Disability within the Indigenous community


Suggested citation

This review - or an updated version can be viewed at:
http://www.healthinfonet.ecu.edu.au/disability_review

Key points
• After correcting for differences in age structure, Indigenous Australians require assistance with a core activity at almost twice the rate of non-Indigenous Australians. In part, this is driven by socio-economic disadvantage and exposure to risk factors such as smoking, high body mass, physical inactivity, poor nutrition and substance abuse.
• There is some scope for the National Disability Insurance Agency, in cooperation with government agencies, to attempt to address the high rate of Indigenous disability through prevention and early intervention. However, addressing the socio-economic disadvantage that underlies the higher rate of Indigenous disability is an issue for all of Australian society and requires a long term whole-of-government approach.
• Indigenous Australians also face significant barriers to accessing disability support services. This occurs due to insufficient services in metropolitan and regional areas, social marginalisation, cultural attitudes towards disability and culturally inappropriate services.
• These barriers to service delivery access suggest that the market based service delivery system underpinning the proposed National Disability Insurance Scheme may not deliver adequate care and support to Indigenous people with a disability. While Indigenous Australians will have access to individualised funding on the same basis as non-Indigenous Australians, it may also be necessary to block fund some service providers in order overcome the additional barriers that Indigenous Australians face.
• A number of strategies can be used to improve accessibility of services for Indigenous people, including embedding services within local communities, employing Indigenous staff and developing the cultural competency of non-Indigenous staff.

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Indigenous Australians have high rates of disability but access relatively few services or supports. The consequences of this are compounded by broad socio economic disadvantage and the geographical isolation that many Indigenous Australians experience. This chapter highlights the importance of addressing Indigenous disability, and provides a starting point for developing a strategy to best support Indigenous Australians under the NDIS. It does so by examining:

- the extent and nature of Indigenous disability (section 9.1)
- some of factors underlying Indigenous rates of disability and preventing the uptake of existing supports (section 9.2)
- some of the options available to the NDIA in response to this challenge (section 9.3).

A snapshot of Indigenous disability

It is very difficult to provide an accurate depiction of disability within the Indigenous community. Prior to the 2002 National Aboriginal and Torres Strait Islander Social Survey (NATSISS), there were no national surveys of Indigenous disability. Two further data collections have occurred since this time, the 2006 Census and the 2009 NATSISS. However, there is reason to suggest that these surveys understate the extent of disability amongst Indigenous Australians.

First, surveys of Indigenous Australians are affected by higher rates of non-response. The estimated undercount (not responding to survey at all) in the 2006 Census was 2.7 per cent for non-Indigenous Australians and 11.5 per cent for Indigenous Australians (ABS 2006a). In addition, the non-response rate for the question about the need for assistance was 2 per cent for non-Indigenous Australians and 7 per cent for Indigenous Australians (ABS and AIHW 2008). This reduces the general accuracy of the estimate of disability and can also introduce sample selection bias. For example, if Indigenous people with a disability are less likely to respond to a survey than those without a disability, then the overall disability rate will tend to be underestimated.

Second, some Indigenous Australians find the concept of disability hard to understand or irrelevant, reducing the likelihood that the surveys accurately recorded disability. For example, the First Peoples Disability Network suggested that ‘in traditional language there was no comparable word to disability which suggests that disability may have been accepted as part of the human experience’ (sub. 542, p. 8)\(^1\).

While the existing data may tend to understate the problem, they still suggest that disability is a serious issue for Indigenous Australians. There are two main dimensions to this:

- the reported rate of disability is considerably higher for Indigenous Australians than non-Indigenous Australians
- Indigenous Australians face greater barriers to accessing disability supports than non-Indigenous Australians.

Disability amongst Indigenous Australians

It is estimated that there are around 19 500 Indigenous Australians that need assistance with a core activity (Census 2006). This represents 4.6 per cent of the Indigenous population, which is higher than the rate of 4.4 per cent for the non-Indigenous population. However, Indigenous Australians have a much younger age profile than non-Indigenous Australians (due to a combination of a higher fertility rate and lower life expectancy). As disability rates tend to increase with age, unadjusted population estimates of disability rates will understate the difference between Indigenous and non-Indigenous Australians. Indigenous Australians between the age of 15 and 24 require assistance with a core activity at around 1.7 times the rate of non-Indigenous Australians, and this gap widens as they grow older. After standardising for differences in age structure, estimates based on the 2006 Census suggest that the rate of the need for assistance with a core activity is almost twice as high overall for Indigenous Australians as it is for non-Indigenous Australians (figure 9.1\(^2\)).

![Figure 9.1 Needs assistance with core activities](source: SCRGSP (2009))

Indigenous Australians were more likely to require assistance with a core activity than non-Indigenous Australians in all states and at all levels of remoteness. The gap is greatest in the Northern Territory and Western Australia, and in remote and very remote areas (figure 9.2).

\(^1\) Similarly Arioti (1999) finds that while there are Pitjantjatjara word for specific impairments, there is no traditional word for the general concept of disability.

