Submissions\internetsubs\sub33.docM:\INQUIRY\urban dwelling\Submissions\internetsubs\sub33.docsidering the special needs of these people.

The lack of special psychiatric services and professional expertise in cross-cultural psychiatry results in Indigenous people becoming particularly vulnerable. The majority of mental health workers responsible for assessing Indigenous people are not Indigenous themselves, resulting in the cultural beliefs, practices, and their relevance to the individual's symptomatology being overlooked.

> "The diversity of Aboriginal cultures creates a dilemma for psychiatrists and psychologists alike because what applies for a particular set of overt conditions (symptoms) in the case of a specific patient and the corresponding appropriate treatment may not be appropriate for an individual with similar problems from a different location and community because of differing cultural beliefs and practices" (Burdekin, 1993, p.702).

Reports suggest that suicide rates, domestic violence and self mutilation in Indigenous communities is high due to high levels of psychological stress associated with daily life. This is intensified due to lack of access to appropriate services. The *National Mental Health Policy* (1992) accepts the principle of universal access to basic health care services, which will be of high quality, equitable, and provided through a mixed public and private delivery and financing system. In addition, the Policy recognises that some groups in the community have special needs, and as such, mental health service systems should be responsive to the varying needs of particular groups, and be planned and delivered in ways which are sensitive to the needs and expectations of different groups in the community. As such, positive consumer outcomes depend on informed and well-trained mental health staff and strong support from carers and advocates.

Due to the lack of available appropriate services, the chances of other members of the community coming into contact with Indigenous people experiencing mental illness is high. Therefore, professional development and education on mental health for all people working in the community, not just health staff, but police and other community workers, should be enforced. This will not only develop a network and support mechanism and increase each individual's own understanding of mental health and the impact it has on Indigenous people, but such knowledge will also facilitate in dealings with all Indigenous people.

When Indigenous people do access mental health services, their needs are rarely met. The present state of mental health services, which are designed and controlled by the dominant society, does not recognise or adapt programs to Aboriginal beliefs and law, causing a huge gap between service provider and user. This may contribute to the prevalence of mental illness in Indigenous people. As Burdekin (1993) reports:

> "Everything in the environment gives us cues as to our standing and place in the universe, our standing within the community, and within our own family groups. The

> situations and structures we've got today in our society, whether they be mental institutions...or wards attached to hospitals, they are a totally alien environment [from what] we need to make us sane...Those people who have been diagnosed or actually put into a situation like that are not getting the necessary cues [so that they can] behave in the right manner – so that there can be some meaningful dialogue with...the people that are actually doing the therapeutic work..." (p.702).
>
> Most Aboriginal people of my acquaintance are very concerned with the quality of their relationships with other people [and] the quality of the relationships with their immediate country. The quality of the relationships are very important barometers of their individual wellbeing. If you have a western psychiatric intervention that just looks at an individual who is several thousand miles from their home without any of their family there and under heavy medication – I'm not sure that you would get much sense out of them in term of their experience of distress because you have taken the individual out of their context and for them context is everything" (p.703).

Both Indigenous and non-Indigenous people need to be trained as health professionals, and non-Indigenous people must receive training in cultural awareness. This would enhance the client/counsellor relationship in counselling settings, promote the level of identity felt by the Indigenous client, and would ensure that Indigenous cultural beliefs, practices, and the relevance this has to an individual's symptomotology be considered. Furthermore, such well-trained health professionals will understand that land, self-esteem, and economic sustainability are all crucial to emotional health and wellbeing, rather than just clinical indications of illness. Professional support mechanisms must also be developed for these professionals, so that they do not have to try and cope on their own, they can call on the network of others for support, guidance and assistance. In addition, counsellors in the counselling network must take a holistic approach.

Burdekin (1993) describes the comments made by one Aboriginal mental health worker who believes that health authorities often assume that because she is Aboriginal, she is automatically able to relate to and care for all Aboriginal people regardless of their medical needs; that government service providers feel that by employing one Aboriginal worker, they are adequately addressing the needs of Aboriginal people. This example reinforces the need for support mechanisms to be developed for Indigenous health professionals and all professionals dealing with Indigenous people.

> "Sometimes you must do the reverse and put in place money and resources for Aboriginal communities to explore the mental health needs of their community with government workers in association with the President of the community or in association with health workers" (Burdekin, 1993, p.710).

Several reports (see Burdekin, 1993; *Ways Forward*, 1995) have attempted to identify reasons why the current delivery of mental health services for Indigenous people is not culturally appropriate:

- health professionals' lack of knowledge and understanding of Indigenous perspectives and cultures;
- the way people conceptualise and define illness and health;
- a limited understanding of the nature and scope of mental health needs within Indigenous communities;

- a lack of consultation by Governments and medical professionals with Indigenous Australians; and
- a lack of education and training.

