Aboriginal and Torres Strait Islander
Communities, Families and Individuals

“Don’t Judge, and Listen”

Experiences of stigma and discrimination related to problematic alcohol and other drug use

Report to
Queensland Mental Health Commission
March 2020

Queensland Government

Acknowledgements

The Queensland Mental Health Commission pays respect to Aboriginal and Torres Strait Islander Elders, past, present and future. We acknowledge the important role played by Aboriginal and Torres Strait Islanders as the First Peoples, their traditions, cultures and customs across Queensland.

We acknowledge people living with mental illness, problematic alcohol and other drugs use, as well as those affected by suicide, their families, carers and support people. We commend their resilience, courage and generosity of time and spirit in sharing their personal stories, experiences and views about what works and what needs to change.

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The *Don't Judge, and Listen* report was completed by ACIL Allen in partnership with The Seedling Group, on behalf of the Commission.

Queensland
Mental Health Commission

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Interpreter

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Contents

Key research findings

The Queensland Mental Health Commission (QMHC) appointed ACIL Allen Consulting in partnership with The Seedling Group to lead research into the impact of stigma and discrimination related to problematic alcohol and other drug use on Aboriginal and Torres Strait Islander communities, families and individuals living in Queensland.

A key part of the research involved community consultations in five locations (Cairns/Yarrabah, Inala, Mount Isa, Rockhampton/Woorabinda and Thursday Island) that offer a 'snapshot' of the diversity in Aboriginal and Torres Strait Islander experiences in Queensland.

Below are the research's key findings.

Definitions and experiences of stigma and discrimination

- Aboriginal and Torres Strait Islander research participants experienced multiple forms of stigma and discrimination related to race, clan, location, and alcohol and other drug use. These resulted in a compound effect that intensified their experiences of stigma and discrimination
- Participants used the term 'racism' to describe these experiences
- Racism was general and pervasive in the lives of participants. It was felt in daily social and commercial interactions and in the workplace

Relationship of stigma and discrimination to stereotypes of alcohol and other drug use

- Racism was attached to several stereotypes of Aboriginal and Torres Strait Islander people, including in relation to alcohol and other drug use
- Public behaviours could be perceived differently if the instigator is an Aboriginal and Torres Strait Islander person. There is an assumption that the person may be drunk or wanting to cause 'trouble'

Impact of stigma and discrimination related to stereotypes of alcohol and other drug use

- Stereotypes of alcohol and other drug use were one of many factors contributing to the overall pressures on the participants' wellbeing
- Participants felt judged by mainstream services and that these services lack understanding of the experiences of Aboriginal and Torres Strait Islander people

Factors that contribute to the impact of stigma and discrimination

- Individual resilience stemming from strong kinship support, stable housing and financial security contributed to alleviating the impact of racism
- Elders assisted the community to overcome trauma/harm associated with racism and problematic alcohol and other drug use

Impact of stigma and discrimination on ability to seek support for alcohol and other drug use

- Where available, participants preferred Aboriginal and Torres Strait Islander service providers, perceived by most as providing culturally appropriate and sustainable support in relation to alcohol and other drug use
- Some participants preferred the anonymity of mainstream services, noting it is important that these services provide a safe and culturally appropriate environment

Existing approaches in Aboriginal and Torres Strait Islander communities

- Most participants felt that they cannot get support with mental health and problematic alcohol and other drug use where and when they need it
- Barriers to accessing services included remoteness and marginalisation within geographic and social contexts, feeling safe and desire for more culturally appropriate service environments, and need for ideal service location and settings to overcome perceptions of shame
- A range of broader state-wide developments were viewed by state-wide government sector research participants as relevant to contributing to improved social and emotional wellbeing outcomes for Aboriginal and Torres Strait Islander people living in Queensland

Executive summary

Background

A role of the QMHC is to undertake research in relation to mental health and substance misuse issues, taking into consideration the views, needs and vulnerabilities of Aboriginal and Torres Strait Islander individuals and communities. In past conversations with QMHC, Aboriginal and Torres Strait Islander people have indicated that racism and discrimination is one of the main issues impacting their social and emotional wellbeing. It directly affects self-esteem and can act as a barrier to services, treatment and supports.[1]

QMHC commissioned ACIL Allen Consulting in partnership with The Seedling Group to further research the impact of stigma and discrimination on Aboriginal and Torres Strait Islander people experiencing problematic alcohol and other drug use, and on the related negative stereotypes that affect the social and emotional wellbeing of all Aboriginal and Torres Strait Islander people irrespective of whether they engage in alcohol and/or other drug use. This research project is the first part of a process by QMHC to guide the development of options for reform that are specific to, and will involve the ongoing engagement of, Aboriginal and Torres Strait Islander people living in Queensland. The long-term aims of these reforms will be to reduce racism, to remove barriers to access alcohol and other drug supports and services, and to improve the social and emotional wellbeing of Aboriginal and Torres Strait Islander people.

Approach

The project was designed to follow best practice in Aboriginal and Torres Strait Islander-related research and was guided by the involvement of Aboriginal and Torres Strait Islander organisations and individuals. The research project was governed by a Project Steering Group of related agencies established by QMHC with strong representation from Aboriginal and Torres Strait Islander people. The community consultation component of the project was supported by local Aboriginal and Torres Strait Islander co-facilitators who provided a critical point of liaison with communities for the effective and efficient implementation of visits.

Key components of the research method were:

a) Literature review – to explore relevant frameworks and definitions, to provide an overview of alcohol and other drug related support, treatment and recovery services in Queensland, to investigate initiatives designed to strengthen social inclusion, reduce stigma and discrimination and improve social and emotional wellbeing, and to identify any gaps in the existing literature.

b) Community consultations – conducted between April and October 2019 in five community locations of Cairns/Yarrabah, Inala, Mount Isa, Rockhampton/Woorabinda and Thursday Island. These communities were selected to provide a 'snapshot' of the diversity in Aboriginal and Torres Strait Islander individuals and communities in Queensland. Research participants included Aboriginal and Torres Strait Islander people experiencing problematic alcohol and other drug use, people who support them, Aboriginal and Torres Strait Islander community members irrespective of whether they engage in alcohol and other drug use, and Aboriginal and Torres Strait Islander community leaders including Elders or community mentors.

c) Sector consultations – with service sector stakeholders from communities visited and state-wide organisations with responsibility related to health, housing, justice, education and employment, and other social support services.

The research framework identified the following research questions:

1. *How is stigma and discrimination defined and experienced in different settings and circumstances by the research participants?*
2. *How does stigma and discrimination relate to stereotypes of alcohol and other drug use?*
3. *How does stigma and discrimination related to stereotypes of alcohol and other drug use impact the social and emotional wellbeing of research participants, their everyday life experiences and their ability to access support services?*
4. *How does stigma and discrimination impact the ability of research participants to seek and obtain support and treatment for harmful alcohol and other drug use, and to recover?*
5. *Which factors contribute to the severity or mildness of the impact of stigma and discrimination?*
6. *Which existing approaches have been proved effective in Aboriginal and Torres Strait Islander communities? What other potential approaches to address stigma and discrimination (including service system responses to improve service access) could be incorporated into Aboriginal and Torres Strait Islander communities?*

Ethics approval for this research was obtained at national and Queensland regional level, including letters of support from local Aboriginal and Torres Strait Islander community organisations and representatives.

1 QMHC, 2016b

Research context

The voice of Aboriginal and Torres Strait Islander people

Overall, there was limited literature found about stigma and discrimination relating to alcohol and other drug use that presents Aboriginal and Torres Strait Islander voices, including by Aboriginal and Torres Strait Islander researchers and involving Aboriginal and Torres Strait Islander research participants. It was also found that most definitions in the literature for 'problematic' use of alcohol and other drugs lack the perspective of the user and exclude the broader socioeconomic impacts and context — elements that are essential to a culturally safe and trauma-informed view. As such there are limited representations of problematic use of alcohol and other drug use that take into consideration the holistic concept of Aboriginal and Torres Strait Islander social and emotional wellbeing. This research project contributes towards addressing these gaps in the literature by presenting Aboriginal and Torres Strait Islander voices on stigma and discrimination related to alcohol and other drug use.

Prevalence of alcohol and other drug use

In relation to the use of alcohol and other drugs, it is known that Aboriginal and Torres Strait Islander people are less likely to drink alcohol than non-Indigenous people, and that the majority of Aboriginal and Torres Strait Islander people who consume alcohol drink in a manner that is not problematic. However, levels of problematic use of alcohol are higher among Aboriginal and Torres Strait Islander people than non-Indigenous people, including by dependent drinkers, those who drink regularly and those who engage in heavy episodic drinking.

While most Aboriginal and Torres Strait Islander people do not use illicit drugs, the proportion of illicit drug use is higher among Indigenous people than among non-Indigenous people. Hospitalisations for mental health/behavioural disorders associated with amphetamine use and the rate of drug-induced deaths are significantly higher among Indigenous people than non-Indigenous people.[2]

Various inquiries have highlighted the link between Aboriginal and Torres Strait Islander peoples' disadvantage, poor health and high levels of alcohol use as a legacy of past government policies.[3]

Support, treatment and recovery service system

The alcohol and other drugs service system in Queensland is serviced by government (including Hospital and Health Services and services commissioned by the state and Primary Health Networks), non-government service providers (including Aboriginal and Torres Strait Islander Community Controlled Health Services) and private healthcare providers (including General Practitioners). Support is also provided by families, friends, carers and community groups.

A specific framework across the continuum of care for alcohol and other drug-related services for Aboriginal and Torres Strait Islander people would enhance understanding of the nature of culturally appropriate services in the sector, and strengthen analysis of coordinated and ongoing service provision in Queensland.

Definition and experiences of stigma and discrimination

Aboriginal and Torres Strait Islander participants in communities consulted for this research described their experiences of stigma and discrimination using the term 'racism'. For many participants, their experiences of stigma and discrimination are intrinsically linked to their racial and cultural identities and how non-Indigenous people perceive and respond to these identities.

Feedback from research participants demonstrated the general and pervasive nature of racism experienced throughout their lifetime and within diverse personal, family and community settings. Elder research participants considered that experiencing racism *'since they were born'* had complicated the ability of Aboriginal and Torres Strait Islander people to understand how racist behaviours impact their lives and wellbeing.

A constant theme in discussions about discrimination was the perceived influence of non-Indigenous people who were considered to hold most positions of power in state and local governments, as well as in most local businesses. Lack of employment opportunities across areas requiring skilled and non-skilled workers was considered a key factor in creating the disadvantage and stress. This included the opportunity for local councils and businesses as major employers, to increase their employment of local Aboriginal and Torres Strait Islander people in jobs currently given to non-Indigenous workers, and for health and community service providers to develop a local workforce better able to respond to the needs of Aboriginal and Torres Strait Islander people.

Participants experienced disadvantage in many ways such as limiting access to a car and to affordable housing to alleviate overcrowding and instability.

Participants recounted their experiences of racism in a variety of situations and settings including in their encounters with police, in the workplace, at school, in accessing government agencies and in shops. The experience of racism was present for both young and older Aboriginal and Torres Strait Islander participants.

In some communities, the impact of past government policies was considered to be evident in community tensions and ongoing fear and distrust of 'white people'. Current and proposed strategies to address problems in these communities such as the Alcohol Management Plan and introduction of the benefit card were perceived to be ongoing examples of discrimination, and opportunities for better engagement with community to find alternative appropriate solutions.

2 *Australian Indigenous HealthInfoNet, 2018; AIHW, 2017; Gray et al, 2018; MacRae, 2016*

3 *Gray et al, 2018*

Relationship of stigma and discrimination to stereotypes of alcohol and other drug use

Research participants recognised that racist behaviour was linked to stereotypes of Aboriginal and Torres Strait Islander people, including in relation to their alcohol and other drug use, which reinforced the overall experience of racism. Participants' experience of stereotyping included anticipation that they were *'wanting to steal', 'at fault'* and *'looking for trouble'*, and that they were *'unintelligent'* and *'will probably fail'* at given tasks.

In relation to stereotypes of alcohol and other drug use, research participants talked about public behaviours being perceived differently if the instigator is an Aboriginal and Torres Strait Islander person with a common assumption that the person may be 'drunk' or wanting to cause 'trouble'. When purchasing alcohol, experiences have included assumptions about being an alcoholic when purchasing a cask rather than a bottle of wine, requirement to provide further identification, restrictive access to pubs and other premises that sell alcohol, and preferential service to non-Indigenous people in pubs and bottle shops.

Research participants held varied views of the prevalence and risks of alcohol and other drug use by Aboriginal and Torres Strait Islander members of their communities. To most participants, regular alcohol drinking and the use of some other drugs like cannabis were not automatically perceived as 'problematic' but rather that they provide a safety valve and means for relieving stress for some Aboriginal and Torres Strait Islander people from circumstances that are largely beyond the control of the individual. Participants with lived experience had varied understanding of the impact of alcohol and other drug use upon themselves. Most did not think that the use of alcohol and cannabis were 'problematic' to themselves but had understanding of the potentially harmful behaviours to their family members.

Some female participants spoke about the family disruption because of binge drinking and considered this was a behaviour that they would like to see changed.

Elder research participants considered that Aboriginal and Torres Strait Islander individuals and groups in their communities use alcohol and other drugs to deal with pain, fear and trauma. The circumstances that contribute to these factors may be incidental, like the loss of a family member, or may be ongoing and more complex, like racism. Elders noted the importance of educating their communities to understand the connection between pain, grief and trauma and the use of alcohol and other drugs.

Other factors that research participants associated with harmful behaviours relating to the use of alcohol and other drugs included: trauma for children and families related to experiences of child safety and care services; experience of domestic, family and community violence; neglect and breakdown of social networks; the level of support services in communities especially for young people; and housing and financial concerns.

Mental health was consistently referred to by many research participants, and especially Elders, as a source of misunderstanding and stigma within communities that may contribute to the use of alcohol and other drugs by community members as a means of masking their mental health issues. It was suggested that amongst family and community members, being seen as 'drunk' was more acceptable than others knowing that there is someone in the family with mental health issues.

Research participants noted that the prevalence of drug use in their communities was linked to their price and accessibility. In some communities, the low use of other drugs, such as methamphetamine, was seen as an outcome of community leaders making it clear that use of these drugs was not accepted within their communities.

Impact of stigma and discrimination related to stereotypes of alcohol and other drug use

Social and emotional wellbeing

The experience of racism, including in relation to stereotypes of alcohol and other drug use, impacted significantly on how research participants felt about themselves, their families and communities. Research participants did not commonly use the term 'wellbeing' but instead understood and articulated the importance of *'how you feel in yourself and in the family and community'*.

Participants felt their best when connected to their families and communities, and when being noticed, respected and cared for. They also felt best when able to support others, including in relation to alcohol and other drug use.

Fundamentally, employment and education were seen as key drivers of good mental health and wellbeing. Lack of employment opportunities, including as a result of racism, was related to poor mental health and harmful behaviours. A low standard of education was seen as a barrier to communication about healthy behaviours with the need for service providers to 'break down the jargon' to help people to understand the meaning of information provided and to be able to talk about their problem.

There was a call for community programs to address social isolation and potential harmful behaviours that relate to experiences of racism and stereotypes of alcohol and other drug use. This included parenting programs, youth camps and social events to provide night-time opportunities for adults to meet.

Ability to access services

Overall, research participants' experiences of mainstream services led them to feel that they were being judged by mainstream service providers and that these services lack understanding of the experiences of Aboriginal and Torres Strait Islander people. Many participants would hesitate to recommend support services without first checking with their family and/or Elders.

Impact of stigma and discrimination on the ability to seek and obtain support and treatment and to recover

Participants with lived experience shared their experiences of hesitating to seek support from service providers because of personal shame and fear that they will be judged by staff or recognised by other Aboriginal and Torres Strait Islander patients. Most tended to only access mainstream services in a crisis and that this encounter only served to reinforce hospitals in particular as places that were not culturally appropriate. It is noted that for staff receiving constant 'crisis' cases, stereotypical perceptions are reinforced, which compounds the problems of racism.

What did appear to engage most individuals effectively was the ability to enter a program offered by an Aboriginal and Torres Strait Islander organisation. The capacity to feel safe within an Aboriginal and Torres Strait Islander-operated service was expressed as being understood, relaxed and able to hear and talk about their experiences and needs. Where an Aboriginal and Torres Strait Islander service was not available, options for some people included women's shelter or family. Some participants also spoke about the value of support services that operated like a hub where a range of needs could be met.

It was considered that mainstream services could assist in overcoming the barrier to accessing services presented by the shame associated with mental health issues. This included mainstream services understanding the importance of *'not looking like a mainstream service'* or enabling discreet access to the building.

Participants with lived experience spoke also about aspects that support or inhibit their ongoing engagement with services and their recovery including:

- the inappropriateness of support in group settings
- challenges in sustaining financial and residential security, particularly when faced with a criminal record
- gaining strength from their connection to their families and to the *'bushland'* and the importance of connecting to *'culture and land'* as part of their recovery
- seeking support from individuals/services that are stable and consistent and can form a *'routine'*.

Factors that contribute to the severity or mildness of the impact of stigma and discrimination

Research participants identified a range of factors that contribute to the extent of the impact of racism on individuals, families and communities:

- Individual resilience appeared to be a strong contributor to better managing the impact of racism in the community and was often demonstrated in community members who might variously be supported by a kinship network, who were educated, those with a strong sense of identity and those who were in employment and had stable housing.
- Connections to land, family and culture were seen as key strengths in being resilient and overcoming racist behaviour. These connections were also important to participants with lived experience, some of whom spoke about being 'forced' to change their behaviour by their family members and/or kinship networks including Elders. This often took the form of an ultimatum to choose, for example, between being excluded from learnings about their culture and/or from contact with their spouse and children. These individuals considered that *'family and culture saved me'*.
- There was a lack of culturally appropriate medicine and healing in mainstream services and a perceived stigma attached to Aboriginal and Torres Strait Islander medicine in western science.
- Individuals look for places of service where there is cultural awareness, respect and consistency/reliability of care. Being able to overcome cultural impediments of perceived shame to accessing services was significantly assisted by the availability of Aboriginal and Torres Strait Islander operated services. Mainstream services needed to be sensitive to the need for privacy, demonstrate an understanding of the social and emotional issues beyond the physical needs of the client and offer an Aboriginal and Torres Strait Islander workforce with experience of local communities.
- Contribution of the media to stigma and community unrest was seen as negative and misleading, reinforcing stereotypes of Aboriginal and Torres Strait islander people with the potential to exacerbate fear and anger in the community.
- Participants with lived experience acknowledged that self-realisation and determination was the most effective cause of change, often driven by a desire to take responsibility for the wellbeing of their children or grandchildren.

Existing approaches in Aboriginal and Torres Strait Islander communities

From the literature, there is a paucity of information about initiatives specific to stigma and discrimination related to alcohol and other drug use of Aboriginal and Torres Strait Islander people. Characteristics of approaches that have been identified in this area are that approaches:

- can be universal or focus on specific systems and settings
- utilise a mix of strategies
- address different manifestations of stigma, including interventions for self-stigma, social stigma and structural/ institutional stigma.
- Lessons learned from existing approaches include:
- development of a multifaceted, multilevel approach
- addressing factors that contribute to discrimination
- addressing negative media portrayals
- empowering communities and individuals
- developing local resilience
- improving service accessibility
- informing and educating the public.

Research participants spoke of their overall weariness with mainstream services. They were sceptical of the effectiveness of services and the support provided to Aboriginal and Torres Strait Islander clients and perceived that the mainstream system overall fails to meet their needs. Most participants perceived that staff employed at mainstream services do not understand the values, lores and diversity of Aboriginal and Torres Strait Islander cultures and peoples.

Some of the issues experienced in the design and operation of mainstream services included:

- focus on mainstream services and failure to consult community
- focus on bureaucratic outputs rather than client outcomes
- missed opportunities with Aboriginal and Torres Strait Islander liaison officers that were either not properly functioning or under-resourced in communities
- failure to support offenders when they are released from prison.

The overwhelming majority of research participants preferred services by Aboriginal and Torres Strait Islander operated providers compared to services provided by the mainstream system.

However, a few participants were dissatisfied with the equity of services offered by Aboriginal and Torres Strait Islander service providers. Some participants also perceived *'gatekeepers'* in communities who were employed in Aboriginal and Torres Strait Islander service provision roles and who controlled how funds and related information are distributed to communities. These people, who may or may not be of Aboriginal and Torres Strait Islander background, are perceived to have been employed in these roles for *'decades'* and contribute to the system's resistance to change.

Most participants felt that they cannot get support with mental health and problematic alcohol and other drug use where and when they need it. Participants attributed this in large part to:

- gaps in services and lack of culturally appropriate services
- lack of services across different levels of potential harm from alcohol and other drug use.

Barriers to accessing services were identified as including:

- remoteness and marginalisation within geographic and social contexts
- feeling safe and the need to develop trust and more culturally appropriate service environments
- ideal service location and settings to overcome perceptions of shame in accessing services.

Views from the service system

Existing initiatives by mainstream services described by local sector stakeholders in the visited communities included the use of Indigenous Liaison Officers, Aboriginal and Torres Strait Islander Mental Health Officers and Aboriginal and Torres Strait Islander Mental Health Coordinators; collaboration with Aboriginal Community Controlled Health Services to promote mainstream programs and establish referral pathways; sharing of clinical staff; local awareness campaigns and events; and use of Aboriginal and Torres Strait Islander specific programs, tools and resources.

Efforts by local sector stakeholders to overcome gaps in services included an increase in prevention and early intervention programs and services, and care coordination that can also address employment and housing needs of individuals who experience problematic alcohol and other drug use. In one instance, new funding had been made available to provide an after-hours service offered by a mainstream Mental Health Service.

A range of broader state-wide developments were viewed by state-wide government sector research participants as relevant to contributing to improved social and emotional wellbeing outcomes for Aboriginal and Torres Strait Islander people living in Queensland. These formalised policies, strategies and regulations included a commitment to a shared goal of supporting communities to move from outcomes of surviving to thriving, legislative recognition of the cultural rights of Aboriginal and Torres Strait Islander people, placing decision making about housing solutions at the local level in partnership with Queensland Health in remote and discrete communities, and advancing education through partnering between education and health, including providing services to address the developmental vulnerability impacting on education outcomes for Aboriginal and Torres Strait Islander students in remote schools.

Sector stakeholders identified a range of approaches that had contributed to improved outcomes for Aboriginal and Torres Strait Islander people. These approaches are consistent with those considered desirable by research participants generally, and included:

- employing Aboriginal Health Workers and people with experience in community
- taking a holistic approach to meeting client needs, and working with families
- educating staff at mainstream services on Aboriginal and Torres Strait Islander peoples, cultures and community history
- engaging the entire community and using local knowledge
- integrating local services to improve earlier access to services
- reaching out into community, door to door, and travelling to other remote communities.

Similarly, challenges to effective service delivery identified by state-wide sector stakeholders are consistent with issues raised by Aboriginal and Torres Strait Islander community member participants. These included a fragmented mainstream mental health system, lack of trust and cultural understanding in mainstream services, recruitment and retention of staff, reduced availability of suitable rehabilitation centres, and complexities of supporting co-morbid mental and alcohol and other drug use conditions.

Opportunities and potential approaches to address stigma and discrimination in Aboriginal and Torres Strait Islander communities

Most research participants expressed a desire for their communities to be properly consulted on any changes to the service system and ultimately to be empowered to find their own solutions to issues relating to mental health and problematic use of alcohol and other drugs. They saw the engagement and empowerment of local Elders and mentors as contributing to a more sustainable and culturally appropriate approach to finding solutions.

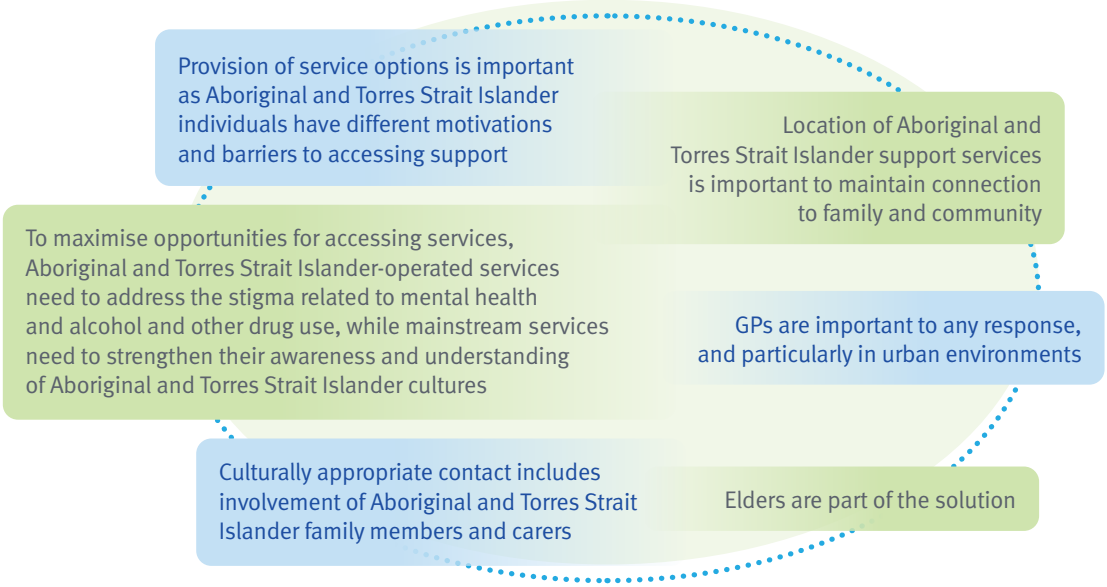
Research participants perceived that to be successful, a multifaceted approach to reducing racism and improving the social and emotional wellbeing of Aboriginal and Torres Strait Islander people should incorporate:

- a whole of system approach to address racism
- a physical, emotional, social and spiritual approach to health
- genuine engagement with community and opportunities to empower the community in addressing issues
- a system serviced by employees who are culturally trained and aware, and who can create a safe place for interaction with Aboriginal and Torres Strait Islander clients.

Suggested improvements from sector research participants to improve service delivery in Queensland included support of cultural understanding and engagement of Aboriginal and Torres Strait Islander people in health services, an increased focus on prevention and primary health care, and addressing trauma and strengths and resilience within communities.

The components of a trauma-informed framework was perceived by research participants to be lacking in most encounters with mainstream service providers. These components included lack of safety, inadequate displays of trustworthiness, lack of trusting relationships, little or no collaboration with community, often no choice in how treatments/services could be offered and no focus on understanding the cultural implications of working with Aboriginal and Torres strait Islander families and communities. These are all areas requiring a strengthened response from mainstream services in contributing to reduced stigma and discrimination and improved health outcomes for Aboriginal and Torres Strait Islander people living in Queensland.

Finally, it is essential that QMHC and related agencies consider how they can further engage and involve Aboriginal and Torres Strait Islander individuals, families and communities when guiding the development of options for reform informed by this research. The following, suggested by research participants and the evidence for good practice, provide a few key principles to continue this conversation.



Section 1

Background and approach

This chapter provides the background and an overview of the approach to this research.

This project is part of QMHC's ongoing conversation with Aboriginal and Torres Strait Islander people living in Queensland.

In previous conversations with QMHC, Aboriginal and Torres Strait Islander people living in Queensland indicated that:

- Social and emotional wellbeing for Aboriginal and Torres Strait Islander people means achieving one's full potential, being happy and fully participating in the community. It includes having a strong sense of identity, being connected and knowing where one fits within their community. Feeling and being safe (not only physically) and valued by the broader community is essential. At the heart of good social and emotional wellbeing is pride in culture
- Self-determination and reconciliation are important to social and emotional wellbeing
- There is a need to focus on healing ongoing trauma relating to historical practices and current circumstances
- Racism and discrimination is one of the main issues impacting social and emotional wellbeing. It directly affects self-esteem but also acts as a barrier to services, treatment and supports. While there are laws in place to protect people from racism, it can be difficult to enforce these rights to be treated fairly and equally (QMHC, 2016b).

Aboriginal and Torres Strait Islander communities, cultures and people are resilient. It is important that efforts to improve social and emotional wellbeing build on and learn from the strengths and resilience within Aboriginal and Torres Strait Islander communities as presented also in this report.

1.1 Research background

QMHC is a statutory body established to drive ongoing reform towards a more integrated, evidence-based, recovery-oriented mental health and substance misuse system in Queensland.

The roles of QMHC include undertaking and commissioning research in relation to mental health and substance misuse issues and considering the views, needs and vulnerabilities of Aboriginal and Torres Strait Islander individuals and communities.

QMHC does not provide direct service delivery but works with other sectors and agencies including health, education, child safety, employment, police and justice, local government, housing and others to meet its responsibilities under the *Queensland Mental Health Commission Act 2013*.

QMHC actively seeks the views and experiences of people with lived experiences[4] to help shape its reform agenda. QMHC's *Strategic Plan 2014–2019* stated as a key principle:

> *'The unique experiences of individuals, families and communities are central to our work. People living with mental health difficulties or issues related to substance use must be engaged as valued partners in guiding reform and in service development, planning, delivery, monitoring, and evaluation. Their active and informed involvement in decisions that affect them will lead to better outcomes.'*

This research project honours this principle, and is part of QMHC's ongoing conversations with individuals, communities and health sector stakeholders in Queensland, and specifically with Aboriginal and Torres Strait Islander people living in Queensland.