\(^2\) ABS and AIHW (2008), have a slightly higher estimate, with Indigenous Australians requiring assistance with a core activity at 2.1 times the rate of Non-Indigenous Australians.
A range of health conditions and disabilities underlie the aggregate rate:

- Despite comprising only 3.8 per cent of the Western Australian population, Aboriginal children make up 8.4 per cent of all children born there between 1980 and 1999 with cerebral palsy (sub. 290, p. 3)
- Indigenous children (under 15) are 3.4 times more likely to be deaf (SCRGSP 2009 - Table 5A 7.2). Over 70 per cent of Indigenous children in remote communities suffer from chronic otitis media that can cause permanent hearing loss and inhibit language and literacy development. (Department of Education and Training, Western Australia 2006)
- In non-remote areas, Indigenous people are twice as likely to be obese as non-Indigenous people (SCRGSP 2009)
- Indigenous Australians are almost 12 times as likely to be hospitalised for care involving dialysis (SCRGSP 2009)
- Indigenous Australians are nearly four times as likely to have an intellectual disability (ABS 2006b)
- 28.2 per cent of Indigenous Australians self-reported their health as fair/poor, as compared with 14.5 per cent of non-Indigenous Australia’s (ABS 2008b).

Considerable resources are dedicated to supporting Indigenous Australians with a disability. In 2001-02 a total of $95.7 million was spent on Indigenous welfare services (CSDA funded disability services and HACC). This represents 3 per cent of total expenditures and around 30 per cent more was spent on Indigenous Australians per person, than non-Indigenous (table 9.1). However, given the higher rate of disability and multiple disability, as well as the significantly higher costs involved in servicing remote Indigenous communities, it is likely that this level of expenditure is still associated with significant under-servicing.
Table 9.1 Total recurrent health-related expenditure, by program and Indigenous status, 2001-02

<table>
<thead>
<tr>
<th>Expenditure ($m)</th>
<th>Expenditure per person ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total welfare services for people with a disability</td>
<td>95.7</td>
</tr>
<tr>
<td>CSDA services Accommodation</td>
<td>37.2</td>
</tr>
<tr>
<td>Community support</td>
<td>16.9</td>
</tr>
<tr>
<td>Respite</td>
<td>9.1</td>
</tr>
<tr>
<td>Community access</td>
<td>6.7</td>
</tr>
<tr>
<td>Employment</td>
<td>5.1</td>
</tr>
<tr>
<td>Other</td>
<td>11.2</td>
</tr>
<tr>
<td>Other services HACC</td>
<td>8.7</td>
</tr>
<tr>
<td>Australian Government rehabilitation services</td>
<td>0.7</td>
</tr>
<tr>
<td>Low-level residential care</td>
<td>0.1</td>
</tr>
<tr>
<td>Health-related ACCHS services</td>
<td>13.7</td>
</tr>
</tbody>
</table>

Source: AIHW 2006, Expenditures on health for Aboriginal and Torres Strait Islander peoples, 2001-02.

Notes:

a Includes Australian Government administrative costs, excludes state and territory administrative costs, concession expenditure and services for older people.

b Excludes state and territory government expenditure on ACCHSs.

Use of services

The main source of data on the use of disability support services is the Disability National Minimum Data Set (NDMS). The NDMS data suggests that, given the underlying population with a disability, less Indigenous Australians with a disability use accommodation and community access services than non-Indigenous Australians. However, the gap is relatively small (figure 9.3). Use of community support services appears greater for Indigenous Australians than non-Indigenous Australians (SCRGSP 2010).

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As expected given the higher incidence of disability, Indigenous people access CSTDA funded services at a considerably higher rate per 1000 population. If Indigenous people face additional barriers to access, it would be expected that this gap would also be observed in terms of the estimated population of people with a disability - referred to as the potential population. The NDMS data suggest that per 1000 potential population fewer Indigenous people with a disability access accommodation support (39.5 per cent versus 41.3 per cent) and community access (49.0 per cent versus 58.9 per cent) (SCRGSP 2010).

This is somewhat at odds with the broad anecdotal evidence that Indigenous people with a disability face significant barriers when trying to access support (particularly in rural or remote settings) and are marginalised within the disability sector more generally (First Peoples Disability Network, sub. 542, p. 6, Australian Disability Network 2007, NSW Ombudsman 2010, Stopher and D’Antoine 2008). This view was echoed in consultations between the Productivity Commission and State and Territory government agencies, as well as Indigenous-focused service providers. The NDMS may inadequately reflect Indigenous Australians’ access to disability services (or conceal the barriers that some Indigenous Australians face):
• as noted above, it is likely that the estimated number of Indigenous people with a disability significantly understates the real figure. If this is the case, the rate that Indigenous Australians access services will be overstated.

• there are wide variations in Indigenous service use by state, suggesting that access may be more of an issue in some areas than others (notably access is relatively low in New South Wales and relatively high in Victoria).

