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

National Aboriginal and Torres Strait Islander Leadership in Mental Health

Together we are strong

**Comments on the Productivity Commission draft report on mental health**

February 2020

The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention (CBPATSISP) and National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH) thank the Commission for the opportunity to comment on the draft report.

The CBPATSISP aims to reduce the causes, prevalence and impact of suicide on Indigenous individuals, families and communities. It achieves this by identifying, translating and promoting the adoption of best practice in Indigenous-specific suicide prevention activity, building on the substantial work of the national *Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP).*

NATSILMH is a group of senior Aboriginal and Torres Strait Islander people working in social and emotional wellbeing, mental health and suicide prevention. It aims to help restore, maintain and promote the social and emotional wellbeing and mental health of Aboriginal and Torres Strait Islander peoples, and reduce suicides, by advocating and providing advice and leadership.

We make this submission jointly, reflecting our shared interests in the mental health and social and emotional wellbeing of Indigenous people and communities, and in particular our shared objectives of advancing the implementation of:

- the CBPATSISP's *Indigenous Governance For Suicide Prevention in Aboriginal and Torres Strait Islander Communities*, which calls for

Indigenous leadership in mental health policy development and service co-design and implementation; and

- NATSILMH's *Gayaa Dhuwi (Proud Spirit) Declaration*, which advocates an approach based on concepts of social and emotional wellbeing and cultural connection and healing, while working holistically with culturally competent clinical services.

These themes are reflected in the responses and comments below, which we have grouped in three sections:

- Additional priorities for the Commission's consideration in its final report
- General comments
- Responses to draft recommendations

**ADDITIONAL PRIORITIES**

1. **The Commission's final report should acknowledge and support the national Indigenous social and emotional wellbeing, mental health and suicide prevention leadership roles of the CBPATSISP and Gayaa Dhuwi (Proud Spirit) Australia**

We welcome the draft report's emphasis on ensuring Indigenous people are at the forefront of making decisions about their own social and emotional wellbeing and mental health. We urge the Commission to connect this in its final report to the work of the CBPATSISP in promoting Indigenous governance in suicide prevention and social and emotional wellbeing programs, and to Minister Hunt's 9 September 2019, $4.5 million announcement of a new national Indigenous social and emotional wellbeing, mental health and suicide prevention leadership body Gayaa Dhuwi (Proud Spirit) Australia, charged with developing a new National Aboriginal and Torres Strait Islander Suicide Prevention Plan. This body is expected to become operational in March 2020.

The following organisations are members of Gayaa Dhuwi (Proud Spirit) Australia, or have the right to appoint directors to the inaugural Board:

- NATSILMH
- Australian Indigenous Psychologists Association
- Australian Indigenous Doctors Association

- CBPATSISP
- National Aboriginal Community Controlled Health Organisation (NACCHO)
- Indigenous Allied Health Australia
- National Indigenous Crisis Response Service.

We also recommend the Productivity Commission works with and is guided by the CBPATSISP and Gayaa Dhuwi (Proud Spirit) Australia to develop more detailed practical recommendations in its final report about how to embed the five *Gayaa Dhuwi (Proud Spirit) Declaration* themes within the mental health system to ensure a 'best of both worlds approach' – a commitment of the Fifth National Mental Health and Suicide Prevention Plan.

## 2. Gayaa Dhuwi (Proud Spirit) Australia should lead the implementation of the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023*, and a renewed *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*

The Commission's support for the development of an implementation plan for the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023* (draft recommendation 22.2), and for a renewed *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* and associated Implementation Plan (draft recommendation 21.2) are particularly welcome.

The Commission's final report should clarify that these processes must be led by Indigenous people. For the reasons outlined in our first point, the final report should explicitly recommend Gayaa Dhuwi (Proud Spirit) Australia to co-lead the development of the implementation plan for the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023*, along with the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group (ATSIMHSPAG), which developed the Framework. Gayaa Dhuwi (Proud Spirit) Australia has already been charged with developing the renewed *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*.

3. **Recognising the challenges in appropriately accommodating the needs of Aboriginal and Torres Strait Islander people through mainstream recommendations, the Commission should consider a specific section in its final report devoted to Indigenous people and issues.**

We note that – unusually for a government report into mental health – there is no distinct section in the Commission's draft report regarding the needs of Indigenous people. This may result from a laudable commitment not to disconnect Indigenous people from important decisions that affect all Australians; however, it has the consequence of leaving our distinctive issues less visible and potentially unaddressed. Indigenous and non-Indigenous experiences of psychological distress and suicide have different patterns of causation, and successful prevention and support depend significantly on cultural safety and competence in service delivery.