QMHC engaged with Aboriginal and Torres Strait Islander individuals and communities during the development of its *Queensland Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Action Plan 2016–18* (the Action Plan).

During community consultations[5], Aboriginal and Torres Strait Islander people living in Queensland articulated the profound impact that racism[6], discrimination and negative stereotypes have on their social and emotional wellbeing. This is also evident in research conducted in Australia and internationally that has shown a strong association between experiences of stigma and discrimination and poor health and psychological distress, mental health conditions, and risk behaviours such as alcohol and/or other drug misuse (Australian Government, 2014).

QMHC heard also from Aboriginal and Torres Strait Islander people living with problematic[7] alcohol and other drug use that stigma and discrimination can be experienced in many ways. It can act as a barrier to people seeking and receiving help and can hinder their recovery.

4 *Person with direct personal experience of mental illness and/or problematic alcohol and other drug use OR family member, carer or support person who has regularly provided unpaid care or support for a person living with mental illness and/or problematic alcohol and other drug use*

5 *A series of community forums were held in the Torres Strait, Cairns, Townsville, Rockhampton, Mount Isa, Logan, Ipswich, Toowoomba and Brisbane between April and June 2016*

6 *Aboriginal and Torres Strait Islander people used the term 'racism' — a form of stigma and discrimination induced from labelling people of the same race — to describe their everyday experiences of stigma and discrimination*

7 *Any use of alcohol or other drugs that leads to immediate or long-term harm*

To address these issues, QMHC's Action Plan included a commitment to:

> *'Scope and commence research into the impact of stigma and discrimination related to problematic alcohol and other drug use on Aboriginal and Torres Strait Islander communities, families and individuals. The project will be developed in consultation with key Aboriginal and Torres Strait Islander non-government organisations and relevant government agencies. The project will recognise that a larger proportion of Aboriginal and Torres Strait Islander people do not drink alcohol. It will consider not only the impact of stigma and discrimination on people who are experiencing problematic alcohol and other drug use but also the negative stereotypes that effect the social and emotional wellbeing of all Aboriginal and Torres Strait Islander people.'*

In early 2018, QMHC commissioned ACIL Allen Consulting (ACIL Allen) in partnership with The Seedling Group, an Aboriginal and Torres Strait Islander consultancy firm, to conduct this research project according to the above commitment.

This research project is part of QMHC's broader investigation to examine ways to reduce stigma and discrimination which have a negative impact on the mental health and wellbeing of people experiencing problematic alcohol and other drug use.

In 2017, QMHC commissioned similar independent research to understand experiences of stigma and discrimination for people experiencing problematic alcohol and other drug use in Queensland's broader population. QMHC used the findings of that research and, following further consultations with related government and non-government organisations and people with a lived experience of problematic alcohol and other drug use, developed the *'Changing attitudes, changing lives'* report (2018a). The report, which is relevant to all people living in Queensland, outlines options for reform to reduce stigma and discrimination for people experiencing problematic alcohol and other drug use in six key domains: human rights, social inclusion, engaging people with a lived experience and their families, access to services, the justice system, and economic participation.

This research project is the first aspect of a similar process to develop options for reform that are specific to, and will involve the ongoing engagement of, Aboriginal and Torres Strait Islander people living in Queensland.

Development of the reform options will be guided by QMHC's review of the findings of this report and further consultations with Aboriginal and Torres Strait Islander communities and relevant government and non-government sector stakeholders.

1.1.1 Research objectives

The objective of this research project is to capture the experiences and views of a selection[8] of Aboriginal and Torres Strait Islander people living in Queensland and sector stakeholders, and develop findings that will be used to inform QMHC's ongoing process to develop options for reform in the mental health and alcohol and other drugs system in Queensland.

The long-term aims of these reforms (which will require ongoing commitment, joint planning and multiple evidence sources) will be to:

- reduce racism experienced by Aboriginal and Torres Strait Islander people living in Queensland
- remove barriers for Aboriginal and Torres Strait Islander people who need to access alcohol and drug support and treatment
- improve the social and emotional wellbeing of Aboriginal and Torres Strait Islander people living in Queensland.[9]

1.1.2 Research scope

The research focuses on identifying and analysing the impact of stigma and discrimination based on the experiences and perceptions of research participants. The research does not aim to quantify the extent of the impact of stigma and discrimination using Western science methodologies, and/or measure how change can be achieved with specific interventions.

The scope of this research project includes qualitative examination of:

- the impact of stigma and discrimination on Aboriginal and Torres Strait Islander research participants who are experiencing problematic alcohol and/or other drug use — including the impact on their social and emotional wellbeing, and on their ability to seek and obtain help/support from the community and from treatment and other support services, and their ability to recover
- the impact of negative stereotypes related to problematic alcohol and/or other drug use on the social and emotional wellbeing of Aboriginal and Torres Strait Islander selected research participants, their everyday life experiences, and their ability to participate in the community and to access services
- how stigma and discrimination in relation to Aboriginal and Torres Strait Islander people presents and manifests in different settings and circumstances, including circumstances where stigma and discrimination is not experienced and differences between problematic alcohol use and/or other drug use.

8 *See 1.3.3, 1.3.4, 1.3.5 for details*

9 *Queensland Mental Health Commission 2017, ITO for Impact of stigma and discrimination related to problematic alcohol and other drug use on Aboriginal and Torres Strait Islander communities, families, and individuals*

1.2 A culturally informed approach

The project was designed to follow best practice in Aboriginal and Torres Strait Islander-related research and was guided by the involvement of Aboriginal and Torres Strait Islander organisations and individuals.

ACIL Allen undertook the project in partnership with The Seedling Group who led engagement with Aboriginal and Torres Strait Islander people and communities. This included facilitating consultations with Aboriginal and Torres Strait Islander people conducted as part of this project.

The research project was governed by a Project Steering Group established by QMHC to inform and support the project with more than 50 per cent representation from Aboriginal and Torres Strait Islander people.

ACIL Allen and The Seedling Group sought multiple letters of support for this research from appropriate Aboriginal and Torres Strait islander community representatives prior to visiting each location. This process involved conducting initial face-to-face meetings in some of the communities, where requested, to introduce the proposed research and discuss the potential involvement of the community.

A key point of liaison with community was established through the identification and remuneration of Aboriginal and Torres Strait Islander individuals who are recognised members of communities who acted as local co-facilitators for community visits.

The research approach was designed to build and strengthen existing community capacity for Aboriginal and Torres Strait Islander people in communities through:

- employing local Aboriginal and Torres Strait Islander co-facilitators
- strengthening the research experience and skills of the local co-facilitators who were involved in identifying research participants and coordinating activities during community visits
- empowering local Aboriginal and Torres Strait Islander decision-making and leadership by involving local agencies and Aboriginal and Torres Strait Islander community leaders in the research
- involving the local Aboriginal and Torres Strait Islander co-facilitators and local agencies in decisions for selecting appropriate consultation dates, venues and food hire, and with arranging cultural protocols; advising on recruitment of research participants and liaising with local stakeholders and communities
- the paid participation of members of the community consistent with QMHC's Paid Participation Policy
- bringing Aboriginal and Torres Strait Islander members of the community together during group discussions, and sharing of food and prayer, which build existing relationships and connect individuals for a common purpose
- providing a safe and inclusive experience for research participants and developing a suitable consultation basis for future engagement with the communities
- developing and sharing snapshots of de-identified community feedback with each of the communities visited for this research.

Trauma-informed practice and care principles

ACIL Allen and The Seedling Group followed culturally safe Trauma-Informed Practice and Care (TIPC) principles during the development and implementation of this research, including culture, safety, choice, trustworthiness, collaboration and empowerment.

The TIPC principles guided the researchers' work from preparation of visits to communities and recruitment of participants through to post-visit engagement with the community.

Prior to visiting each community, regular contact was made with the local Aboriginal and Torres Strait Islander co-facilitators and relevant agencies to ensure the TIPC process has been one of collaboration and informed by local needs. Co-facilitators and community Elders were able to choose venues for the community consultations, collaborate on who attended and supported community member participants, what cultural protocols where appropriate and empowered to say how they would like to share knowledge and how they would like to receive knowledge in return.

Related procedures included:

- recruiting participants with low likelihood of experiencing adverse impacts
- ensuring participants felt physically and emotionally safe and that they were comfortable with the proceedings, including selecting venues where participants felt safe to share their experiences
- facilitating discussions in a culturally appropriate and trauma-informed manner
- ensuring support is available and accessible to research participants, following their participation
- following up with communities after our visit to ensure that information on local supports is still available to participants.

Ethical and research governance approvals

This research project was approved by the:

- Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS) Human Research Ethics Committee (HREC)
- Queensland Hospital and Health Services HRECs:
  - Far North Queensland
  - Townsville
  - Central Queensland.

Research governance approval for conducting this research at individual Queensland Health sites was provided by:

- Torres and Cape Hospital and Health Service
- North West Hospital and Health Service
- Central Queensland Hospital and Health Service
- Metro South Hospital and Health Service.

The ethics approval requirements included letters of support from specific Aboriginal and Torres Strait Islander service providers and/or individuals with authority to speak for community. In some instances, this necessitated a further round of requests for written support. Where this did not align with research governance requirements further consultation was required to follow due process.

1.3 Research methodology

The research project involved three data collection and analysis activities, namely:

1. Literature review

The literature review, completed in 2018 to inform subsequent stages of the research project, sought to:

1

Explore relevant frameworks and suggest definitions for:

- social inclusion
- stigma and discrimination
- problematic use of alcohol and other drugs
- social and emotional wellbeing.

These terms will be defined and explored further during our conversations with research participants in communities.

2

Provide an overview of the support and recovery service system in Queensland for individuals who are experiencing problematic alcohol and other drug use, and specifically for Aboriginal and Torres Strait Islander Queenslanders.

3

Summarise and analyse international, inter-state and Queensland research, programs and initiatives or other mechanisms that:

- strengthen social inclusion
- reduce stigma and discrimination
- improve social and emotion al wellbeing.

4

Identify and list gaps in existing research.

Key findings from the literature review are presented in this report.

2. Community consultations

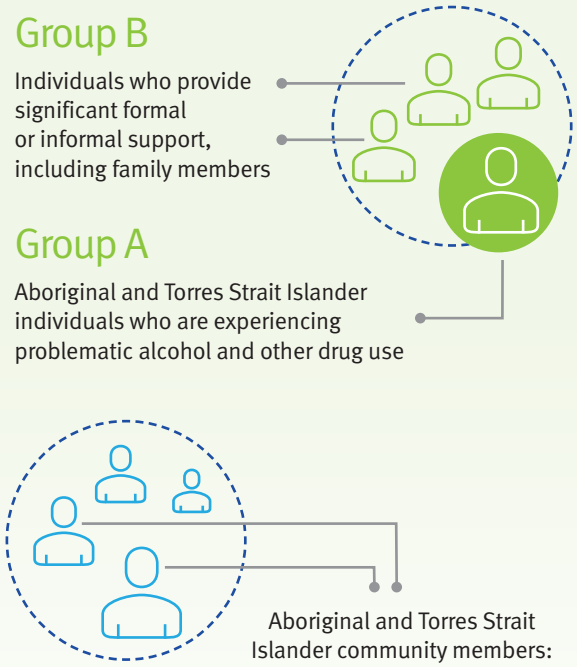
Between April and October 2019, ACIL Allen and The Seedling Group (the researchers) visited five locations in Queensland (Cairns/Yarrabah, Inala, Mount Isa, Rockhampton/Woorabinda and Thursday Island) to capture the views and experiences of:

i) A portion of Aboriginal and Torres Strait Islander people who are experiencing problematic alcohol and/or other drug use, and the people who support them (referred to as Group A and Group B research participants, *see diagram right*)

ii) Aboriginal and Torres Strait Islander community members irrespective of whether they engage in alcohol and/or other drug use (Group C)

iii) Aboriginal and Torres Strait Islander community leaders, including Elders or community mentors (Group D).

Community research participants



3. Consultations with sector stakeholders

The researchers have interviewed local sector stakeholders in the communities visited, and *Queensland-wide* sector stakeholders (Group E, *see diagram right*).

Sector stakeholders work in government and non-government agencies that provide:

a) support for Aboriginal and Torres Strait Islander people experiencing problematic alcohol and other drug use[10]

b) broader health, housing, justice, education and employment, and other social support services.

The Queensland-wide sector consultations included individuals from the Queensland Department of Health, Department of Housing and Public Works, Department of Education, Department of Youth Justice, Department of Aboriginal and Torres Strait Islander Partnerships, and Family Matters Queensland.

Sector research participants

Group E

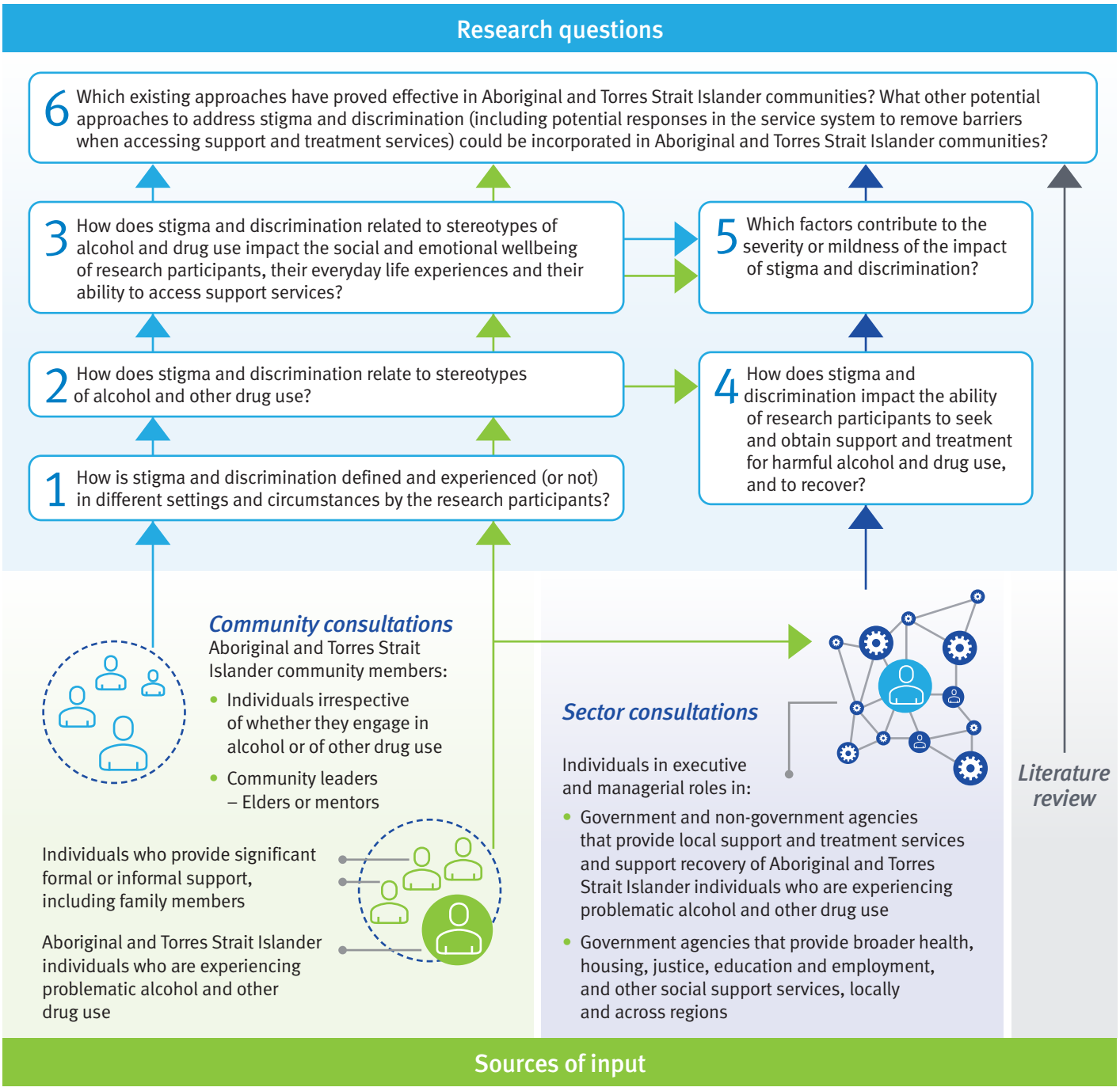
Individuals in executive and managerial roles in:

- Government and non-government agencies that provide local support and treatment services and support recovery of Aboriginal and Torres Strait Islander individuals who are experiencing problematic alcohol and other drug use
- Government agencies that provide broader health, housing, justice, education and employment, and other social support services, locally and across regions

10 *Including organisations servicing the general public*

1.3.1 Research framework

The diagram below demonstrates the research's conceptual framework — essentially, how the three research data collection and analysis activities (literature review, community consultations, and sector consultations) provide input to our analysis. This final report addresses the six research questions set out in the diagram.



1.3.2 Research governance

The project was guided by a Project Steering Group (PSG). The PSG was established by QMHC to include representation from Aboriginal and Torres Strait Islander people, and representation from related agencies in Queensland.

PSG members have included:

1. Eddie Fewings (Chair), a Mbabaram man; Queensland Aboriginal and Islander Health Council and Queensland Indigenous Substance Misuse Council representative
2. Rebecca Lang; Queensland Network of Alcohol and other Drug Agencies (QNADA)
3. Dion Tatow, an Iman and Wadja man and a South Sea Islander; Queensland Aboriginal and Torres Strait Islander Child Protection Peak (QATSICPP)
4. Jayde Fuller, Kamilaroi woman; Aboriginal and Torres Strait Islander Health Branch, Queensland Department of Health
5. Jade Daylight-Baker; Aboriginal and Torres Strait Islander Health Branch, Queensland Department of Health
6. Julie Reidy; Mental Health, Alcohol and Other Drugs Branch, Queensland Department of Health
7. Jodie Luck, a Gurang Gurang/Kooma woman; Anti-Discrimination Commission Queensland
8. Ian Mackie; Deputy Director General, Queensland Department of Aboriginal and Torres Strait Islander Partnerships.

1.3.3 Selecting locations

The project involved visits to five locations (Cairns, Inala, Mount Isa, Rockhampton and Thursday Island) in Queensland to conduct consultations with members of the community and sector stakeholders.

The focus on five locations reflects the need to develop in-depth rather than generic understanding of the research questions, while allowing for appropriate and respectful engagement of research participants.

ACIL Allen recognises that these five locations and the individuals who participated in our research are not representative of the extensive diversity in history, knowledge systems, world views, values, beliefs and experiences of Aboriginal and Torres Strait Islander people living in Queensland. The lived experiences of the research participants are presented as only a 'snapshot' of the diversity in Aboriginal and Torres Strait Islander individuals and communities in Queensland.

The five locations for community consultations were selected in collaboration with QMHC and the PSG, aiming to maximise diversity in geographic, community and alcohol and other drugs service settings in Queensland.

Following recommendations from local Aboriginal and Torres Strait Islander co-facilitators, the researchers consulted also with individuals in the Woorabinda and Yarrabah communities as part of their visits to Rockhampton and Cairns respectively. Although these communities are situated geographically close to their respective cities, they are significantly different in that they are discrete communities with their own distinct histories and social fabric.

1.3.4 Selecting community research participants

The researchers involved local Aboriginal and Torres Strait Islander people in decisions that related to the community visits and the selection of Aboriginal and Torres Strait Islander community research participants.

This included working with:

- local agencies (including Queensland Health Hospital and Health Service sites via formal research governance processes) and community groups that provide support to Aboriginal and Torres Strait Islander people who are experiencing problematic alcohol and/or other drug use to identify and recruit Aboriginal and Torres Strait Islander individuals in each community who are experiencing problematic alcohol and/or other drug use (Group A participants), and people who support them, including family members (Group B participants)
- local Aboriginal and Torres Strait Islander co-facilitators to identify and recruit Aboriginal and Torres Strait Islander community members (Group C participants) irrespective of whether these members engage in alcohol and/or other drug use
- local Aboriginal and Torres Strait Islander co-facilitators in each community to identify and recruit appropriate Aboriginal and Torres Strait Islander community leaders, including Elders or community mentors (Group D participants).

1.3.5 Selecting sector research participants

The researchers selected sector research participants in each location following discussions with the local agencies/community groups that assisted in the recruitment of Group A and B participants, discussions with the local Aboriginal and Torres Strait Islander co-facilitators and via Queensland Health's formal research governance processes for Hospital and Health Service employees.

Sector stakeholders who are not based in the five research locations and who work in agencies covering services across Queensland were selected via consultation with QMHC.

1.3.6 Methodological challenges

The original methodology for this research included obtaining ethics approval from the AIATSIS HREC. The AIATSIS HREC is registered with the National Health and Medical Research Council and reviews research projects against the National Statement on Ethical Conduct in Human Research and against the AIATSIS Guidelines for Ethical Research in Australian Indigenous Studies.

The application to the AIATSIS HREC outlined a strong community consultation component, supported by a partnership with The Seedling Group, and involving a respectful and considered approach to each selected community. As set out in *Section 1.2*, this approach featured:

- identification and remuneration of local co-facilitator(s)
- obtaining letters of support from each community
- meetings with key community members prior to conduct of research to ensure an understanding of the research purpose and to gain an awareness of any community issues to be taken into account to ensure effective engagement
- commitment to provide feedback to community about what we heard.

Considerable effort was needed to demonstrate to the AIATSIS HREC the value of qualitative research into the experiences of stigma and discrimination to the potential to make a difference to the lives of Aboriginal and Torres Strait Islander people.

At the meeting of this project's PSG on 26 September 2018 it was suggested that any research in Queensland involving a Queensland Health and Human Services (HHS) site may require a separate set of ethics approvals. Working through QMHC, this requirement was confirmed with no opportunity to pursue a potentially more streamlined central process that might have been more proportionate to the impost on HHS sites and level of risk, and to have given some weighting to research approval received from AIATSIS HREC.

The HHS ethics and research governance approval processes are summarised in *Section 1.2*. These processes were commenced in November 2018 and clearance was received for the last of the five locations to be visited in September 2019. The ethics clearance process for this project had originally been estimated at up to three months and in the event, the three-tiered process (national, regional and local) and the requirement for additional submissions and letters of support from communities, had taken a total of 14 months.

The following factors contributed to the extended HHS ethics and research governance approval timeframe:

- ongoing changes to the HHS processes relating to ethics and research governance submissions including recent transition to an online portal (ERM) for submissions
- high staff turnover in ethics and research governance coordinator roles in some HHS
- despite the centralised portal for submission (ERM), distinct requirements in each HHS for:
  - letters of support from communities
  - application and submission forms and documentation (including researcher Curriculum Vitae forms, and additional forms to the standard HREA submission form)
  - hard copy and/or online submission of documents
  - research collaboration agreements
  - authorisations and related forms for HHS site operational and financial executive approval
  - notification of research commencement and progress reports.

The separation of Alcohol, Tobacco and Other Drug (ATOD) services and Aboriginal and Torres Strait Islander health units within Queensland Health further complicated these processes. One of the HHS ATOD units maintains its own research governance processes in addition to the overall HHS processes and separate to requirements from HHS sites for Aboriginal and Torres Strait Islander clients.

Some of the complexities encountered in navigating these processes that challenged communities, QMHC and the researchers included:

- Time elapsed between contact with communities to identify local co-facilitators and the ability to enter community to conduct research, which required maintaining the connection with the local Aboriginal and Torres Strait Islander co-facilitators and ensuring that a suitable later start to the visit was feasible
- Delay in QMHC being in a position to consider a strengthened evidence base in contributing to planning to improve access to services for Aboriginal and Torres Strait Islander people living in Queensland
- Additional financial and in-kind resources from QMHC, the PSG and the researchers to ensure that HHS sites were given an opportunity to contribute to the research.

Section 2

Research context

This chapter clarifies the research's terminology and provides high-level context for alcohol and other drug use by Aboriginal and Torres Strait Islander individuals and related support, treatment, and recovery services in Queensland.

2.1 Key terms

The following are definitions adopted by QMHC in its various publications.

Stigma
The labelling and stereotyping of difference, at both an individual and structural societal level, that leads to status loss (including exclusion, rejection and discrimination) (QMHC, 2018a)

Discrimination
The lived effects of stigma — the negative material and social outcomes that arise from experiences of stigma (QMHC, 2018a)

Problematic use of alcohol and other drugs
Any use of alcohol or other drugs that leads to immediate or long-term harm (QMHC, 2018b)

Lived experience
A person is considered to have a lived experience if they:

- have a direct personal experience of mental illness and/or problematic alcohol and other drug use
- are a family member, carer or support person, and have regularly provided unpaid care or support for a person living with a mental illness and/or problematic alcohol and other drug use
- have experienced suicidal thoughts, survived a suicide attempt, cared for someone who has attempted suicide, or been bereaved by suicide. (QMHC, 2018b)

Social and emotional wellbeing
QMHC held community forums to understand Aboriginal and Torres Strait Islander experiences of social and emotional wellbeing as part of developing the *Queensland Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Action Plan 2016–18*.

During these forums, Aboriginal and Torres Strait Islander Queenslanders defined good social and emotional wellbeing as 'feeling happy, being and feeling culturally safe, having and realising aspirations and being satisfied with life… having a strong sense of cultural identity, being resilient and being able to cope and withstand adversity as well as recovering and healing from trauma' (QMHC, 2016a).

ACIL Allen's consultations with communities in Queensland and review of available literature found that few Aboriginal and Torres Strait Islander voices use the terms 'stigma' and 'discrimination'.

Aboriginal and Torres Strait Islander researchers and members of the community generally use the term 'racism' to describe experiences of stigma and discrimination.

2.2 Gaps in the available literature

As an initial component of this research, ACIL Allen conducted a review of existing research, programs and initiatives that address stigma and discrimination related to alcohol and other drug use, including within the broader principle of social and emotional wellbeing.

When conducting the literature review ACIL Allen acknowledged the importance of placing prominence on the voices of Aboriginal and Torres Strait Islander people, of critically examining the sources for underlying assumptions and of 'challenging the widely accepted belief that Western methods and ways of knowing are the only objective, true science' (Simonds & Christopher, 2013).

Overall, ACIL Allen found limited literature relating to stigma and discrimination relating to alcohol and other drug use that presents Aboriginal and Torres Strait Islander voices, including by Aboriginal and Torres Strait Islander researchers and involving Aboriginal and Torres Strait Islander research participants. This limits our understanding of Aboriginal and Torres Strait Islander peoples' lived experiences of stigma and discrimination in relation to alcohol and other drug use.

In research pertaining to experiences of Aboriginal and Torres Strait Islander people, stigma and discrimination is often referred to by the broader term 'racism'. From this perspective, the relationship between racism and other forms of stigma and discrimination is not well documented.

Lastly, most definitions in the literature for 'problematic' use of alcohol and other drugs lack the perspective of the user and exclude the broader socioeconomic impacts and context. As such, there are limited representations of 'problematic' use of alcohol and other drug use in the literature that take into consideration the holistic concept of Aboriginal and Torres Strait Islander social and emotional wellbeing, and are consistent with a culturally-safe and trauma-informed view.

This research project contributes towards addressing these gaps in the literature by presenting Aboriginal and Torres Strait Islander voices on stigma and discrimination related to alcohol and other drug use.

2.3 Alcohol and other drug use among Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people are less likely to drink alcohol than non-Indigenous people, and most Aboriginal and Torres Strait Islander people who consume alcohol drink in a manner that is not problematic (Australian Indigenous Health*Info*Net, 2018; AIHW, 2017; Gray et al., 2018).

Most Aboriginal and Torres Strait Islander people do not use illicit drugs (Australian Indigenous Health*Info*Net, 2018; AIHW, 2017; MacRae, 2016).

Levels of problematic use of alcohol, however, are higher among Aboriginal and Torres Strait Islander people than among non-Indigenous people, including by dependent drinkers, those who drink regularly and those who engage in heavy episodic drinking (Gray et al., 2018). Aboriginal and Torres Islander males are hospitalised in relation to alcohol use at 4.0 times the rate of non-Indigenous males and Aboriginal and Torres Islander females are hospitalised at 3.4 times the rate of non-Indigenous females (Australian Indigenous Health*InfoNet*, 2018).

Similarly, the proportion of illicit drug use is higher among Aboriginal and Torres Strait Islander people than among non-Indigenous people (MacRae, 2016). Hospitalisation for mental/behavioural disorders from use of amphetamines is 3.7 times higher for Aboriginal and Torres Strait Islander people than non-Indigenous people. The rate of drug-induced deaths is 1.9 times higher for Aboriginal and Torres Strait Islander people than for non-Indigenous people (Australian Indigenous Health*Info*Net, 2018).

Data limitations

The sources of health information in Australia rely on accurate identification of Aboriginal and Torres Strait Islander people, which is a complex and persistent challenge in data collection (Australian Indigenous Health*Info*Net, 2018).

