Statement of Dr Tracy Westerman

Name:	Dr Tracy Westerman
Professional address:	Known to the Royal Commission
Occupation:	Psychologist
Date:	24 November 2020

1. This statement made by me accurately sets out the evidence that I am prepared to give to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. This statement is true and correct to the best of my knowledge and belief.

2. The views I express in this statement are my own based on my education, training, and experience. Where I rely on research prepared by others, I believe it to be correct.
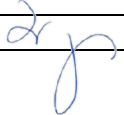
Professional background

3. I am a practicing Psychologist of Aboriginal descent. I am of the Njamal people from the Pilbara region in the Northwest of Western Australia. I hold a Post Graduate Diploma in Science (Psychology), a Masters Degree in Psychology (Clinical and Health), and a Doctor of Philosophy (PhD) in Clinical Psychology. I was the first Aboriginal person to complete a combined Masters/PhD in Clinical Psychology. My specialisation as a psychologist is in the mental health and psychological assessment of Aboriginal people.

4. I am the Managing Director of Indigenous Psychological Services (**IPS**), which I founded in 1998. IPS is a private consultancy company based in Perth, Western

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Australia. As Managing Director of IPS, my work focuses upon providing organisational cultural and clinical governance audits and development; providing measurements of individual and organisations cultural competency; and targeted training of mental health practitioners to improve them in working effectively with Aboriginal clients.

5. I am also the founder of the Westerman Jilya Insitute for Indigenous Mental Health, which is an initiative of IPS. 'Jilya' means 'my child' in Nyamal language: for this is about our children. It reflects the underlying vision of Jilya – to provide a world in which our most vulnerable Indigenous children can have at the very least, an equal opportunity to thrive. The Westerman Jilya Institute for Indigenous Mental Health aims to provide a clinical and cultural best practice response to the needs of at risk Aboriginal communities across Australia. It involves four major streams and includes the Dr Tracy Westerman Indigenous Psychology Scholarship Program for Aboriginal psychologists. It also involves a scholarship program for Aboriginal psychologists, which I launched in 2018 with Curtin University. The Jilya Institute was launched in 2020 enabling the expansion of the scholarship to evolve beyond Curtin University and to go national. By eliminating the very real financial barrier for Aboriginal students to study, my scholarship program aims to facilitate the training of more Indigenous psychologists, skilled evidence based best practice across in Indigenous-specific mental health, suicide prevention and intervention programs, ultimately taking their experience back to the most disadvantaged, high-risk communities to facilitate real change. To date, we have personally raised over $800,000 in commitments and have awarded 15 psychology scholarships. All of these students are also being personally mentored by myself to ensure we have capacity into future generations.

6. Before founding IPS, I was employed as a Welfare Officer in child protection in the remote Western Desert communities for almost seven years, from 1992 until 1998. I was the first Aboriginal person in Australia to complete a combined Masters and

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PhD in Clinical Psychology in 2003. I was also the first Indigenous psychologist to be employed in the Department responsible for child protection.

7. I was awarded Australian of the Year (WA) in 2018. I was recognised for my two decades of work to reduce the burden of mental illness in Aboriginal people and ensure minimum standards of cultural competence in the psychological profession.[1] I was also inducted into the Women's Hall of Fame and Awarded the Curtin University Lifetime Achievement Award in 2018.

8. A full list of my professional experience and achievements is set out in my curriculum vitae, which is annexed to my statement.
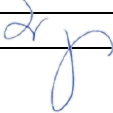
The development of mental health assessments and other psychometric tests

9. As a psychologist, I was trained in the assessment, development, understanding and administration of psychometric tests. Through that training and my research and practice with Aboriginal people, I became aware that mainstream assessments for mental health conditions (including those constituting psychosocial disability) have limitations when used for Aboriginal people.

10. I will address this further in this statement. However, in short, the presentation of mental health conditions (including psychosocial disabilities) of people of different cultures can be different. When mainstream tests are applied to Aboriginal people for the purpose of assessment, because of their cultural inappropriateness for Aboriginal people, they can result in what is often referred to in psychology as 'test error' and misdiagnosis. As I refer to it, 'test error' refers to errors in the measurement of factors (i.e. mental health, intelligence) that a test claims or purports to measure, compromising how valid a measure the test actually is of that characteristic.