Challenges to supporting Indigenous Australians with a disability

High level of Indigenous disadvantage

Indigenous disadvantage across a range of indicators is broad in scope, profound and entrenched. In addition to higher rates of disability and chronic disease described above, gaps persist between non-Indigenous and Indigenous Australians in terms of life expectancy, child mortality, education attainment, income, employment and interactions with the justice system. Socio-economic disadvantage interacts with disability in a circular fashion (SCRGSP 2009). On the one hand, socio-economic factors contribute to the higher incidence of disability in the same way as they do in other disadvantaged groups in society. For example, low education attainment is linked to a higher rate of smoking, excessive alcohol consumption and poor nutrition amongst Indigenous Australians (ABS and AIHW 2008). These risk factors increase the chance of acquiring a disability. On other hand, disability entrenches socio-economic disadvantage. For example, Indigenous children with hearing loss suffer poorer education outcomes, which in turn limits their employment and income prospects.

Both socio-economic disadvantage, and higher levels of exposure to risk factors (such as tobacco, alcohol and violence) have been linked to the history of dispossession and marginalisation that has contributed to the breakdown of traditional family or societal structures, feelings of loss or despair and the social dysfunction that afflict some Indigenous communities (Salvatori 2010, Bostok 2004, sub. 542, p. 7). Indigenous Australians are twice as likely (on average) to engage in or be exposed to a range of activities that can lead to disability, including smoking, binge drinking, using illicit drugs, and being victims of violence. Indigenous Australians are also more likely to be physically inactive and subject to more than one of these risk factors (AIHW 2008). These risk factors explain a large proportion of the difference in health outcomes and rate of disability between Indigenous and non-Indigenous people (table 9.2).

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Percentage contribution to the gap in DALYs between Indigenous and non-Indigenous Australians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco</td>
<td>17.4</td>
</tr>
<tr>
<td>High body mass</td>
<td>15.9</td>
</tr>
<tr>
<td>Physical inactivity</td>
<td>11.6</td>
</tr>
<tr>
<td>High blood cholesterol</td>
<td>7.1</td>
</tr>
<tr>
<td>Alcohol</td>
<td>6.8</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>5.7</td>
</tr>
<tr>
<td>Low fruit and vegetable intake</td>
<td>5.1</td>
</tr>
<tr>
<td>Illicit drugs</td>
<td>3.8</td>
</tr>
<tr>
<td>Intimate partner violence</td>
<td>3.3</td>
</tr>
<tr>
<td>Child sexual abuse</td>
<td>1.5</td>
</tr>
<tr>
<td>Unsafe sex</td>
<td>1.6</td>
</tr>
<tr>
<td>11 Risk factors combined</td>
<td>48.5</td>
</tr>
</tbody>
</table>

Source: Calculations based on Vos et al. 2003.

Notes:

a Disability Adjusted Life Years are a measure of the burden of disease that takes into account the effect on life expectancy and the amount of time spent with a disability

b This estimate takes account of the combined causal pathways between many of these risks factors, and thus is lower than the sum of each effect considered in isolation.

Social marginalisation and mistrust of authority

Numerous participants in this inquiry noted that negative experiences within communities and with government agencies or service providers can make Indigenous Australians with a disability reluctant to seek support. As noted in the NSW Ombudsman’s report:

For Aboriginal people, a collective legacy of negative experiences with mainstream agencies and services has led to a significant degree of fear and mistrust (2010, p. 27)

This issue was also noted at the first state conference of the Aboriginal Disability Network of New South Wales was that:

Some Aboriginal people retain the fear that their children will be removed by government authorities. Furthermore that Aboriginal children remain over represented as wards of the state and that Aboriginal children with disability and Aboriginal parents with disability remain vulnerable to this fact. (ADN 2002, p. 8)
Even in the absence of specific negative experiences, Indigenous Australians may be reluctant to seek services because of a general sense of social exclusion, or a feeling that services are there for white people and not them. Hepburn (2005) relates the following view from a rural worker:

Indigenous people in rural country areas don’t feel they are part of, or are welcome, in the rural towns. They feel that mainstream services do not or are not willing or able to provide a service for them. If they need assistance or support they are afraid to ask for help or they feel that it would be a waste of time and effort. Many people have a defeatist attitude towards services. They are more likely to say things like ‘They won’t help me’. (p. 20)

Similarly, Stopher and D’Antoine (2008) quoted once participant in their study who stated ‘Aboriginal people are reluctant to use services as they feel they are for whitefellas’. (p. 13).

In other situations, some mainstream providers may be unwilling to take on Indigenous clients because they feel there are specialised services funded to do so (NSW Ombudsman, p. 30).

### Indigenous perceptions of disability

Some Indigenous Australians, particularly those living a more traditional way of life, have a different perception of disability to non-Indigenous Australians (First Peoples Disability Network, sub. 542, p. 8). Indigenous views on disability are diverse, matching the diversity of Indigenous cultures and beliefs, the diversity of individual lived experience with disability and individual’s economic and social standing (Senior 2000). Nevertheless, two frequently cited generalisations about Indigenous perception of disability may be relevant to the delivery of disability support services in some areas:

- some Indigenous people may not have a general concept of disability, which can result in under-reporting (as noted above) and, potentially, under utilisation of the available supports from government or service providers.
- some Indigenous communities view some types of disability (such as congenital disabilities) as a consequence of ‘marrying wrong’ (First Peoples Disability Network, sub. 542, p. 8), or attribute it to supernatural causes stemming from eating certain foods or doing certain activities while pregnant (Senior 2000). While this is a potential source of shame that may dissuade some Indigenous Australians from seeking support, Elliot (1994) and Senior (2000) suggest that stigmatisation within communities is limited.