Burdekin (1993) also highlights the current status of mental health service delivery to Indigenous people.

> "The network of psychiatric services in Australia is designed to meet the needs of the mentally ill who present in the European manner. Consequently, there are no special psychiatric services...[or] specific policies for the diagnosis and treatment of Aboriginal people with mental illness."
>
> "The current psychiatric system has a basic underlying cultural difference which creates for Murris [Aborigines] increased difficulties in dealing with mental health problems. Any form of incarceration, isolation, removal from family, friends, and the Murri community, is fundamentally alien to culturally appropriate methods of dealing with any Murri cultural problem. [For example] one person I spoke to related to me how her family would pack up and move to each town that she was moved to. They followed her from one hospital to another to give her the support she needed...Removing Murri people from the Murri community and placing them within an alien psychiatric system is like trying to force a square peg into a round hole. We do not fit" (p.711).

The *National Aboriginal Health Strategy – An Evaluation* (1994) found the recommended ways of ensuring more culturally appropriate and accessible mental health services including employment of Aboriginal liaison officers to communicate between psychiatric ward staff and Aboriginal Health Service staff and the community; and employment of specialist psychiatric Aboriginal health workers in Aboriginal communities, had not been implemented. These recommendations were made in 1989, however they remain relevant today. Strategies must be developed and implemented to extend mainstream services to Indigenous people and ensure that diagnosis and treatment are culturally appropriate.

The *Aboriginal and Torres Strait Islander Emotional and Social Well-Being (Mental Health) Action Plan* (1996) outlines priority areas for Commonwealth expenditure for Aboriginal and Torres Strait Islander emotional and social well-being (mental health), and directs initiatives undertaken across a number of areas impacting on indigenous mental health. The Plan aims to raise the health status and health outcomes of Indigenous peoples by improving access to culturally appropriate, high quality health care. The Plan has eight objectives addressing youth suicide, trauma and grief counselling, communication, development of a range of culturally appropriate mental health care models, intersectoral activity, specialist regional centres in mental health training and service delivery, data collection, and research and evaluation.

While it is recognised that more mental health services and improved access to services are required in the general community, for Aboriginal and Torres Strait Islander peoples, existing services must be made more culturally appropriate to meet the needs of Aboriginal and Torres Strait Islander peoples. In addition, health professionals must be educated about Aboriginal and Torres Strait Islander peoples culture and views on health, and adopt a holistic approach when dealing with Aboriginal and Torres Strait Islander peoples.

2. Ways to extend the involvement of urban indigenous people in decision making affecting their local communities, including partnership governance arrangements.

The *Second National Mental Health Plan* (1998) acknowledges the importance of Aboriginal and Torres Strait Islander people participating in developing partnerships for service reform. Priority partnerships for Indigenous mental health services are most likely to include general health and primary care services, Indigenous networks and organisations, rural and remote health services, adult and juvenile justice systems, and drug and alcohol services.

> "The report of the National Consultancy on Aboriginal and Torres Strait Islander Mental Health entitled *Ways Forward* documents the policy framework for Indigenous mental health. An essential principle in achieving progress for Indigenous people is to ensure that they play a central role in determining acceptable partnerships for service reform. At the national level, an Action Plan has been developed and there is now a need for each State and Territory to develop a mental health policy and strategic plan which identifies priorities for action at a local level" (p.17).

An effective best way to promote access for Aboriginal people to primary health care settings is through Aboriginal Community Controlled Health Services (ACCHS). Such services are managed by Aboriginal people and as a result, ensure the cultural appropriateness of the service. (Such services also promote self-determination for Aboriginal people). Aboriginals who manage ACCHS also bring to the service a range of networks, including community networks.

ACCHS are recognised as important and influential bodies impacting on the needs of Aboriginal and Torres Strait Islander peoples. Increasing Indigenous participation is more than physical presence. Types of influence and power Aboriginal and Torres Strait Islander peoples have in making changes must be reviewed. Influence ensures participation is genuine rather than tokenistic. ACCHS provide a forum which ensures genuine Indigenous participation.

While ACCHS encourage utilisation of Indigenous workers, the value and expertise of non-Indigenous health workers is not discounted. Indeed, ACCHS often approach non-Indigenous specialists due to limited resources and expertise. However, it is important that non-Indigenous health professionals also enter the ACCHS environment and setting, in order to experience a culturally appropriate setting, increase cultural awareness, and promote partnerships between services.

Genuine involvement will eventuate when the value and necessity of Aboriginal and Torres Strait Islander peoples input is realised by non-Indigenous and other organisations. This will be aided by reconciliation processes.