Further, it is unclear how some of the major reform proposals – notably those relating to service planning and commissioning; research and data; and social determinants/comorbidities – would be likely to play out for Aboriginal and Torres Strait Islander people.

## GENERAL COMMENTS

The draft report is complex, detailed, and sometimes challenging to navigate as the content of individual chapters inevitably overlaps with other thematic areas. Therefore, the following general observations seek to assist the Commission to keep some important concerns of Aboriginal and Torres Strait Islander people in mind during the preparation of the final report.

### Social determinants

The report is clear that social determinants of mental health, including housing, education and income, are beyond the scope of the inquiry except as they relate to specific programs targeted at people who already experience or are at risk of mental ill health (p123).

In practice it is impossible in practice to separate health determinants – historical, political and social – from Indigenous mental health. These determinants include racial discrimination, unemployment, exposure to adverse childhood events, housing stresses, family violence, alcohol and drug comorbidities and lower access to health and mental health services. Their effects are powerfully described in the report by the WA Coroner into the suicide deaths of 12 Indigenous children.

The Coroner wrote: *"To focus only upon the individual events that occurred shortly before their deaths would not adequately address the circumstances attending the deaths. The tragic individual events were shaped by the crushing effects of intergenerational trauma and poverty upon entire communities. That community-wide trauma, generated multiple and prolonged exposures to individual traumatic events for these children and young persons."*

The Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report details the associations between psychological distress in Indigenous people and their experiences of insecure housing, racism and discrimination, child removal, unemployment and household poverty.

As the Commission itself acknowledges in supporting the development of an Implementation Plan for the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023*: "the rationale for this strategy as a complement to the Fifth Plan lies in the disproportionately high rates of psychological distress,

mental illness and suicides and social determinants" experienced by Aboriginal people.

Some intersectional issues – for example the mental health of Aboriginal people who are incarcerated – are considered in detail in the Commission's draft report, and innovative responses proposed. This is valuable.

However, drawing the boundary of this inquiry to exclude the wider social context of people's lives misses an opportunity to address key issues for Aboriginal people, whose poorer mental wellbeing and higher rate of suicide are deeply linked to social disadvantage.

Across the whole population, The Australian Institute of Health and Welfare has found that if all Australians had the same suicide death rates as the 20% of Australians living in the areas with the highest SES, in 2009–2011 there would have been 1,323 fewer deaths due to suicide (18.8% fewer). This is one of the strongest associations between disadvantage and any cause of death (The connection is stronger only in the case of lung cancer, chronic obstructive pulmonary disease, liver cirrhosis and diabetes). Since those figures were released – the most recent to track all causes of death by socioeconomic inequality – there has been a further increase in excess suicides among people who are in the most disadvantaged quintile, by 3.5% a year (compared to 0.2% in the highest quintile). The suicide death rate among the most disadvantaged men is nearly double that of the least disadvantaged. The effect is most pronounced among those aged 25 to 44. AIHW:

Aboriginal and Torres Strait Islander people are twice as likely to die by suicide as other Australians, and the excess deaths are concentrated among people aged 15 to 44, according to the Australian Bureau of Statistics. Meanwhile the ABS also found Aboriginal people are three times as likely as other Australians to be in the most disadvantaged population quintile, and a quarter as likely to be in the highest quintile.

This means Aboriginal people are disproportionately likely to experience levels of disadvantage that are strongly associated in national datasets with poorer mental health and suicide.

Meanwhile new evidence from overseas strongly suggests that suicide can be prevented through interventions that address poverty directly. A decade-long study of all US states found that raising the minimum wage by $1/hr decreased the suicide rate by 1.9%, and that if that wage rise had been

applied consistently across the whole country, 8000 lives could have been saved.

This emerging evidence suggests that the exclusion of social determinants from the Commission's report will limit the potential of its recommendations to improve mental wellbeing and prevent suicide deaths in all Australians – and particularly Indigenous Australians.

**Alcohol and other drug services**

**INFORMATION REQUEST 23.1** (p104) asks whether alcohol and other drugs should be included in the remit of Regional Commissioning Authorities under the Rebuild model.