Like many groups in Australia, Indigenous Australians have a strong cultural belief that it is the responsibility of family to provide care and support. As noted by O’Neil, Kirov and Thomson (2004), throughout Australia - in remote, rural and urban areas - most Indigenous people with a disability were, and are, cared for within their extended family. This presents a particular challenge for supporting Indigenous Australians with a disability. On the one hand, a core component of a ‘good’ disability system is respecting the wishes of people with a disability and those who care for them - including the cultural beliefs about the appropriate role of family. On the other hand, there is a risk that assumptions about Indigenous family care could result in an excessive burden of caring, and/or inadequate levels of care. This is a particular issue when families’ capacity to offer care and support is affected by socio-economic disadvantage (such as poverty), carers’ own health problems, family breakdown or social dysfunction. The death of Kate Bugmy in 2007 presents a tragic example of this. As noted by State Coroner Mary Jerram (2010):

> The extreme disabilities with which Kate Bugmy was born required fulltime care, with which her family struggled to cope, staunchly resisting alternative, outside care. Although that resistance clearly arose from love, it came at a price and may not have been best for Kate, at least in her later years (p. 11).

### Cultural competence

The norms, beliefs and expectations embodied within a culture have value within their own right. They also make it easier for people within a cultural group to communicate, and for human interaction and ordinary social exchange to take place (including marketplace exchange). Conversely, people from different cultural backgrounds may find such interactions more difficult and miscommunication more frequent. Many Australians who identify as Aboriginal or Torres Straight Islander experience little difficulty in understanding or interacting with non-Indigenous Australians, including those providing disability support services. However, in some cases, differences in cultural background between service providers and Indigenous Australians can form an impediment to effective delivery of support services. Indigenous culture is diverse (meaning cultural competence within one area may not be relevant to another), but some commonly identified areas where cultural differences impact on the delivery of disability support services include:

- perception of disability (discussed above)
- relationship to the land
- triggers and responses to shame (O’Neill, Kirov and Thomson 2004; Jenkins and Seith 2004)
- rules governing the interactions between men and women, and within kinship systems (SNAICC 2010)
- styles of communication, including the use of eye contact, silence within conversation, and appropriate ways of requesting information (Pheonix consulting, sub. 311, p. 1; Jenkins and Seith 2004; McConnel 2010; SNAICC 2010)
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Such cultural differences can result in service offerings that are not attractive to Indigenous Australians, or misunderstandings that give Indigenous Australians a negative impression of disability support services. It can also make service providers tentative about proactively seeking Indigenous clients. As noted by Regan and Harriden (2008):

In general, non-Aboriginal service providers appeared to be anxious about their ability to engage with Aboriginal people and services in a culturally appropriate manner. This idea is perhaps best summed up by a respondent who noted that the “fear of doing the wrong thing” by non-Aboriginal service staff was one of the dominant issues limiting their work with Aboriginal communities. (p. 14)

Conversely, some Indigenous Australians who want to engage with the disability system may be constrained by a lack of knowledge about the necessary requirements (such as paper work and personal information), or lack confidence or understanding of their rights or entitlements.

Salvatori (2010), describes how the feeling of cultural misunderstanding, combined with broad disadvantage and negative past experiences can be a powerful deterrent to seeking support:

When accessing mainstream services, the effects of trans-generational trauma can be evidenced when clients feel inferior, shamed, misunderstood, not educated enough and feel that they have no voice. Aboriginal people have different ways of communicating and thinking and feel that the Aboriginal ‘way of being’ is not understood. Feelings of intimidation, racism and fear due to past history often stand in the way and keep our clients from using mainstream services. Many do not feel safe.

Isolation

Almost half of Indigenous Australians live in outer regional, remote or very remote areas, compared to around 10 per cent of non-Indigenous Australians (figure 9.4). There is significant variation across jurisdictions. For example, Victoria has a relatively urban Indigenous population, with 84 per cent living in a major city or inner regional area. Conversely, around 80 per cent of Indigenous Australians in the Northern Territory and 42 per cent of in Western Australia, live in remote or very remote areas.

![Figure 9.4 Proportion of the population by remoteness area, 2006](image)

Data source: Experimental Estimates of Aboriginal and Torres Strait Islander Australians, ABS, Cat. no. 3238.0.55.001

As with other services (such as health and education) remoteness creates particular difficulties in providing disability services to Indigenous Australians. These difficulties are compounded by

- lower levels of vehicle ownership by Indigenous Australians (77 per cent versus 90 per cent). In very remote areas vehicle ownership is 47 per cent for Indigenous people
- inadequate or no public transport options (with taxi drivers sometimes reluctant to enter Indigenous communities - Australian Disability Network 2007)
- difficult weather conditions in some areas, including regular periods of heavy rain and flooding.
- lack of access to appropriate housing and urban infrastructure (including clean water and sanitation)
- lack of access to specialists.

