National Aboriginal and Torres Strait Islander Leadership in Mental Health
Together we are strong

The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention

Report of the Workshop on Gayaa Dhuwi (Proud Spirit) Declaration Implementation and the Indigenous Governance Framework

14 November 2018

The National Aboriginal and Torres Strait Islander Leadership in Mental Health and Centre for Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention thank the **Queensland Mental Health Commission** for their support in hosting this workshop.

1. Overview

With the support of the Queensland Mental Health Commission, the National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH) and Centre for Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention (CBPATSISP) hosted a stakeholder workshop on the 14 November 2018. This was facilitated by Professor Kerry Arabena.

The workshop provided an opportunity to reflect on the *Fifth National Mental Health and Suicide Prevention Plan* (Fifth Plan) as it pertains to Aboriginal and Torres Strait Islander communities in Queensland, with particular reference to NATSILMH's *Gayaa Dhuwi (Proud Spirit) Declaration* which is to be implemented by Australian governments and their agencies through the Fifth Plan. Further, to reflect on the draft *Indigenous Governance Framework* developed by the CBPATSISP with the Black Dog Institute. This addresses the importance of Indigenous governance in suicide prevention in Aboriginal and Torres Strait Islander communities but is of greater application as the principles it espouses are relevant in many areas of mental health and related area service and program delivery.

Attendees included senior Aboriginal and Torres Strait Islander health sector and service representatives, senior Queensland Health officers as well as senior representatives from the Queensland Primary Health Networks and Health and Hospital Services - see Appendix A to this Report for a list of attendees.

2. The Program

The workshop program is included as Appendix B to this Report. It was structured around five challenges that relate to *Gayaa Dhuwi (Proud Spirit) Declaration* implementation and its 'best of both worlds' approach to Aboriginal and Torres Strait Islander mental health, and its focus on Aboriginal and Torres Strait Islander presence as workers, practitioners and leaders within the mental health system. It also looked at challenges relating to agencies working with, and ensuring, Indigenous governance - such as supporting co-design and community control within the mental health sector.

Against each challenge, in table-based discussions, participants in groups were asked to identify:

- What was already taking place to implement the respective challenge subject matter;
- What were the barriers to implementation; and
- What could be done to implement the challenge subject matter in the short and medium term.

3. Workshop report

This Report focuses on the third element of discussions – what could be done to implement the challenge subject matters in the short and medium term in Queensland. These parts of the discussion, framed as recommendations, complement (and will be used to enhance) NATSILMH's already published *Gayaa Dhuwi (Proud Spirit) Declaration Implementation Guide* and the draft CBPATSISP *Indigenous Governance Framework*. Ultimately, these recommendations will be used to shape the ongoing implementation of the *Fifth National Mental Health and Suicide Prevention Plan* (Fifth Plan) as it pertains to Aboriginal and Torres Strait Islander communities in Queensland and across Australia. Information from each workshop will also be collated and brought to the joint Australian Mental Health Commissioners meeting for further consideration.

WORKSHOP REPORT

Challenge	Notes	Short and medium-term action
1. Supporting ACCHSs enhanced role in the mental health space How do we achieve a state-wide and regional mental health system where ACCHS play a much greater role in promoting, preventing, detecting and treating mental health problems, and in recovery, in Indigenous settings, including through building ACCHS-based Mental Health & Social and Emotional Wellbeing Teams?	Challenges to implementation include: • silos • lack of funding • lack of government agency trust in ACCHSs • 'we know best' government agency mentality • compliance-based implementation rather than community or consumer-responsive implementation • questioning of Indigenous ways rather than respect • agencies and ACCHSs 'speaking different languages' Conflict of interest is being used to	1. There are many ACCHS-based programs, including some supported by PHNs, operating successfully in Queensland and which can be modelled and/or built upon to support this challenge. These examples should be documented to provide an evidence base and best/good practice examples for application. 2. Commence implementation of existing policy including the *Fifth National Mental Health and Suicide Prevention Plan* and the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017- 2023* which already requires an enhanced primary mental health service delivery role for ACCHSs. 3. All providers (including PHNs as service-commissioners) and HHSs committing to co-design processes with Aboriginal and Torres Strait Islander communities and people with lived experience when developing responses to Aboriginal and Torres Strait Islander community mental health and related needs. This should include proactively addressing privacy concerns if they exist. 4. All providers (including PHNs as service-commissioners) and HHSs committing to supporting place (Aboriginal and Torres Strait Islander community/ ACCHS)- based mental health and related services in their Reconciliation Action Plans. In cases where ACCHS do not exist, existing ACCHSs should be considered for providing expanded outreach service provision to these areas rather than establishing new services at first instance. As a general principle, services should aim to meet people in their communities and homes and not vise-versa. 5. Commence the systematic co-location and placement of existing and future PHN commissioned-service and HHS mental health and related staff in ACCHSs. Such staff should receive local community approved 'cultural training'. Willingness and capacity to co-locate and train should be part of relevant job-descriptions. The co-location of staff should be an important step towards the achievement of a stepped system of care as per point 6 below. 6. An enhanced role for ACCHSs <u>does not</u> mean that people with severe and complex mental health needs, or when in crisis, are referred to them at first instance or when mainstream parts of the overall system simply cannot cope. Rather, an enhanced ACCHSs role includes their integration into a stepped system of care in which MoU-based respectful, robust and trusting ACCHS – other agency relationships are the norm, and where care navigators and mainstream agencies are given the appropriate training to provide a culturally competent and safe service to an Aboriginal and Torres Strait Islander person with severe and complex mental health needs or in crisis within an overall system response to their needs. Co-designed referral