As described above (social determinants), Indigenous people are disproportionately affected by disadvantage and health and mental health challenges linked to disadvantage. Aboriginal and Torres Strait Islander people are less likely to use alcohol and drugs in ways that are harmful, compared to other Australians. However, they are more impacted by the consequences of harmful use.

There is strong evidence linking alcohol and other drug (AOD) use and poor mental health among Aboriginal and Torres Strait Islander people. For the period 2011–2015, the rate of deaths from mental health and behavioural disorders linked to alcohol was five times as high among Indigenous people compared to Australians overall. 40% of Indigenous male suicides and 30% of female suicides were attributable to alcohol use. (Australian Indigenous Health Bulletin Vol 18 No 1, January – March 2018)

It is clear that harmful alcohol and other drug use is closely related to mental health and social and emotional wellbeing in Indigenous people. The holistic concept of social and emotional wellbeing, which includes the body as well as the mind and extends to family and community, means these issues should be considered together in an Aboriginal context, and the CBPATSISP therefore supports the inclusion of AOD in the event that the Rebuild model is selected.

**System architecture and commissioning**

The CBPATSISP welcomes the Commission's explicit support for Indigenous leadership of suicide prevention programs for Indigenous people and communities (draft rec 21.2 p868) and particularly the recommendation that

evaluations of such programs need to recognise cultural factors. This follows the earlier recommendations of the ATSISPEP project and of the National Mental Health Commission (2019).

However, the context in which Aboriginal mental health, social and emotional wellbeing and suicide prevention programs would be commissioned, and how this autonomy would be enabled, is not clear from the Commission's descriptions of a future mental health system (the Renovate and Rebuild options). Nor does the report engage with a key recommendation of the submission by NACCHO that funding for social and emotional wellbeing services for Aboriginal and Torres Strait Islander people should be delivered directly to the community-led ACCHO sector rather than via PHNs, LHNs (or the proposed RCAs). Considering the important status of ACCHOs, which deliver about half of primary health services to Indigenous people, the CBPATSISP is disappointed that this recommendation was not discussed in the draft report.

In relation to **INFORMATION REQUEST 23.1** (Architecture of the future mental health system) and 24.1 (Regional funding pools), the CBPATSISP makes the following comments – which apply to any model in which PHNs or RCAs continue to be fund-holders and gatekeepers for Aboriginal and Torres Strait Islander services:

- ACCHOs are diverse organisations and deeply attuned to the needs of their communities, but they are often small with limited financial and human resources. To support their success, commissioning agencies need to establish realistic, culturally-appropriate performance and evaluation measures and reporting obligations that recognise the scale and capacity of ACCHO partners. The Commission has not suggested what the scale of RCAs might be, or whether they would be smaller or larger (in terms of geographic boundaries) than the current 31 PHNs. However, it is clear (Table 23.4) that the $1 billion in combined annual funding drawn from current budgets for PHN primary mental health support, carer support and psychosocial services would be dwarfed by the $5 billion notionally allocated from state hospital and community mental health services, which are focused on acute conditions. The risk here is that primary care and prevention could be overwhelmed and marginalised within a much larger clinical system, which might have negative implications for small, specialist commissioned service organisations – including ACCHOs.

- Because of their smaller scale and specialised expertise, ACCHOs often find it challenging to meet the varying and sometimes misaligned

reporting requirements of multiple commissioning agencies – including PHNs, LHNs, family and social support agencies, and non-government services (CBPATSISP PHN Engagement Project). In principle, a move to RCAs has the potential to streamline these requirements into a unified set of KPIs through centralised commissioning, which could helpfully reduce their reporting burden. In the draft report the Commission appears pessimistic about the prospect of effective co-commissioning between PHNs, LHNs and other agencies under current arrangements (pp 941-945), but this has not yet been properly trialled or incentivised. Streamlined commissioning, which has the potential to benefit ACCHO providers and Aboriginal people, is not guaranteed under either model and may be more dependent on organisational cultures than on the sources of funding contributions.

- In the five years since the establishment of PHNs, some (though not all) have developed respectful and supportive relationships with ACCHOs and local Aboriginal communities. The Commission's report states: *While RCAs would take on some of the roles currently performed by PHNs and State and Territory Government departments, these bodies have developed expertise in regional planning and commissioning mental health services that RCAs should harvest. To some extent this would likely happen quite organically, as some staff could transfer from existing bodies to the RCAs.* (p961). This understates the nature of the culturally appropriate commissioning expertise that has been developed in current funding structures; a transition to RCAs could not simply harvest relationships through staff transfers but would require organisational trust to be redeveloped with the new structures under new governance. Disruption to relationships, with the potential to disrupt delivery of services, is to be expected with any major change to funding and governance structures, and should be considered a disadvantage of the Rebuild model as it relates to Indigenous people.