Remoteis reduces the scope of the services that can be delivered, and dramatically increase their costs. In some communities, only ‘fly in fly out’ services are available - for example for respite or specialists. This approach cannot provide adequate support for people with a high level or complex needs on an ongoing basis and Indigenous Australians with disabilities will sometimes need to move to regional centres to receive the supports they need. However, as many Indigenous Australians have a strong bond with both the land and their local community, they may be very reluctant to do so.

Language barriers

For many Indigenous Australians, particularly in remote areas and among older people, language can be a barrier to accessing services, or can lead to misunderstandings or ineffective service provision. For some Indigenous Australians, English was not the first language learnt, nor is it the main language used. In other areas, local varieties of English are spoken, which can also make communication difficult. The NATSISS (2008) suggests that around 11 per cent of Indigenous Australians aged 15 and over speak

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4 For example culturally inappropriate activities at day care centres (O’Neill, Kirov and Thomson 2004, p. 7).
5 Interestingly, Victoria has a dramatically higher rate of usage of CSTDA funded services by Indigenous Australians than other states and territories.
an Aboriginal or Torres Straight Islander as their main language overall, and around 40 per cent in remote areas.

**Indigenous disability and the NDIS**

**Addressing the high rate of Indigenous disability**

The most important issues surrounding Indigenous disability is its relatively high incidence compared with the non-Indigenous population. This gap is driven by complex combination of socio-economic disadvantage and exposure to a broad range of risk factors (such as smoking, binge drinking, obesity, substance abuse and violence). Addressing Indigenous disadvantage has been a longstanding (and so far largely unsuccessful) policy objective of a broad range of government initiatives. This effort was formalised in 2008, in the form of the COAG agreements that make up the Closing the Gap initiative (box 9.1). This initiative commits governments to working toward reducing Indigenous disadvantage as revealed through a set of specified indicators. Closing the Gap is aimed at providing greater transparency and accountability of government, greater coordination of effort, increased and more consistently maintained resources, and improving the knowledge base.

Addressing broad disadvantage requires the ‘whole-of-government approach’ contained with the Closing the Gap initiative, which raises the question as to the appropriate role of the NDIS. Many areas (such as increasing year 12 attainment rates) are clearly beyond the scope of the NDIS. However, other initiatives, particularly in the health area, are more closely aligned to the objectives of the scheme. Specifically, part of the function of the proposed NDIA is to fund early intervention and prevention approaches in areas where there is robust evidence of both effectiveness and cost effectiveness (chapter 11). While not a frontline provider of such interventions, there may be a role for the NDIA, in cooperation with other government agencies (such as the Australian National Preventive Health Agency), to fund preventative measures with an Indigenous focus. There may also be a role for the NDIA to fund or conduct research specifically directed towards the prevention or treatment of conditions that are pervasive in the Indigenous community and could potentially result in long term disability.

For example, early intervention targeting otitis media (which can lead to deafness) among Indigenous children could potentially decrease the rate of disability and have important socio-economic flow on effects (such as improved educational outcomes). The

NDIA, in co-operation with Indigenous communities, state and territory health agencies and Australian Hearing, could expand initiatives aimed at reducing the incidence of otitis media in children through:

- Indigenous community led ear health education programs
- early intervention through mobile ear health clinics
- other types of preventative interventions with demonstrated benefits, such as the provision of swimming pools in local schools (SCRGSP 2009).

However, it is not obvious the extent to which responsibility for such prevention activities should lie with the NDIA or with existing government agencies, or how collaborative efforts could be encouraged and facilitated. It would obviously be undesirable for the NDIA to duplicate the efforts of existing agencies with greater expertise, or to run programs that are inconsistent or conflict with existing ones.

The Commission seeks further feedback on the merits of the NDIA funding prevention and early intervention measures specifically targeting Indigenous communities, and how this could work in practice.

**Box 9.1 Closing the Gap**

The Closing the Gap initiative is a joint effort by all levels of government to reduce the disadvantage experienced by Indigenous Australians. It is underpinned by a set of agreements by the Council of Australian Governments (COAG) to work towards reducing the disparity revealed by a set of specific indicators within a nominated time frame. The National Indigenous Reform Agreement (NIRA) commits COAG to:

- closing the life-expectancy gap within a generation
- halving the gap in mortality rates for Indigenous children under five with a decade
- ensuring access to early childhood education for all Indigenous four year olds in remote communities within five years
- halving the gap in reading, writing and numeracy achievements for children within a decade
- halving the gap for Indigenous students in Year 12 (or equivalent) attainment rates by 2020 (amended to 2015 in April 2009)
- halving the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade.
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NIRA also contains the over-arching framework for Closing the Gap, including the service delivery principles that should be adhered to and the basic ‘building blocks’ that governments should focus on in order to make progress on the Closing the Gap targets. These are early childhood, schooling, health, economic participation, healthy homes, safe communities and governance and leadership.