3. The situation and needs of indigenous young people in urban areas, especially relating to health, education, employment, and homelessness (including access to service funded from the Supported Accommodation Assistance Program).

Health

The Indigenous population of Australia is 303,261 *(National Aboriginal & Torres Strait Islander Survey*, 1994, ABS). There is currently limited valid data available on psychiatric morbidity rates and occurrence of specific psychiatric disorders among Indigenous people. Despite this, Indigenous communities are acknowledged as having among the highest rates of illness in modern Australian society, however their illness often goes undiagnosed, unnoticed and untreated.

Available evidence suggests Indigenous people experience mental health problems such as depression at a much higher rate than non-Indigenous people. The rates of self-harm and suicide are higher among Indigenous than non-Indigenous people, and substance abuse, domestic violence, child abuse and disadvantage have been identified as additional risk factors (*Ways Forward*, 1995).

There are a number of difficulties in determining the rate of mental illness among Indigenous communities. For instance, in such communities, people experiencing mental illness are often cared for within their community and may not come into contact with health professionals. As Burdekin (1993) reports:

> "The Aboriginal community has the capacity to hold its ranks and support someone who displays patterns of strange behaviour. And, though they are not described as mentally ill, they [may exhibit symptoms of mental illness]. [However], the community, rather than isolate that individual or sending them off to [a psychiatric institution], maintains them in the community with protection from their peers and families" (p.699).

Indigenous people have a holistic definition of general health and mental health, as encompassing not only the physical wellbeing of an individual, but the social, emotional, spiritual, and cultural wellbeing of the whole community (NSW Aboriginal Mental Health Policy, 1997). Indigenous reports emphasize the strong relationship between mental health and wellbeing and physical health, and the loss of mental wellbeing is seen as a major contributor to poor physical health and health outcomes for Indigenous people (*Ways Forward*, 1995). Indigenous people exhibiting symptoms of mental illness are often perceived by their community as experiencing a normal reaction to spiritual forces or a curse. They are often considered spiritually ill rather than mentally ill, and the hallucinations they experience may not be a fantasy but a reality within their cultural context. As such, they may rely on their community for assistance and spiritual treatment. Indigenous people often receive a diagnosis of mental illness when they are exhibiting 'unusual' behaviour which is appropriate in Indigenous terms (Burdekin, 1993).

One way of coping with issues is to express behavioural and psychological problems through anti-social and self-destructive behaviours. This may be an underlying cause supporting the high prevalence of Indigenous people who come into contact with the criminal justice system (*Ways Forward*, 1995).

> "[There is] a link between the socioeconomic conditions of Aboriginal people and their mental health...In many circumstances the links are [demonstrated] in domestic violence, alcohol abuse, child neglect and abuse and other forms of 'anti-social behaviour', and these problems have their roots in the powerlessness of Aboriginal communities and the subsequent high levels of stress and tensions within them.
>
> Jails and children's institutions are full of Aborigines who have been branded anti-social and many have been diagnosed as having a behaviour disorder.
>
> Many Aboriginal people have seen their brothers and sisters labeled as mentally ill (and hospitalised and incarcerated as a result) when they understand and know the problem as a social and political one. The diagnoses are always 'white' non-Aboriginal ones and the solutions are seen as another form of oppression.
>
> The most fundamental causes of over-representation of Aboriginal people in custody are not to be found in the criminal justice system but in those factors which bring Aboriginal people into conflict with the criminal justice system in the first place...The most significant contributing factor is the disadvantaged and unequal position in which Aboriginal people find themselves in the society – socially, economically, and culturally" (Burdekin, 1993, p.697).

Mental illness among Indigenous people is difficult to understand because of their unique culture and experience as a dispossessed people. Indigenous people often do not talk about mental illness - they talk about emotional and spiritual wellbeing. The simple use of terminology, language and associated connotations presents an additional barrier restricting the potential effectiveness mental health services can play in promoting the psychological wellbeing of Indigenous people. Burdekin (1993) suggests "*the underlying causes of the physical and emotional ill-health prevalent in Aboriginal communities lie in the continuing social, political and economic disadvantage that Aboriginal people experience"* (p.692).

The historical context contributing to Indigenous health and wellbeing must be taken into account when reviewing Indigenous mental health. Swan (1988, cited in *Ways Forward*, 1995) described the historical context of Indigenous people.

> "Aboriginal peoples of different tribes, speaking their own languages and having their own cultural beliefs and practices were forced from their country.
>
> Their rights and laws were totally disregarded. They were treated with contempt and forced into a sub-human existence.
>
> They were herded onto missions and government reserves. The government and missionaries rationed out nutritionally inadequate foods - refined sugar, white flour and tea.
>
> Discriminatory legislation was passed that empowered government officials, police, welfare workers and mission managers to force Aborigines onto reserves that were staffed and totally controlled by resident white managers.