	discriminate against Aboriginal and Torres Strait Islander involvement in HHS ad PHN activity in Aboriginal and Torres Strait Islander communities, particularly when ACCHS could benefit from the activity. This must be addressed.	pathways between agencies and ACCHSs are an important support to ensuring ACCHSs can provide an enhanced service but are not inadvertently overwhelmed and effectively set up to fail by being the inappropriate referral place for severe and complex/ crisis patients. 7. Queensland Aboriginal and Torres Strait Islander Leadership in Mental Health Alcohol and Other Drugs Leadership Group to champion ACCHSs enhance role. 8. The broader question of short-term ACCHSs funding terms and the reporting 'overburden' need to be addressed as a part of this challenge. 9. The enhancement of the role of communities in assessing the services that work with their members should be used to support the ongoing implementation of this challenge subject matter. 10. ACCHSs' mental health care and prevention roles should be seamlessly connected. 11. ACCHSs should have advisory groups for particular consumer cohorts - LGBTIQ, Elders, etc. *Specific to ACCHSs-based Mental Health and Social and Emotional Wellbeing Teams (Teams)* 12. While Team models may be developed, particular community needs should drive the establishment of Teams and their change over time. 13. Breaking down 'local siloes' and connecting up existing small local organisations to support the building of Teams is critical. 14. Co-locate and place staff from smaller organisations in ACCHSs as Team members. Financial support for this. 15. Teams should support cross-agency co-case management (child safety/ housing and etc.) 16. A team should not just be multi-disciplinary but able to work effectively with diverse customer groups including LGBTIQ, and provide customised care pathways to such groups. 17. Team members should have placed-based cultural and community training. 18. Teams should be formally connected to relevant cultural and community leaders to enhance their work and effectiveness. 19. Teams should prioritise the use of local professionals and workers and proactively identify, and develop strategies to meet, local gaps. 20. The general principle of investment in Teams and not individual practitioners should be applied.
2. An Aboriginal and Torres Strait Islander specialist mental health workforce At the state and regional levels,	Local Aboriginal and Torres Strait Islander workforce development is critical to ACCHS-enhancement and the development of ACCHSs-based Mental	*Identify* 1. Positions and offices requiring Aboriginal and Torres Strait Islander specialist mental health workers are identified according to co-designed, state-wide or national criteria and flexible co-design process that involve communities and people with lived experience and address particular community needs. These are made Aboriginal and Torres Strait Islander -specific 'identified' positions in part to support the permanent presence of Aboriginal and Torres Strait Islander people in the mental health workforce.