- The Commission's recommendation that boards of RCAs should be "skill-based, not representational" (Box 23.11, p962) should be amended to include a requirement for at least one Indigenous person at board level. Drawing on the ATSISPEP report, the CBPATSISP considers high-level representation by Indigenous people essential to good governance in agencies that commission services for Indigenous people, honouring the key principle of self-determination. This is not at odds with notions of "skill". Many Aboriginal and Torres Strait Islander people are highly skilled and can bring business, clinical or

other backgrounds to boards, in addition to their essential cultural knowledge. Gayaa Dhuwi (Proud Spirit) Australia will be well placed to advise on these matters.

- Box 24.3 – PHNs are currently required to quarantine funding for some services for Indigenous people. The proposal to deduct MBS-funded services from an RCA's flexible budget is intended to incentivise RCAs to contain MBS expenditure. However, in practice this may be challenging and result in a reduced flexible pool and further funding constraints on Indigenous services. This funding model may therefore disproportionately impact Indigenous and other disadvantaged people, who are less likely to use private-practice fee-for-service mental health services from GPs and psychologists.

**Data and evaluation**

The Commission proposes increased mining and linkage of client data to better understand the effectiveness of services (pp 991-1037, draft recommendations 25.1, 25.2, 25.3, 25.4, 25.5, 25.6, 25.7, 25.8, 25.9), as part of a general move towards more rigorous use of evidence and evaluation. The CBPATSISP agrees that it is critical that government funds are spent in ways most likely to be effective in improving people's lives. However, in the context of Aboriginal people and communities it is important to:

- Ensure there is community support for the stated objective of any program, through co-design with communities of projects and their implementation and monitoring.

- Recognise that epidemiological and other quantitative methods developed for the mainstream community may have limitations in evaluating outcomes for Aboriginal people, for whom more holistic indicators may be more appropriate. Inclusive and narrative methods, that emphasise the views of communities and Elders rather than relying only on the collection of empirical numbers, should be considered.

- Respect Aboriginal people's concerns about the use of personal data, which historically has been used in punitive ways against them. In particular the notion of "shared outcome indicators" - across health, housing, human and social services, education and training, employment and justice – is likely to alarm some Aboriginal people and may have the effect of discouraging them from seeking health

care for – for example – alcohol use, if they feared this information would be accessible to other parts of the human services system. In its submission to the Commission's inquiry, NACCHO has detailed the concerns of the Winnunga Nimmityjah ACCHO (p6) about the possibility of re-identifying personal data in the context of sensitive mental health consultations, which has led it to decline funding. These concerns should be addressed directly in the Commission's final report, with consideration given to the balance between the privacy and personal risk of Indigenous individuals, and potential benefits to communities from improved understanding of services.

- The Productivity Commission's Indigenous Evaluation Strategy, currently under development, will be essential in this regard. As the two pieces of work progress in parallel they will need to take account of each other:

Elsewhere in the report (Draft recommendation 21.2), the Commission acknowledges in the context of suicide prevention that: *For all organisations providing programs or activities into Indigenous communities, the requirement of performance monitoring, reporting and evaluation should be adapted to ensure they are appropriate and reflective of the cultural context.*
These same principles, framed powerfully here, should be adopted across the whole spectrum of mental health and social and emotional wellbeing services for Indigenous people and communities. This will assist in ensuring services are acceptable to their intended users and are judged and funded according to legitimate measures of their value.

**Workforce**

Cultural understanding, especially of Indigenous concepts of mental health and social and emotional wellbeing, is essential to providing high quality support to Aboriginal and Torres Strait Islander people. All workforces that support Aboriginal people's mental health and social and emotional wellbeing should be required to undertake cultural competency training relevant to their geographic region and professional practice domain, and to maintain this focus through regular continuing professional development. The professional colleges and other representative organisations vary in their levels of commitment to this objective, and few of them (the RACGP is an exception) model shared governance with Aboriginal and Torres Strait Islander people in their own organisational structures. We provide an internal working paper that describes the colleges' and peaks' policies (not for publication): *Mainstream clinical peak groups' policies and positions on*

*Aboriginal and Torres Strait Islander people's mental health and social and emotional wellbeing*