> With institutionalisation came the forced abandonment of social practices, breakdown in culture and life of authority and traditional law, resulting in a soul destroying dependency.
>
> The differences in cultural beliefs and practices between groups caused social disharmony and were recorded as anti-social behaviour" (*Ways Forward,* 1995, p.15-16).

Indigenous mental health may therefore have two dimensions:
(a) Mental distress and poor self image resulting from colonisation and poor socioeconomic circumstances in which Indigenous people presently live; and
(b) Diagnosable psychiatric disorders which are also prevalent in the non-Indigenous community.

The *NSW Aboriginal Mental Health Policy* (1997) was modeled on the following key principles, which if followed, will ensure mental health service delivered to Aboriginal and Torres Strait Islander peoples will be effective and appropriate.

- Services working in partnership
- Flexibility
- Accessibility of services
- The ability to follow clients across areas
- Reflecting respect for Aboriginal people
- A holistic approach to mental health
- The involvement of family and others in care
- Treating an individual as part of a family, society, and nation
- The provision of education and training which is two-way
- Prevention

Aboriginal and Torres Strait Islander peoples should have equitable access to appropriate mental health services which are of equal quality to those available to non-Indigenous people and which take into consideration the historical, cultural, spiritual and social factors which determine the health of Indigenous peoples.

The *NSW Aboriginal Mental Health Policy* (1997) identifies a number of barriers which restrict Aboriginal and Torres Strait Islander peoples accessing mental health services. These include:

- racism
- an absence of services that address the issues that are important to Indigenous people
- the inadequate assessment of Indigenous persons presenting to Accident and Emergency Departments of hospitals and in some instances to Departments of Surgery and Medicine
- culturally inappropriate services
- overt or covert discrimination by staff
- lack of understanding of Indigenous issues amongst mental health staff
- fragmentation of service delivery
- difficulties in accessing transport to mental health services
- lack of staff with training in mental health in Indigenous Medical Services
- double disadvantage as a result of having a mental illness and being an Indigenous person
- fear of mental health services and staff attitudes and behaviours
- the role and functioning of police in relation to mental health services

Substance Use

Another issue confronting indigenous people in urban areas is use of alcohol and other drugs. The use of alcohol and other drugs in adolescence may be related to the developmental nature of individuals during this life stage. Adolescence is a period marked by personal growth, development, exploration, and experimentation of life opportunities, often involving risk-taking activities such as substance use. Several theories attempt to explain adolescent substance use such as the disease model, self-medication theory, stress-vulnerability theory, reputation enhancement theory, the bio-psycho-social model, and cultural influences especially in Aboriginal and Torres Strait Islander populations.

Peer groups, family, school, and individual self-esteem have been identified as significant factors influencing adolescent substance use. In addition, Hawkins, Catalano and Miller (1992) identify 17 specific risk factors.

1. Social laws and social norms favourable to drug use
2. Availability of drugs
3. Economic deprivation
4. Neighbourhood disorganisation
5. Certain psychological characteristics of the individual
6. Early and persistent history of behavioural problems and conduct disorder
7. Family history of substance abuse and/or dependence
8. Poor family management practices
9. Family conflict
10. Lack of connection to family
11. Academic failure
12. Lack of commitment to school
13. Early peer rejection
14. Social influences encouraging drug use
15. Alienation and rebelliousness
16. Attitudes favourable to drug use
17. Early initiation into drug use

Odgers, Houghton and Douglas (1996) found Australian secondary students who are substance users had a tendency to portray themselves as mean, nasty, unreliable, and troublemakers; had little self-confidence; believed they were disliked by their families; and used more non-productive coping strategies and fewer productive coping strategies compared to non-substance using peers.

Kinnier, Metha, Okey and Keim (1994) found substance abuse increased when depression and a sense of a lack of purpose in life increased, and when self-esteem decreased. However Odgers (1998) suggests "the occasional substance use of many adolescents may be more a symptom of 'healthy' curiosity and rebelliousness than a sign of psychological dysfunction" (p116).

In adolescence, the most common psychiatric disorders comorbid with substance use include conduct disorder, mood disorders, ADHD, and anxiety disorders (Gilvarry, 2000). Research suggests early onset of drug use is associated with poorer prognosis in adulthood (Gilvarry, 2000). Therefore, early intervention and prevention strategies are crucial in promoting the mental and physical health of young people later in life.

Children of parents with alcohol problems are considered to be at greater risk of developing substance use problems, and tend to have histories of aggressive and delinquent behaviours, scholastic underachievement, and poor peer relations (Gilvarry, 2000).