The National Drug Strategy Household Survey (NDSHS), the most prevalent source for alcohol-related data, depends on sampling methods that assume linguistic and cultural understanding between interviewers and participants, and excludes homeless, itinerant people, and those who are in institutions such as hospitals and prisons — limitations that may lead to misrepresentation of actual consumption (Gray et al., 2018). The small sample size of Aboriginal and Torres Strait Islander people included in the NDSHS does not allow for robust comparisons with non-Indigenous Australians (MacRae, 2016).

The National Aboriginal and Torres Strait Islander Social Survey (NATSISS), and the Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS) — key sources for illicit drug use information — rely on self-reported data that may underestimate the true extent of use (MacRae, 2016). The NATSISS and AATSIHS' methods for collecting data on alcohol consumption are less rigorous than, and non-comparable to, the NDSHS results (Gray et al., 2018).

Data relating to Aboriginal and Torres Strait Islander people are criticised for focusing on the negative, reproducing rather than redressing the status quo, and being developed under limited Indigenous data sovereignty in Australia — gathered *'about rather than for or by Aboriginal and Torres Strait Islander people'* (Walter, 2018).

Causes

Data on the problematic use of alcohol among Aboriginal and Torres Strait Islander people needs to be understood within the historical and social context of colonisation, dispossession of land and culture, and social and economic disadvantage and exclusion (Gray et al., 2018). Factors contributing to alcohol use among Aboriginal and Torres Strait Islander people include the availability, price and marketing of alcohol, racism, and personal factors like stress, early life experiences, educational and employment disadvantage, and food insecurity (Gray et al., 2018).

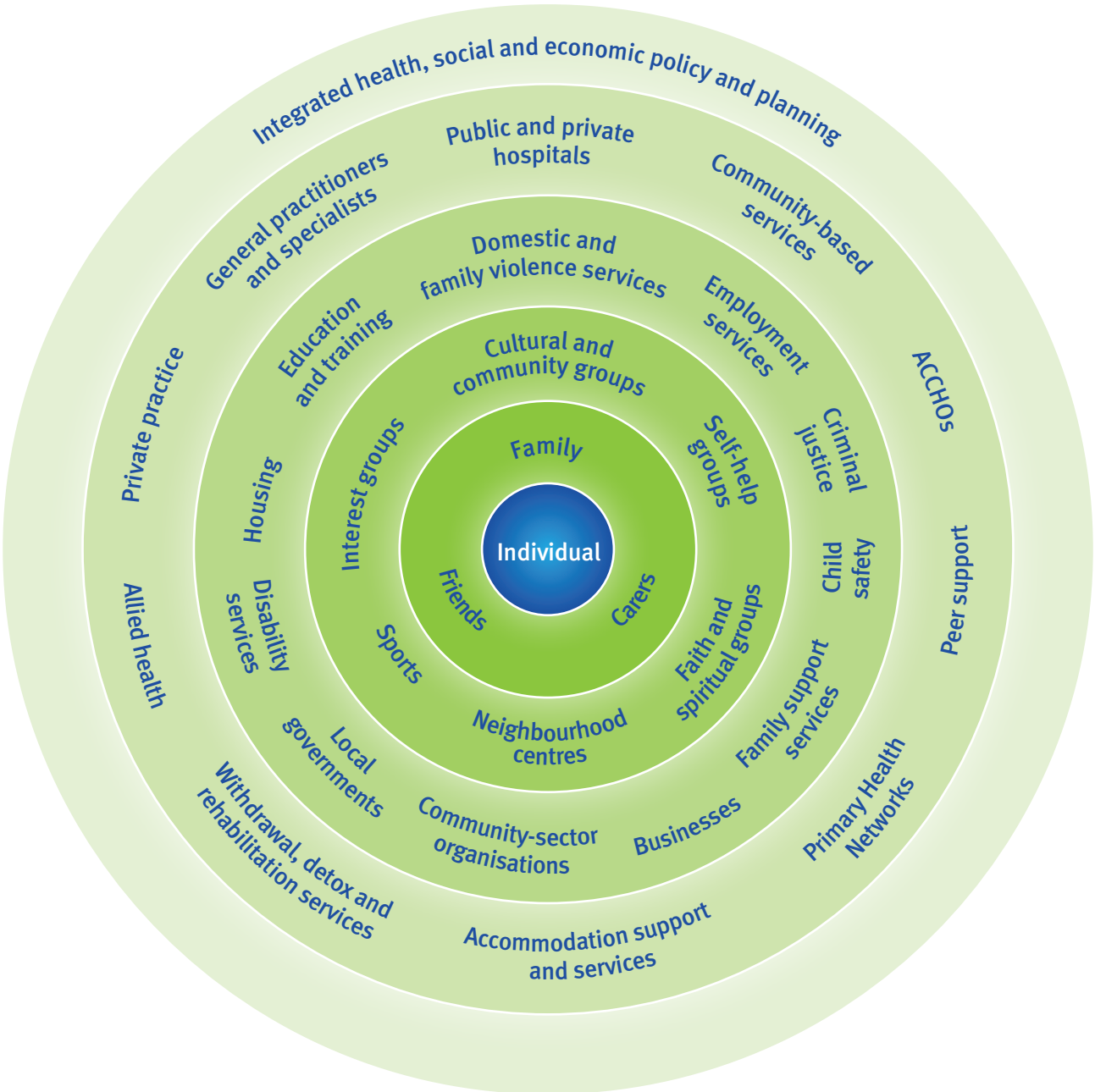
Various inquiries have highlighted the link between Aboriginal and Torres Strait Islander disadvantage, poor health and high levels of alcohol use as a legacy of past government policies (Gray et al., 2018).

2.4 Alcohol and other drugs support, treatment and recovery services in Queensland

The alcohol and other drugs service system in Queensland is serviced day-to-day by government (including Hospital and Health Services and services commissioned by the state and the PHNs), non-government service providers (including Aboriginal and Torres Strait Islander Community Controlled Health Services), and General Practitioners and other private healthcare providers.

The system operates within broader non-health policies and programs that are involved in supporting mental health and alcohol and other drug use interventions in Queensland and that contribute to the social and emotional wellbeing of individuals who experience problematic alcohol and other drug use. Support from families, friends, carers and community groups is also a core aspect of this context, as shown in *Figure 2.1*.

Figure 2.1 *Policy and service map for mental illness and problematic alcohol and other drug use.*



Source: Queensland Mental Health Commission 2018B

Support, treatment and recovery services for alcohol and other drug use can take many forms and occur in a variety of settings, bridging primary health care, early intervention, acute care and community-based and longer-term rehabilitation. A distinction is often made between generalist services that offer some alcohol and other drugs support and specialist alcohol and other drugs treatment services (MacBean, 2015).

Related services can focus on:

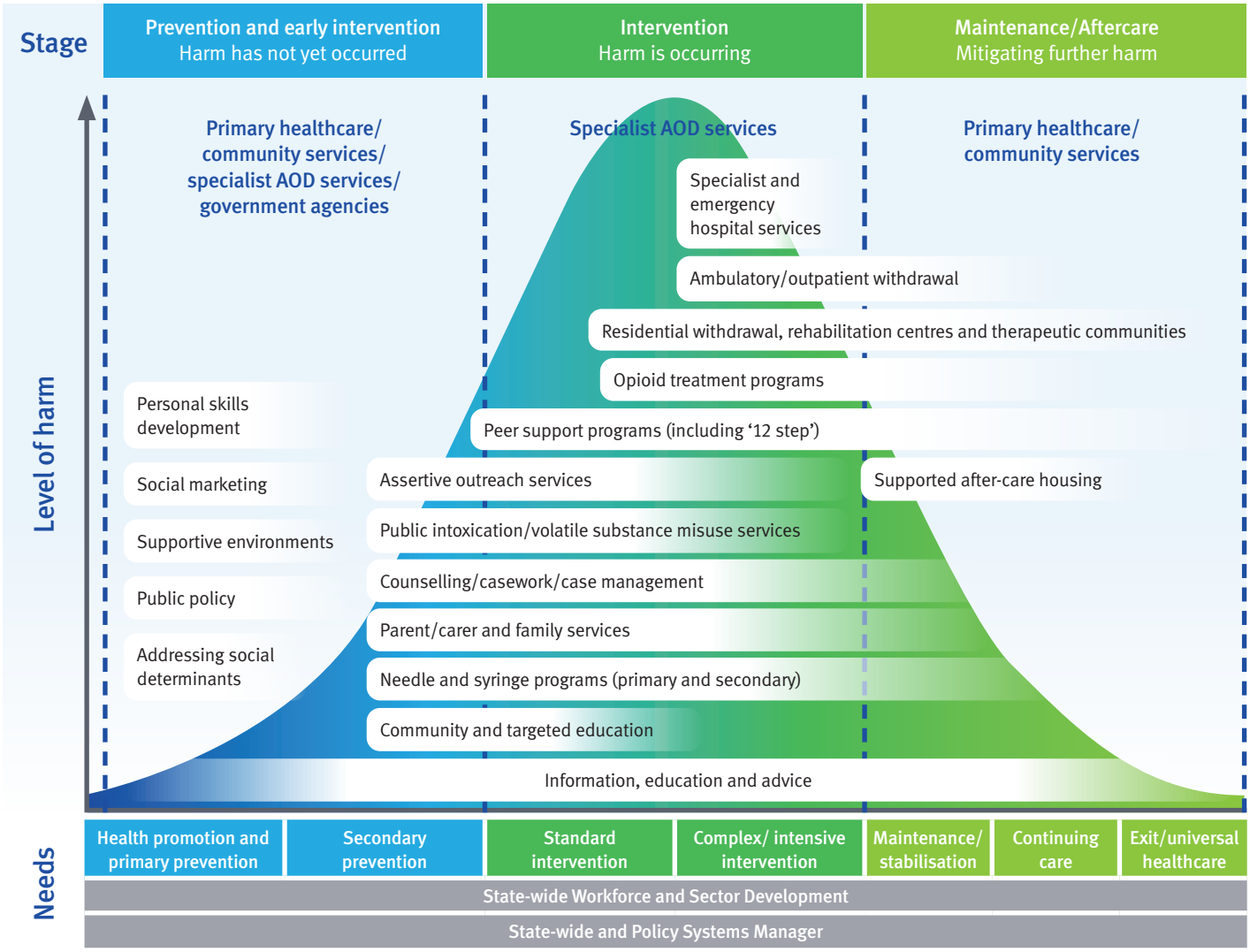
- information provision
- counselling and referral
- withdrawal management/detoxification
- residential treatment/rehabilitation
- medication-assisted treatment (for example opioid substitution therapy)
- post treatment support and relapse prevention
- case management, care planning and coordination
- diversion programs.

Figure 2.2 illustrates an overview of the alcohol and other drugs-related services in Queensland against the spectrum of substance-related harm.

The above framework applies to services for all Queenslanders. If it were developed, a specific framework for alcohol and other drug services for Aboriginal and Torres Strait Islander people would enhance understanding of the nature of culturally appropriate services in the sector, and strengthen analysis of coordinated and ongoing service provision in Queensland.

ACIL Allen's literature review found no information on the extent and overall sector effectiveness of alcohol and other drug service provision for Aboriginal and Torres Strait Islander people living in Queensland. The last mapping and review of alcohol and other drug service provision by the community-controlled Aboriginal and Torres Strait Islander sector in Queensland was completed in 2009 (Gray et al., 2009).

Figure 2.2 *Overview of alcohol and other drug-related services in Queensland.*



Source: Adapted from MacBean, R., Hipper, L., Buckley, J., Tatow, D., Podevin, K. & Fewings, E. (2015). Queensland Alcohol and Other Drug Treatment Service Delivery Framework. Qnada, Dovetail, QISMC, QAIHC and the Queensland Government.

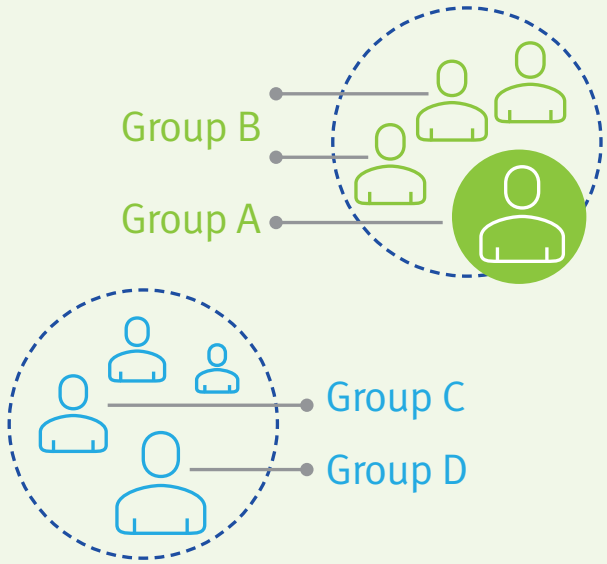
Section 3

Experiences and views

This chapter provides analysis based on discussions with Aboriginal and Torres Strait Islander research participants about their experiences of stigma and discrimination, including in relation to alcohol and other drug use, and the impact on their social and emotional wellbeing.

Community research participants

See Section 1.3



3.1 The shared experience

This section provides feedback from all Aboriginal and Torres Strait Islander community research participants: Elders, community members irrespective of whether they engage in alcohol and other drug use, and individuals with lived experience of problematic alcohol and other drug use.

This chapter's references to 'research participants' involve analysis of feedback from all the above groups.

The analysis includes also references to specific participant groups to highlight key variations of opinion from the other participant groups and to identify the source of quotations.

3.1.1 Racism as the predominant form of stigma and discrimination

Aboriginal and Torres Strait Islander participants in communities consulted for this research described their experiences of stigma and discrimination using the term 'racism'. For many participants, being stigmatised and discriminated against are intrinsically linked to their racial and cultural identities and how non-Indigenous people perceive and respond to these identities.

Participants spoke of all forms of racism, including interpersonal, both overt and covert, as well as institutional (for example, where data systems don't allow for culturally safe practice, such as building relationships within community, to be recorded in work logs).

Research participants recognised that racist behaviour was linked to stereotypes of Aboriginal and Torres Strait Islander people, including in relation to their alcohol and other drug use, which conflate and reinforce the overall experience of racism. These stereotypes are discussed in *Section 3.1.2*.

Research participants demonstrated the general and pervasive nature of racism throughout their lifetime and within diverse personal, family and community settings.

> *Being black is a thing... People talk behind our backs. At Woollies, Centrelink... You feel it everywhere.*
>
> Elder research participant

> *(Racism) is everywhere... people's body language says a lot. The way they act towards us at Centrelink at places like Kmart. It's everywhere.*
>
> Community member research participant

Elder research participants perceived that most Aboriginal and Torres Strait Islander members in their communities have been experiencing racism *'since they were born'*, which complicates levels of understanding and awareness of their human rights and how racist behaviours impact their lives and wellbeing.

> *Most (Aboriginal and Torres Strait Islander people) don't understand their human rights and that how others treat them is not normal.*
>
> *White privilege — they don't understand what it is. What the impact is. When someone goes to a shop and they get serviced last, they don't know that's wrong. They think that's how things are.*
>
> *There's a lot of shame in the community. People are crushed, they can't look up and (they) think that being discriminated is normal... But it makes them feel bad.*
>
> Elder research participants

Research participants held diverse views and attitudes towards their experiences of racism. Some participants found strength to call out racist behaviour when they experienced it or *'rise above it'*. Others were more resigned and assumed racism is the *'normal state of things'*. Some participants were highly attuned to racist behaviour resulting in an overall caution and an element of apprehension in their dealings with non-Aboriginal people. A few participants expressed feelings of shame, hopelessness and anger about their experiences of racism and considered discussions about racism as being 'taboo'.

> *I was born guilty. So I had to prove them wrong. I got to fight for who I am and prove everyone is wrong... I've worked in security where racism is alive. I deal with racism, but I laugh at it. I was safe when I was wearing my work uniform but not when I was out shopping at the same place (laughs). You get followed and eyeballed...*
>
> Community member research participant

Participants who have lived or travelled in different community settings, including between communities with majority and minority Aboriginal and Torres Strait Islander populations, and in rural and urban areas, were most attuned to the presence and impact of racism.

> *I was brought up in the Torres Strait and I did not experience racism there. Only when I got to (regional town) did I experience it.*
>
> Elder research participant

Examples included the discomfort and isolation felt by a research participant in walking down the main road of a country town in a southern state where he recounted being stared at and being too intimidated subsequently to leave his accommodation. Another young man spoke about his experiences in a post-secondary education setting where there was an assumption that if he was 'proper black' he would have been poor and students wanting to know if the government was paying for him.

The pervasive impact of non-Indigenous people in community

Research participants perceived that many of the challenges that they and other Aboriginal and Torres Strait Islander community members experience are linked to the influence of non-Indigenous people, whom they described in most communities as 'white people'. Participants understood that 'white people' held most positions of power in state and local governments, as well as in most local businesses.

Lack of employment opportunities across areas requiring skilled and non-skilled workers was perceived as a key factor in creating the disadvantage and stress experienced by Aboriginal and Torres Strait Islander people. This included the opportunity for local councils and businesses, as major employers, to increase their employment of local Aboriginal and Torres Strait Islander people for jobs currently given to non-Indigenous workers, and for health and community service providers to develop a local workforce better able to respond to the needs of Aboriginal and Torres Strait Islander people.

> *They would rather give the job to someone not living here, to a foreigner, and do not give me an explanation, a straight answer as to why. I need honesty... I want to be treated equally.*
>
> Participant with lived experience

> *No training for young kids. Kids coming out of boarding school straight into alcohol and drugs. Too many people coming in from outside doing the jobs that community could do. Council is the biggest employer. Observed no real action within policies and programs.*
>
> Community member research participant

Participants experienced disadvantage in many ways, including limiting access to employment, a car and to housing where the cost of rental properties was reported to be too high.

In a community where most jobs were government jobs, a community member with a criminal record for not paying fines was unable to be employed.

In the Torres Strait, the housing support provided to workers recruited to positions in the Islands was viewed as both an issue of preferential treatment and a matter of overlooking a locally viable workforce, as well as a contrast to the perceived lack of a solution to housing access, high rents and overcrowding for local families.

> *Institutional racism occurs where accommodation support is provided for those coming into community to work but local families experience overcrowding.*
>
> Elder research participant

In other communities, high rents were also linked to housing supply. This was further complicated by unemployment and use of alcohol and other drugs, leading to an itinerant lifestyle and homelessness.

Many research participants spoke about widespread discriminatory behaviour by the police. This behaviour reflected a stereotyping of Aboriginal and Torres Strait Islander people by police officers, and the perception that police officers do not have adequate knowledge and experience in Aboriginal and Torres Strait Islander communities to respond appropriately to incidents. Examples included research participants being targeted for vehicle offences with excessive scrutiny by the police. Other stories recounted included a young male participant who spoke of undergoing a citizen's arrest while riding his new bicycle, with the local police insisting that he be detained until they arrived and checked the serial number of his bicycle. An older female participant was targeted by police when sitting with friends in a park, the alcohol carried in their bags being confiscated even though they were not drinking.

The police... they pick them (the Aboriginal and Torres Strait Islander kids) straight away. You don't see any (other racial group) in detention... A lot of the families hate the police and if you have those feelings they (police) will do things to you back.

The police should be taking them (the kids) home and talk to the family, not to the detention centre. Police are young and underqualified, they don't know how to react to things and it all escalates quickly. The young police can't handle it.

The police need proper cultural awareness. They are not listening to us, they need to step back and talk to us at ground level. They don't know how to treat us.

Elder research participants

There was an incident, there was a brawl, and the police came. I went with my niece and nephew to see what was going on with our car, and at some point I left and told (my niece and nephew) to wait for me there. The police went to my nephew and asked him to leave but he wouldn't 'cause he was respecting what I said to him. So they arrested him and took him to jail. They didn't approach him properly. They didn't listen. He was just respecting his auntie, but they thought he was after trouble.

Community member research participant

Some participants acknowledged that stigma and discrimination was experienced by many other groups in their communities of different racial backgrounds, genders, sexualities and geographic locations. Participants in communities with diverse populations acknowledged solidarity with other racial and cultural groups who also experience discrimination from 'white people'.

All around here, there's good people, especially the foreigners. They respect our culture, they know the struggles that we went through... the Africans.

Elder research participant

All this multicultural stuff here happening, I think it's better. Back in the day it was black against white, now it's different.

Community member research participant

Experiencing racism in everyday life

Research participants described several settings and situations where they experienced racist behaviours, including:

- in their encounters with the police as described in the earlier section
- in the attitudes of their non-Indigenous work managers and colleagues, including being overlooked for promotions or losing their job if seen as outspoken about the history and rights of Aboriginal and Torres Strait Islander peoples
- at school, in the attitudes of teachers and peers
- in their encounters with government agency staff, including in health and human services. Participants spoke about staff at health services questioning their parenting or assuming that they cannot support their children, or occasions when 'white people' will be attended to first in an Emergency Department
- at business and shopping centres, in the attitudes of security and sales personnel who would limit the size of the group of Aboriginal and Torres Strait Islander people on their premises and require they make a purchase or leave the premises.

The experience of racism was present for both young and older Aboriginal and Torres Strait Islander participants.

Young people spoke about differential treatment at school and in the workplace. One young participant was offered a lower standard of accommodation to that available to non-Indigenous people, while another was the first to be accused of causing damage to property despite being innocent. This treatment often led to leaving school and/or employment and needing to access welfare payments.

At high school, teachers didn't want to teach me. I was getting in trouble for things I didn't do. They were just assuming things about me, that I don't want to learn. Teachers were vicious.

Little black kids sit at the back. There's no aides to support teachers and kids.

Community member research participants

Older participants spoke about a fear and distrust of 'white man' as a legacy of recent and catastrophic policies of removing Aboriginal and Torres Strait Islander people from their communities and denying cultural practices. The impact of these policies was evident in community tensions and emerging generations and reinforced by current policies to manage use of alcohol in Aboriginal and Torres Strait Islander communities *(see Box 3.1)* and the prospect of introduction of the 'benefit' card.

Other participants acknowledged that the trauma and pain of historical injustice and discrimination of Aboriginal and Torres Strait Islander people is passed on by older people in the community, but held a desire to move beyond history to make a better life.

I can't change other people's minds. I gotta watch my own self. Our parents told us stories, they put their attitudes onto us. Felt their injustices. That affected the younger generation coming up. Their problem, not mine – trying to live a better life.

Community member research participant

Box 3.1 Views about Alcohol Management Plans

Participants who had personal experience or knew others in communities under alcohol management plans (AMP) associated AMPs with mostly adverse impacts on individuals and communities.

A participant perceived that AMPs resulted in individuals attempting to develop and/or sell counter products that pose a higher risk to health than alcohol.

> *Kids would homebrew alcohol that would be mainly sugar and that created sugar addictions. There is a lot of reselling and 'tampering' with the drinks. By the time (alcohol) gets down to the communities it's poison.*
>
> Community member research participant

Consistent with that perception was the unintended consequences of the restriction.

> *The AMP is about carriage limit rather than drunkenness. We have people going out of the community and binge drinking or bringing it back and drinking it before they get caught.*
>
> Participant with lived experience

The AMP itself was associated with stigma and was considered difficult to justify based on the statistics that showed a small number of people in community were affected by alcohol.

> *The AMP brings stigma – it is always bringing us down. Living like in my grandfather's day.*
>
> Participant with lived experience

There were perceptions that the AMP allowed people to be locked up if they presented to the hospital intoxicated, and that could lead to a criminal record which would disqualify people for government jobs.

> *If they get a criminal record they are not eligible for government jobs. People are scared off by needing a police check.*
>
> Participant with lived experience

Other participants perceived that punitive measures are not effective in changing behaviours.

> *Our mob is smart. They get adjusting to whatever measure is taken.*
>
> Community member research participant

Note: A review of Alcohol Management Plans (AMPs) was undertaken by the Queensland Government and finalised in mid-2019. Communities with AMPs in place that are in scope for this research are Woorabinda and Yarrabah. The review resulted in a renewed approach to AMPs that retains carriage limits but aims to implement a co-design approach with communities in the development of Community Safety Plans. The review was also informed by analysis that showed that breach of alcohol restrictions under the AMP had a low impact on criminal history.

Source: ACIL Allen Consulting 2020

Participants also talked about feeling that they are 'invisible'. This was often associated with the need to access health services, for example, where their interaction with staff was viewed as 'being talked down to', that no-one was listening to them and that they were being disrespected.

> *I was in the army, in Vietnam and did not find racism then. It was just brothers in arms. I didn't realise I had PTSD, that it was that bad. And I started seeking help. I had to talk to a psychiatrist, but they don't know nothing about black fellas. I felt stigma then... A lot of people (doctors) go by the book. This is what they know, they don't make it simple for us don't ask simple questions, to make people feel comfortable. They don't understand our culture. When they come in they don't know how to understand the whole thing.*
>
> Elder research participant

> *When I had depression, people could be around me but I felt isolated. 'I see you' – acknowledgement is a big thing. Separating the person from the problem is a big issue.*
>
> Participant with lived experience

Invisibility also came from a lighter skin colour where people might be included in racist discussions amongst mates because they were not perceived to be 'black'.

Discrimination amongst Aboriginal and Torres Strait Islander cultural and kinship groups

A few participants noted that they occasionally experience discrimination by other Aboriginal and Torres Strait Islander people because of their cultural, kinship and family backgrounds. These participants perceived that staff members at Aboriginal and Torres Strait Islander service providers provide preferential treatment to Aboriginal and Torres Strait Islander people of similar kinship and family backgrounds.

> *I went to this place (Aboriginal and Torres Strait Islander service provider) and they treated me differently. I had to be one of those people to get special help. You gotta be certain people for them. They get special treatment through family connection, and leave you waiting.*
>
> Participant with lived experience

> *We get discrimination at hospital, police, court houses but it's worst when done from our own.*
>
> *There's a lot of Indigenous workers in the service that are just in for the dollars. They gotta stop picking their own and choose the disadvantaged families. Not who they know.*
>
> Community member research participants

3.1.2 Stereotypes of Aboriginal and Torres Strait Islander people

As noted earlier, research participants recognised that racist behaviour was linked to stereotypes of Aboriginal and Torres Strait Islander people. Participants felt that they were stigmatised on the basis of their race, locality and assumed behaviours, including that they use alcohol and other drugs. These stereotypes conflated and reinforced their overall experience of racism.

Many participants exercised caution when interacting with non-Indigenous people in anticipation of being stereotyped as 'wanting to steal', 'at fault' and 'looking for trouble'.

> *There's a stigma attached to being black. When you walk into the shops, they think that you gonna steal. You are followed around. It's the colour of the skin, it's racial profiling.*
>
> *...the way you are greeted you know straight away and body language. First Nations people we can pick up anything from their body language.*
>
> *People judge you for everything. I feel the attitude of people, they may not say anything but I feel uncomfortable.*
>
> *You scope who is around you.. you don't go to places where they are going to run you around.*
>
> Community member research participants

Participants felt that they are often perceived by non-Indigenous people as 'unintelligent', including by their work managers and co-workers, and that they will 'probably fail' at given tasks.

> *Got to watch what you say and who you are around. You have your favourite places to go to where you don't get talked down.*
>
> *Sometimes find it hard to get your message across to a white person so play it a little dumb first to see where you are.*
>
> *When we go to meetings at work, we have to deal with their perceptions that we are not intelligent. They never think that we may have something to say. They don't know that we have a rich culture and a lot of useful information. That we are developed. That we can be better than them.*
>
> Community member research participants

Participants recognised that not all non-Indigenous members of their communities held stereotypical views of Aboriginal and Torres Strait islander people, and that these impressions are broken down once they establish regular social contact or when Aboriginal and Torres Strait Islander individuals are in leadership roles.

> *When people get to know you, they say 'black people are fun' and 'you are one of the good ones'.*
>
> *I don't have the same problem when I take tours and talk about culture.*
>
> Community member research participants

Elder participants spoke of the need to educate the broader population on racist behaviour.

> *We don't want the white fellas to feel guilty. Feeling guilty will not make any change. They just need to be aware that what they are doing is hurtful and that they can change their behaviour.*
>
> Elder research participant

Stereotypes of alcohol and other drug use

Research participants considered that assumptions about their use of alcohol and other drugs were part of the general stereotypes associated with their experiences of racism. The reported stigma and discrimination in this context was consistent with the experiences described earlier in this section.

Participants talked about public behaviours being perceived differently if the instigator is an Aboriginal and Torres Strait Islander person with a common assumption that the person may be 'drunk' or wanting to cause 'trouble'.

A young person spoke of being approached by strangers in nightclubs who assumed that he could sell them drugs.

> *When I am out, I am always being asked (by strangers) if I can get drugs. If you are the one (Aboriginal and Torres Strait Islander) person in the club you get asked. I am just out trying to have a good time, stop asking me for drugs!*
>
> Community member research participant

Community members shared common experiences of discriminatory behaviour from retail and entertainment businesses when attempting to purchase and consume alcohol, including:

- judgement and default limitations when attempting to purchase alcohol, including sellers assuming that the buyer is an 'alcoholic' when buying casks instead of bottles, buyers being asked for further identifications or being asked to register their details prior to purchases
- restrictive access to pubs and other premises that serve alcohol, including being refused entry with no explanation and automatic denial of entry in multiple premises
- preferential service to non-Indigenous people at pubs and bottle shops.