In 2016-17, Aboriginal Community Controlled Health Organisations delivered primary health care services to about half of the Aboriginal and Torres Strait Islander population. The remainder of Aboriginal and Torres Strait Islander people do not appear to use an ACCHO for their health care, according to Australian Institute of Health and Welfare statistics. This may be attributable to issues including accessibility, concerns about confidentiality, or preference. In remote areas, ACCHOs provide the bulk of all primary health services to Indigenous people, but even when there are ACCHOs present, mainstream services may have an important role for Aboriginal people. The Commission's chapter on the mental health workforce (pp 367-412) should include cultural competency as a core skill across all professional disciplines.

In addition, Indigenous people are likely to be disproportionately impacted by the workforce shortages the Commission has described in rural and remote areas, as 22% of Indigenous people live in remote and very remote locations, compared to 2% of non-Indigenous people.

In its consideration of the needs of Indigenous people in this chapter, the Commission focuses on the professional development of Indigenous workers in supporting the mental health and social and emotional wellbeing of Aboriginal and Torres Strait Islander people. We support this emphasis, and make the following observations:

- It will require decades of commitment to develop significant numbers of highly skilled, respected Indigenous mental health workers across multiple professions. There needs to be strong commitment to the multiple needs of Aboriginal and Torres Strait Islander people in the development of:
    - the *National Mental Health Workforce Strategy*
    - the *National Aboriginal and Torres Strait Islander Health Workforce Plan*
    - additions to the *National Mental Health Service Planning Framework* relating to the workforce needs of Aboriginal and Torres Strait Islander Peoples
    - The *National Suicide Prevention Strategy* (NSPS), which requires a dedicated Aboriginal and Torres Strait Islander Peoples' Suicide Prevention Plan, addressing workforce needs alongside other issues.

- The Djirruwang Program, which runs the Bachelor of Health Science (Mental Health) degree at Charles Sturt University, offers a model for how Aboriginal or Torres Strait Islander can benefit from education programs that are tailored to Indigenous people's needs – both for students and for community members seeking support. The essence of the Program is to grow a mental health workforce locally within the community in which people live. Other models that depend on importing a workforce are not sustainable. The NSW Aboriginal Mental Health Workforce Program (AMHWP) utilises the Djirruwang Program as the education provider across all Local Health Districts and the Justice Health & Forensic Mental Health Network.
  The degree is endorsed by the NSW Ministry of Health for reasons including its cultural relevance, the mapping of the curriculum against the National Practice Standards for the Mental Health Workforce (revised 2013) and relevance to sector needs. It is deemed equivalent to a degree in counselling (in terms of determining an appropriate Award for graduates' employment), and graduates are able to perform clinical professional roles as mental health workers.

**INFORMATION REQUEST 11.1** - ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH WORKERS

The information provided above as one example shows how Aboriginal mental health workers may be comparably qualified and credentialled in relation to other mental health workforces. Therefore the assumption that they might routinely prefer to move to a mainstream workforce in order to progress their careers may not be valid. Appropriate recognition by employers of Aboriginal mental health worker training and skills, and deep integration of these skills into service provision, also has strong potential to enhance career progression for this workforce.
The Djirruwang model could be scaled up and replicated through national support for emerging workforces, while ensuring that all appropriate professional standards are applied.
At the same time, individuals and the community stand to benefit from higher rates of entry by Aboriginal and Torres Strait Islander people into mainstream mental health professions. Work undertaken by the Indigenous Australian Doctor's Association (AIDA) highlights the potential to develop workforces that are Aboriginal or Torres Strait Islander. AIDA along with the Australian Medical Association and the Deans of Faculties of Medicine of Australia and New Zealand is the only collective group across health and human services that has achieved parity for people who are Aboriginal or Torres Strait Islander entering medical degrees.

Workforce parity should become the minimum target for all helping professions across health and human services, including mental health. More effort and responsibility need to be applied across the professions that have less than population parity of Aboriginal and Torres Strait Islander workforce.

**RESPONSES TO DRAFT RECOMMENDATIONS**

We note the following recommendations of the Commission are particularly significant for Indigenous people, and suggest that these are modified or expanded to include specific references to Aboriginal and Torres Strait Islander people. This is especially important where the Commission recommends trials or pilots of new approaches – in order to ensure that Indigenous people benefit at least equally from any subsequent widespread adoption of these approaches, and are not inadvertently disadvantaged by them.