Education

Education plays a critical role in assisting individuals achieve their maximum potential in society. Educational performance may be impaired by factors such as lack of confidence and poor self esteem. These traits are often more pronounced in people who have experienced negative stereotyping, prejudice or neglect – factors which are commonly experienced by Indigenous peoples.

Aboriginal and Torres Strait Islander peoples may not have the same educational opportunities as non-indigenous people, often due to financial constraints, and attitudes. The employment of Indigenous teachers who appreciate Indigenous students' socioeconomic background and current level of education, can tailor their teaching methods to meet the needs of Indigenous students.

Employment

Economic independence widens choices and opportunities to participate fully in society. However, vocational rehabilitation for people who experience mental illness has received little priority in overall service provision (Burdekin, 1993).

Barriers to employment include attitudes, type of job and job design, effects of psychiatric illness and treatment on capacity to work, and access to vocational services (Burdekin, 1993).

Aboriginal and Torres Strait Islander peoples often do not have the same employment opportunities as non-Indigenous people, often stemming from limited educational opportunities. Indigenous people removed to missions and institutions received little or no education, and any education they did receive was of little value (*Bringing Them Home*, 1997).

To increase equality in the workforce, Indigenous people must be given the same educational, vocational and employment opportunities as non-Indigenous people, and other barriers such as negative attitudes must be addressed.

Homelessness

The prevalence of mental illness among homeless people has been recognised in numerous reports. For instance, the report *Accommodating Homeless Young People with Mental Health Issues* (1999) found over 50% of young people accessing housing and homelessness agencies have one or more mental health issues. Furthermore, young homeless Australians between 15 and 24 years are up to four times more likely to have a mental health issue than peers with safe and secure housing.

1996 census data published by the ABS in 1999, estimates there are 105,300 homeless people in Australia, of which only 12,900 (12%) utilise services funded through the Supported Accommodation Assistance Program (SAAP), which provides funding for around 1,200 crisis services to homeless people. In 1999, 90,700 homeless people gained access to SAAP-funded services, with some returning to such services on more than one occasion. Furthermore,

approximately 116,400 requests for homeless services (funded through SAAP) were not met during 1998-99.

The Australian Federation of Homelessness Organisations (AFHO) suggests that during 1999, SAAP-funded services catered for:

- more women (54%) than men (46%);
- more young people (36% of users were under 25 years) than older people (87% of users were under 45 years of age);
- indigenous people (13%) were over-represented;
- 11% of users were people from non-English speaking backgrounds; and
- up to 65,800 children accompanied adults in SAAP services during 1998/99.

There are a number of risk factors for homelessness in Australia, including:

- Unemployment (91% of SAAP users are unemployed or not in the labour market);
- Poverty (93% of SAAP users rely on government benefits or have no income);
- Lack of affordable housing; and
- Discrimination in obtaining housing or employment or both.

The AFHO identifies specific risk factors for different groups:

- Youth homelessness – family conflict and unemployment
- Women homelessness – domestic and family violence
- Family homelessness – unemployment, lack of suitable long-term accommodation, and low vacancy rates in the private rental market
- Indigenous homelessness – displacement, discrimination, and low incomes

Burdekin (1993) suggests "*Access to appropriate accommodation is regarded by many as the most important determinant in the success or failure of people with chronic mental illness living in the community...the policy of deinstitutionalisation cannot succeed unless it is complemented by appropriate policies on housing – and a commensurate allocation of resources"* (p.337).

The belief that it would be more beneficial for people with mental illness to live and be treated within the community assumes they will have somewhere to live, which may frequently not be the case. With the increased emphasis on community care, there has been an increased need to ensure people with mental illness have access to affordable, appropriate, and good quality housing. However, with the increased demand for housing for people with mental illness, there has been a consequent increase in homelessness. While deinstitutionalisation is supported, there are limitations of community-based care if the community sector is not adequately resourced. Available accommodation is often expensive, substandard or inappropriate, and as such crowed, dilapidate boarding houses are common.

Lack of accommodation may result in people with mental illness living on the streets, utilising emergency accommodation which is only temporary, higher rates of hospital admissions and re-admissions, longer hospital stays, serious impediment on recovery and potential for relapse. Unsuitable or non-existent accommodation can destroy the benefits of treatment and rehabilitation received in hospitals. The lack of facilities, support and consequent effects are often intensified particularly in localities away from major cities (Burdekin, 1993).

The availability of SAAP services in rural and remote localities must be addressed, as currently in some localities there is a total absence of services or support for such services (Burdekin, 1993). For instance, services in cities are often required to provide support in nearby regional

areas, which results in such services being 'over-stretched' and numerous people living outside a city being in serious housing need.