> *If you go to bottle shop, the pub, you get refused entry. They ring other bottlers and once they know you it's hard to go in.*
>
> *All think that because you are black you are an alcoholic. Automatically think you are going to buy a cask... Judged if buy a cask but not a bottle.*
>
> *They would get your driver's license and car registration to buy anything, but there's no real policy around that, they don't do that with other customers.*
>
> *"They (businesses that sell and serve alcohol) make up things here, their own rules and laws. Different rules for different people."*
>
> Community member research participants

3.1.3 Perceptions of alcohol and other drug use in the community

Research participants held varied views of the prevalence and risks of alcohol and other drug use by Aboriginal and Torres Strait Islander members of their communities.

To most participants, regular alcohol drinking and the use of some other drugs like cannabis were not automatically perceived as 'problematic', but rather that they provide a safety valve and means for relieving stress for some Aboriginal and Torres Strait Islander people from circumstances that are largely beyond the control of the individual.

There was little recognition amongst research participants of 'problematic' drinking in the context of binge drinking. Any violence associated with drinking, for example, was seen as reconciled the next day amongst mates and family members.

> *Alcohol was normal, it was drinking and fighting... the boys used to come and take mum to drink at the pub. After dad died, when she was 54, she started drinking cause there was nothing to do.*
>
> Community member research participant

Some female participants spoke about the family disruption because of binge drinking and considered this was a behaviour that they would like to see changed.

Some participants, including participants who use other drugs, held strong views towards, and abstained from, using alcohol as a response to their parents' drinking and related behaviours.

Dealing with pain, loss and trauma

Elder research participants noted that Aboriginal and Torres Strait Islander individuals and groups in their communities use alcohol and other drugs to deal with pain, fear and trauma.

The circumstances that contribute to these factors may be incidental, like the loss of a family member, or may be ongoing and more complex, like racism.

The Elders recognised that dealing with the loss of a family member is difficult and that individuals in their communities should be encouraged to grieve in culturally appropriate ways. They noted the importance of educating their communities to understand the connection between pain, grief and trauma and the use of alcohol and other drugs.

> *Grief brings people together, but it also makes them drink. We need to make sure that loss is not an excuse for drinking. We need to be more aware of that. People need to be educated to understand the connection between pain and what they are doing.*
>
> Elder research participant

Factors that contribute to potentially harmful behaviours

Research participants discussed the factors that may contribute to some members of their communities experiencing potentially harmful behaviours relating to the use of alcohol and other drugs. These factors, which are not presented in any hierarchy, included:

- a child and their family's traumatic experiences with child safety and care services

> *Kids go drinking and sniffing and end up suicidal... It's the way they were treated in care. Child safety is not good. They (the kids) come back and their lives are ruined.*
>
> Elder research participant

- experiences of domestic, family and community violence
- neglect and breakdown of social networks resulting in lack of family support and communication between family members

> *The kids need a hug. They need love. Someone to treat them well.*
>
> Elder research participant

- imitation of parent behaviour resulting in intergenerational drug use

> *As a father, I was there for my kids. But a lot of these kids don't have parents... it's how they are being brought up. If they don't get love... Kids are having kids. The parents are doing it (using alcohol and drugs) themselves. And the kids don't know how to speak to their parents... They don't know how to speak what the problems are, they can't find the words.*
>
> Elder research participant

- desire to belong to a group and peer pressure, particularly for males and as part of 'masculine' behaviours

> *It's the people around you, cousins mates they want to follow your lead so there's pressures.*
>
> Participant with lived experience

- experiences with the police, justice and corrective services, and the overall level of the system's response (either too strict or too lenient)
- lack of support services in communities, particularly for the youth

> *There's no place here for them (young people) to go when they need support. They just end up at the detention centre.*
>
> Elder research participant

- experiences of racism, stigma and discrimination relating to alcohol and other drug use
- financial concerns, including being unemployed.

The connection to mental health and related stigma

Many research participants, and particularly Elders, acknowledged that there are misunderstandings and stigma associated with the term 'mental health' and that this term is not used or discussed widely in their communities.

They noted that stigma related to mental health may contribute to some members of their communities using alcohol and other drugs to mask mental health issues, and may discourage these individuals from accepting and seeking support for their mental health. There was a perception that amongst family and community members, being seen as 'drunk' is more favourable than others knowing there is a person with 'mental health' issues in the family.

> *(People with lived experience) don't want to think it's mental health, but it is mental health. They need to get mental health sorted first before anything else.*
>
> Community member research participant

> *When younger, believed mental health meant a padded cell. It was taboo to talk about any of that stuff. Fear of being ostracised by my peers and family. Able to hide depression real good. Self-medication with alcohol. Hid within stereotype of black fella he's just drunk…when I drank I had a sense of euphoria and it would work away the pain…when I visited the hospital for alcohol poisoning they were like someone of privilege talking down to me… they did not really care about me, they were there to put me down. My support group were my drinking mates.*
>
> Participant with lived experience

The availability of alcohol and other drugs

Research participants noted that the prevalence of drug use in their communities was linked to their price and accessibility.

> *Drug dealers are selling to everyone these days… even underage people.*
>
> *It's easy to get here. You can get it off the street, the shopping centre.*
>
> *In those days there was too much alcohol around and it was cheap. It's not cheap now. Drugs are cheaper.*
>
> Community member research participants

> *Now it's too easy to get drugs. But that can make you stronger. You can get past them and say no. Before I couldn't do that.*
>
> Participant with lived experience

A few participants perceived that the police and criminal justice system are lenient to people who distribute and sell drugs.

> *Drug dealers are left to do their job. People are taken to prison for use, but the dealers are not prosecuted.*
>
> Community member research participant

At Inala, participants acknowledged that drugs like methamphetamine are readily available and part of everyday interactions amongst some members of the community, including between members of the same family.

In other communities, non-Indigenous people were perceived as the source of bringing drugs into their communities.

In some communities, the capacity to minimise the impact of other drugs was seen as an outcome of community leaders making it clear that use of these drugs was not accepted within their communities.

Support and resilience

Supporting and caring for people with lived experience was an intrinsic part of the lives of many research participants.

> *I had to take one brother to the hospital, he couldn't feel anything he was drunk. He would get the shakes and you couldn't do anything to help him. I would say drink water and he would say 'I hate water' (laughs).*
>
> Participant with lived experience

Elder participants spoke of their own efforts to support and bring their communities together.

> *When there's problems, everyone gets together to try to help. We (as Elders) have meetings about it, everyone comes in… people are helpful.*
>
> *We (the Elders) had a gathering, brought kids from homes and the streets and brought them here and fed them and played games. It was a good day.*
>
> Elder research participants

3.1.4 Impact on emotional and social wellbeing

The experiences of racism as described earlier in this chapter, including in relation to stereotypes of alcohol and other drug use, impacted significantly on how research participants felt about themselves, their families and communities. This impact was described universally and regardless of the participants' consciousness of racist behaviours.

Research participants did not readily use the term 'wellbeing', but instead understood and articulated the importance of *'how you feel in yourself and in the family and community'*.

Most participants were able to discuss how they felt about themselves, with the exception of some male participants. These male participants do not usually disclose their feelings and thoughts with others, as was the case in their interactions with other males in their communities.

Participants felt their best when connected to their families and communities, and when being noticed, respected and cared for. They also felt best when able to support others, including in relation to alcohol and other drug use.

> *Being well is about being strong and staying strong. Being a father and black fella... I want to try to help others on the street. Seeing others succeed because of my help, seeing others doing good is feeling well yourself. It makes you want to push more.*
>
> *I want to be a mentor to someone to see where they are coming from. Staying on the positive side. Being a role model. Talking and listening helps...*
>
> Community member research participants

Fundamentally, employment and education were seen as key drivers of good mental health and wellbeing. Lack of employment opportunities, including as a result of racism, was related to poor mental health and harmful behaviours, which in many cases contributed to affected children suffering from neglect and hunger.

> *When you have a job, you don't think about alcohol and drugs and all that.*
>
> Community member research participant

Being engaged in meaningful activity and given the same opportunities to access and retain employment was valued whether this took the form of support to develop and promote their artistic talents through an Arts Centre *('Art is a means of overcoming racism, you experience all nationalities... [The Centre] is working with young people through fashion. [The Centre] is making us stronger through our art.'* Community member), or work in a mine.

At the same time, the experience of racism in the workplace had created a strong sense of injustice and, as reported by one community member, was less acceptable than resigning and working for the dole. This ability to see the contrasting treatment of Aboriginal and non-Indigenous workers was also perceived as an opportunity to make change by building a local workforce rather than recruiting to local positions from outside. This opportunity existed, for example, through local council led employment strategies that better utilised a potential local Aboriginal and Torres Strait Islander workforce, and through health services that could better invest in trained local people.

A low standard of education was seen as a barrier to communication about healthy behaviours with the need for service providers to *'break down the jargon'* to help people to understand the meaning of information provided and to be able to talk about their problem.

> *Some people too scared to talk. Given a Panadol and told to go home – didn't explain what was wrong with them. Need someone to break down the jargon. Lot of people don't want to say their problem. Lot not well educated.*
>
> Community member research participant

There was a call for community programs to address social isolation and potential harmful behaviours that relate to experiences of racism and stereotypes of alcohol and other drug use. This included parenting programs, youth camps and social events to provide night-time opportunities for adults to meet. With the closure of pubs and the introduction of alcohol management plans in some communities, there had been no plans for suitable opportunities for adults to access community events. For example, the promise of establishment of an RSL subbranch in one community had not come to fruition.

3.1.5 Impact on ability to access support services

Overall, research participants felt they were being judged by mainstream service providers and that these services lack understanding of the experiences of Aboriginal and Torres Strait Islander people.

> *No-one wants white fella talking to them, they don't know what we are experiencing…I talk to suits but don't feel they can hear…they need to reach out to people before talking about services, let them know that they are not going to judge, everyone has an input. Your voice and opinion matters.*
>
> Community member research participant

Many participants hesitated to recommend support services to others without first checking with family and/or Elders.

> *If I was asked by others where to go for support for an alcohol or drug problem, I would ask family for advice about where to go. If I could see the service, I would still ask family… Just knowing you are safe and equal where you go and that it is ok to speak up about any problems that you have.*
>
> Community member research participant

The sense of shame associated with a mental health problem was consistently seen as a barrier to accessing support. This included mainstream services understanding the importance of *'not looking like a mainstream service'* or enabling discreet access to the building.

There was support for the approach in some schools where there were opportunities for Aboriginal and Torres Strait Islander students to regularly meet informally.

> *For young kids they can be too shamed to talk about how they feel (when they are depressed) because others might think they are weak. Yarning circles in schools have people there they can talk to. Get Indigenous students together to talk about things in general.*
>
> Community member research participant

3.1.6 Factors that contribute to the impact of racism

The following outlines factors shared by research participants that contribute to the severity or mildness of the impact of racism to individuals, families and communities. The factors are not presented in any hierarchy.

Individual resilience

Individual resilience appeared to be a strong contributor to better managing the impact of racism in community. This resilience was often demonstrated in community members who might variously be supported by a kinship network, who were educated, those with a strong sense of identity and those who were in employment and had stable housing.

Connection to land, family and culture as strength

Cultural and family connections were seen as key strength factors in being resilient and overcoming racist behaviours.

> *We deal with so much grief… Our mob is broken. We gotta go back to families and families need to go back to country.*
>
> Community member research participant

Elders assist the community to overcome trauma/harm

We note that racism is known to adversely impact those who are survivors of trauma (Helms et al 2010).

Support from Elders and community mentors was crucial in addressing harm and trauma from racist behaviour in the community. While Elders in some communities had a strong influence on their community, in other communities they felt that they have been repeatedly ignored and disregarded by official processes *('mainstream ways of doing things')*, eroding their traditional authority in community.

Lack of culturally appropriate medicine and healing

Participants felt that there is stigma attached to Aboriginal and Torres Strait Islander medicine in western science, and perceived that the health system does not allow for traditional medicine to be incorporated in the provision of care to Aboriginal and Torres Strait Islander people — for example, no healers allowed at hospital, or there is lack of understanding of cultural terms.

Individuals look for places of service where there is cultural awareness, respect and consistency/ reliability of care

Participants asked for services to be sensitive to the need for privacy for Aboriginal and Torres Strait Islander people accessing their services, demonstrate an understanding of social and emotional issues beyond the physical needs of the client and offer an Aboriginal and Torres Strait Islander workforce with experience of local communities.

For most participants, being able to overcome cultural impediments of perceived shame to access services was significantly assisted by the availability of Aboriginal and Torres Strait Islander operated services where there was confidence in not being judged, and being able to incorporate cultural healing practices. Some participants preferred the anonymity of mainstream services and expected that these can provide a safe and culturally appropriate environment.

Media contribute to stigma and community unrest

Finally, traditional and social media were seen as presenting negative/misleading stories, including in relation to stereotypes of Aboriginal and Torres Strait Islander people and interactions with police, that may exacerbate fear and anger in the community and cause disturbances.

> *Media only focus on bad stories. A lot gets lost on Facebook. People would see something and start a fight.*
>
> Community member research participant

3.1.7 Diversity in experiences

Table 3.1 lists key variations in socio-economic experiences across the different groups of Aboriginal and Torres Strait Islander research participants, including in relation to racism and alcohol and other drug use.

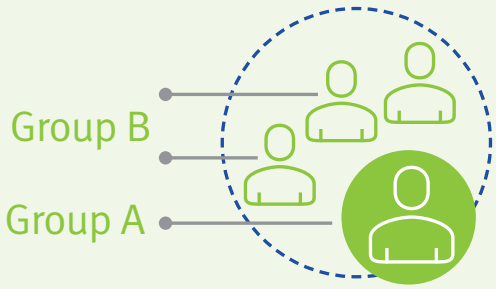
Table 3.1 *Diversity in experiences*

Participant group/ characteristic	Key points of differentiation from other participant groups
Discrete communities	• Predominant experiences of institutional racism • Need for increased knowledge and understanding of potentially harmful effects of alcohol and other drug use • Fewer opportunities to access services where individuals are not known by the staff • Fewer options for recreational opportunities for all ages • Impacted by alcohol restrictions and 'sly grog' trade • Impacted by higher costs of food and fuel
Torres Strait Islander communities	• Colonial history differs from other areas in Australia • Religion plays a large part in peoples' lives • The area is geographically isolated from other parts of Australia • Minimal opportunities for employment • Housing shortages have a severe impact on stress and anxiety levels • Comments from participants suggested the prevalence of patriarchal settings and social structures
Urban communities	• Division between Aboriginal and Torres Strait Islander and non-Indigenous groups is more visible, resulting in high level of experiences of overt racism • Participants expressed a heightened sense of 'invisibility' and lack of 'voice'
Regional and remote communities	• Impacted by higher costs of food and fuel • Fewer options for services
Elder participants	• Differed greatly from younger participants because of their point of reference. They perceived the current state of things as an improvement from the 'old days' when laws stopped them from doing things • Confident and philosophical about speaking out against racism
Younger participants	• Predominantly reserved and angry about covert racism • Many young participants struggled to self-regulate emotions when speaking about racism and discrimination
Male participants	• Tendency to feel uncomfortable speaking about their thoughts and feelings
Female participants	• Recognised potentially harmful effects of binge drinking, more than the male participants • Concerned about child safety and effects of domestic violence

Source: ACIL Allen Consulting 2020

Participants with Lived Experience

See Section 1.3



3.2 The individual experience

This section analyses feedback from research participants with lived experience of alcohol and other drug use, and concludes with case studies from these participants.

Individuals with lived experience participating in this research varied in their current and past use of alcohol and other drugs. Most had used alcohol and other drugs at some point, occasionally using a combination of alcohol and other drugs or engaging only in alcohol or other drugs use.

Participants experienced also varied periods of abstaining from all alcohol and other drug use.

3.2.1 Awareness of potential harm

Participants with lived experience had varied understandings of the impact of alcohol and other drug use upon themselves.

Most did not think that the use of alcohol and cannabis were 'problematic' to themselves, but had understanding of the potentially harmful behaviours to their family members.

Participants who used methamphetamine were more attuned to its impact on their wellbeing but felt less able to control its use.

Some participants understood that using alcohol and other drugs provided a safety valve and means for relieving stress from their personal circumstances, including financial stress and past traumatic experiences.

> *Getting drunk and passing out was a way of coping and sleeping.*
>
> Participant with lived experience

Experiencing trauma

In a focus group with three generations of women from the same family who had spent the night in an Aboriginal and Torres Strait Islander operated diversionary centre, there was a shared view that the trauma they had experienced (either as a victim survivor or a witness) from domestic violence would not be visited on their children because 'they were safe'. Being safe meant that they had agreed that the children (of the youngest generation) be taken into care by Child Protection.

> *'Kids see drinking, smoking and violence and copy that behaviour. Our kids are protected from seeing that – they are in a safe house.'*

Looking at this situation through a trauma lens would suggest that the controlled emotionless state of these women's narration potentially demonstrates a level of disassociation, enabled to manage their lack of control over being able to care for and protect their children, and the pain associated with removals. Their story shows both collective complex intergenerational trauma and individual complex trauma.

3.2.2 Overcoming personal shame is a major barrier for seeking support

A consistent theme was about overcoming shame about their use of alcohol and other drugs to reach out and access help. This was complicated by experiences of being stigmatised by some family members and kinship networks, while being supported and encouraged to seek help by others.

> *Shame we bring on ourselves, before family members and everyone else, main thing to overcome to get help.*
>
> *There's judgement from family. It's in the house before it comes from outside.*
>
> *They see you differently when you are drinking, they ask why you are drinking, should be doing other things, try to put me down. Some people need to stop being judgemental... Your own mob and brother that talk to each other like this.*
>
> *There's certain mobs that come to preach on what you should be doing, a lot of (expletive) gets said that shouldn't be said.*
>
> *There's a lot of shame, fear, to ask for help.*
>
> *I drove (my nephew) there and waited for him at ATODs but he wouldn't tell me when the next appointment was. I tried taking him, dropping him at the front door but he wasn't going in. He would say that he can do it himself... I think it's shame and fear and the mindset that they can do it themselves.*
>
> Participants with lived experience

Participants shared experiences of hesitating to seek support at service providers because of personal shame and fear that they will be judged by staff or recognised by other Aboriginal and Torres Strait Islander patients.

> *They are ashamed to go (to a local Aboriginal and Torres Strait Islander service provider) because they know people who go there. They think people will judge them.*
>
> Elder research participant

> *I feel embarrassed. Every time you go back to services, they are judging you. If you want to get off drugs, but every time they are judging you... You don't feel like talking, like you are having an STD.*
>
> *You get that instant judgement... I see hate in their hearts, but it doesn't affect me.*
>
> *Sometimes I would feel shame to ask for help if there were lots of people there.*
>
> Participants with lived experience

Self-shame and stigma from family and other Aboriginal and Torres Strait Islander community members was more present in research participants who primarily use other drugs compared to research participants who primarily use alcohol.

3.2.3 Drivers of change

Participants acknowledged that self-realisation and determination was the most effective cause of change, often driven by the desire to take responsibility for the wellbeing of their children or grandchildren.

> *I know it affected my family... I couldn't really support them, even for food... I know I was a bad father... It hurts now to know this.*
>
> *When I learned (my daughter) was pregnant I thought I need to think about my grandchild now, I can't be like that.*
>
> Participants with lived experience

Some participants were 'forced' to change by their family members and/or kinship networks including Elders in the form of an ultimatum requiring those affected to choose, for example, between being excluded from learnings about their culture and/or from contact with their spouse and children, and their behaviour. These individuals considered that *'family and culture saved me'*.

Participants who were ordered to attend programs for their alcohol and other drug use by correctional services did not find them successful. These programs were perceived to instigate compliance rather than real behavioural change.

3.2.4 Accessing services

Participants with lived experience shared varied experiences with treatment and recovery services.

Most had the tendency to access mainstream services only in crisis and that this encounter only served to reinforce hospitals in particular as places that were not culturally appropriate. For staff receiving constant 'crisis' cases, stereotypical perceptions are reinforced which compounds the experience of racism.

> *Staff in hospitals did not really care about me. My support group was my friends. They have no experience. Talking about the physical body and not the mental impact or spiritual impact that my grandfather was able to talk to.*
>
> Participant with lived experience

There were also stories about mainstream services that had been accessed to overcome an immediate need for support but little evidence that this had been sustainable.

In addition, there were misconceptions about the use of mainstream services, and practical issues where services were located outside of community.

> *If you end up in hospital intoxicated, then fear that you could get locked up so people are not going there.*
>
> *If you go into [town] to be assessed and don't meet their criteria, then no way of getting back to community.*
>
> Participants with lived experience

What did appear to engage most individuals effectively was the ability to enter a program offered by an Aboriginal and Torres Strait Islander organisation. The capacity to feel safe within an Aboriginal and Torres Strait Islander service was expressed as being understood, relaxed and able to hear and talk about their experiences and needs.

> *...soon as I walked in and saw all of the black faces I thought this was the right thing... got back into the rhythm of things...*
>
> *Would not have gone to mainstream services. I am a strong Indigenous woman and believe in our own connections. Brings an understanding that is not in a white man's base. People know how to communicate here, there is an automatic relationship. Would need to work on that in mainstream services. There is no disrespect or shame between clients and workers. Recognition for us being Indigenous.*
>
> Participants with lived experience

The preference for Aboriginal and Torres Strait Islander service providers was not universal. A few participants with lived experience hesitated to visit Aboriginal and Torres Strait Islander-operated providers in their community because of the stigma attached to mental health and alcohol and other drug use in their communities and fear that they will be recognised. This showed their need for services where they are not recognised, either in mainstream services in their community or Aboriginal and Torres Strait Islander-operated services outside their community.

Where an Aboriginal service was not available in their community, options for some people included women's shelter or family.

Some participants with lived experience also spoke about the value of culturally safe and holistic models of service delivery — support services that functioned like a hub where a range of needs could be met. This existed in some places as a 'drop in centre' where assistance would be provided with personal items, Centrelink and housing. The support provided through a diversionary centre was viewed similarly.

> *The diversionary centre provides free accommodation, meals, a bed and a shower or you can come and relax. A similar 'hub' was needed (in my local area).*
>
> Participant with lived experience

In some instances, Wellbeing Centres have functioned as a place to learn about potential harms from problematic use of alcohol and other drugs.

> *Services owned by community work. Listen to people about what works and doesn't, allowing us flexibility to work at community level without being precious. Allowing business to be finalised, cultural processes aren't allowed to happen, therefore, higher incarceration rate because people would rather break mainstream laws than cultural lore which is more severe.*
>
> Participant with lived experience

3.2.5 Recovery and sustaining wellbeing

Participants spoke of several aspects that support or inhibit their ongoing engagement with services and their recovery including:

- the inappropriateness of support in group settings

> *There's a shame in doing group sessions, but group sessions are considered part of the process to determine a person's commitment to getting support.*
>
> Participant with lived experience

- challenges with sustaining financial and residential security, particularly when faced with a criminal record

> *I just want a job, but I can't get one... The first thing they ask is 'Have you been to prison?'. How am I to get a job then?*
>
> Participant with lived experience

- gaining strength from their connection to their families and to the 'bushland' and the importance of connecting to 'culture and land' as part of their recovery
- seeking support from individuals/services who are stable, consistent and can form a 'routine'. One of the core principles of trauma-informed care is 'trustworthiness' and individuals experiencing trauma respond better in predictability and minimal change

> *I come here every day because I know they will be here. They are always here. There's no surprises.*
>
> *(A local Aboriginal and Torres Strait Islander organisation) are doing good, cause they are always here they are reliable they never change. In other places you need to have appointments, can you come back, whatever. You can just drop in here, Murri time.*
>
> Participants with lived experience

Finally, a few participants talked about the importance of religion in their lives and described how their interactions with religious organisations and clerics were instrumental to their recovery and sustained wellbeing.

> *I started talking to (a priest) and realised what I was doing wrong... I believe in Him now. I pray and He gives me strength.*
>
> Participant with lived experience

Case studies

Aboriginal and Torres Strait Islander research participants with lived experience of alcohol and other drug use

Male, 52 years old

Jim* had a long history of alcohol use, but he has been sober for the past two years.

He previously spent several years in prison for various family violence and alcohol-related offences, including driving under the influence. He is now required to perform community service to be allowed to drive again.

Jim's priority is to find a job and secure an income for his family. Finding a job has been difficult without a driving licence and certificates for specific trades. He has experienced discrimination from potential employers who ask him to disclose his past imprisonments.

> *I just want a job, but I can't get one... The first thing they ask is 'Have you been to prison?'. How am I to get a job then?*

When he was using alcohol, Jim was unaware of its impact on himself and his family. He did not perceive his drinking as problematic and did not seek support from related service providers. He now realises and regrets the harm that he may have caused with his drinking.

> *I didn't want the support when I was drinking. I didn't think it was a problem. I thought I was bullet proof... but I wasn't.*
>
> *I know it affected my family... I couldn't really support them, even for food... I know I was a bad father... It hurts now to know this.*

Jim was in prison when he realised that he needed to change his life. He found out that his daughter was pregnant and decided to take on responsibilities to ensure the wellbeing of his grandchildren.

> *When I learned (my daughter) was pregnant I thought I need to think about my grandchild now, I can't be like that.*
>
> *I need to focus now to pay my bills... I got to put my kids for education.*

Jim faces stigma and discrimination in his interactions with government services and potential employers.

> *They feel shame when I talk to them. They put their head down like they are ashamed. They look guilty... But they won't pass my CV when I give it to them... All I need is honesty... I want to be treated equally.*

Jim feels that services in his community do not understand him and his culture.

> *They don't know the culture, the background. They can't connect to me...*
>
> *They don't understand how I am living, how I am paying my bills...*
>
> *I want services that are honest and understand my culture. They need to understand us, what we do and how we do it... Some don't even understand when there's sorry business going on.*

Jim visits a local community service organisation daily to socialise and participate in yarning groups. He values the consistency and reliability of the support he receives.

> *I come here every day because I know they will be here. They are always here... There's no surprises.*

Jim wants to be useful to his community and would welcome opportunities to teach younger Aboriginal and Torres Strait Islander people and service providers about his culture. At the end of the interview he was optimistic and talked about an appointment for a job interview the next day.

** Names have been changed for confidentiality.*

Case studies *continued...*

Women's group

One of the communities invited us to attend a yarn with a group of women who meet regularly at a local service provider. The women attending the group had either lived experience of alcohol and other drug use or were the main carer of a person with lived experience.

The women acknowledged that drinking alcohol and using other drugs is a 'way to cope' with pain and trauma in their lives.

The women shared experiences of racism in their everyday lives.

> *Oh you see it on people. They don't want to touch you, they put the money on the counter, so they don't have to touch your hand.*
>
> *People look at you like you got germs or smell.*
>
> *People treat me like I am no good, they ignore me.*
>
> *Some people cross the road so not be near me, and don't talk to me.*
>
> *Always people think you must be drunk, even if you just old or sick.*

Most women in the group sought support with their alcohol and other drug use either in times of crisis or after being ordered by the court or the police.

The women with lived experience of alcohol and other drug use received ongoing support from family members, Elders in the community and the service provider that organised their meetings. Support from other women in their families and communities was an important shared experience.

> *Strong ones, aunties and others look out for us and get us help.*

The women distrusted most service providers, and the police, as being culturally inappropriate and unsafe.

> *I don't go to service cause they don't listen.*
>
> *They got no cultural healer, just (western medicine).*
>
> *There's no cultural support, just feel like we are filling out surveys.*

** Names have been changed for confidentiality.*

Case studies *continued...*

Male, 31 years old

Matthew* has always lived in his community.

> *I had a good upbringing, my parents were hard working but there was no love or attachment. I had to seek for my own self, my own identity... I left home when I was 17 but stayed around same area.*

When growing up, Matthew experienced problematic use of alcohol in his family that discouraged him from using alcohol.

> *I am not a drinker, I've seen violence around with drinking and that put me off... Everyone drinks in my family.*

From an early age and throughout his school years, Matthew has experienced fear and violence in his family and in his community.

> *In high school I used to play Street Fighter at the arcade... All that violence, everything that was in the game was happening in the streets. Everything was the product of our environments.*
>
> *Growing up in (community) was a test... School was all knives, guns and heroin... I was at a shooting with my cousins when I was 11... I am always conscious who is around... You need to be tough out there.*

Matthew has a long history of other drugs use, predominately as part of his social interactions with male peers at school, prison and in the community.

> *I've done all drugs... Sniffed toilet spray, chroming, heroin, now ice. I smoked bongs since I was 11, had my first needle at 14, speed at 15.*
>
> *When I started sniffing... it was about belonging in a group... bonding with the brothers.*
>
> *Sometimes I take the drugs from others, cause if I don't they'll overdose. And then I take them myself...*

Matthew feels that, like himself, many people in his community have had traumatic experiences and have disconnected from their families and social networks.

> *People lose themselves here. They don't know who they are... I feel like I am a torn man.*

Matthew has several children from different partners. In the past, Matthew did not voluntarily seek support for his drug use but has been ordered to attend programs for rehabilitation and detoxification as a condition for maintaining contact with his children and partners.