These objectives are pursued through a number of specific agreements that commits governments to a common framework of outcomes, progress measures and policy directions’ and ‘builds on current initiatives, address shortfalls and in many cases provide significant additional funds’ (FaHCSIA 2011). These agreements relate to health, housing, early childhood development, economic participations, remote service delivery, remote internet access, and closing the gap in the Northern Territory.

Source: (FaHCSIA 2011).

Getting services to Indigenous people with a disability

While the obstacles to service delivery described in section 9.2 are frequently noted in the literature, there is no clear guide as how prevalent or important they are in practice. For health services, it appears that scarcity and proximity are more important issues than mistrust or culturally inappropriate services (table 9.3).

Table 9.3 Types of problems faced by Indigenous Australians aged 15 years and over seeking health services years, 2008

<table>
<thead>
<tr>
<th>Problem</th>
<th>Non-Remote</th>
<th>Remote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting time too long/not available when needed</td>
<td>55.0</td>
<td>33.2</td>
</tr>
<tr>
<td>No services in the area</td>
<td>27.3</td>
<td>50.9</td>
</tr>
<tr>
<td>Not enough services in area</td>
<td>34.0</td>
<td>47.1</td>
</tr>
<tr>
<td>Transport/distance</td>
<td>24.7</td>
<td>45.8</td>
</tr>
<tr>
<td>Cost of service</td>
<td>37.5</td>
<td>16.5</td>
</tr>
<tr>
<td>Don’t trust services</td>
<td>7.3</td>
<td>5.6</td>
</tr>
<tr>
<td>Services not culturally appropriate</td>
<td>5.5</td>
<td>4.7</td>
</tr>
</tbody>
</table>


To the extent that this holds true for disability services, the increased resources under the proposed NDIS, combined with support from case managers and advocacy groups, will bring about a dramatic increase in the supports they receive. Indigenous Australians living in rural areas will be supported by regional NDIS offices and will be able to access self-directed funding on the same basis as all other Australians. More generally, the increased choice and flexibility of the proposed scheme will empower many to seek out the supports that best suit their individual situation.

Nevertheless, the cultural appropriateness of disability services and perceptions of government, service providers and the NDIA itself may become relatively more important as shortages in the disability sector are eased. It is not clear that the proposed consumer choice model would, on its own, adequately facilitate the delivery of such services. The remoteness of some Indigenous communities is one factor inhibiting the emergence of a competitive market for disability support services. However, in both rural and urban settings, socio-economic disadvantage, marginalisation and a lack of culturally appropriate services are a major barriers inhibiting many Indigenous Australians from accessing the services and supports available to them and exercising their consumer rights effectively.

For this reason, block funding the provision of disability support services specifically focussed on ensuring Indigenous people with a disability can access the supports they need, is likely to remain a feature of the disability system under the NDIS, at least over the short to medium term. In order to make good funding decisions and provide guidance for service providers, the NDIA will need to develop an understanding of the characteristics of effective service delivery to Indigenous Australians. While the experience of state and territory government agencies will be a valuable source of expertise, the Commission recognises the difficulty and complexity of this task. There are no easy or comprehensive answers. Moreover, it is often unclear how broadly the lessons from local solutions can be applied - often solutions will be specific to circumstances of a specific community and place based planning will be the appropriate approach. Nevertheless, there is a growing literature describing the basic strategies that can assist in meeting the needs of Indigenous people. Some of these are discussed in the following section.

Embedding services within the community

The extent to which disability services are in and of the Indigenous communities they serve is a critical factor to their acceptance and success. The capacity of not-for-profit providers to be representative of the communities they serve suggest they may have an advantage over government run services in this area (Productivity Commission 2010a), particularly if they are managed by the Indigenous community themselves. Also, having staff that are culturally competent or Indigenous themselves is clearly an important part of service providers gaining acceptance (discussed below).

Beyond this, establishing trust and rapport with Indigenous
communities is a long-term task involving integration into the social, political and economic activities of the community (NDS 2010, Gilroy 2008). While there is no one way to achieve this, some common strategies includes:

- participating in local events and community meetings
- establishing relationships with other Indigenous services providers, schools and medical centres. In particularly, in remote communities Aboriginal Medical Services may be a hub of ‘community activity connection and organisation’ - making them a useful contact point for newly established disability support service providers (SNAICC 2010, p. 41). However, an evaluation of coordinated care trials suggested that the effectiveness and community acceptance of these organisations themselves can be mixed (DOHA 2007).
- using existing networks, getting referrals from trusted sources within the community and establishing a mechanism through which ongoing communication with key elders, community workers and other service providers can occur (Regan and Harriden 2008).
- effective and authentic consultation with the community. The Community Health Committees used in the Sunrise Health trial is useful example of this (DOHA 2007)
- developing an understanding of local community. This includes community and family structure, the identification of influential community members and elders and an awareness of community politics and factions (NDS 2010).