how do we identify and achieve the required mix and level of Indigenous specialist mental health workers (including emerging workforces), paraprofessionals and professionals to meet the SEWB mental health needs of Indigenous people and communities?	Health and Social and Emotional Wellbeing Teams as above. Challenges to implementation include: Not enough clinical training opportunities of staff who may otherwise have cultural, community or lived experience	2. The need for joint male and female workers roles to meet gendered cultural needs should be assumed unless otherwise indicated in services. 3. Workers should be trauma-informed/ trained as a core qualification. 4. Aboriginal and Torres Strait Islander workers are particularly important for working with Aboriginal and Torres Strait Islander people in the critical window after a suicide attempt where suicide made be re-attempted without appropriate or sensitive care. 5. Specialist staff include those with the capacity to work effectively with particular groups including LGBTIQ. *Achieve* 6. Expanding the Aboriginal and Torres Strait Islander specialist mental health workforce by improving access to clinical training should be made a standing item on PHN and HHS relevant committees and Boards. 7. Affirmative action – Local workforce clinical training and other targets should be adopted by PHN and HHS relevant committees and Boards based on delivering co-designed and evidence based population – worker ratios. Link to PHN and HHS service contracts. 8. Affirmative action – State chapters of professional bodies and universities/ training institutions should be required to deliver an Indigenous mental health clinical workforce according to agreed targets. Lived, cultural and community experience should be recognised to help Aboriginal and Torres Strait Islander gain access to such educational opportunities. Link to KPIs/government funding. 9. Aboriginal and Torres Strait Islander people and community representatives should control and otherwise oversee recruitment processes for services and programs intended for them. 10. Place much greater weight on lived, cultural and community experience in job application evaluation processes to weight them towards Aboriginal and Torres Strait Islander people. 11. The pay scale of Aboriginal and Torres Strait Islander workers should be reconsidered with greater weight and remuneration for lived, cultural and community experience. 12. Mentors are employed within service team structures to support in general, and including the upskilling of, existing Aboriginal and Torres Strait Islander workers. 13. Workers should be assessed as to the effectiveness of their practical work in real community situations. 14. Incentives for attracting and retaining remote and rural staff. Otherwise, the issue of training people in these areas needs particular attention and incentives.
3. Cultural healers At the state and regional levels, how do we ensure	Cultural healers are a critical part of the 'workforce mix' to work with Aboriginal and Torres Strait Islander	1. Taking the provisions of the *WA Mental Health Act* and the *SA Mental Health Act* that, to varying degrees, require the States to provide Aboriginal and Torres Strait Islander people access to cultural healers as a starting point, co-design and legislate similar requirements in Queensland. Work to ensure the adoption of consistent legislation across the country. 2. Access to cultural healing should be embodied in relevant Queensland mental health policy.

Indigenous people and communities are able to access cultural and traditional healers?	people facing mental health difficulties. They should be integrated into the Mental Health and SEWB Teams discussed above.	3. Communities must be empowered to identify cultural healers. Otherwise, the systems around cultural healing should be respectful/not be overly bureaucratic. 4. Healing places should also be recognised by communities and incorporated into an overall cultural healing approach. 5. Cultural healers should be remunerated appropriately including by being supported through health insurance and the MBS. 6. Aboriginal and Torres Strait Islander consumer cultural needs (potentially leading to cultural healing) should be assessed by mental health services. 7. At the state and regional levels, cultural healing opportunities should be mapped against the stepped system of mental health care. 8. Apps could be developed within an overall cultural healing approach. 9. The establishment of Healing Centres to support Aboriginal and Torres Strait Islander peoples' access to cultural healers and healing should be considered. 10. PHN-commissioned service and HHS staff should be trained to work with cultural healers. 11. Particular healing practices and healers should be developed and/or available to work with particular consumers i.e. LGBTIQ. 12. The knowledge underpinning cultural healing and practice should be protected by legislation.
4. Leadership Design a five-year program to identify and fill relevant mental health governance and leadership positions within government, Health and Hospital Networks, and PHNs with suitably qualified		1. As per 2.1 above, positions and offices requiring Aboriginal and Torres Strait Islander leadership are identified according to co-designed, State-wide or national criteria and flexible process that involve communities and people with lived experience and address particular community needs. Support with legislation. Link to KPIs/ PHN and HHS service contracts. 2. Develop employment contracts and work culture that acknowledges cultural obligations - Cultural leave recognised. 3. Require male and female Aboriginal and Torres Strait Islander/ ACCHSs Board representation on PHNs and HHSs. Support with legislation. Link to PHN and HHS service contracts. 4. Leadership role of the Queensland Aboriginal and Torres Strait Islander Leadership in Mental Health Alcohol and Other Drugs Leadership Group to be enhanced. 5. Elders and emerging Elders training and mentoring.

Indigenous people.		
Co-design Identify planning and development processes that should be co-designed with Indigenous communities, governing bodies, consumers and lived experience groups. Design a framework to ensure co-design is consistently used in efforts to improve Indigenous social and emotional wellbeing and mental health	The example of the Charleville suicide prevention program was cited as an example of excellence in community design strengths that should be captured in co-design processes. By this, the community monitor social media for indications of people challenged by suicide and respond.	*Service and program responses that should be developed through co-design* See above. Additional areas identified include: 1. Emergency departments – how services should deal with clients experiencing suicide ideation or psychosis. 2. Integrated responses – hospitals and police. 3. Gender and LGBTIQ-specific responses.