> *I didn't think I needed to go (for support). I wouldn't go for help unless I was forced to.*

Matthew has recently acknowledged that his drug use is 'problematic', but his past experiences with service providers and stigma associated with drug use are discouraging him from seeking help. He perceives that the mainstream service provider for alcohol and other drugs use support in his community is not culturally appropriate. He hesitates to visit the Aboriginal and Torres Strait Islander provider because he knows the people who work there. Matthew feels there is nowhere for him to go where he can be heard and that he can trust.

> *The drugs are a problem for me... It stops me from being the person I can become.*
>
> *I tried to see a counsellor but did not get a good reaction from them... I never connected with the ATODs place. I wouldn't go there. They are too clinical, too professional... Organisations are not genuine. We need someone to be there. We need to be consistent, to connect to the person.*
>
> *I've slept on a lot of things. There's been no avenue for me to lay my thoughts off.*

Matthew occasionally reaches out to his neighbours for help.

> *I'll go to my neighbours if I need help... they have more routine... they are more stable. It's bad if you don't have that...*

Matthew longs for stability. He is now trying to re-connect with his family and wants to create a home where all his children can be raised together.

> *I need to work and have all of my kids under one roof... I need stability.*
>
> *I could have straightened up with family... cultural interactions... rather than losing myself as a person.*

** Names have been changed for confidentiality.*

Case studies *continued...*

Female, 19 years old

Anna* was separated from her mother when she was a child. She was raised by her grandma before she passed away, and now lives with her father and some of her siblings.

> *Mum was unhealthy and unstable, drugs, bad environment. One day I went to school with big marks on my legs and child safety came and talked to us. We had to leave mum, but my nanny asked for us to stay with her to keep the family.*

Anna dislikes alcohol. She has used methamphetamine since she was 14, at times daily. She currently uses cannabis.

> *I used to love ice, it was my everyday thing... I'm off ice now, don't have good relationship with that. But weed, I still love it... I stick to weed now, it helps me sleep, relax during the day. I think too much.*

Anna has experienced racism in her interactions with the wider community.

> *When I go shopping they follow me around the shop. The way they stare... It turns you off from going shopping. If they are looking at you and follow you around. I say it (expletive) it. I say I know what you doing, I am not going to steal, I have money. The way they look at you like every other black man. I know stealing is a sin, don't think about me like that.*
>
> *It does break my heart when I go to places like that. It's not fair, to be treated differently. We are all the same no matter what colour we are.*

Anna experiences discrimination when seeking services at Aboriginal and Torres Strait Islander service providers due to her kinship and family background.

> *I try to avoid (expletive) places all together. Some places if I say I am (name) they ask 'What's your last name' and then I get different treatment because I am from another mob.*

She has had negative experiences with welfare services, including difficulties in obtaining support because she lacks a birth certificate.

> *Services around here... there's no really help. They say that you have to wait or you gotta go get this and that, and the other place say the same but different words, that I need birth certificate, and I don't have anything.*

Anna feels that service providers cannot empathise with her and lack appropriate understanding of her background and circumstances. She feels that no one goes out of their way to reach out and help her.

> *...when I open up I can see it in their eyes that they don't know, they give mad advice.*
>
> *No one comes to me.*

These experiences have discouraged Anna from seeking support for her drug use in her community. She also feels 'shame' to ask for help and is unaware of alternative options available for support in her community.

> *I feel shame when around people, when I need to ask for help and don't know how to talk. When it comes to getting help I find it's hard.*
>
> *There's no information around here, you need to know people to find things.*

Anna finds strength in writing and keeping journals.

> *A couple of weeks ago I was going to suicidal thought... I stayed away from everybody. I wrote things down and that helped me. I like doing that.*
>
> *I taught myself to write, I started writing and got four journals now.*

She now lives with her father, who is her main supporter and whom she loves.

> *My dada helped me lot, looking for me in the house and telling my mates to leave me out of trouble. He goes around to suppliers and tells them to not (expletive) with my daughter. He used to tell everyone to get away from me so they don't give me ice.*
>
> *I love being with my family now. I used to block them out but now it's different. I like just chilling out and having good vibes. It was hard when granny left.*
>
> *My dad used to be bad heroin user. His babies made him stop. He's got two kids on the way.*

** Names have been changed for confidentiality.*

Case studies *continued...*

Male, 48 years old

Ben* is Anna's* father. His mother's experiences with alcohol have deterred Ben from using alcohol. He's been using other drugs since his mid-20s, mostly heroin.

> *Drugs have been the road for me. Alcohol, don't have much to do with it... Mum used to drink in younger years.*

Ben has experienced racism from service providers, businesses and the police.

> *I get the looks from different people... when serviced behind counter. The way they chuck the money at you. They just categorise you. And taxi drivers. We just don't catch Ubers...*
>
> *The police they pretty much judge you. The other day they were going to arrest me. I walked to see what was happening, they were arresting someone and told me to go away unless they will get me too.*

He has also experienced stigma for using other drugs, including from his family members.

> *Once they know you are on drugs they categorise you. People judge me. Family is the biggest thing, they judge you the most.*

Ben attended a drug treatment program at a clinic outside his community about six years ago. He completed it and was not using drugs for a short period, but he relapsed following a death in the family.

> *A friend told me about (the clinic). It was a bit far but was really good, I completed the program, I was clean but ended up getting up on it.*

Ben hesitates to seek support for his drug use from the local Aboriginal and Torres Strait Islander health service. He now attends a counselling program at the mainstream ATODs service every few months. He wants the ATODs services to be 'more hands on'.

> *It's good that the ATODs is not at the (Aboriginal and Torres Strait Islander health service). I don't want the (Aboriginal and Torres Strait Islander health service) to find out. But they (ATODs) can do more with connection and follow up, more hands on.*

Ben has received support from friends and family, but believes that self-realisation is the most effective driver for change.

> *Family tried to help before but it's up to the individual. I can't be told what to do.*

Ben has decided to stop using other drugs so that he can care for and support his children.

> *I am the leader of the family, I have to put a good example otherwise it will go downhill.*
>
> *I am the oldest. That responsibility I didn't think before didn't care about it, but now I do. I tell my kids the bad things about it (heroin). They've seen me... I'm trying to get my family out of it altogether.*

Ben's current priorities are reinstating his driving license and finding a job. He is finding some difficulty in accessing services and 'cutting through' because his current name is different to the name listed in his birth certificate.

> *I need to change the name in my documents to get it same with birth certificate. It's a big process. I've been living with this name all my life and it's not the right name...*
>
> *I want to get my license and get another job. No one is going to help me. I got to do it by myself.*

** Names have been changed for confidentiality.*

Case studies *continued...*

Male, mid-30s

Jonah* is in a relationship and employed. His upbringing on a remote island was difficult and he had an early history of alcohol and cannabis use.

> *I took drugs because life was hard. There was a lot of violence in families when I grew up and I was being violent myself. I had to realise that it was not right, it was wrong. I didn't have a clear picture in my mind of the world – I stayed in the laundry and smoked weed. And when I drink, I would be happy.*

Jonah continues to use alcohol, which he perceives to be important to his wellbeing and potentially a modelled behaviour.

> *If my partner stresses me, she is very strict, I will take a six pack and drink it in a quiet place and wait until the stress goes away, then go home, have a feed and go to bed...My mother stressed my dad.*

Jonah's mother influenced him to get help because of her concern about how withdrawn he had become.

> *Mother decided for me to see mental health service because maybe at times I wasn't talking. It was good for someone else to tell me. I first met them outreach [after] my mother approached them.*

When Jonah left the island to get work, the outreach team followed him up. It was difficult for Jonah to accept the support.

> *I knew I was getting into a lot of problems and violence... I had gone too far down. It was a big challenge for me and I had to be really strong to do it. I was diagnosed with psychosis and have been getting injections regularly for the past 11 years. It was hard to come the first time and I was worried about the effects of the injections.*

Jonah's relationship with the mental health service provider has become a key support.

> *When my grandparents died, the family split apart, living in different places, so I have no one to talk to except the mental health service...Don't get that negative vibe here (mental health service). Very positive view...think the best for you...I can contact them if I want to talk to them.*

Jonah identifies as a half caste and describes himself as a 'middleman' who had grown up in a 'black' community, feeling it was hard to take sides. His religion has become important to him as a way of deflecting that responsibility.

> *Don't want to be the judge of that situation. We can't be the judge of anything else. The only thing that is going to stop all problems in this world is Christianity which likes all races.*

Jonah believes that discrimination against 'black' people does exist but that it had done so for generations.

> *So a lot of tension in island people worried about white people taking things. There was no escaping race.*

Jonah talked about what it meant to him to be an active member of society rather than looked upon as a drug user.

> *I have a job and a partner and feel like I am living in society. Really nasty feeling when I did drugs and people looked at you – don't like feeling judged.*

Jonah believes that drinking in his community is related to a lack of certainty about the future which could be seen as relating to change and loss of traditional frameworks and 'connection'.

> *Island people really love their drink. It helps them deal with their fear of death, wanting to have most of the good times, not knowing where they are going to go. It releases the stress but you forget that when you wake up things are still the same.*

The perceptions of negativity and positivity are important to Jonah's view of what made connections attractive. He described peer support similarly to his earlier reference about not getting 'negative vibes' from the health service that he attended.

> *The druggies are coming together and being positive together.*

Jonah believes that promotion of services, inclusion of an Aboriginal and Torres Strait Islander workforce *('All doctors here are white')* and straightforward explanations about the harmful effects of drug use could make health services more accessible.

> *Need to appeal to people to use the services...Friends will go to a doctor if they need help but will use (drugs) again. It matters what they feel in their life, whether they really want to make a change...Doctors need to break it down for them, to see what will happen if they keep smoking (for example).*

** Names have been changed for confidentiality.*

Case studies *continued...*

Male, early 40s

Gavin's* parents and grandparents had been impacted by policies relating to Aboriginal and Torres Strait Islander people in Queensland, including those giving rise to the stolen generation and to birthing being disallowed in Aboriginal and Torres Strait Islander communities. Gavin came to his current community as a teenager because of his link to his grandmother.

> *My grandma was one of the first born here but taken (to another place) as soon as she was born. I had a good relationship with my grandma so came to this place and didn't leave.*

Gavin's use of alcohol was a way of coping with his depression.

> *I was able to hide my depression real good. I self-medicated with alcohol and hid within the stereotype of 'black fella, he's just drunk'...The drink gave me a sense of euphoria and took away the pain. I drank for 15 years from the age of 17.*

Gavin's mother had ensured that he obtained an education. Gavin was employed for much of the time that he used alcohol.

> *I didn't think I had a problem even when I was losing friends and family. With education, I was able to work so could afford alcohol. Everyone was around me because I could afford it. Some days I would turn up to work and couldn't think or I would take sick days. Nothing was said at work.*

Gavin had some experience of support services during this period but they were in response to emergency events and had failed to engage him.

> *No-one came to us to talk about harm, we would need to go to the service. I had two visits to the hospital for alcohol poisoning. Staff in the hospital reminded me of growing up on a mission where someone of privilege would talk down to me. The hospital staff did not really care about me – my support group was my drinking mates – they were there to put me down. They don't know the life experience, they have no experience. They were talking about the physical body, not the impact mentally and spiritually...Separating the person from the problem is a big issue.*

Gavin wants services with staff who understand the ways in which pain has been experienced by Aboriginal and Torres Strait islander people. He believes that effective support requires an understanding about a cultural approach to disconnecting pain.

> *Services are not culturally relevant. Even Indigenous people (as co-facilitators or liaison officers) if they have not lived the life we have lived, become like the oppressor, taking their side and advocating for them, not for us...As a kid, could go to school all day and not have food or water. It was a constant thing that we would go without. Taught culturally how to disconnect from pain, but not taught that until I gave up alcohol.*

Gavin perceived that Aboriginal and Torres Strait Islander people lack confidence in mainstream services because of the negative impact of past policies and practices.

> *History plays a big role in the lack of faith in mainstream services. The conspiracy theorists would say that government programs are not to be trusted... (For example,) the stigma associated with the Alcohol Management Plan had led people to fear that if you end up in hospital intoxicated then you could get locked up, so people are not going there until late.*

Gavin's turning point was an ultimatum from his wife asking him to choose between alcohol and his wife and child, and from his grandfather who told him that he would not pass on the knowledge unless he gave up alcohol.

> *I wanted to learn more... My grandfather brought me traditional healing practice. I had no faith in services that showed no real action in Indigenous beliefs and spiritual health...Family changed things...I had an active kinship system therefore I had to deal with my mother's sisters and aunties...Family and culture saved me.*

** Names have been changed for confidentiality.*

Case studies *continued...*

Male, early 30s

Frank* was a methamphetamine user for three years and prior to that had been clean for five years. He has two children, had experienced marriage problems and was currently going through a divorce. He came to an Aboriginal and Torres Strait Islander operated detoxification facility having experienced problems with the law and a breakdown in his relationship with his mother and father.

> *I always knew where to get ice. I have been using ice for three years. It had started causing violence (verbal abuse) and the police had turned up. My partner uses marijuana and pills at night. My marriage problems were because I was struggling to deal with my mindfulness. Relationships with my mother and father had broken down. I have to prove myself to my family again.*

Frank brought himself to the treatment facility because he was concerned about his mental health and losing the support of his family.

> *I placed myself here knowing that my mental health was starting to be affected by it [ice]. I thought the best way to deal with it was outside town because I didn't want to be embarrassed in my own town. I need to prove myself to my family then they will support me financially and emotionally.*

** Names have been changed for confidentiality.*

Case studies *continued...*

Female, mid-30s

Maree* has a long history of alcohol and other drug use that she describes as precipitated by domestic violence. This spiralled into depression and the use of cannabis and methamphetamine with her partner. Maree has had seven children, six now, all of whom have been taken into child protection because of the abusive relationship with her partner.

> *My partner used ice. I had my first taste at 17 and continued to use drugs for 19 years. I had connections with whites so got good ice...it was easy to get. I was depressed and went from smoking ice to injecting. When I couldn't afford ice I would use alcohol. I was depressed when my twin child died. The father didn't acknowledge my post-natal depression and ran away a few times and left me on my own. But I would always leave the door open for the children's sake. The bills and him became toxic. Lost my kids to child safety because of domestic violence with my partner. Took six coppers to pin me down and take my children from me.*

Maree talked about the pain of losing her children nine months ago and how the shame she felt she had brought upon herself made it difficult to seek support for her problems.

> *I drifted when my children got taken away. I thought I was on my own and no one understood. Felt like I was always shamed. Moved around from house to house, drank myself to sleep because I couldn't live without my kids. The shame we bring on ourselves, before family members and everyone else is the main thing to overcome to get help.*

With the continued encouragement of her family, Maree sought help from an Aboriginal and Torres Strait Islander treatment and rehabilitation service. A driving motivation for Maree was the desire to be reunited with her children.

> *I took a long time to be convinced by my family members that I was ready. My Auntie spoke to me about this place (Aboriginal treatment and rehabilitation facility). My main poison was alcohol and other drugs so went this way. I did external programs whilst waiting a month before detox place was available. I have been in the program for five weeks. The medication helped me. I was a bit nervous to use them but couldn't handle the ice, all the stealing, no fear, no circle of friends or family, on my own. I dropped all of my responsibility so too much time and freedom to junk up. I've got no babies, nothing else to lose. What's the point of getting high if I couldn't enjoy it. I would rather have my children back in my life.*

Being in the treatment program had helped Maree to progress her goal of reunification with her children. This was a powerful focus and an enabler to overcome her pain.

> *I have been able to show the courts that I have been clean for four months and have had more than twenty charges dropped. Initial supervised visits with my children are now non-supervised with my mum. I would hate to see the hurt and pain in my kids' eyes again. I am finally back to my normal self today thanks to (treatment service). I have been supported here with Child Protection with clean drug tests and attendance at meetings. I didn't realise all these other opportunities came with this service.*

Maree felt strongly about her culture and was upset that her children were in the care of people who were not related, and had no confidence that mainstream treatment services could bring the level of understanding needed to connect to Aboriginal and Torres Strait Islander people at a spiritual level.

> *I would not have gone to a mainstream service. I am a strong Indigenous woman and believe in our own connections. Understanding of that is not in a white man's base. In this place, people know how to communicate, there is an automatic relationship. This would need to be worked on in mainstream services. Here there is no disrespect or shame between clients and workers and there is recognition for us being Indigenous. There is respect for sorry business and we are helped to make our way back and forth. Workers always check up on us. We run our own meetings once a week and are slowly learning how to support ourselves.*

** Names have been changed for confidentiality.*

Case studies *continued...*

Male, early 30s

Charlie* comes from a mixed family with an Aboriginal and Torres Strait Islander mother and non-Indigenous father. He has more to do with his mother's side of the family and referred to his father's family as a 'bit racist'. Charlie had a good education and is a qualified tradesperson. Growing up, his experience of racism occurred in both community and education settings and related to the better opportunities he had as a young person. Nonetheless, Charlie considered that he had a good childhood and did not commence use of alcohol and other drugs until the age of 21.

> *Dad's family was a bit racist, I have cousins in town who will ignore me. I felt I didn't really fit in – people would tell racist jokes and assumed it wouldn't affect me because I am not black, I was the only Aboriginal person in my Catholic School, I would have rocks thrown at me if I rode past the State School on my way to school, locals made a citizen's arrest when I rode my new bicycle to the shop because they expected that it had been stolen, when I was 16, other students in my TAFE class assumed that I must be on a scholarship and that I would struggle with my studies because black fellas don't know how to read or write.*

Charlie referred to having to learn not to retaliate and constantly having to prove himself. This continued with his marriage to a non-Indigenous woman whose parents were not happy about the marriage.

> *Had to prove myself again. Had a good job, went to the pub to eat, had a few drinks and went home on weekends. I stopped worrying about money and gave it all to her (spouse). Bought a bigger house when there were more kids – as long as the kids were fed and had a house, I didn't care. I became a functioning alcoholic during the week and on the weekend I would write myself off smoking.*

Charlie became isolated and giving up his friends when he married. He referred to his partner as a 'control freak'. His partner had a restraining order against him *('police didn't believe me that I was not violent when she threw beer bottles at me')* and chose to leave the family home because he was concerned about being deemed to have breached the order. Charlie's Aunt and Uncle worked at a government organisation and were able to give him information about places to go for help.

> *I got tested for alcohol and other drugs at work and blew over so knew I was out of control. Getting drunk and passing out was my way of coping and sleeping. I first came here (Aboriginal operated detoxification service) ten years ago. I did a day course. That was my first wake up call. I went to a detoxification facility in (Queensland city) for seven days and was then good for three months before I got back into a bad routine. Last year I went to a rehabilitation centre in (New South Wales city) so I could start again with my wife and kids. It blew up in my face and I went back to drink and drugs. I was still seeing a psychologist in town (for about two years) who mentioned this place to me. As soon as I walked in and saw all the black faces I thought this was the right thing. I started the day program and it was great, I got back into the rhythm of things but congratulating myself on the way home by visiting the servo would undo me. I was then offered the residential program.*

Charlie also reflected on his experience of the mainstream detoxification facility in a Queensland city which contrasted with his current place of treatment.

> *It was horrible, the way they treated you in there with all walks of life.*

Since his placement in the residential detoxification facility, Charlie was able to point to some improvements in his life.

> *I am on supervised visits with my kids – saying goodbye kills me. I let my mum talk to my partner.*

** Names have been changed for confidentiality.*

Section 4

Stigma and discrimination in the service system

This chapter provides analysis on how the service system addresses stigma and discrimination relating to problematic alcohol and other drug use as experienced by Aboriginal and Torres Strait Islander people living in Queensland.

The chapter includes a summary of our desktop review of existing approaches to addressing stigma and discrimination, analysis on the experiences of Aboriginal and Torres Strait Islander research participants with current services, and feedback from sector research participants on their services.

4.1 Existing approaches

ACIL Allen's desktop review of existing research, programs and initiatives found limited references that are specific to stigma and discrimination related to alcohol and other drug use of Aboriginal and Torres Strait Islander people.

ACIL Allen also found limited evidence of the effectiveness of interventions that aim to reduce stigma and discrimination related to alcohol and other drug use. Systematic reviews of interventions that aim to reduce stigma and discrimination related to alcohol and other drug use were limited by the size of the studied population, the short duration of outcome measurement, and the lack of focus on populations known to be important for preventing and reducing stigma (like children and youth). Furthermore, there is no evidence on how changes in institutional policies and professional practices improve perceptions and experiences of stigma (Livingston et al., 2012).

As such, there is a need for further research into structural/institutional interventions for stigma and discrimination, interventions for specific populations (including Aboriginal and Torres Strait Islander people) and for the long-term effects of initiatives aimed at reducing stigma and discrimination.

The geographically, culturally, and linguistically diverse voices of Aboriginal and Torres Strait Islander individuals and communities are fundamental to the legitimacy of any further research in this area.

Characteristics of approaches to reduce stigma and discrimination related to alcohol and other drug use

Approaches that aim to reduce stigma and discrimination related to alcohol and other drug use:

- can be universal or focus on specific systems and settings (for example place-based or community-based approaches) (Lancaster et al., 2017)
- utilise a mix of strategies, including:
  - local and/or national educational campaigns (including via mass media and literacy programs in schools/university)
  - direct contact with people who misuse substances
  - peer services
  - protest and advocacy
  - legislative and policy change (National Academies of Sciences, 2016).
- address different manifestations of stigma, including interventions for self-stigma, social stigma and structural/institutionalised stigma. Self-stigma interventions can focus on self-help therapy, skills training, vocational counselling, and surgical procedures to remove physical scars. Social stigma interventions tend to focus on public education and motivational campaigns. Structural/institutionalised interventions can focus on educating medical students and practitioners and police officers (Livingston, 2012).

Lessons learnt

Given the lack of a strong evidence-base in the alcohol and other drugs space, ACIL Allen have compiled lessons learnt and factors that have contributed to the success of broader related approaches to addressing stigma and discrimination, including in relation to racism and mental health, strengthening social inclusion, and improving the social and emotional wellbeing of Aboriginal and Torres Strait Islander people. These are summarised in *Box 4.1* and provided in full in ***Appendix A***.

Box 4.1 lessons from existing approaches

(The themes are not presented in order of significance)

Develop a multifaceted, multilevel approach

A review of stigma-reducing interventions across the alcohol and other drug, mental health and HIV/AIDS fields that was conducted as part of developing QMHC's 'Changing attitudes, changing lives' paper highlights the importance of multifaceted and multilevel approaches (QMHC, 2018a)

Address factors that contribute to discrimination

Victoria's 'Building on our strengths' framework highlights a number of factors at individual, organisational, community and societal levels that contribute to race-based discrimination thought to be amenable to change through interventions (Paradies et al., 2019)

Address negative media portrayals

An analysis of online and print articles found overwhelmingly negative portrayals of Aboriginal health, with alcohol, child abuse, petrol sniffing and violence being the most common negative topics (Stoneham et al, 2014).

Empower communities and individuals

Several strategies and programs, including NSW's *Living Well: A strategic plan for mental health in NSW 2014–24* and Victoria's *Localities Accepting and Embracing Diversity*, show the importance of involving communities in the development and execution of interventions.

Develop local resilience

Several programs, including the *Social and Emotional Wellbeing Program (Bringing Them Home)* and Queensland's *Creative Recovery* project, show the importance of developing local resilience to strengthen social inclusion and improve social and emotional wellbeing.

Improve service accessibility

Interventions to improve service accessibility have focused on addressing self-stigma and fears of rejection and discrimination of alcohol and other drug users; as well as structural/institutionalised stigma via education of health practitioners and government officials (Lancaster et al., 2017).

Inform and educate the public

Australian and international campaigns that relate to racism and other forms of stigma and discrimination highlight the importance of positive and appropriate messaging, local execution and involvement of people with experience of the stigmatised conditions.

*Source: ACIL Allen Consulting 2019 — detailed approaches are presented in **Appendix A***

4.2 Views from Aboriginal and Torres Strait Islander research participants

This section provides an overview of the views and experiences of Aboriginal and Torres Strait Islander community research participants in relation to service provision in their communities.

Participants spoke of their experiences within the range of services illustrated in *Figure 2.1*, including broader mainstream services, services by Aboriginal and Torres Strait Islander-operated providers, and services related to mental health and alcohol and other drug use.

4.2.1 Experiences with broader mainstream services

Overall detachment and scepticism

Research participants spoke of their overall weariness with mainstream services. They were sceptical of the effectiveness of the services and the support provided to Aboriginal and Torres Strait Islander clients and perceived that the mainstream system overall fails to meet their needs.

Racist behaviours and lack of empathy and cultural understanding

Most participants perceived that staff employed at mainstream services do not understand the values, lores and diversity of Aboriginal and Torres Strait Islander cultures and peoples.

As detailed in Chapter 3, participants shared experiences of racist and discriminatory behaviours by staff at mainstream services whom they perceive lack empathy, personal touch and understanding of Aboriginal and Torres Strait Islander clients.

> *(Staff at mainstream services) still see Indigenous people as one dimensional.*
>
> *We are never human beings in their eyes. (Staff at mainstream services) see our mob as clients for their services, don't see them as people.*
>
> *They don't spend time building relationships they are just about getting outcomes they want. Not invested in community, to them it's a job.*
>
> *They don't understand us. We need to take people with us (when visiting services) for support, but they won't allow others to accompany us.*
>
> *They don't respect our lore, how we have different rules for interacting with males and females. We need male and female doctors. And they don't have interpreters at the court... They use big words, they don't try to explain.*
>
> *They don't use our language, they don't have it in their heart for the black people.*
>
> *One of my grandchildren was sick and we took them to the hospital, and they wouldn't tell me what was happening because I was not next of kin. They don't understand what grandmother means in our culture; they don't understand our culture.*
>
> Community member research participants

> *People with problems will go to their own people rather than strangers. Others judge you, when you go there. At Centrelink... you go there and they treat you with no feelings.*
>
> *Racism is a problem in the services. (Service providers) don't put their heart into it. They are all looking at their watches. Even the coppers... they are not legit. They need to be there for the public, they need to be educated.*
>
> Elder research participants

Opportunities in service system design and operation

Many participants were dissatisfied with how the system is designed to deliver services to Aboriginal and Torres Strait Islander clients. The following are key areas of perceived opportunities for improvement in the service system.

Focus on mainstream services and failure to consult community

Several participants spoke of the current emphasis on mainstream models of service delivery. There was consistent feedback about the failure for community to be consulted about service developments in a meaningful way, disillusion with the way in which their input had been represented and frustration with the inability of decision makers to work with existing Aboriginal and Torres Strait Islander-operated services to provide integrated responses to community need.

Focus on bureaucratic outputs rather than client outcomes

Research participants questioned whether support was directed towards their most material needs — perceived to be employment and housing by most participants — and expressed scepticism over the mainstream providers' focus on 'bureaucratic' outputs and reporting rather than delivering outcomes for their clients.

> *Services don't want us to succeed. People are ok but the system doesn't want us to succeed.*
>
> *Only want to help you if they can charge for the service they give you, like Medicare code.*
>
> *The health system is a money-making machine. They keep making money from us. We are being sent from one service to the other so that they can make money. It's all about money, not our health.*
>
> *Employment agencies will just keep you cause they want the money. There's a lot of unnecessary reporting, no transparency, no honesty.*
>
> Community member research participants

Missed opportunities with Aboriginal and Torres Strait Islander liaison officers

Research participants acknowledged the importance of Aboriginal and Torres Strait Islander liaison officers in mainstream services but perceived that these roles are either not properly functioning or under-resourced in their communities.

> *The liaison officers don't actually engage with people in the community.*
>
> *We need more Aboriginal liaison officers. They got two now but it's not enough for all patients. One female one male. But others are asking for their help too, especially mums and bubs.*
>
> Community member research participants

Failure to support offenders when they are released from prison

Many participants spoke of the system's failure to support Aboriginal and Torres Strait Islander offenders when they are released from prison.

Participants perceived that current services are not coordinated to provide holistic support for individuals to transition back to society.

4.2.2 Experiences with Aboriginal and Torres Strait Islander-operated service providers

The overwhelming majority of research participants preferred services by Aboriginal and Torres Strait Islander-operated providers compared to services provided by the mainstream system.

However, a few participants were dissatisfied with the equity of services by Aboriginal and Torres Strait Islander-operated providers. As described in Chapter 3, a few participants perceived a tendency by some Aboriginal and Torres Strait Islander providers to hire members of their own family and discriminatory behaviours amongst members of different families, kinship and clans.

Participants expressed frustration with individuals in their communities, described as 'gatekeepers', who are employed in Aboriginal and Torres Strait Islander service provision roles and who are perceived to control how funds and related information are distributed in the communities. These individuals, who may or may not be of Aboriginal and Torres Strait Islander background, are perceived to have been employed in these roles for 'decades' and contribute to the system's resistance to change.

> *Gatekeepers have worked there forever. They have been in this space for so many years. Nothing has changed. They need to ask themselves, what have they done to change things? But they don't that.*
>
> *There's lot of Indigenous workers in the service that are just in for the dollars. They gotta stop picking and choose the disadvantaged families. Not who they know.*
>
> Community member research participant

As discussed in Chapter 3 and the following section, some research participants preferred to access mainstream services rather than Aboriginal and Torres Strait Islander-operated services for support with their mental health and alcohol and other drug use as a result of feeling shame.