**Indigenous staff**

The value of Indigenous staff to service providers and their clients is widely acknowledged (O’Neil, Kirov and Thomson 2004). Gilroy (2008) outlines a number of reported benefits to service providers from having Indigenous staff, including:

- increased-cross cultural awareness of the organisation
- greater awareness of local indigenous issues (both cultural and political)
- greater capacity to network with Aboriginal community services and develop programs that effectively target and cater for Indigenous clients.

While hiring Indigenous staff members may lead to complications arising from broader community tension in some areas (for example between kinship factions), overall the presence of Indigenous staff appears to have a strong affect on use of services by Indigenous people (NDS 2010, p. 28). Similarly, the NSW Ombudsman (2010) states:

> While it is a myth that Aboriginal people will not utilise mainstream services simply because they do not employ Aboriginal staff, it is clear that employing Aboriginal workers is one of the most effective ways for organisations to demonstrate that they welcome Aboriginal clients and are capable of providing culturally responsive services. (p. 23)

For this reason, there is merit in both the NDIA (for example as case managers attached to regional NDIS offices), and service providers in communities with substantial Indigenous populations, establishing dedicated positions for Indigenous people within their organisations.

Success in recruiting Indigenous staff is dependent on a number of factors, such as reputation in the community (NDS 2010) and whether there are already Indigenous staff within the organisation (Gilroy 2008). The NDS (2010) provided a number of recommendations to assist recruitment, including having Indigenous Australians on the recruitment panel, working with Aboriginal job network services and offering traineeships. Gilroy (2008) argued that a lack of skills or qualifications is common barrier to recruiting Indigenous Australians and suggested a greater role for government to assist service providers with the costs of training and development.

Working conditions can also be difficult for Indigenous staff, which can cause problems with staff retention. This has a number of facets:

- Indigenous staff being ‘pigeon holed’ into positions that solely deal with indigenous communities. This can reduce career opportunities and impact upon workplace satisfaction (NDS 2010).
- A shortage of Indigenous staff can result in them being overloaded with work, which, combined with cultural expectations, can lead to staff working significant unpaid overtime (Hepburn 2005).

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7 Sometimes referred to as Aboriginal Community Controlled Health Organisations.
8 The NSW Ombudsman (2010) noted that a common criticism by Indigenous people is that communities are not consulted until after decisions are made about the development and implementation of programs (p. 7).
9 The NDS (2010) suggested that in areas where kinship factions are prominent, employing an Indigenous Australian from one family group can reduce the prospect of recruiting from or delivering services to another. the NDS (2010) and ADN (2007) suggest that in some cases Indigenous run service providers face similar issues. Potential responses to this is are deliberately hiring from multiple family groups, and involving elders in conflict resolution. ADN (2002).
• Indigenous staff may be caught between the conflicting demands of their employers and their community. For example, a member of the Indigenous community may ask Indigenous staff for things that agency policy forbids from providing, such as money, transportation or simply taking the time to visit elder groups and socialise with Aboriginal community members while at work (O’Neil, Kirov and Thomson 2004; NDS 2010). However, refusing such requests may undermine their standing in the community.

• Standard working conditions may be difficult to reconcile with personal cultural responsibilities (such as attending funerals). Conversely, Indigenous staff who can access more flexible working conditions may experience friction with non-Indigenous staff, who feel they receive preferential treatment (ARP 2010).

Appreciating the additional pressures that Indigenous staff may be facing will be an important factor in developing strategies for staff retention. Beyond this, the NDS (2010) also recommended building the capacity for non-Indigenous staff to serve the needs of the Indigenous community, thereby alleviating some of the demands made on Indigenous staff. This is reliant on non-Indigenous staff developing a sufficient level of ‘cultural competence’ and understanding of the Indigenous community they serve. This is discussed in the following section.

### Indigenous Cultural Awareness Training

Cultural competency arises from a number of sources, including

- individual staff experience with Indigenous communities
- the institutional knowledge base developed by providers as to what service delivery strategies are most effective and appropriate in meeting the needs of Indigenous clients in different situations (itself derived through organisational experience and consultation).

Beyond this, Indigenous Cultural Awareness Training (ICAT) is an important and widely used strategy for improving cultural competency in dealing with Indigenous clients or staff. It is offered within the mainstream education system (such as university and TAFE), by specialist training providers and sometimes ‘in-house’ by organisations themselves. In some cases, funding agreements between government agencies and disability service providers require a certain proportion of staff to have undertaken ICAT (Gilroy 2008). Courses tend to follow a short workshop format and aim to provide a better understanding of Indigenous culture and history, to develop skills and strategies for better service provision and to improve cross cultural communication skills.

Whilst an important strategy, a number of studies caution against assuming that ICAT can provide a stand alone solution to the achieving cultural competency and that a tokenistic, ‘rubber stamp’ approach to ICAT is contrary to its stated objectives (NDS 2010, Gilroy 2008). Moreover, like other education and training services, the quality of ICAT providers, and the applicability of course content to disability support services providers, is likely to be varied. In particular, the NDS (2010) noted that courses with generalised (rather than specific to disability support services) and non-local content were less effective. In some instances, ICAT appeared to have been counter-productive:

Many disability services reported that aboriginal cultural awareness training (ACAT) can make disability workers feel intimidated and apprehensive in working with Aboriginal people. The ARP received reports of disability service staff leaving ACAT feeling averse and disinclined to engage with the Aboriginal community for fear of insulting people. Some disability service staff reported that ACAT reinforces the perception that Aboriginal people are difficult service users.