- DRAFT RECOMMENDATION 5.2 – assessment and referral practices
  - Aboriginal and Torres Strait Islander people may present with higher acuity and require a different service mix from the mainstream stepped care model, and their needs should be reflected in this recommendation.

- DRAFT RECOMMENDATION 5.6 – practitioner online referral treatment service
  - We support the Commission's advocacy for the PORTS model developed in Western Australia, which is appropriately inclusive of Indigenous concerns.

- DRAFT RECOMMENDATION 6.1 – supported online treatment options should be integrated and expanded
  - Indigenous people are more likely to experience technical access and literacy challenges that may inhibit online service use, and these issues should be explicitly considered. These services should complement existing services and not replace them

- DRAFT RECOMMENDATION 5.5 – encourage more group psychological therapy
  - Any new Medicare item should be designed to take into account the cultural requirements of Indigenous people in group therapy, or there should be a separate item to meet our needs.

- DRAFT RECOMMENDATION 5.4 – MBS-rebated psychological therapy
  - The Commission should recognise Indigenous people's access to MBS-funded psychological services is likely to be relatively low, as these services are concentrated among more advantaged geographic areas, and ensure any expansion does not create further disadvantage.

- DRAFT RECOMMENDATIONS 5.7, 7.2 Psychiatry consultations by videoconference
    - This has the potential to expand services for Indigenous people in rural and remote areas, but there needs to be flexibility in the MBS items rules to respond to individual situations. Telepsychiatry should be offered where appropriate within a comprehensive service model which includes face to face consultations, complementing existing services and not replacing them.

- DRAFT RECOMMENDATIONS 10.3, 10.4 Single care plans, care coordination services
    - A requirement to meet the needs of Aboriginal and Torres Strait Islander people should be included in both recommendations.

- DRAFT RECOMMENDATION 13.3 Family focused and carer-inclusive practice
    - This is very important for Indigenous people and families, and there needs to be flexibility in the MBS items rules to respond to individual situations.

- DRAFT RECOMMENDATION 15.1 Housing security for people with mental illness
    - Indigenous people are more likely to experience housing insecurity and their needs should be specifically considered in this recommendation.

- DRAFT RECOMMENDATION 16.4 Incarcerated Aboriginal and Torres Strait Islander people
    - This recommendation is supported, but we recommend it is expanded to explicitly acknowledge the disproportionate and discriminatory levels of incarceration of Indigenous people, and call for a fair justice system.

- DRAFT RECOMMENDATION 16.5 Disability justice strategies
    - Aboriginal people with a disability – especially psychosocial disability and cognitive impairment – are greatly over-represented in the justice system, and their particular needs should be recognised in this recommendation.

- DRAFT RECOMMENDATIONS 17.1, 17.2, 17.3, 17.4, 17.5, 17.6 regarding social and emotional wellbeing in the early years

- Each of these recommendations should recognise the diversity of the population, including the different values and priorities inherent in Indigenous people's understanding of social and emotional wellbeing. This is especially important when defining screening practices, teacher development and data collection.

- DRAFT RECOMMENDATION 20.1 – Stigma campaign
  - This recommendation should recognise that stigma and shame may also operate as discrimination in Indigenous communities. Any work to prevent mental health stigma will need to be co-designed with Aboriginal and Torres Strait Islander people, and require investment at community level.

- DRAFT RECOMMENDATION 20.3 Traditional healers
  - The Commission's acknowledgement of intergenerational trauma and the need for Indigenous empowerment is welcomed, along with its support for traditional healing. However this recommendation should recognise that in many circumstances healing can properly be offered as the primary mode of support, and not necessarily in partnership with mainstream mental health care. The WA Mental Health Act 2014 offers sound guidance for how traditional healing can be included in the mental health system, and could serve as a model for other states.

- DRAFT RECOMMENDATION 21.1 – Universal access to aftercare
  - The needs of Indigenous people after a suicide attempt differ in some key respects – including how families and communities should be engaged and how the potential for stigma and shame can be managed. These issues are explored in projects under the National Suicide Prevention Trial and should be referenced in this recommendation.

- DRAFT RECOMMENDATION 21.2 Empower Indigenous communities to prevent suicide
  - This recommendation is warmly supported and we thank the Commission for listening to the views of Aboriginal and Torres Strait Islander people in this critical issue. We have offered further advice in relation to this recommendation elsewhere in this response.

**CONTACTS**

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