4.2.3 Experiences with mental health and alcohol and other drug use support services

The issues listed in the earlier sections applied also in the participants' experiences with mainstream mental health and alcohol and other drug use support services.

Lack of understanding and breakdown of trust

Research participants spoke of a lack of empathy and cultural understanding in mainstream mental health and alcohol and other drug use support services. These included participants who chose to visit mainstream services rather than services provided by Aboriginal and Torres Strait Islander providers because of shame.

> *You might take them to ATODs but they are not telling me anything as a carer. They need more communication with family, cultural awareness. Need to know how to deal with the family.*
>
> *I want services that are honest and understands my culture. They need to understand us, what we do and how we do it... Some don't even understand when there's sorry business going on.*
>
> *If you are asking what services should do, I would say don't judge, and listen.*
>
> Participants with lived experience

A few participants shared experiences of racist behaviours at, and breakdown of trust with, mainstream mental health and alcohol and other drug use support services. This resulted in participants refraining from accessing any support services.

> *They had a needle exchange program at the hospital but they had officers there, and the police would follow you after.*
>
> *My daughter had some mental health issues and sought support. The service provider then questioned my parenting. I felt I was stigmatised for being Aboriginal, that I was at fault. Such a bad experience can stay with you, and I don't know now who I can trust to help us. I don't want that judgement.*
>
> Participants with lived experience

Participants also spoke of the lack of Aboriginal and Torres Strait Islander workers recognised by the community, and the lack of appropriate cultural competency training for mainstream staff.

> *Relevance of cultural competency training depends on who writes it and who delivers it.*
>
> Community member research participant

Lack of services where and when needed

Overwhelmingly, participants felt that they can't get support with mental health and problematic alcohol and other drug use where and when they need it.

Limited services and resources

Participants identified service gaps resulting either from limited operation of services (days and hours of operation) and limited resources, or from a complete lack of culturally appropriate services for Aboriginal and Torres Strait Islander people in their communities.

> *They (mainstream ATODs service) seem to only target court related clients because they must. They don't have a lot of capacity.*
>
> *If you are a male with anxiety you don't know where to go.*
>
> *They wouldn't reach out to Beyond Blue for after hours. There's no lines for Aboriginal people. There's no place to go if you feel anxiety after hours and in the weekends.*
>
> Community member research participants

Experiencing trauma

My son killed himself... It was only a matter of weeks... He was 21. He was not hooked up to any support, I didn't know that the drugs were bad. This was back in 2000s. My other son was 11 at the time, he found it hard to get through school. (My other son) was not doing well and we wanted to take him to the youth mental health services for support but it was Good Friday. We couldn't take him anywhere until the Tuesday. My sister and I looked after him all day and night till Tuesday. My sister and I tagged along cause that's what we do. When we went on Tuesday they were helpful. They said we can go back on Thursday and they helped him. My mother at the time was helping me, and my sister... As long as I got someone to talk to, I was ok.

Participant with lived experience

Youth suicide prevention had not been adequately addressed in one community where the Emergency Department was the only night-time service available with a recommendation to contact a doctor the next day for those seeking assistance for a mental health concern.

In some communities, outreach services were viewed as fragmented, and there was a call for locally accessible diversionary services and community workers on the street.

> *Want someone else telling me where places are. Someone who knows what they are talking about and can explain it.*
>
> Participant with lived experience

A few participants shared stories of family members being 'put on waiting list' when requiring immediate help. They spoke of a need for services to address immediate needs and at the crucial time when individuals 'open up' to seek help. They suggested services being available on a 24-hour basis and over weekends.

> *We need liaison officers on public holidays and night time. We need after hours services. We only have the hospital. When the bad times are, that's when you need the counselling. Public holidays big events, night-time that's when things happen.*
>
> *We need somewhere meaningful to connect with... Like a 24-hour hub, somewhere to talk to someone. There's nowhere to go to talk to get things off. Somewhere to feel the bond, feel the energy.*
>
> Participants with lived experience

Participants with lived experience spoke also of the challenges of seeking support and rehabilitation outside their communities, which can result in further isolation and could discourage them from returning to the community either as a result of being 'ostracised' by other members of the community or fear of lapsing back to alcohol and other drug use.

> *You are ostracised if you try to break away.*
>
> *Usually if they get better they go away and stay away.*
>
> Community member research participants

Lack of services across different levels of potential harm from alcohol and other drug use

Research participants perceived that services that relate to alcohol and other drug use in Queensland:

- provide only emergency-related services
- have polarised requirements for admission — whether sober or intoxicated, with no middle ground
- service only complex needs, rather than moderate and minimal needs (preventative spectrum).

Participants found the lack of culturally appropriate rehabilitation services particularly problematic.

> *We need better services for rehabilitation for Aboriginal people. I've been trying to get my nephew into one, all the paper work and then they want to know if you got money. He got to the end and they said sorry there's no room left. We found out later he was denied because he had a criminal past, 20 years in jail. This place was a church group and did not forgive him. Where was their forgiveness.*
>
> Community member research participant

4.2.4 Barriers to accessing services

Remoteness and marginalisation

Participants described remoteness and marginalisation within geographical and social contexts:

- As a result of their distance to other communities and service providers. Lack of transport to and from appointments, and lack of services in their own communities were problematic for some participants.
- As a result of disconnection with other family and community members, including feelings of shame for alcohol and other drug use and mental illness amongst family members. Stigma from family members contributed to some participants isolating themselves and refraining from accessing support.
- As a result of racism from the broader population. Past experiences with, and anticipation of, racist behaviours discouraged some participants from seeking support again.

Issues with accessing services applied to remoteness and isolation in the above contexts, at times resulting in a compounded effect on a person's ability and willingness to access services. This may explain why participants at Inala who felt isolated from their families spoke of the need for services to 'reach out' to them; a need also voiced by participants from geographically remote locations like Mount Isa and Woorabinda.

For younger participants, services were needed in proximity to the community to maintain connections to family.

> *They have places in the city for the young people, they can go there and stay, take a shower... But it's too far from here, it separates them from the family.*
>
> *We had to go to counselling, men's groups, AA but the thing is they were all in town until we sorted some in (closer community).*
>
> Participants with lived experience

Feeling safe

Many participants disliked the 'clinical' environment of mental health and alcohol and other drug support services and expressed a desire for services to develop trust and a presence in the community to 'meet' clients in more culturally appropriate and 'safe' environments.

> *Reach out to people first before talking about services. Let them know that you're not going to judge and that your voice and opinion matters.*
>
> *When there's no funding, they abolish programs that reach out to us. ATODs think that people have to come to them... why wouldn't they come to the people?*
>
> *It's a big thing mental health. You go to ATODs and speak to a counsellor but you don't feel comfortable to open up. They need to get a car, pick them up and sit in the park. You are not going to open up to someone in the office.*
>
> Community member research participants

> *It would be good to meet counsellors at the park or Maccas, I don't like them to be in the room.*
>
> *Door to door I would say. Drop in. More hands on. People feel more comfortable at home, they are usually shy, so at home they open up a bit more.*
>
> Participants with a lived experience

Ideal service locations and settings to overcome shame

As described in Chapter 3, some participants with lived experience hesitated to visit Aboriginal and Torres Strait Islander-operated providers because of stigma attached to mental health and alcohol and other drug use in their communities.

> *I go to Indigenous service for certain things, but I'd rather go to a white doctor for other things. There's no privacy (at the Aboriginal and Torres Strait Islander health service). They all talk amongst each other. It feels more confidential with the white doctors.*
>
> *When you go to Indigenous service you don't know who will be there. You go and people are like what are you doing there cousin, so you have to make up stories cause they would say.*
>
> Participants with lived experience

Participants expressed varied preferences on the ideal location and setting for mental health and alcohol and other drug use services in their communities to overcome this stigma.

Some research participants valued privacy and preferred that mental health support services are located away from popular commercial spots and/or offer discreet entrances. A few participants noted that they can't access services in commercial centres if they have been banned from entry to these centres.

> *Don't put services on the main drag. Have waited for the traffic to hide me while I run into the building so no-one sees me*
>
> Participant with lived experience

A few participants with lived experience felt uncomfortable attending group sessions as part of mental health support and alcohol and other drug rehabilitation.

> *Headspace in high school was a group thing and didn't want to do it. I wanted one-on-one but they didn't offer that option and didn't want to tell my family cause I didn't want to stress them. Indigenous mums they are more aggressive, so we don't want to tell them to embarrass us (laughs).*
>
> Community member participant

Sector research participants

See Section 1.3

Group E

4.3 Views from sector stakeholders

This section provides an overview of the views of sector stakeholders consulted as part of this research. Sector research participants included individuals in executive and managerial roles in government and non-government agencies that provide support to Aboriginal and Torres Strait Islander clients in the communities visited for this research, and individuals in government agencies that provide services across Queensland.

4.3.1 Existing focus and approaches in local communities

Local stakeholders in the visited communities identified key initiatives by mainstream services to engage Aboriginal and Torres Strait Islander individuals and communities, including:

- Indigenous Liaison Officers
- Aboriginal and Torres Strait Islander Mental Health Officers; and Aboriginal and Torres Strait Islander Mental Health Coordinators for both in-patient and in-community services
- collaboration and engagement with Aboriginal Community Controlled Health Services and other local organisations to promote mainstream programs and referral of Aboriginal and Torres Strait Islander clients to mainstream services
- sharing of clinical staff between Aboriginal and Torres Strait Islander health services and mainstream health services
- campaigns involving local media and community and sports events to raise community awareness and provide information on support options for mental health and alcohol and other drug use (for example 'Shattering stigma' and 'Stigma buster' campaigns, and events during NAIDOC week)
- use of Aboriginal and Torres Strait Islander-specific programs tools and resources like the IRIS screening instrument and risk card, and trauma-informed guidelines. Box 4.2 details examples of these initiatives at Metro South Health and Hospital Services.

Box 4.2 Indigenous approach to wellbeing — Metro South Health and Hospital Services

- **Trauma-informed Care guidelines**
  Guidelines to improve the journey of Aboriginal and Torres Strait Islander patients have been launched by Addiction and Mental Health Services. Trauma-Informed Care and Practice: A guide to working well with Aboriginal and Torres Strait Islander people will help ensure hundreds of Aboriginal and Torres Strait Islander patients receive culturally-appropriate care.

  The guidelines are designed to increase awareness that Indigenous Australians experience different types of trauma to the non-indigenous population.

- **Way Forward program**
  The Way Forward Program is a culturally informed, strengths-focussed approach to improving mental health and addictions outcomes for Aboriginal and Torres Strait Islander community members in Metro South and Metro North Hospital and Health Services. It aims to develop Indigenous professional development and career pathways that empower staff and encourage retention, build relationships by working for and working with the community, and promoting and supporting non-traumatic access to acute services.

Source: https://metrosouth.health.qld.gov.au/mental-health/initiatives/way-forward-an-indigenous-approach-to-wellbeing

Sector stakeholders acknowledged the gaps and challenges in the service system as identified by Aboriginal and Torres Strait Islander community member research participants.

They highlighted efforts to:

- increase activities and programs in the prevention and early intervention stages of the potential harm spectrum, recognising that most current efforts focus on intervention and aftercare
- increase care coordination and a whole-of-system approach to supporting individuals who experience problematic alcohol and other drug use, including addressing employment and housing needs (*Box 4.3* provides an example of a service provision 'hub' at Toowoomba)
- strengthen support in local schools for Aboriginal and Torres Strait Islander students via Guidance Officers and Community Education Councillors *(see Box 4.4)*
- strengthen public intoxication services to provide a culturally safe environment *(see examples at Box 4.5)*
- minimise the gap between Aboriginal and Torres Strait Islander clients and other populations on discharge against medical advice across public hospital wards
- provide after-hours support through new funding at a mainstream Mental Health Service.

Box 4.3 Toowoomba Housing Hub

The Toowoomba Housing Hub is a place where Queenslanders in need in the Toowoomba Region can access housing, homelessness and other support services in one location.

At the Hub people can connect to local services and support. Customers can access assistance from housing, homelessness, disability support and mental health organisations through the Hub.

The Toowoomba Housing Hub is a partnership between state government, non-government and community organisations in the Toowoomba region.

Our key partners in the delivery of the Toowoomba Housing Hub include:

- Lifeline Darling Downs
- YellowBridge Qld
- Salvation Army
- Red Cross Australia
- St Vincent De Paul
- Mission Australia
- Toowoomba and South-West Housing Service Centre.

Source: https://www.yoursayhpw.engagementhq.com/toowoomba-housing-hub

Box 4.4 Supporting the wellbeing of Aboriginal and Torres Strait Islander students

Guidance officers

Guidance officers are specialist teachers who deliver a broad range of services to school community members. They contribute to the development of a comprehensive student support and wellbeing program that is responsive to the needs of the school community.

Guidance officers may work directly with students in addition to working with a student's teachers, school support personnel, family, other specialists or external support providers.

Support offered by guidance officers includes providing advice and counselling on educational, behavioural, vocational, personal, social, family, and mental health and wellbeing issues.

Psychoeducational assessments and career development also form an important part of the work guidance officers undertake to enhance positive educational outcomes and career pathways for all students.

Guidance officers provide leadership, support and case management in responding to some of the most complex and challenging of circumstances including student protection matters, critical incidents, mental health issues, and suicide prevention and postvention support.

Community education councillors

Counsellors work closely with guidance officers and their local communities, and provide a significant service to Aboriginal and Torres Strait Islander students. More than 100 community education counsellors are located generally in schools with significant numbers of Aboriginal and Torres Strait Islander students, as well as in clusters of schools throughout the state.

They work with teachers to embed Aboriginal and Torres Strait Islander perspectives in curriculum, teaching methods and case management.

District community education counsellors advocate on behalf of students where a community education counsellor is not available.

Source: https://education.qld.gov.au/students/student-health-safety-wellbeing/student-support-services

Box 4.5 Examples of culturally informed public intoxication services

Diversion Centres

Rest and Recovery provides a safe, monitored and culturally appropriate place for intoxicated people to sober up; a reduced risk of harm from being intoxicated in public spaces; an alternative to being held in police custody for public intoxication offences; and support to access services that would help the person to give up or reduce drinking (Cairns, Palm Island, Townsville, Rockhampton, Mt Isa and Brisbane)

Managing Public Intoxication Program

Assertive Outreach provides outreach functions as an important gateway to more individualised service elements and supports. Over time where appropriate, workers build a relationship of trust with Service Users and encourage their engagement and participation in more formalised support activities (such as case management). As such workers require considerable knowledge of referral pathways and relevant support services for clients (Brisbane, Townsville and Rockhampton)

Source: Queensland Government (N.D) Queensland Productivity Commission inquiry into imprisonment and recidivism

Sector stakeholders acknowledged the shift in government funding from Aboriginal Community Controlled Health Services towards mainstream service organisations. A few stakeholders contested this and highlighted the need for further evidence base to support the government's funding decisions.

For those agencies with a focus on social and emotional wellbeing, there was a perception that there was a funding and power imbalance that favoured support for mental health programs (largely provided through mainstream services) over support for wellbeing programs (a focus of Aboriginal and Torres Strait Islander-provided services).

4.3.2 Broader state-wide developments

Health sector

The Queensland Government's *Making Tracks* strategy for closing the gap in health outcomes for Aboriginal and Torres Strait Islander people living in Queensland outlines priority areas for action, including alcohol, tobacco and other drugs youth treatment programs. There are currently Aboriginal and Torres Strait Islander Alcohol, Tobacco and Other Drugs Youth Programs in Cairns, Cherbourg, Mount Isa, Townsville and the Gold Coast.

As noted in the *Making Tracks* strategy,

> *'Queensland Health continues to fund drug and alcohol management and treatment services across the State through Hospital and Health Services and non-government organisation treatment providers. Specialist treatment services are provided to Aboriginal and Torres Strait Islander peoples specifically, and as part of services delivered to the broader population.'*

Queensland Health's *Aboriginal and Torres Strait Islander Cultural Capability Framework 2010–2023* outlines a plan to provide culturally appropriate health services to Aboriginal and Torres Strait Islander individuals and communities.

State-wide approaches to engage Aboriginal and Torres Strait Islander individuals and communities are supported by strategic advice from the Queensland Network of Alcohol and Other Drug Agencies (QNADA) and the Queensland Aboriginal and Islander Health Council (QAIHC).

Other sectors

Sector research participants who oversee state-wide approaches to service delivery outlined several current developments that could contribute to improving the social and emotional wellbeing of Aboriginal and Torres Strait Islander people living in Queensland. These included[11]:

- *Tracks to Treaty – Reframing the Relationship with Aboriginal and Torres Strait Islander Queenslanders (Tracks to Treaty)* initiative. Tracks to Treaty includes a Statement of Commitment to reframe the relationship between Aboriginal and Torres Strait Islander peoples and the Queensland Government and has two elements under a shared goal of supporting communities to move from outcomes of surviving to thriving: implementing the *Local Thriving Communities* reform, and establishing the *Path to Treaty* in Queensland *(see Box 4.6)*.

Box 4.6 Tracks to Treaty initiatives

Statement of Commitment to reframe the relationship between Aboriginal and Torres Strait Islander peoples and the Queensland Government

Aboriginal and Torres Strait Islander peoples and the Queensland Government are building a reframed relationship that acknowledges, embraces and celebrates the humanity of Indigenous Australians. We are proud that Aboriginal and Torres Strait Islander peoples have continuing rights and responsibilities as the first peoples of Queensland, including traditional ownership and connection to land and waters.

In the spirit of healing, we recognise the past acts of dispossession, settlement and discriminatory policies, and the cumulative acts of colonial and state governments since the commencement of colonisation which have left an enduring legacy of economic and social disadvantage that many Aboriginal and Torres Strait Islander peoples have experienced and continue to experience. It is time to nurture hope and optimism. It is time to focus on strengths and not deficits and to move from surviving to thriving. This can only be done by the Queensland Government doing things with Aboriginal and Torres Strait Islander peoples, and not 'to them'.

We will move forward together with mutual respect, recognition and a willingness to speak the truth about our shared history.

Through our continued shared commitment to reconciliation, all Queenslanders will be part of this journey.

- Recognition of the cultural rights of Aboriginal and Torres Strait islander peoples in the Human Rights Act 2019.
- The development of the *Aboriginal and Torres Strait Islander Housing Action Plan 2019–2023* (Queensland Government, 2019a) that places local decision-making at its forefront. The plan will be delivered in remote and discrete communities through the Local Thriving Communities reform and involves working in partnership with Queensland Health to develop housing solutions to support improved health outcomes.
- The development of *Advancing Aboriginal and Torres Strait Islander education: An action plan for Queensland* (Queensland Government, 2019b). The plan includes actions for partnering between education and health, including *'working with allied health professionals and remote schools through initiatives including Be Well Learn Well to provide therapy-based services to address developmental vulnerability impacting on education outcomes for Aboriginal and Torres Strait Islander students'*.
- The development of whole-of-government approach programs like *Be Well Learn Well (see Box 4.7)*.

Box 4.6 Tracks to Treaty initiatives

Local Thriving Communities

The Queensland Government is committed to working with the state's 19 remote and discrete Aboriginal and Torres Strait Islander communities to establish greater decision-making authority in service delivery and economic development through the Local Thriving Communities (LTC) reform.

LTC is a significant long-term reform that will embed change, resulting in a visibly different way of working alongside communities across the state to improve outcomes for Aboriginal and Torres Strait Islander Queenslanders.

This approach is based on mutual respect and high expectations relationships, applying a collaborative approach to give Aboriginal and Torres Strait Islander communities a greater voice in shaping their future.

Independent decision-making bodies will begin providing a representative voice for engaging with Queensland Government to:

- make decisions about their own future
- build on their strengths as a community
- invest in the things that will make communities stronger, that will make a difference to people's lives
- create thriving communities.

Community knowledge, research and evidence and lessons learnt over time will inform LTC, with the principles of self-determination, participation, equality and culture underpinning the initiative.

LTC will not replace existing decision-making structures.

Path to Treaty

Path to Treaty is the Queensland Government's commitment to commence the journey towards negotiated treaties with Aboriginal and Torres Strait Islander Queenslanders. It will ensure that the voices of all Queenslanders are heard in the treaty conversation and will benefit all by promoting reconciliation and shared pride in culture and heritage.

Source: https://www.datsip.qld.gov.au/programs-initiatives/tracks-treaty/local-thriving-communities/about-local-thriving-communities; https://www.datsip.qld.gov.au/programs-initiatives/tracks-treaty

11 We present these as current strategic directions and activities. We have not reviewed their implementation and/or achieved outcomes, and whether they address the issues outlined in this report.

Box 4.7 Examples of whole-of-government approach programs

Be Well Learn Well

The Be Well Learn Well program (BWLW) is a Department of Education program. CheckUP, in partnership with Gidgee Healing and the Apunipima Cape York Health Council, leads a strong, effective consortium to deliver targeted allied health services to support Aboriginal and Torres Strait Islander student developmental needs in remote state schools across Queensland.

The integration of early intervention and health promoting methodologies in the school setting is central to the BWLW program, which brings together the education and health workforce in remote Aboriginal and Torres Strait Islander communities. The delivery of the program is in a school setting, as opposed to a clinical setting, and is central to the program's implementation. The program allows for an integrated workforce of education and health professionals to respond holistically and in a timely way to the risk factors influencing child development and schooling outcomes. The services incorporate input from principals, teachers, guidance officers, the student's family and the wider community in the process of improving the learning outcomes for the student.

The aim of the Be Well Learn Well program is to identify and address behavioural and learning issues to improve educational outcomes for Aboriginal and Torres Strait Islander students, from pre-prep to year 12, in remote state schools.

The BWLW program supports Aboriginal and Torres Strait Islander student developmental needs through the delivery of targeted Speech Pathology, Occupational Therapy, Psychology and Clinical Psychology services to identify and address behavioural and learning issues.

The objectives of BWLW include:

- conducting classroom and individual student developmental needs assessments and targeted therapy where needed;
- conducting home visits and introducing conversations in the home and community around comprehensive care and specific intervention strategies; and
- strengthening knowledge and capacity of school staff through training in identifying learning difficulties and utilising evidence-base strategies in the classroom environment.

Cherbourg Heightened Response

Community concern regarding crime rates in the community saw the implementation of the Cherbourg Heightened Response. The Response is a multi-agency collaborative approach working in partnership with the Cherbourg community to address keeping kids in schools, helping families deal with issues that may arise and supporting those in need or at risk of offending to help address underlying social issues. Agencies involved include the Department of Education, DCSYW, Department of Housing and Public Works, Queensland Health, DATSIP and Queensland Police Service.

Source: https://www.checkup.org.au/page/checkup_health_services/be_well_learn_well/about_the_program/

4.3.3 What works

Sector stakeholders noted that they have found some success with engaging with, and achieving outcomes for, their Aboriginal and Torres Strait Islander clients who experience problematic alcohol and other drug use when:

- employing Aboriginal Health Workers and people with experience in the community

> *...community groups work well for aspects of alcohol and other drug use – had an Aboriginal Health Worker until funding stopped for the worker.*
>
> Sector stakeholder

What works

We had a program, a few years ago, supporting individuals with lived experience to get back on their feet after their treatment. We would recruit local people to support local people.

(One participant) was couch surfing, had lost access to his children, had lost his job and license. Our worker helped him sort out things, step by step, a case management approach. (The participant) would come to counselling, the counsellor will come here at our offices, a local Indigenous boy who quit his job but started volunteering for this case. The worker would take the participant to the job agency, to have his hair cut, he found him a job at (company). (The participant) had to drive at 3am so he couldn't drink. (The participant) started volunteering at our events and cook the barbie. But then he breached his DV order he texted his woman and went to jail. Before the text thing, (a media outlet) wanted to do a story for him but because he went to jail they saw it as a failure. That's judgement, not seeing the whole picture. (The participant) is back from jail now and re-engaged, and he is back to work. He is not a failure. And we need to be open when they are ready, when they get back, to support them.

What worked with this case is the relational aspect. By having community people work with us, that relationship gets built and there's negotiation on that relationship, and you need to have strong leadership to help the workers navigate that stuff. Government would see it as conflict of interest. The government does not realise that it is family that navigates people. Lots of families taking the burden of mental health so it's not conflict of interest. It's mob healing mob.

Sector stakeholder

- taking a holistic approach to meeting client needs, and working with families instead of just individuals

> *My role is to guide people, for example, how to make their own Centrelink application and identify what keeps people strong and community (non-clinical) supports. In mainstream, there is an expectation that the worker will do it all.*
>
> *Mental health system is individualised but here we work with the family. We will go to the most appropriate significant person in that person's life.*
>
> *Our model is small but caring. More of a homely set up, family atmosphere. Talk to them, find out their wellbeing. We have social and emotional wellbeing workers.*
>
> Sector stakeholders

- educating staff at mainstream services on Aboriginal and Torres Strait Islander peoples, cultures and community history
- focusing on the community by engaging the entire community and using local knowledge

> *We had a very successful local steering committee recently that coordinated development of a new service agreement. We are aiming for more community control and look how funding can be used now within the context of other funding that was in place. Everybody has a win out of that.*
>
> *The strength comes from the community. Overseeing by the community, driven by them.*
>
> Sector stakeholders

- reaching out into the community, door to door, and travelling to other more remote communities
- integrating local services and funding across the spectrum of support.

> *Gurriny in Yarrabah had tremendous success in addressing their community. They are co-located with range of other services. They have community health plan for individuals.*
>
> *(Service provider) receives funding for residential rehabilitation, but they are a community organisation as well, so they can effectively step up and down people if needed across the spectrum of services.*
>
> *Case Coordination Working Group (comprised of frontline case managers from a range of NGOs) meets once a fortnight to discuss clients that are falling between the cracks. They share information real time. (The approach) makes services accountable, client focussed and looks for solutions.*
>
> Sector stakeholders

Other aspects of what makes a service attractive that is tailored to the needs of Aboriginal and Torres Strait Islander clients included:

- a mix of personnel providing a multi-Indigenous culture
- providing a space for yarning
- culturally appropriate counselling that stops before 'getting into the illness' – mental health seen as more mainstream and designed to look after the 'illness'
- talking about clan groups/kinship
- outreach services including mobile Centrelink 'that goes around the park'
- open communication with police to ensure services are optimised.

A few sector stakeholders acknowledged the importance of local General Practitioners in the system's response to mental health and problematic alcohol and other drug use. They found some success when engaging and collaborating with local General Practitioners to increase awareness of community health issues, and referrals to available programs.

> *GPs play a critical role, they do all the community education stuff.*
>
> Sector stakeholder

It was also important that service providers were approachable and strategies to build trust included removing outward signs of associations with government.

> *No logo on my clothes saying Queensland Health. They don't like seeing Queensland government because of transgenerational trauma. We have had to change our identity.*
>
> Sector stakeholder

Addressing shame

The following outlines key approaches by local sector participants to address potential barriers associated with feelings of shame to access their services.

Understanding feelings of 'shame'

Service providers sought to understand their clients' feelings of shame and develop strategies in anticipation of the lack of confidence to use their services because of the fear of being judged. Service providers understood shame as mostly linked to the impact of people's alcohol and other drug use and associated mental health issues on their family, although other explanations were also provided.

In relation to stigma, perceptions of shame can be linked to transition to manhood/trying to find their identity can be a barrier to accessing services earlier.

In asking a question about how they feel, shame is in the answer. Shame against themselves, regret your past and your future, makes you less of a man. Shame because of family and how they regard alcohol/drug use. Why would you change when that is what people thought of them – failure/rejection. Shame among your own people.

We see amongst our clients a fear of being treated differently because of culture. Need to go with them to a referred service and do a warm referral. Will work with person and learn about what they want (off alcohol or manage to support a tenancy – harm minimisation).

Sector stakeholders

Discreet locations

Service providers sought to provide discreet entrances to their services and/or chose locations that provide privacy.

In our other office we tried to have services upstairs to eliminate shame. But it was still difficult. I could see people who I knew, and I knew they thought I was judging them.

What happens here won't put it on social media. The building we have here is behind the front of building so people can walk in the back if they want to. We have got to understand the mindset of the person.

Sector stakeholders

Diverse service offering

Service providers were supportive of the 'hub' approach that anonymised service access and improved service user confidence in the privacy of their engagement with specialist services. This also extended to effectively 'rebranding' of services to achieve change in community perception.

No men walk in the door. Have a different building for men. Trying to strengthen the perception of [the service provider organisation] – not just emergency – can come for other issues. Sought to change perception through calendar events to promote programs and drive recruitment to the services.

Sector stakeholder

Protective factors

In one community, religion and culture were seen as protective factors that supported the social and emotional wellbeing of community members. This would work both to prevent problems as well as to restore health and wellbeing.

4.3.4 Challenges

Sector stakeholders acknowledged and reiterated many of the issues and challenges identified by Aboriginal and Torres Strait Islander community member participants.

System challenges

A fragmented and complicated mainstream mental health system

Stakeholders acknowledged the complexities in accessing services that can be disjointed and have long waiting lists.

The system in mental health irrespective of whether you are Aboriginal and Torres Strait Islander person or not is confusing... Just trying to navigate it. It's even harder if English is not your first language. If you fail at that first step they won't take up the service.

Services are not available when (clients) are ready. People make a leap of faith and come for help and you tell them not available for six months.