People with mental illness may have difficulty finding and maintaining accommodation due to poverty, high rates of unemployment, discrimination and stigma, and the nature of their illness. Support and housing services are therefore crucial for prevention of, recovery from and management of mental illness.

Indigenous people who are discharged from psychiatric facilities experience particular problems when obtaining accommodation, often due to discrimination and stigma held by those accommodation houses catering for people with disabilities.

Often, the accommodation that is available is inappropriate and there are minimal accommodation programs for Indigenous people with a mental illness.

Often, Indigenous people who have a mental illness also have an alcohol or other drug addiction and if they return to their community where drug abuse is widespread, their illness may be exacerbated (Burdekin, 1993)

Additional issues arise when people with mental illness have children who also require housing and accommodation. SAAP services must consider the impact and appropriateness of such services on children who are also homeless. As suggested previously, the AFHO found that up to 65,800 children accompanied adults in SAAP services during 1998/99.

People with mental illness who are homeless may also have other health issues, such as physical health issues. SAAP services may be in a position to provide other health assistance to people with mental illness by contracting doctors and nurses to provide their services at SAAP service sites.

The *National Homelessness Strategy* (2000) recognises homelessness as a complex and growing problem with devastating consequences for individuals, families and the community. Homelessness "...*requires a flexible range of coordinated responses across the breadth of the family and community service delivery system and across government jurisdictions"* (p.1). Through the following objectives, the National Homelessness Strategy aims to provide a comprehensive framework for preventing and addressing homelessness:

- provide a strategic framework that will improve collaboration and linkages between existing programs and services, to improve outcomes for clients and reduce the incidence of homelessness;
- identify best practice models, which can be promoted and replicated, that will enhance existing homelessness policies and programs;
- build the capacity of the community sector to improve linkages and networks; and
- raise awareness of the issue of homelessness throughout all areas and levels of government and in the community.

Adequate housing is crucial to maintaining a person's mental health, and also managing and recovering from a mental illness. While SAAP services assist in providing short-term accommodation for people who are homeless, strategies must be developed which provide people with long-term housing options. Long-term accommodation and housing options promote stability and can assist in 'breaking' the homelessness cycle where people are shifted from one form of short-term accommodation to another.

4. The maintenance of Aboriginal and Torres Strait Island culture in urban areas, including where appropriate, ways in which such maintenance can be encouraged.

An effective best way to promote access for Aboriginal people to primary health care settings is through Aboriginal Community Controlled Health Services (ACCHS). Such services are managed by Aboriginal people and as a result, ensure the cultural appropriateness of the service. (Such services also promote self-determination for Aboriginal people). Aboriginals who manage ACCHS also bring to the service a range of networks, including community networks.

ACCHS are recognised as important and influential bodies impacting on the needs of Aboriginal and Torres Strait Islander peoples. Increasing Indigenous participation is more than physical presence. Types of influence and power Aboriginal and Torres Strait Islander peoples have in making changes must be reviewed. Influence ensures participation is genuine rather than tokenistic. ACCHS provide a forum which ensures genuine Indigenous participation.

While ACCHS encourage utilisation of Indigenous workers, the value and expertise of non-Indigenous health workers is not discounted. Indeed, ACCHS often approach non-Indigenous specialists due to limited resources and expertise. However, it is important that non-Indigenous health professionals also enter the ACCHS environment and setting, in order to experience a culturally appropriate setting, increase cultural awareness, and promote partnerships between services.

The establishment of local Indigenous support groups provide an opportunity for Indigenous people to come together, provide support for one another, share common interests and activities, and maintain Indigenous culture.

Indigenous participation policies which ensure Indigenous people are involved in all aspects of Indigenous life is another way of promoting and maintaining Indigenous culture. Indigenous people employed in workplaces concerned with both Indigenous and non-Indigenous issues can promote Indigenous culture and customs and ensure they are maintained.

Educational systems may also play a role in promoting Indigenous culture. From infant school, students may be taught Indigenous history and culture, and learn to appreciate from a young age, the significance and value of Indigenous heritage. Such learning at a young age may also promote and instill a positive attitude towards Indigenous people and their culture, and assist in preventing the development of discrimination and racism, both of which cause significant barriers for Indigenous people participating fully in the community and creating a satisfying lifestyle.

5. Opportunities for economic independence in urban areas.

Economic independence widens choices and opportunities to participate fully in society. However, vocational rehabilitation for people who experience mental illness has received little priority in overall service provision (Burdekin, 1993).

Barriers to employment include attitudes, type of job and job design, effects of psychiatric illness and treatment on capacity to work, and access to vocational services (Burdekin, 1993).