These issues highlight the point that the ICAT should be an output, rather than input based exercise (that is the goal should not be to ‘tick the box’ but rather to develop cultural competence in a practical way that improves the service offering). Nevertheless ICAT should remain a key tool to improving cultural competency, alongside an ongoing commitment by service providers to developing their own local knowledge base about cultural competent services practices that can be used as guide by staff. Gilroy (2008) and the NDS (2010) suggest a number of features that are likely to increase the usefulness of ICAT to service providers, including:

- being locally focused
- involving the local community in training
- providing information on important people (such as elders) and organisations (such as other not-for-profit service providers or aboriginal-owned business) with whom to establish networks
- covering other relevant topics such as appropriate communication styles, appropriate topics for conversation, myths and misconceptions, cultural taboos or sensitivities, and gender roles (such as men’s business and women’s business).
Conclusion

Supporting Indigenous Australians with a disability should be an important, specific goal of the NDIS. A key challenge to achieving this goal is overcoming the barriers to accessing services experienced by Indigenous people. The market-based service delivery system underpinning the proposed NDIS will not always be the most appropriate funding method, at least for the medium term. In such cases, the NDIA should block fund service providers to deliver disability supports to Indigenous Australians. In doing so, it should work with existing government agencies, Indigenous advocacy groups, funded service providers and the Indigenous community.

Indigenous people themselves are a key resource in addressing Indigenous disability. There are considerable advantages in employing Indigenous staff, and from fostering the development of not-for-profit service providers managed by Indigenous members of the local community. However, this can present a governance and accountability challenges where the skills and experience necessary to run such organisations are limited. One potential response to this is to use a lead agency type model, whereby a larger experienced service provider supports smaller community-based operations that engage local staff. This could allow local Indigenous service providers to build their administrative and organisational capability, with the long-term objective of handing over control entirely.

While the proposed scheme will seek to dramatically improve the standard of living for many Indigenous Australians with a disability, there are limits to what can realistically be expected to be achieved. First, the diversity and level of care and support available in major cities cannot be replicated in very remote areas. In some cases, Indigenous Australians with complex needs will have to move to regional centres or major cities to receive the appropriate care and support (as is also the case with non-Indigenous Australians). Additionally, in some cases non-government service providers may be unable or unwilling to service very remote communities. In such cases government-run service providers may be the only practical option. Similarly, in remote settings, sharing infrastructure (for example, with health or aged care), while not ideal, may also be necessary.

Second, as the NDS is (by definition) primarily focused on offering support to people with a disability, it does not directly address the underlying issue of the relatively high rate of Indigenous disability. The causes of this lie in the socio-economic disadvantage and marginalisation experienced by many Indigenous Australians and the risk factors to which they are exposed. While the NDS may have a role in funding early intervention and prevention approaches, it is not a panacea for broad Indigenous disadvantage. Addressing Indigenous disadvantage is an issue for all of Australian society and requires an ongoing cooperative approach from all levels of government and the Australian people (both Indigenous and non-Indigenous) more generally.

The Australian Government and state and territory governments should consider the feasibility of overcoming the barriers to service delivery in the NDIS for Indigenous people with a disability by:

- fostering smaller community-based operations that consult with local communities and engage local staff, with support from larger experienced service providers
- employing Indigenous staff
- developing the cultural competency of non-Indigenous staff.

In its initiatives for delivering disability supports to Indigenous people, the NDIS should be mindful of the wider positive measures addressing Indigenous disadvantage being adopted throughout Australia.
Disability within the Indigenous community

http://www.healthinfonet.ecu.edu.au/disability_review
The Australian Indigenous HealthInfoNet is an innovative Internet resource that contributes to ‘closing the gap’ in health between Indigenous and other Australians by informing practice and policy in Indigenous health.

Two concepts underpin the HealthInfoNet’s work. The first is evidence-informed decision-making, whereby practitioners and policy-makers have access to the best available research and other information. This concept is linked with that of translational research (TR), which involves making research and other information available in a form that has immediate, practical utility. Implementation of these two concepts involves synthesis, exchange and ethical application of knowledge through ongoing interaction with key stakeholders.

The HealthInfoNet’s work in TR at a population-health level, in which it is at the forefront internationally, addresses the knowledge needs of a wide range of potential users, including policy-makers, health service providers, program managers, clinicians, Indigenous health workers, and other health professionals. The HealthInfoNet also provides easy-to-read and summarised material for students and the general community.

The HealthInfoNet encourages and supports information-sharing among practitioners, policy-makers and others working to improve Indigenous health – its free on line yarning places enable people across the country to share information, knowledge and experience. The HealthInfoNet is funded mainly by the Australian Department of Health and Ageing. Its award-winning web resource (www.healthinfonet.ecu.edu.au) is free and available to everyone.