Sector stakeholders

Overall lack of resources and funding

Stakeholders noted that, overall, services that relate to alcohol and other drug use and are specific to Aboriginal and Torres Strait Islander people have limited funding and resources.

A key barrier is our capacity in AOD. It's limited across the portfolio.

Demand exceeds supply for services. It's an undersourced and underfunded area across Australia. It needs at least double the current funding, Australia wide.

Sector stakeholder

Discontinued funding and limited capacity to help

Stakeholders in some communities spoke of discontinued funding in some ATOD and Indigenous Health Worker roles that resulted in limited capacity to support their communities.

It's hard to ask for help. Services can't actually help. Waiting lists at ATODs are huge.

Sector stakeholder

Location and outreach

Some stakeholders noted challenges with accessing multiple services and reaching out to the community.

Services are physically in three locations. They need to access services at one spot, otherwise they get side-tracked.

It's no point having someone behind a desk. The service needs to do outreach.

Sector stakeholders

Recruitment and retention of staff

Mainstream providers talked about challenges in recruitment and retaining staff, particularly in remote locations and in Aboriginal and Torres Strait Islander-identified roles. A few providers were investigating how to build their workforce and attract skilled workers with limited success.

> *There's good initiatives, but we need people on the floor to translate them.*
>
> *Recruitment options are very limited and a major challenge in our area.*
>
> *Transience of professionals can be an issue.*
>
> *Training is a challenge for Aboriginal Health workers with little AOD specific knowledge and support for training. You can recruit potential workers from remote communities with the view that they will go back to community but people need formal training rather than in-house 6-week training only.*
>
> Sector stakeholders

Some remote communities are addressing shortage of professionals by training people in the community to provide support to others.

> *We have a partnership with TAFE Qld. For 14 outreach workers to come into [location] for one week for six blocks plus a Support Worker to assist staff to complete their studies (James Cook University). Cost of $400,000 which includes $25,000 per charter flight while the TAFE course is relatively cheap at $10,000.*
>
> Sector stakeholder

However, in these communities, securing accommodation for new staff could be a challenge, and for non-government service providers it was not possible to compete for rental accommodation against the high prices paid by government services.

Servicing Aboriginal and Torres Strait Islander people

Lack of trust and cultural understanding in mainstream services

Most sector stakeholders acknowledged that there is limited cultural understanding of Aboriginal and Torres Strait Islander peoples and their cultures within mainstream service providers and in some cases limited trust between the Aboriginal and Torres Strait Islander community members and mainstream services. These contribute to:

- Aboriginal and Torres Strait Islander clients being misdiagnosed (pathologised) over cultural conditions like sorry business

> *Conditions (e.g. sorry business) can get pathologised very quickly by other service providers operating under a western medical model. There is an opportunity for the HHS' social and emotional wellbeing referral team to educate providers in this area... Grief and loss is the main problem in incorrect mental health services referrals.*
>
> Sector stakeholder

- Aboriginal and Torres Strait Islander clients failing to return for further treatments and support

> *Western 'model of care' is a barrier especially where there is no previous experience of working in an Indigenous community. Issues can include lack of transport, communication and engagement.*
>
> Sector stakeholder

- Aboriginal and Torres Strait Islander members of the community not accessing mainstream services due to bad reputation in the community

> *Cultural gaps result in disengagement. We are looking now to try to reduce that and speak more with the community about their needs.*
>
> *We struggle to keep Aboriginal and Torres Strait Islander patients, to maintain a supporting model of care that goes to the end.*
>
> Sector stakeholders

Understanding community

A constant theme was the importance of understanding the community that is being serviced. This included ensuring community engagement in local service design/investment decisions, the challenge of operating in a service environment that is driven remotely by policy, the perception that decisions are being made in secret and causing division in community

> *Need local community involved – feels like we are getting railroaded. Lot of stuff done in secret...No community representation. Consideration given to setting up an ACCO – not logical, population too small... Fear that they are taking away primary health care. No one talking to community allowing community to fight amongst themselves. Set off anger – concern about jobs. We don't have activists. Have whole host of trained people but not one of them runs the show.*
>
> Sector stakeholder

Challenges with rehabilitation services

Stakeholders identified an overall reduction of rehabilitation services and a shortage of culturally appropriate rehabilitation centres. They noted that Aboriginal and Torres Strait Islander patients are usually sent to mainstream rehabilitation centres or need to wait for culturally appropriate support.

> *There are challenges with offering recovery services. There's long waiting lists at the moment.*
>
> *There needs to be education for community for smaller goals to not set them up for failure. It's about getting the person to that point where they can receive help.*
>
> *I know lots of people who had the burden of people detoxing in their house. They are not skilled they are doing it because it's their brother or sister.*
>
> Sector stakeholders

A few stakeholders noted the connection between rehabilitation and correction services.

> *Most go there just to get out of jail. It's more punitive than actually getting help.*
>
> Sector stakeholder

Ineffective support after prison

Stakeholders spoke of ongoing challenges in supporting inmates after prison.

> *We need to look at mental health. We need to support people when they get out of jail. Services are not connected when someone gets out of jail. In jail they have support workers, but they also need to be supported on the outside as well.*
>
> Sector stakeholder

Group versus individual help

Stakeholder recognised that models of support involving group help can be inappropriate for Aboriginal and Torres Strait Islander people.

> *We set people up to fail. They come out of jail and are asked to talk about their feelings in groups... That creates anxiety and paranoia. They get them to write journals, but they can't read so they feel shame. They are all different, they need to be treated differently. They need individual help instead of group help.*
>
> Sector stakeholder

Co-morbidity

Alcohol and other drug use was not regarded as a challenge in itself, but providing support was challenged when it was coupled with mental health.

> *We aim to be visible, such as football carnivals, but despite promotion on the ground we don't attract people to the stall. There is no shame associated with alcohol and other drug use but coupled with mental health issue it becomes a barrier.*
>
> Sector stakeholder

Family and kinship connections

A few stakeholders spoke of the challenges arising from the family and kinship connections in their workforce and clientele. They can include conflict of interest for staff because of family ties, issues around age and gender, and the need for staff to understand work/family distinctions.

Social challenges

Conservatism and stigma

Stakeholders acknowledge a trend towards conservatism in social views and attitudes, which complicates efforts to address stigma and discrimination.

> *We sometimes get push back from communities when trying to develop services for alcohol and other drug use. There's fear and stigma attached to rehabilitation services.*
>
> *We are seeing some broader conservative attitudes, instability and change and fear in community, we are seeing increasing stigma.*
>
> Sector stakeholders

Media malpresentation

Stakeholders noted that media can sensationalise coverage of alcohol and other drug use, and/or focus their coverage on specific populations like Aboriginal and Torres Strait Islander people.

> *Media coverage is not representative of actual problems with alcohol and drug use.*
>
> Sector stakeholder

Section 5

Key findings and opportunities ahead

This chapter provides a summary of our key findings and outlines potential responses to address stigma and discrimination in the service system based on feedback from research participants.

5.1 Key findings

The key views and experiences of research participants are summarised below.

Definitions and experiences of stigma and discrimination

- Aboriginal and Torres Strait Islander research participants used the term 'racism' to describe experiences of stigma and discrimination
- There were misunderstandings and stigma associated with the term 'mental health', and the term was not widely used as a result of the stigma
- Racism was general and pervasive in the lives of Aboriginal and Torres Strait Islander research participants. It was felt in daily social interactions and commercial transactions with the broader community and in the workplace
- Participants experienced multiple forms of stigma and discrimination related to race, clan, location and alcohol and other drug use. It was difficult to isolate experiences in each form. The compound effect intensified the overall experience of 'racism'
- Racism was associated with feelings of being 'invisible' and of shame, hopelessness and anger
- Employment was a major area of racist discrimination
- The police were generally viewed as stereotyping and discriminating against Aboriginal and Torres Strait Islander people

Relationship of stigma and discrimination to stereotypes of alcohol and other drug use

- Racism was attached to several stereotypes of Aboriginal and Torres Strait Islander people. It was difficult to isolate the impact of specific stereotypes on the overall experience of racism
- Public behaviours could be perceived differently if the instigator is an Aboriginal and Torres Strait Islander person. There is an assumption that the person may be drunk or wanting to cause 'trouble'
- Retail (including alcohol sales) and entertainment venues discriminated against Aboriginal and Torres Strait Islander participants irrespective of whether they engage in alcohol and/or other drug use

Impact of stigma and discrimination related to stereotypes of alcohol and other drug use

Social and emotional wellbeing

- 'Wellbeing' was not a widely used term, but understood best as 'how you feel in yourself and in family and community'. Feeling well about one's self, family and community is about being connected, noticed, respected and cared for
- Stereotypes of alcohol and other drug use were one of many factors contributing to the overall pressures on wellbeing
- Employment and education were key drivers of wellbeing

Ability to access services

- Participants felt judged by mainstream services and that these services lack understanding of the experiences of Aboriginal and Torres Strait Islander people

Factors that contribute to the severity or mildness of the impact of stigma and discrimination

- Individual resilience stemming from strong kinship support, stable housing and financial security contributed to alleviating the impact of racism
- Elders assisted the community to overcome trauma/harm associated with racism and problematic alcohol and other drug use
- Participants sought out services where there's cultural awareness, respect and consistency/reliability of care
- Stigma/lack of acceptance of spirituality and Aboriginal and Torres Strait Islander medicine in western science exacerbated experiences of racism
- Traditional and social media can present negative/misleading stories that exacerbate fear and anger in the community and cause disturbances

Impact of stigma and discrimination on ability to seek support for alcohol and other drug use

- Alcohol and use of some other drugs (like cannabis) are not automatically perceived as problematic to the individual (user), but as a means of alleviating stress and trauma (including pain and loss) from conditions outside the user's control and including the hurt felt from racism and discrimination. Where stigma related to mental health is strong alcohol and other drug use can be viewed as more favourable than having mental health issues
- There is a tendency to access mainstream support services only in crisis. Where available, Aboriginal and Torres Strait Islander service providers were preferred and perceived by most as providing culturally appropriate and sustainable support in relation to alcohol and other drug use
- Some participants preferred the anonymity of mainstream services, noting it is important that these services provide a safe and culturally appropriate environment
- Existing approaches in Aboriginal and Torres Strait Islander communities
- Most participants felt that they cannot get support with mental health and problematic alcohol and other drug use where and when they need it
- Barriers to accessing services included remoteness and marginalisation within geographic and social contexts, feeling safe and desiring more culturally appropriate service environments, and the need for ideal service location and settings to overcome perceptions of shame
- Sector stakeholders identified a range of approaches that had contributed to improved outcomes for Aboriginal and Torres Strait Islander people. These approaches are consistent with those considered desirable by research participants
- A range of broader state-wide developments were viewed by state-wide government sector research participants as relevant to contributing to improved social and emotional wellbeing outcomes for Aboriginal and Torres Strait Islander people living in Queensland

5.2 Opportunities ahead

5.2.1 Suggestions for improvement from community participants

Most research participants expressed a desire for their communities to be properly consulted on any changes to the service system and to ultimately be empowered to find their own solutions to issues relating to mental health and problematic alcohol and other drug use.

They saw the engagement and empowerment of local Elders and mentors as contributing to a more sustainable and culturally appropriate approach to finding solutions.

> *The Elders have the answers but we get hit on the head every time we try to do something, cause the government pulls off the carpet.*
>
> Elder research participant

Research participants offered several suggestions to improve the mainstream service system and support services for mental health and problematic alcohol and other drug use. These included:

- educating staff in mainstream services on Aboriginal and Torres Strait Islander cultures and about racist behaviour
- a stronger focus on providing non-emergency services, and extending the hours of operations of these services when people often feel anxious or isolated
- a stronger focus on services to individuals with moderate and low needs at the preventative spectrum, such as formal yarning groups, e.g. men's groups
- strengthening of the continuity of services and the 'healing' journey — currently this is perceived as fragmented
- strengthening access and outreach of services to the community and away from central commercial locations, including by reaching out to communities and investing in building relationships with members of the community
- combining alcohol and other drug use services with other types of provision to minimise stigma
- respect and inclusion of cultural diagnosis and healing (including use of traditional medicine) in the mainstream service system
- racism to be included as a focus on government accountability/auditing processes
- strengthening accountability/transparency over allocation and management of government funding for Aboriginal and Torres Strait Islander services, potentially via oversight/auditing by an independent body
- increasing education in communities on human rights and mental health using culturally appropriate concepts (personification of concepts) and outside the perceived 'gatekeepers'.

The importance of a multifaceted approach

The Aboriginal and Torres Strait Islander individuals who participated in our research shared experiences of prevalent stigma and discrimination on the basis of their racial and cultural backgrounds, compounded by experiences of shame and discrimination in relation to their own use of alcohol and other drugs or the stereotypical views held by other members of their communities of attitudes and behaviours of Aboriginal and Torres Strait Islander peoples.

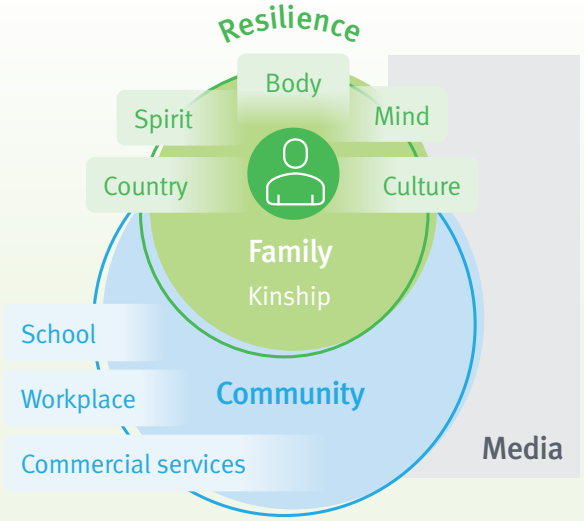
Stigma and discrimination occurred in their personal and socio-economic interactions and interaction with the service system as illustrated in *Figure 5.1*:

- connections with culture, country, spirit, families and kinship drove stories of resilience
- stigma and discrimination was experienced everywhere: in the community, the school, the workplace and in commercial services
- traditional and social media contributed to experiences of stigma and discrimination
- there was an understanding that stigma and discrimination is imbedded in the foundations of the system
- stigma and discrimination is not isolated to a specific sector and can vary according to service elements like location, staff and timing.

Figure 5.1 *Stigma and discrimination occurrence and opportunities for change*

Where stigma and discrimination occurs

Personal and socio-economic interactions



System interactions

System foundations	Legislation and justice	Human rights	Government policies and planning

Services and service delivery

Broader

- Child Safety
- Corrective Services
- Criminal Justice
- Disability
- Domestic and Family Violence
- Education/Training
- Employment
- Family support
- Financial Advice
- Housing
- Recreation and sports
- Welfare

Health

- General practitioners
- Telephone information
- Accident and emergency
- Primary healthcare

AOD

Service elements	
Location	• Inside vs outside community • Community controlled organisation vs mainstream
Staff	• Aboriginal and Torres Strait Islander staff • Cultural awareness • Trauma awareness • Experience in community
Timing	• Preventative stage • 24-hours/weekends • Post-jail

Source: ACIL Allen Consulting 2020

As discussed in Chapter 3, research participants acknowledged the complex cultural, social and economic factors that contribute to the experiences of Aboriginal and Torres Strait Islander people living in Queensland, including experiences of racism and alcohol and other drug use.

Based on these acknowledgements, and the understanding of the co-morbidity of ensuing issues in the health and social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples, research participants highlighted the importance of a multilevel, multifaceted approach (involving the elements illustrated in *Figure 5.1*) to reducing racism and improving the social and emotional wellbeing of Aboriginal and Torres Strait Islander individuals, families and communities in Queensland.

Research participants perceived that to be successful a multifaceted approach should incorporate:

1. a whole-of-system approach to address racism. Participants understood the issues involving alcohol and other dugs use and racism as being interconnected with broader social, economic and cultural issues as addressed by the whole service system — including in employment, education and training, and police and criminal law. They perceived that current piecemeal approaches are not delivering results and that a broader focus on providing employment, cultural education at schools, and strengthening parenting skills can be effective
2. a physical, emotional, social and spiritual approach to health. Participants perceived that the current mental health system focuses on treating the individual, which does not align with the social and cultural structures of Aboriginal and Torres Strait Islander communities where family and connections with community are crucial. An increased focus on family and community mental health would be ideal
3. genuine engagement with the community and provision of opportunities to empower the community to identify, agree on and implement solutions
4. a system serviced by employees who are culturally trained and aware, and who can create a safe place for interactions with Aboriginal and Torres Strait Islander clients. Preferably employees should be of Aboriginal and Torres Strait Islander background and/ or have existing relationships with the local Aboriginal and Torres Strait Islander community.

Finally, participants noted that racism is ingrained in the broader population and Aboriginal and Torres Strait Islander-specific policies and legislation, which are perceived to violate their basic human rights. They call for racism to be addressed at the higher levels of government policy and legislation.

5.2.2 Suggestions for improvement from sector stakeholders

Respect, equity and wellbeing of Aboriginal and Torres Strait Islander people

Stakeholders suggested that improving respect, equity and the wellbeing of Aboriginal and Torres Strait Islander people in Queensland must be an ongoing endeavour that involves broader initiatives and consultation.

A key stakeholder listed the following as essential steps:

- National truth telling, apology and acknowledgement of the harm inflicted on Aboriginal and Torres Strait Islander people upon colonisation.
- Implementation of the *Uluru Statement From the Heart*.
- Teaching an accurate account of the history of colonisation in all schools.
- Celebrating Aboriginal and Torres Strait Islander languages and cultural practices in schools, workplaces, at sporting events etc to build awareness, cultural capability and national pride in Aboriginal and Torres Strait Islander culture.
- Influencing non-Aboriginal and Torres Strait Islander Australians to acknowledge the history of Australia and advocate with Aboriginal and Torres Strait Islander people.
- Embracing Aboriginal and Torres Strait Islander representation in leadership positions across sectors.

Services for Aboriginal and Torres Strait Islander people

Sector research participants offered several suggestions to improve service delivery for Aboriginal and Torres Strait Islander people living in Queensland.

These included:

- Increase focus on preventative and primary health care.
- Increase involvement of Aboriginal and Torres Strait Islander communities and Aboriginal and Torres Strait Islander-operated service providers in governance arrangements and development of services.

> *(We need to support) First Nations' leadership in the design and delivery of services.*
>
> Sector stakeholder

- Strengthen cultural appropriateness, understanding and safety in mainstream services, and support engagement of Aboriginal and Torres Strait Islander individuals (including Elders) in health services.

> *We know that delivering culturally appropriate services is important. We need culturally safe and culturally informed service.*
>
> *There's work to be done in Queensland to strengthen community-controlled organisations and make non-community controlled deal with Aboriginal and Torres Strait Islander issues.*
>
> *Indigenous Liaison Officers need more funding. And we need culturally appropriate counselling.*
>
> *Elders are left out sometimes now. They don't sit in an appropriate place in the (decision making) structure. Sense that they are low therefore Elders sit lower but their status is higher. Elder position has no meaning for community. Main objective is to get Elders back in their right status in community.*
>
> *(We need) culturally safe programs and services that delve deeper than responding to the symptoms of substance use to therapeutically explore trauma backgrounds, holistic health (connection to land, culture, family etc), self-limiting beliefs, self-esteem, coping, resilience and practical needs (e.g. employment, social connections etc), respecting secret and sacred knowledge. Mental health and alcohol and other drugs are one of the only areas that expect people to tell clinicians all their inner most thoughts and personal experiences – there needs to be respect for this privilege and understanding when it is not culturally appropriate to share information... (We need to ensure) that managers are culturally competent so that they can facilitate a culturally safe environment and pick up when staff are being culturally unsafe/manage this.*
>
> Sector stakeholders

- Strengthen adaptability of services to address everyday challenges.

> *(We need) after hours availability and more day or night programs to work around child care or work needs; accounting for transport barriers in rural and remote areas; addressing financial barriers.*
>
> Sector stakeholder

- Focus on addressing trauma and strengths and resilience within communities.

> *We need to teach people about their experiences and explain cross generational trauma. It makes them feel better to understand that it is not their fault, to teach them they are strong.*
>
> *We need to highlight the resilience. We need programs for people to engage in cultural practices, teach them to be stronger in their identity. This is part of the holistic picture to have everything taken care of.*
>
> *Trauma has become normalised in the Aboriginal and Torres Strait Islander experience. Some clients they report so many multiple traumas in their lifetime. You have to make them see it's not normal.*
>
> Sector stakeholders

- Address gap in trauma-informed and mental health-related training that is specific to Aboriginal and Torres Strait Islander clients.

Stakeholders reiterated the importance of cultural safety, trauma-informed practice and flexibility when supporting Aboriginal and Torres Strait Islander communities. They noted a current gap in providing appropriate and trauma-informed training to service providers that is specific to mental health and Aboriginal and Torres Strait Islander people.

> *(We need to prioritise) the development and delivery of cultural capability training, trauma-informed care training, and training in the administration of culturally safe screening and assessment tools to promote care and recovery.*
>
> Sector stakeholder

- Support carers and community groups.

> *We were talking about suicide and a young girl said she had to take so many calls from peers who wanted to commit suicide.*
>
> Sector stakeholder

- Strengthen alignment between federal and state government initiatives and requirements, and increase collaboration between funding portfolios (including in sharing of data).

> *We need to move outside funding silos. Is there duplication? How can we use existing resources to meet needs? We need to work together to assess these silos.*
>
> *(We need to) enhance data collection, analysis and service integration to reach high risk patients earlier in their care journey, outside of hospital (e.g. formally partnering with housing, child safety, family violence services etc).*
>
> *What's state and what's federal? It's never clear cut.*
>
> *The system is the thing that needs to change.*
>
> Sector stakeholders

- Allow for some flexibility in local funding and reporting to Government.

  We try to adapt available funding to specific local needs but there's limitations.

  Sector stakeholder

- Improve workforce participation and support career pathways in provision of alcohol and other drug use services.

  There's no strong pathways in AOD and the workforce is ageing. We need to plan ahead to attract a new workforce.

  Sector stakeholder

- Develop culturally appropriate outcomes and goals for government programs.

  (We need to) regularly evaluate services on measures such as cultural capability, patient/ carer/ staff satisfaction, and indicators of recovery (e.g. readmission rates, community contact, preventative activity, measures of wellbeing).

  We set people up for failure. We need smaller goals to avoid failure.

  Sector stakeholders

5.2.3 Trauma-informed care and practice considerations

Throughout this research, multiple layers of different types of trauma were recognised in the lives of most, if not all, of Aboriginal and Torres Strait Islander participants with lived experience.

Complex trauma and intergenerational trauma have impacted many participants with stories of child removals (sometimes whole families of children) and parents who use drugs and alcohol as coping strategies, either intentionally or inadvertently introducing children to drugs and alcohol.

Collective trauma was evident especially in discrete communities where whole communities are impacted by poverty, lack of basic education and unemployment.

The lack of trauma-informed practice is highlighted repeatedly throughout the stories from the participants of this research which constantly puts individuals at risk of retriggering when coming into contract with service providers.

Specifically, the components of a trauma-informed framework that were perceived by participants to be lacking in most encounters with mainstream service providers included:

- Lack of ***safety***, particularly cultural and psychological
- Intermittent and inadequate displays of ***trustworthiness*** within service provision
- Lack of ***trust***ing relationships and the will to form these in many service environments
- Very little or no ***collaboration*** with community
- Often no ***choice*** in how treatments or services could be offered
- No focus on including ***culture*** in service provision or understanding cultural implications of working with Aboriginal and Torres Strait Islander individuals, families and communities.

5.2.4 A concurrent alignment and gap of needs and service provision

With few exceptions, Aboriginal and Torres Strait Islander research participants held an overall impression of a service system that does not treat them equally, does not understand their cultures, does not genuinely listen to their feedback, does not involve them in decisions relating to service provision, and at most times does not meet their needs.

> *We are sceptical of the government's intentions and are tired of the endless efforts to 'fix' our problems. We are judged and not allowed to make mistakes. We are penalised in every misstep, institutionally, financially, physically. We need to be allowed to find our own solutions and be allowed to make mistakes. We need to deal with our traumas, and that's messy. This will take time and people need to be patient. There's a lot of knee-jerk reactions and little long-term thinking or understanding of a path out of this.*
>
> Elder research participant

These views and experiences are consistent with findings from numerous studies involving the participation of Aboriginal and Torres Strait Islander people living in Australia, and add to the well-documented and persistent impact of historical and current social and economic disadvantage and exclusion of Aboriginal and Torres Strait Islander people, and the resulting intergenerational trauma from colonisation, dispossession of land and culture, and past government policies.

The sector stakeholders who participated in this research acknowledge and understand the impact of stigma and discrimination on Aboriginal and Torres Strait Islander individuals, families and communities and the challenges of supporting people who experience problematic alcohol and other drug use. As detailed in *Chapter 4*, different sectors are addressing related needs and challenges.

The sector stakeholders' feedback and the existing or imminent initiatives and programs that they shared with us mostly align with the expectations of Aboriginal and Torres Strait Islander community participants in this research.

Yet despite this alignment, Aboriginal and Torres Strait Islander community member participants were mostly unaware of, unable and/or hesitant to access services.

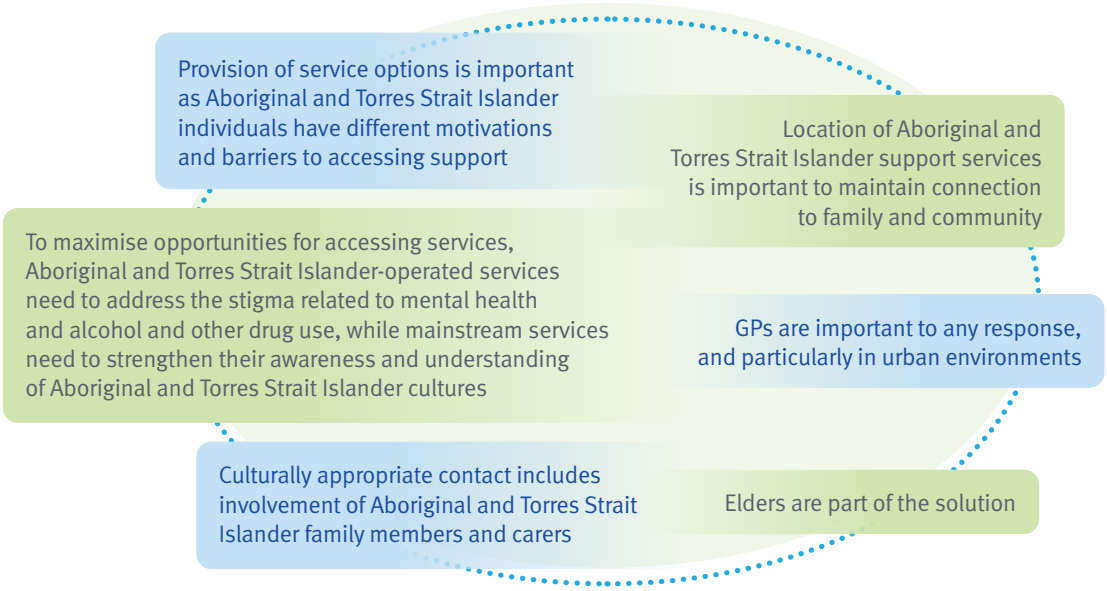
The gap between Aboriginal and Torres Strait Islander individuals and the service system is a persistent challenge in Australia that is beyond the scope of this research. As suggested by the participants, it requires a whole-of-system vision, approach and long-term solutions.

Addressing the barriers to accessing services that relate to alcohol and other drug use will require this whole-of-system approach.

QMHC has recognised the importance of whole-of-system improvement as a key focus area in its 2018–2023 strategic plan (2018b). The findings of this research validate and heighten the need for this focus.

Finally, it is essential that QMHC and related agencies consider how they can further engage and involve Aboriginal and Torres Strait Islander individuals, families and communities when guiding the development of options for reform informed by this research.

The following, suggested by research participants and the evidence for good practice, provide a few key principles to continue this conversation.



Appendix A

Lessons from existing literature

Overall, there is limited evidence of the effects of approaches that aim to reduce stigma and discrimination related to alcohol and other drug use, particularly in the medium- to long-term (Lancaster, 2017; Livingston, 2012).

Some positive effects were found in relation to therapeutic interventions, such as group-based Acceptance and Commitment Therapy (ACT) and vocational counselling; and programs focused on educating medical students and police officers about substance use problems and exposing them to people with substance use disorders. Surprisingly, educational factsheets were found not to achieve meaningful improvements in stigmatising attitudes among the general public (Livingston, 2012).

Given the lack of strong evidence-base in this space, we have compiled in this section lessons learnt and factors that have contributed to the success of broader related approaches, including in relation to racism and mental health, strengthening social inclusion, and improving the social and emotional wellbeing of Aboriginal and Torres Strait Islander people.

These are grouped as potential themes for action, which can be explored further in the later stages of this research. The themes and examples are not presented in order of significance.