Aboriginal and Torres Strait Islander peoples often do not have the same employment opportunities as non-Indigenous people, often stemming from limited educational opportunities. Indigenous people removed to missions and institutions received little or no education, and any education they did receive was of little value (*Bringing Them Home*, 1997).

To increase equality in the workforce, Indigenous people must be given the same educational, vocational and employment opportunities as non-Indigenous people, and other barriers such as negative attitudes must be addressed.

Vocational programs in schools may assist in exposing Aboriginal and Torres Strait Islander peoples to the workforce. Such exposure may allow for streaming of educational courses into areas of interest, and thus allow for greater experience and therefore greater opportunity of gaining employment in a certain field.

Indigenous participation policies similar to consumer and carer policies in mental health in all areas relating to Indigenous needs may allow for greater opportunity for employment of Indigenous peoples and result in the needs of Indigenous people being more adequately addressed.

6. Urban housing needs and the particular problems and difficulties associated with urban areas.

1996 census data published by the ABS in 1999, estimates there are 105,300 homeless people in Australia, of which only 12,900 (12%) utilise services funded through the Supported Accommodation Assistance Program (SAAP), which provides funding for around 1,200 crisis services to homeless people. In 1999, 90,700 homeless people gained access to SAAP-funded services, with some returning to such services on more than one occasion. Furthermore, approximately 116,400 requests for homeless services (funded through SAAP) were not met during 1998-99.

The Australian Federation of Homelessness Organisations (AFHO) suggests that during 1999, SAAP-funded services catered for:

- more women (54%) than men (46%);
- more young people (36% of users were under 25 years) than older people (87% of users were under 45 years of age);
- **indigenous people (13%) were over-represented;**
- 11% of users were people from non-English speaking backgrounds; and
- up to 65,800 children accompanied adults in SAAP services during 1998/99.

There are a number of risk factors for homelessness in Australia, including:

- Unemployment (91% of SAAP users are unemployed or not in the labour market);
- Poverty (93% of SAAP users rely on government benefits or have no income);
- Lack of affordable housing; and
- Discrimination in obtaining housing or employment or both.

The AFHO identifies specific risk factors for different groups:

- Youth homelessness – family conflict and unemployment
- Women homelessness – domestic and family violence
- Family homelessness – unemployment, lack of suitable long-term accommodation, and low vacancy rates in the private rental market
- **Indigenous homelessness – displacement, discrimination, and low incomes**

Lack of accommodation may result in people with mental illness living on the streets, utilising emergency accommodation which is only temporary, higher rates of hospital admissions and re-admissions, longer hospital stays, serious impediment on recovery and potential for relapse. Unsuitable or non-existent accommodation can destroy the benefits of treatment and rehabilitation received in hospitals. The lack of facilities, support and consequent effects are often intensified particularly in localities away from major cities (Burdekin, 1993).

The availability of SAAP services in rural and remote localities must be addressed, as currently in some localities there is a total absence of services or support for such services (Burdekin, 1993). For instance, services in cities are often required to provide support in nearby regional areas, which results in such services being 'over-stretched' and numerous people living outside a city being in serious housing need.

Indigenous people may have difficulty finding and maintaining accommodation due to poverty, high rates of unemployment, discrimination, stigma, financial constraints, limited housing resources, and access/barriers to access such resources. Indigenous people who are

discharged from psychiatric facilities experience particular problems when obtaining accommodation, often due to discrimination and stigma held by those accommodation houses catering for people with disabilities.

Often, the accommodation that is available is inappropriate and there are minimal accommodation programs for Indigenous people with a mental illness. Often, Indigenous people who have a mental illness also have an alcohol or other drug addiction and if they return to their community where drug abuse is widespread, their illness may be exacerbated (Burdekin, 1993)

Additional issues arise when people with mental illness have children who also require housing and accommodation. SAAP services must consider the impact and appropriateness of such services on children who are also homeless. As suggested previously, the AFHO found that up to 65,800 children accompanied adults in SAAP services during 1998/99.

While SAAP services assist in providing short-term accommodation for people who are homeless, strategies must be developed which provide people with long-term housing options. Long-term accommodation and housing options promote stability and can assist in 'breaking' the homelessness cycle where people are shifted from one form of short-term accommodation to another.

The *National Homelessness Strategy* (2000) recognises homelessness as a complex and growing problem with devastating consequences for individuals, families and the community. Homelessness "...*requires a flexible range of coordinated responses across the breadth of the family and community service delivery system and across government jurisdictions"* (p.1). Through the following objectives, the National Homelessness Strategy aims to provide a comprehensive framework for preventing and addressing homelessness:

- provide a strategic framework that will improve collaboration and linkages between existing programs and services, to improve outcomes for clients and reduce the incidence of homelessness;
- identify best practice models, which can be promoted and replicated, that will enhance existing homelessness policies and programs;
- build the capacity of the community sector to improve linkages and networks; and
- raise awareness of the issue of homelessness throughout all areas and levels of government and in the community.