Appendices

1. ATTENDEES

Alistair Macdonald	Primary Health Network – Western Queensland
Bec Johnson	LGBTI National Alliance
Brett Mooney	LGBTI National Alliance
Cheryl Leavy	Queensland Child and Family Commission
Chris Holland	NATSILMH member
Christian Woodward	Department of Health
Christopher Henaway	Department of Health
Dawie Scheepers	Department of Health
Deanne Minniecon	Primary Health Network – Brisbane South
Ged Farmer	Primary Health Network – Brisbane North
Glenis Grogan	Ngoonbi Community Services Indigenous Corporation
Glynis Schultz	Queensland Mental Health Commission
Jackie Hanson	Black Dog Institute
Janet Martin	Department of Health
Judi Enoch	Ngoonbi Community Services Indigenous Corporation
Judith Milliken	Department of Health
Julie Allen	Queensland Aboriginal and Islander Health Council (QAIHC)
Julie Henderson	Department of Health
Kath Thompson	Primary Health Network – Central Queensland, Wide Bay, Sunshine Coast
Kathy Brown	Department of Health
Kerry Arabena	Facilitator
Kerry Crumblin	Cunnamulla Primary Health Care Centre

Kieran Kinsella	Central Queensland Hospital and Health Service
Kim Sutton	Queensland Mental Health Commission
Kimina Andersen	Department of Health
Leilani Darwin	Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention
Lelsey Maidment	Institute for Urban Indigenous Health
Lucille Chalmers	Primary Health Network – Brisbane South
Lynette Anderson	Department of Health
Maleeta Richards	Nukal Murra Alliance
Mark Wenitong	NATSILMH member
Marlene Nungarrayi Bennett	Department of Health
Matthew Cook	Primary Health Network – Western Queensland
Maxine Goulson	Department of Health
Melissa Browning	Gold Coast Hospital and Health Service
Michael Smith	North West Hospital and Health Service
Michelle Combo	Metro South Hospital and Health Service
Pat Dudgeon	Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention
Paul Stephenson	Apunipima – Cape York Health Council
Rebecca Reynolds	Queensland AIDS Council
Richard Abednego	Metro South Addiction and Mental Health Services
Ron Weatherall	Department of Child Safety, Youth and Women
Russell Evans	Queensland Mental Health Commission
Sam Wild	NATSILMH member
Sandy Gillies	NATSILMH member
Sara Goodson	Queensland Mental Health Commission

Sheryl Lawton	Charleville and Western Areas Aboriginal and Torres Strait Islanders Community Health Limited
Shirley Wigan	North West Hospital and Health Service
Simone Caynes	Queensland Mental Health Commission
Steffanie Von Helle	Black Dog Institute
Tash Hydon	North West Hospital and Health Service
Tealia Jacobs	West Moreton Hospital and Health Service
Tegan Schefe	University of the Sunshine Coast
Tom Brideson	NATSILMH chair
Yasmin Muller	Metro North Hospital and Health Service

2. PROGRAM

Workshop on Gayaa Dhuwi (Proud Spirit) Declaration Implementation and the Indigenous Governance Framework

Paterson Room, Novotel
200 Creek Street
Brisbane 4000

9.00am – 4.30pm, 14 November 2018

Facilitator: Professor Kerry Arabena

9.00 am	Arrive and settle (Coffee and registration)
9.30 – 9.40	Welcome to Country
9.40 – 10.00	Attendee Introductions *Led by Professor Kerry Arabena*
10.00 – 11.00	An introduction to: • Social, cultural and emotional wellbeing • NATSILMH, *the Gayaa Dhuwi (Proud Spirit) Declaration*, and the *Fifth National Mental Health and Suicide Prevention Plan* *Mr Tom Brideson, NATSILMH Chair* • CBPATSISP and the *Indigenous Governance Framework* *Professor Pat Dudgeon, CBPATSISP Director*
11.00 – 11.15	Break/ morning tea
11.15 – 12.00	Aboriginal Community Controlled Health Services, Hospital and Public Health Services, and Community and Services *Led by Professor Kerry Arabena/ table discussion*
12.00 – 12.30	Culturally Respectful Mainstream Services *Led by Professor Kerry Arabena/ table discussion*
12.30 – 1.15	Lunch
1.15 – 2.00	Indigenous Cultural Healers and Community Based, Cultural Programs *Led by Professor Kerry Arabena/ table discussion*
2.00 – 2.45	Organisational Commitment to Indigenous Governance and Leadership in the Mental Health System *Led by Professor Kerry Arabena/ room discussion*
2.45 – 3.00	Break/ afternoon tea
3.00 – 3.45	Working Effectively with Indigenous Governance in Communities *Led by Professor Kerry Arabena/ room discussion*
3.45 – 4.25	Next steps *Led by Professor Kerry Arabena/ room discussion*
4.25 – 4.30	Close