Theme 1: Develop a multifaceted, multilevel approach

A review of stigma-reducing interventions across the alcohol and other drug, mental health and HIV/AIDS fields that was conducted as part of developing the *'Changing attitudes, changing lives'* paper highlights the importance of multifaceted and multilevel approaches:

> *'Stigma-reducing interventions need to be focussed on both the social, political and economic causes of stigma, as well as on changing individuals' discriminatory attitudes and behaviours.*
>
> *Approaches must be multifaceted to address the extensive mechanisms which produce discriminatory outcomes, but also multilevel to address issues of both individual and structural discrimination.'*
>
> *(Queensland Mental Health Commission, 2018a)*

Theme 2: Address factors that contribute to discrimination

Victoria's 'Building on our strengths' framework highlights a number of factors at individual, organisational, community and societal levels that contribute to race-based discrimination thought to be amenable to change through interventions. These are listed below.

Individual

- Belief in racial hierarchy and racial separatism
- Belief that some groups do not fit into Australian society
- Fear, anxiety, discomfort, avoidance or intolerance of diversity
- Denial that discrimination occurs and/or that it is serious
- Negative stereotypes and prejudices
- Failure to recognise own negative attitudes/behaviours and/or a belief that they are 'normal'
- Poor conflict resolution skills
- Limited positive inter-group relationships and interaction

Organisational

- Organisational cultures that do not recognise discrimination or value diversity
- Organisations that support or have weak sanctions against discrimination
- Policies, practices and procedures that favour the majority group
- Inequitable recruitment, evaluation, training, remuneration, turnover or promotion of staff
- Limited opportunities for positive inter-group relationships and interactions
- Leadership that supports, fails to recognise or has weak sanctions against discrimination or does not value diversity

Community

- Limited relationships and interaction between people from different groups
- Neighbourhood, family and peer cultures that are supportive of, or have weak sanctions against, discrimination
- Resource competition
- Local demography, historical context and community identity
- Leadership that supports, fails to recognise or has weak sanctions against discrimination or does not value diversity

Society

- Institutional, media, cultural and political support for, or weak sanctions against, discrimination
- Limited connections between people from different groups
- Impacts of colonisation
- Inequitable distribution of material, informational and symbolic resources
- A national identity that excludes certain groups
- Leadership that supports, fails to recognise or has weak sanctions against discrimination or does not value diversity

Source: Paradies, Y, Chandrakumar, L, Klocker, N, Frere, M, Webster, K, Burrell, M & Mclean, P 2009, Building on our strengths: a framework to reduce race-based discrimination and support diversity in Victoria. Full Report, Victorian Health Promotion Foundation, Melbourne

Theme 3: Address negative media portrayals

An analysis of online and print articles found overwhelmingly negative portrayals of Aboriginal health, with alcohol, child abuse, petrol sniffing and violence being the most common negative topics (Stoneham, 2014b). Suggested strategies to overcome these negative depictions include:

- focus on positive role models and voices of change and commitment in Aboriginal communities
- upskilling Aboriginal advocates through media training
- development of ethical media policies and procedures
- cultural competence education as part of cadetships and university education for journalists (Stoneham, 2014a).

Theme 4: Empower communities and individuals

The strategies and programs presented below show the importance of involving communities in the development and execution of interventions.

Integrated Social and Emotional Wellbeing and Primary Care model (QLD)

Description/Aims

Apunipima Cape York Health Council's model of care promotes and supports individuals' and communities' social and emotional wellbeing and empowers Aboriginal and Torres Strait Islander people by providing culturally competent, comprehensive primary health care through Aboriginal Community Controlled Organisations. The holistic services consider the social, emotional, spiritual and cultural needs of individuals, families and communities.

Lessons learnt/Success factors

To be embraced by the local Aboriginal and Torres Strait Islander community, the program needed to empower local people to make local decisions regarding their healthcare and the types of services needed, and to consider community opinions when making decisions regarding funding. This includes providing the Family Wellbeing program and Aboriginal and Torres Strait Islander Mental Health First Aid at the request of the community. This approach fostered trust and participation in the program.

Further, the program has built community trust by training local Aboriginal and Torres Strait Islander people for further employment in healthcare service provision.

Source: Queensland Mental Health Commission (2016). Queensland Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Action Plan 2016–18. Queensland: QMHC

Apunipima Cape York Health Council (2013). About. Accessed 14 August 2018: http://www.apunipima.org.au/about. Queensland: Apunipima Cape York Health Council

Living Well: A strategic plan for mental health in NSW 2014–24 (NSW)

Description/Aims

Living Well is a NSW plan for reform of the mental health system in NSW over 10 years. It is based on social equity and early intervention and aims to:

- Increase positive mental health and wellbeing, participation by people with a mental illness, positive experiences of service delivery and the proportion of NSW mental health funding spent on community-based services
- Decrease psychological distress, discrimination and stigma, suicide and suicidal behaviour, the use of involuntary treatment orders and the proportion of people in prison who have mental illness.

Lessons learnt/Success factors

Living Well was developed in response to lessons learnt from extensive consultation by the NSW Mental Health Commission with the NSW community and government agencies. This incorporated the experiences and expertise of consumers and carers alongside professionals. The resulting approach involves:

- stronger local decision making, greater accountability and a community-based mental health system
- stronger partnerships with Aboriginal communities
- consumer and carer participation at all levels
- improved prevention and early intervention for children and young people
- complete de-institutionalisation
- better integration of care and coordinated responses
- better use of technology, innovation, learning and leadership.

Source: NSW Mental Health Commission (2014). Living Well: A Strategic Plan for Mental Health in NSW. Sydney, NSW Mental Health Commission.

Localities Accepting and Embracing Diversity (LEAD) (VIC)

Description/Aims

The LEAD program had two main aspects: implementation of a place-based approach to reduce race-based discrimination and support cultural diversity, and evaluation of this approach to inform current and future activity in this area.

The program ran between 2007–2013 at Greater Shepparton and the City of Whittlesea — both have a high proportion of Aboriginal Victorians compared to other localities.

Specific activities conducted over the length of the program included:

- developing new tools and resources to support organisational change
- changing policies, procedures and communication strategies within organisations
- delivering pro-diversity and cultural awareness training programs
- holding events celebrating cultural diversity
- running social marketing campaigns
- changing media reporting practices

Lessons learnt/Success factors

Community surveys confirmed that there is a relationship between race-based discrimination and poorer mental health, and they highlighted the role that particular settings, such as public spaces and employment and retail outlets, have in determining the exposure to race-based discrimination.

The program's process evaluation identified several strengths of a place-based approach, and the impact evaluation found evidence of increased pro-diversity attitudes in the councils and workplaces involved in the LEAD program.

Overall, the program's evaluation demonstrated how local governments can contribute to reducing discrimination and supporting cultural diversity within local communities and organisations.

Source: VICHEALTH 2014, Localities Embracing and Accepting Diversity (Lead) Program: Summary Report, Victorian Health Promotion Foundation, Melbourne, Australia

The Family Wellbeing Empowerment Program (AUS)

Description/Aims

Family Wellbeing is a cultural healing program that increases capacity to manage everyday life stresses and to work collaboratively to empower participants to take greater control and responsibility for themselves and their family, work and community life through personal transformation, harmonising physical, emotional, mental and spiritual aspects of life.

The program aims to:

- facilitate empowerment by developing analytical and problem-solving skills to address life challenges
- improve self-esteem, confidence and psychosocial skills
- promote friendship and connectedness.

Lessons learnt/Success factors

This program was developed in collaboration with Aboriginal and Torres Strait Islander people affected by the Stolen Generation. This has been critical to the program's success, with partnerships with Aboriginal and Torres Strait Islander communities strengthening both the sustainability of empowerment strategies and their evidence base.

The program was developed in a manner that enables the capacity for hope, empathy, a sense of connectedness and respectful communication with loved ones. These were identified as essential for empowering participants to manage day-to-day challenges without being overwhelmed by them.

Source: Tsey, K. & Every, A. (2000). Evaluation Of An Aboriginal Empowerment Program. Alice Springs, Northern Territory: Menzies School Of Health Research.

Tsey, K., Whiteside, M., Haswell-Elkins, M., Bainbridge, R., Cadet-James, Y. & Wilson, A. (2010). Empowerment And Indigenous Australian Health: A Synthesis Of Findings From Family Wellbeing Formative Research. Health And Social Care Community. 18(2), 169-79.

McEwan, A. & Tsey, K. (2009). The Role of Spirituality in Social and Emotional Wellbeing Initiatives: The Family Wellbeing Program at Yarrabah, Discussion Paper No. 7. Darwin: Crcah.

National Empowerment Project (AUS)

Description/Aims

The development of the National Empowerment Project was led by Professor Pat Dudgeon at the University of Western Australia. It aims to:

- strengthen cultural, social and emotional wellbeing
- increase resilience
- reduce psychological and community distress
- reduce high rates of suicide in Aboriginal and Torres Strait Islander communities.

A pilot was conducted in Kuranda and Cherbourg, Queensland, led by the Ngoonbi Community Services Indigenous Corporation. This provided Mental Health First Aid and Cultural Social and Emotional Wellbeing programs to empower community members with the knowledge and tools to assess, prevent and respond to mental health issues.

The Project is underpinned by the principles of human rights and social justice, community ownership, community capacity building, resilience-focus, empowerment and partnership and respect for local knowledge.

Lessons learnt/Success factors

The Project was designed according to a set of principles developed from community-based research. This identified that empowerment (through community ownership and participation in the Project), healing and leadership programs were effective in beginning to address Aboriginal and Torres Strait Islander peoples' sense of powerlessness and disconnection from cultural, social and emotional wellbeing as a result of historical and social determinants.

Source: National Empowerment Project (2014). Home. Accessed 14 August 2018: http://www.nationalempowermentproject.org.au. Perth, WA: University Of Western Australia.

Queensland Mental Health Commission (2018). National Empowerment Project. Accessed 14 August 2018: https://www.qmhc.qld.gov.au/awareness-promotion/aboriginal-torres-strait-islander-wellbeing-initiatives/national-empowerment-project. Queensland: QMHC.

Working Together: Mental Health and Alcohol and Other Drug Engagement Framework 2018–2025 (WA)

Description/Aims

This co-designed Engagement Framework aims to develop a vibrant, collaborative community to achieve better outcomes in the mental health and alcohol and other drug sectors. It focuses on the key principle of Safety: developing cultural, physical, moral and emotional safety, as well as the four interrelated core principles of Authenticity, Humanity, Equity and Diversity.

Lessons learnt/Success factors

The principles the Engagement Framework is based on were identified by key stakeholders as fundamental to best practice approaches of meaningful and effective engagement. By applying these principles, the resulting strategies and practices will support the development of strong partnerships between government, non-government organisations and the broader community to drive change and deliver better outcomes for people experiencing mental health and alcohol and other drug problems.

Source: Commissioner for Children and Young People (2018). Working Together: Mental Health and Alcohol And Other Drug Engagement Framework 2018–2025. Perth: Western Australian Government.

Theme 5: Develop local resilience

The programs described below show the importance of developing local resilience to strengthen social inclusion and improve social and emotional wellbeing.

Creative Recovery project (QLD)

Description/Aims

The Creative Recovery project is an arts-based wellbeing and mental health recovery initiative targeting rural and remote Aboriginal and Torres Strait Islander communities. Trialled in Cape York, the program is founded on the connectedness between social cohesion (social capital) and social and emotional wellbeing.

The program aims to:

- promote recovery of people with mental health needs by engagement in a creative process
- improve quality of life and health outcomes for people with mental health needs by building on capacity and wellbeing
- improve social inclusion of people with mental health needs, reduce stigma and foster mental health literacy
- build on talent, skills and creativity of people with severe mental health needs to provide a sense of belonging within the community and to foster economic independence.

Lessons learnt/Success factors

This program is based on evidence from similar programs operating in Victoria and Western Australia and in the United Kingdom.

A review of this program identified:

- the need to invest in long-term, sustainable approaches that address the social determinants of health, decrease social exclusion and increase social capital
- the need to 'think outside the box' and move away from medicalised, service-based solutions
- implemented through engagement with Aboriginal and Torres Strait Islander people and in accordance with Aboriginal and Torres Strait Islander protocols.

Source: Dyer, G. & Hunter, E. (2009). Creative Recovery: Art For Mental Health's Sake. Australasian Psychiatry, 17.

The Social and Emotional Wellbeing Program (Bringing Them Home) (AUS)

Description/Aims

The program focuses on identifying pathways and methods to build resilience and enhance the wellbeing and social outcomes or life chances of individuals, families and groups. This is achieved through appropriate interventions with Aboriginal and Torres Strait Islander families, including social and emotional wellbeing services and counselling support and fostering a better understanding of the role of social and cultural relationships as determinants of health.

Lessons learnt/Success factors

An evaluation of the program identified the importance of:

- understanding how resilience is promoted within Aboriginal family and social relationships despite the adverse impacts of social change and colonisation, to enable support and fostering of this resilience
- building the capacity and capability of counsellors working with Aboriginal and Torres Strait Islander people to ensure quality of support and prevent staff burnout and turnover.

Source: Wallace, A. & Wilczynski, A. (2007). Evaluation of fhe Bringing Them Home and Indigenous Mental Health Programs: Final Report. Sydney: Urbis Keys Young.

Theme 6: Improve service accessibility

Interventions to improve service accessibility have focused on addressing self-stigma and fears of rejection and discrimination against alcohol and other drug users; as well as structural/institutionalised stigma via education of health practitioners and government officials (Lancaster, 2017).

Stretch2Engage (QLD)

Description/Aims

The Stretch2Engage think tank is part of a larger project to develop a contemporary set of best practice principles to guide the engagement of people using services and their families and friends in Queensland's mental health, alcohol and other drugs sectors.

Lessons learnt/Success factors

Stretch2Engage is based on eight concepts or principles considered central to effective engagement of people in mental health and alcohol and other drugs sector:

- respect and recognition of the value and expertise people bring
- reciprocity and mutual exchange of respect of each other's interests
- right support tailored to the needs of participants
- safety including welcoming people from diverse backgrounds and freedom from legal sanction
- integration promotion of personal strength and connection of services to their communities
- genuine action and commitment to meaningful involvement
- honesty and transparency
- diversity and commitment to seeking a range of views.

Source: Stretch2Engage Partnership (Queensland Alliance, Qnada & Enlightened Consultants) (2017). Stretch2engage Engagement Framework for the Mental Health (MH) and Alcohol and other Drug Services (AOD). Queensland: QMHC.

DRUMBEAT (WA)

Description/Aims

DRUMBEAT is a therapeutic program using drumming to engage at-risk youth who are alienated from school. It aims to address issues relating to healthy relationships, self-esteem and antisocial behaviour and collaborative and cooperative behaviour through cognitive behaviour therapy.

Lessons learnt/Success factors

An evaluation has shown that:

- Music expression and cognitive behaviour therapy can be used as an effective therapy to engage young people who are historically difficult to engage and are most at risk of alienation from mainstream society
- By positively engaging youth in a social activity, participants showed an improvement in social skills and feelings of self-worth. This is important for building resilience, reconnecting with the school community and protecting from social isolation.

Source: Faulkner, S., Wood, L., Ivery, P. & Donovan, R. (2012). It is not just Music and Rhythm... Evaluation of a Drumming-based Intervention to Improve the Social Wellbeing of Alienated Youth. Children Australia, 37(1), Pp. 31–39.

Looking Forward Aboriginal Mental Health Project 2011–2015 (WA)

Description/Aims

The Looking Forward Aboriginal Mental Health Project aims to change the way mental health and alcohol and other drug support services respond to the needs of Nyoongar families south-east of Perth, with the aim of increasing service accessibility. The key objectives were:

- to develop a suitable model of service delivery for working with Aboriginal families
- using participatory action research methods to develop and implement a framework to create organisational change to improve delivery of culturally accessible and responsive services to Aboriginal people. The framework is called Minditj Kaart-Moorditj Kaart, meaning 'from a sick head to a good head'.

Lessons learnt/Success factors

The project has three aspects that were important in achieving positive outcomes:

- Ample time and understanding required to develop trust and strong relationships between Nyoongar Elders and service providers. This was important for facilitating an understanding of, and respect for, Nyoongar culture and its centrality to mental health and wellbeing.
- Engagement of Nyoongar consultants to ensure compliance with Nyoongar cultural protocols.
- Building service capacity to work with Nyoongar families in a culturally appropriate way.

Source: Wright, M, O'connell, M, Jones, T, Walley, R And Roarty, L (2015). Looking Forward Aboriginal Mental Health Project: Final Report. Western Australia: Telethon Kids Institute.

Northern Territory Multicultural Participation Framework 2016–19 (NT)

Description/Aims

This Framework is built on the principles of valuing diversity, supporting accessibility, ensuring participation and inclusion and strengthening mutual respect and social cohesion.
It aims to:

- enable opportunities for people from culturally and linguistically diverse backgrounds to participate in all aspects of territory life
- foster public respect and value of cultural, religious and linguistic diversity
- support participation in employment and contribution to the economy
- provide the opportunity and support for people from culturally and linguistically diverse backgrounds to participate in education
- ensure access to safe and secure accommodation
- ensure access to quality health and wellbeing services
- ensure people from culturally and linguistically diverse backgrounds feel safe at home, at school, at work and in the community
- foster support, showcasing, sharing and celebration of cultural diversity.

Lessons learnt/Success factors

The Framework was developed from lessons learnt from consultation with the Minister's Advisory Council on Multicultural Affairs and feedback from community consultation.

The implementation of the Framework is expected to occur through an iterative process, utilising lessons learnt to develop new initiatives to respond to emerging issues.

Source: Northern Territory Government (2016). Northern Territory Multicultural Participation Framework 2016–19. Darwin: Northern Territory Government.

Theme 7: Inform and educate the public

The Australian and international campaigns described below relate to racism and other forms of stigma and discrimination and highlight the importance of positive and appropriate messaging, local execution and involvement of people with experience of the stigmatised conditions.

Stop. Think. Respect (AUS)

Description/Aims

This beyondblue campaign focuses on improving the Australian community's understanding of discriminatory behaviour and the impact it can have on the mental health of lesbian, gay, bisexual, trans, and intersex (LGBTI) communities. It was been designed to promote respect for differences between people and prompt people to stop and consider the impacts of discrimination, and how such comments could cause real distress and harm.

Lessons learnt/Success factors

This campaign was developed based on lessons learnt from real life experiences and understanding of the discrimination faced by members of the LGBTI communities, and the impact of this discrimination has on individual's depression, anxiety, and access to mental health services. The research showed:

- that subtle and overt discrimination is prominent for LGBTI communities and requires national leadership to reduce the impact of depression and anxiety in the Australian community
- targeting of more vulnerable groups (such as youth) was required to address the most immediate and serious incidences of discrimination.

Source: Beyondblue GLBTI Reference Group (2012). In My Shoes: Market Research Summary. Victoria: Beyondblue.

Beyondblue (2012). Stop. Think. Respect. Accessed 14 August 2018: https://www.beyondblue.org.au/who-does-it-affect/lesbian-gay-bi-trans-and-intersex-lgbti-people/stop-think-respect. Victoria: Beyondblue.

Racism. It stops with Me (AUS)

Description/Aims

'Racism. It stops with me' is a national public-awareness campaign that supports the goals of the National Anti-Racism Strategy.

Lessons learnt/Success factors

An evaluation of the campaign found that it achieved significant results with little resources due to the network of partners and supporters developed to take action against racism and encourage communities to use the national campaign to support their individual and organisational efforts.

Source: Australian Human Rights Commission (2017). Home. Accessed 14 August 2018: https://itstopswithme.humanrights.gov.au/who-we-are/publications. Sydney: Australian Human Rights Commission.

Australian Human Rights Commission (2015). Evaluation of the National Anti-Racism Strategy and Racism. It Stops with Me. Sydney: Australian Human Rights Commission.

Respect (AUS)

Description/Aims

The 'Respect' campaign was launched by Australians for Native Title and Reconciliation (ANTaR) in 2009 and focused on challenging stereotypes about Aboriginal and Torres Strait Islander people. The campaign used positive images of an Aboriginal person to build mutual respect and relationships between Aboriginal and Torres Strait Islander people and non-Indigenous people, as well as provide additional information about Aboriginal peoples and cultures. The end goal of the project was to get people to sign the pledge 'I believe in a new relationship between Indigenous and non-Indigenous people based on mutual Respect'.

Lessons learnt/Success factors

The major lesson from the campaign was that although the messaging was 'softer', the campaign organisers received feedback that the issue was confronting for people. This highlights how potent and challenging the issue of 'racism' is in Australia, and the importance of developing a way to foster effective discussion.

Source: Australians for Native Title and Reconciliation (2012). Submission in Response to the Anti-Racism, Strategy Discussion Paper. Sydney: ANTaR.

Racism makes me sick (WA)

Description/Aims

This print campaign was developed by Australians for Native Title and Reconciliation (ANTaR) in 2008. It aimed to:

- raise awareness and impassion people about the link between the Aboriginal and Torres Strait Islander health inequality and the need for action
- change attitudes and behaviour of all Australians to challenge negative stereotypes about Aboriginal and Torres Strait Islander peoples and do something positive and respectful to support Aboriginal people.

The campaign asked individuals to combat racism by:

1. reading the facts about Aboriginal and Torres Strait Islander peoples
2. challenging and speaking up to racist stereotypes and misinformed comments
3. taking positive action in support of Aboriginal and Torres Strait Islander peoples.

Lessons learnt/Success factors

The campaign was built on the evidence of the interconnectedness between racism, physical health and SEWB. This evidence states that racism is prevalent and has a direct, negative impact on physical health, including links to heart disease, premature births, hypertension and mental illness; and that it contributes to health inequality and is associated with increased cannabis and alcohol consumption.

Lessons learnt from the implementation of the program showed:

- engaging people in a discussion about racism was difficult, and hence it was important to keep the messaging simple and clear
- it is important to create a safe space to discuss these issues
- the need to prepare the campaign messengers with the right information and strategies to deal with negative reactions.

Source: Australians for Native Title and Reconciliation (2012). Submission in Response to the Anti-Racism, Strategy Discussion Paper. Sydney: ANTaR.

Like Minds, Like Mine (NZ)

Description/Aims

'Like Minds, Like Mine' is a multi-year project delivered by the New Zealand Ministry of Health. Developed in 1997, it is a collaboration between five national and 26 regional organisations. It utilises print, radio and television materials and provides education and training to emphasise human rights and normalise mental illness.

The aims of the program are to:

- reduce the stigma of mental illness and the discrimination that people with experience of mental illness face
- change discriminatory attitudes and behaviours through direct contact
- promote rights and challenge organisations, communities and individuals not to discriminate.

Lessons learnt/Success factors

The program was developed using lessons learnt from previous evidence of what works to change attitudes of stigma and discrimination, including:

- a well-developed strategic plan that seeks transformative change at the population, organisational and individual level
- involvement of people with lived experiences in program development and delivery
- local delivery using national partnerships in collaboration with public health agencies, mental health service providers, consumer control organisations, non-governmental organisations and Maori and Pacific partners
- measurable behavioural targets aligned with outcome goals
- regular research to develop an evidence base, and the subsequent program modification required to shift attitudes and behaviours
- coordination with stakeholders to develop plans for policy, practice, and legislative change.

Source: Thornicroft, C., Wyllie, A., Thornicroft, G. & Mehta, N. (2014). Impact of the "Like Minds, Like Mine" Anti-Stigma and Discrimination Campaign in New Zealand on Anticipated and Experienced Discrimination. Australian & New Zealand Journal Of Psychiatry, 48(4) 360–370.

See Me (Scotland)

Description/Aims

'See Me' is part of a national Scottish campaign aimed at eliminating the stigma and discrimination of mental illness, promoting improved quality of life and social inclusion and equality. The program raises public awareness of how stigma and discrimination affect people with mental health problems by voicing and challenging individual experiences of discrimination and involving people in anti-stigma activities at both national and local levels. The program is nationally coordinated with regional and local programming and sector-specific experience.

The aims are to:

- change public understanding, attitudes and behaviours so that the stigma and discrimination associated with mental ill-health is eliminated
- enhance the ability of people to challenge stigma and discrimination
- ensure that all organisations value and include people with mental health problems and those who support them
- improve media reporting of mental ill-health.

Lessons learnt/Success factors

The use of an integrated, multifaceted campaign was shown to be effective at reaching multiple groups with different communication needs. Importantly, this was informed by evidence obtained from a national survey of public attitudes to mental health, mental wellbeing and mental health problems.

'See Me' has evolved over time as a result of external evaluations. This continual adaption has enabled the program to respond to changes in social attitudes, methods of communication, and focus, and thus remain relevant, targeted and effective.

A major challenge remains in addressing systemic/ organisational discrimination.

Source: See Me Scotland (2018). See Me Scotland. Accessed 14 August 2018: https://www.seemescotland.org.

Time to Change (UK)

Description/Aims

'Time to Change' is a national multimedia awareness campaign to enhance social inclusion, promote health and reduce discrimination of people who experience mental health problems. This approach is collaborative and aims to inspire people to work together to end the discrimination surrounding mental health by facilitating social contact between members of the general public and people with mental illness on a large scale.

The campaign is delivered through multiple channels:

- Get Moving!; a mass participation physical activity event
- At the Living Library; a face-to-face education led by people with mental illness
- Education Not Discrimination; a targeted anti-stigma training programme delivered to medical students, trainee teachers and educational professionals.

Lessons learnt/Success factors

The program was developed using lessons learnt from previous evidence of best practice from Scotland, New Zealand and other established anti-stigma activities, including:

- taking a national focus with local program delivery, collaboration across sectors and communities and leadership by people with experience of mental health problems
- expert advice and leadership from a consortium of mental health groups
- uses an evidence-based approach and independent evaluation to improve the delivery and content of the program to most effectively reach the general public.

Source: Time to Change (2018). About. Accessed 15 August 2018: https://www.time-to-change.org.uk. Uk: Mind and Rethink Mental Illness.

References

AIHW (2017). *National Drug Strategy Household Survey 2016: Detailed findings*. Canberra: AIHW.

Australian Government, Department of the Prime Minister and Cabinet (2014), *Aboriginal and Torres Strait Islander Health Performance Framework 2014*. Canberra

Australian Indigenous Health*Info*Net (2018). *Overview of Aboriginal and Torres Strait Islander Health Status 2017*. Perth, WA: Australian Indigenous Health*Info*Net.

Gray, D., Cartwright, K., Stearne, A., Saggers, S., Wilkes, E., & Wilson, M. (2018). *Review of the harmful use of alcohol among Aboriginal and Torres Strait Islander people*. Perth, WA: Australian Indigenous Health*Info*Net.

Helms, J. E., Nicolas, G., & Green, C. E. (2010). Racism and ethnoviolence as trauma: Enhancing professional training. *Traumatology*, 16(4), 53–62.

MacBean, R., Hipper, L., Buckley, J., Tatow, D., Podevin, K. & Fewings, E. (2015). *Queensland Alcohol and Other Drug Treatment Service Delivery Framework*. Queensland: QNADA, Dovetail, QISMC, QAIHC and the Queensland Government.

MacRae, A., & Hoareau, J. (2016). *Review of illicit drug use among Aboriginal and Torres Strait Islander people*. Perth, WA: Australian Indigenous Health*Info*Net.

QMHC (2018a). *Changing attitudes, changing lives: Options to reduce stigma and discrimination for people experiencing problematic alcohol and other drug use*. Brisbane: Queensland Government.

QMHC (2018b), *Shifting Minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018–2023*. Brisbane: Queensland.

QMHC (2016a). *Queensland Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Action Plan 2016–18*. Brisbane: Queensland.

QMHC (2016b), *Strategic Conversation: Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Communique*. Brisbane: Queensland.

Queensland Government (2019a), *Aboriginal and Torres Strait Islander Housing Action Plan 2019–2013*. Australia: Brisbane.

Queensland Government (2019b), *Advancing Aboriginal and Torres Strait Islander education: An action plan for Queensland*. Australia: Brisbane.

Lancaster, K., Seear, K. & Ritter, A. (2017). R*educing stigma and discrimination for people experiencing problematic alcohol and other drug use. A report for the Queensland Mental Health Commission*. Australia: University of New South Wales and Monash University.

Livingston, J. D., Milne, T., Fang, M. L., & Amari, E. (2012). The effectiveness of interventions for reducing stigma related to substance use disorders: a systematic review. *Addiction*, 107(1), 39-50.

National Academies of Sciences, E., and Medicine. (2016). *Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change*. Washington, DC: The National Academies Press.

Paradies, Y., Chandrakumar, l., Klocker, N., Frere, M., Webster, K., Burrell, M., & McLean, P. . (2009). *Building on our strengths: a framework to reduce race-based discrimination and support diversity in Victoria*. Melbourne: Victorian Health promotion Foundation.

Simonds, V., & Christopher, S. (2013). Adapting Western Research Methods to Indigenous Ways of Knowing. *American Journal of Public Health*, 103(12).

Stoneham, M. J., Goodman, J., & Daube, M. (2014a). *Bad news: negative Indigenous health coverage reinforces stigma*. Retrieved from https://theconversation.com/bad-news-negative-indigenous-health-coverage-reinforces-stigma-24851

Stoneham, M. J., Goodman, J., & Daube, M. (2014b). The Portrayal of Indigenous Health in Selected Australian Media. *The International Indigenous Policy Journal*, 5(1).

Walter, M. (Ed.) (2018). *The voice of Indigenous data* (Vol. 60). Queensland: Griffith University, QUT and Australia Council for the Arts.

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