The *National Homelessness Strategy* (2000) reports that $91 million per year is spent on indigenous housing and infrastructure through the Aboriginal Rental Housing Program, and over $200 million is spent by the Aboriginal and Torres Strait Islander Commission (ATSIC) in this area through the Community Housing and Infrastructure Program. Appropriate allocation of financial resources, implementation of the *National Homelessness Strategy* , equality in educational and employment opportunities, and programs combating negative attitudes including racism, discrimination and stigma, will assist in improving the housing outcomes and options for Indigenous people.

Summary

- Not enough is known about the incidence or prevalence of mental illness among Indigenous Australians.

- The separation of families and children, dispossession of land, and continuing social and economic disadvantage have all contributed to widespread mental health problems among Indigenous people.

- Mental health professionals have little understanding of Aboriginal culture and society, resulting in misdiagnosis and inappropriate treatment.

- Existing mainstream mental health services are inadequate and culturally inappropriate for Indigenous people.

- Governments must provide funding and resources to enable Indigenous-controlled health services to develop and deliver appropriate mental health services to Indigenous people.

- Governments should ensure that mental health policy, planning and program delivery is developed in consultation with Indigenous people.

- Tertiary courses in mental health or any courses where an individual is likely to deal with Indigenous people must cover Aboriginal history and contemporary Aboriginal society.

- Mental health professionals should acknowledge the role and significance of traditional healers in certain communities.

- Priority must be given to training Aboriginal health workers and other Aboriginal community-based resource people as mental health workers.

- Health departments should identify positions for Aboriginal mental health workers in areas with significant Aboriginal populations.

- Aboriginal Liaison Officers should be employed by relevant mainstream service providers to improve communication and consultation at all levels of the mental health system.

- All Government and non-Government mental health services should provide cross-cultural training for staff.

- Mental health services for Aboriginal people should be expanded to include community development, mental health promotion and prevention, and crisis intervention for individuals and families.

- Mental health workers must consult with family and community members (within existing legislative frameworks) before deciding that any individual experiencing mental illness requires care or treatment away from the community. Community members should be kept informed about the treatment, progress and likely return of anyone removed from their community.

- Mechanisms must be put in place to ensure the above recommendations are implemented.

Implications

In consideration of the issues addressed, there are a number of recognised implications:

- It is important that all health professionals and potential health professionals who work with Indigenous children, families and communities receive training. Training should be through programs owned, planned, and run by both Indigenous and non-Indigenous people. Such programs will result in culturally and socially appropriate services, the history and effects of forcible removal being taken into account when dealing with Indigenous people, and enhanced empathy and understanding in the health professional/client relationship. The right of individuals to have their cultural background taken into consideration in the provision of mental health services is highlighted in the *Mental Health Statement of Rights and Responsibilities* (1991).

- It is clear that there is a significant need for the implementation of a comprehensive plan to improve Indigenous cultural awareness of non-Indigenous health providers. This cultural awareness must address issues such as attitudes, racism and discrimination.

- Every Indigenous person who is affected by forcible removal must have access to support and assistance services. They must also have the right to determine to whom and to what extent information contained on their records is expressed to another person.

- Teams of Indigenous and non-Indigenous health professionals should be continually funded to work in Indigenous communities to determine the needs in light of the culture of such communities.

- It is important that recurrent funding be made available to assist with family tracing and reunion, and referral. Reuniting with one's family would significantly aid in the promotion of one's mental health. Funding should also be granted to relevant Indigenous organisations to establish parenting and family well-being programs.

- Long-term funding would also assist in the establishment of referral networks, research and education into the history and effects of forcible removal, and advocacy.

- Organisations dealing specifically with Aboriginal and Torres Strait Islander issues such as the National Aboriginal Community Controlled Health Organisations (NACCHO) should have significant input into research and evaluations of emotional and well-being effects of forcible removal policies.

- *"The most fundamental principle is that of self-determination. This means that problems affecting Aboriginal people can only be effectively dealt with if Aboriginal people are in control of the process"* (Burdekin, 1993, p.717). Long-term strategies must be developed to enable Indigenous people to develop the skills and resources needed to develop and maintain their own mental health services.

- The *National Indigenous Mental Health Data Workshop* (1996) identified the need for Aboriginal and Torres Strait Islanders and their communities to be involved in every step of data collection. Community consultation and culturally sensitive methods and tools are essential for collecting appropriate, accurate and valid data.

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