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[1] Australian of the Year Awards, 'Dr Tracy Westerman', *Australia Day,* 2018.
<https://www.australianoftheyear.org.au/recipients/tracy-westerman/1988/>

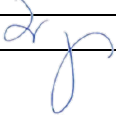| Signature		Witness	

11. Through my practice, I have come to understand that there are a range of challenges associated with the assessment and treatment of mental health conditions in Australian Aboriginal youth and adults. In my view, these challenges arise from a general lack of culturally validated tests for use with Aboriginal Australians, which also have systemic ramifications.

12. In my practice as a psychologist and through IPS, I have sought to address this gap through developing unique, psychometrically validated, tests and assessments designed for Aboriginal people. I have also designed tests in respect of the cultural competence of people working with Aboriginal people, in particular in the mental health and child protection fields. Cultural competence, or a lack of cultural competence, can impact upon decision-making in working with Aboriginal people, including through psychological diagnoses as I will address further in this statement.

13. The focus of my PhD was on the development of a number of unique assessments and psychometric tests designed specifically for Aboriginal people at risk of suicide and mental ill health and to determine the 'predictors' of cultural competency for those working in the general field of Aboriginal mental health, health and wellbeing.

14. Since completing my PhD, through IPS, I have developed and personally self-funded seven psychometric tests to address, broadly: suicide risk of Aboriginal people; mental health risk of Aboriginal people; and cultural competency measurements in respect of the culture of Aboriginal peoples given the absence of Government funding. The self-funding of these tools has been critical to the end goal of prevention. Psychometric tests enable us to determine, at a whole of population level, if risk factors are indeed different, and if aetiology for disease is different. This then dictates the focus of intervention. The fact that this had never been explored before tells us that we had no opportunity of ensuring that treatment and intervention with Aboriginal people were correctly addressing the right factors.

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15. It is not just an issue of Australian significance, but an issue of global significance. It became a personal responsibility to self-fund unique test development, given that there has been a failure to explore difference as explanatory of the over-representation of Aboriginal people across all of the major mental health and wellbeing services. Those seven tests are:

   a. The Westerman Aboriginal Symptom Checklist – Youth (**the WASC-Y**). The WASC-Y is a psychometrically evaluated and culturally validated tool to identify early stages of mental health risk for Aboriginal youth aged between 13 to 17 years old. It is unique to Aboriginal Australian youth and is currently used by practitioners across Australia. The tool enables the identification of mental health risk and cultural resilience factors specific to Aboriginal people. Its purpose is to enable mental health treatment planning for Aboriginal people to be specific to Indigenous risk and resilience and measure treatment outcomes in their effectiveness for Aboriginal people.

   b. The Westerman Aboriginal Symptom Checklist – Adults (**the WASC-A**). The WASC-A was developed based upon the WASC-Y and is a psychometrically validated scale for screening Aboriginal adults for depression, anxiety, suicidal behaviours, alcohol and drug use, impulse control. The tool also provides a scale for cultural resilience as a moderator of risk, providing a measure of cultural connection and disconnection and the extent to which an individual's identity is capable of 'buffering' risk factors.

   c. The Acculturative Stress Scale for Aboriginal Australians. There are increasing calls within psychology for racism and its manifestations to be included in diagnostic criteria for post-traumatic stress disorder.[2] The
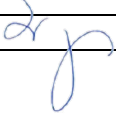
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[2] R Carter and Jessica M. Forsyth, 'A guide to the forensic assessment of race-based traumatic stress reactions', (2009), vol 31 (1), *The Journal of the American Academy of Psychiatry and the Law*, pp 28 - 40*;* T Chou, A Asnaani & SG Hofmann, 'Perceptions of racial discrimination and psychopathology across three U.S. ethnic minority groups', (2012), vol 18 (1), *Cultural*

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Acculturative Stress Scale is a tool designed to measure acculturative stress, racism, marginalisation and its direct impacts on an Aboriginal Australian individual.

d. The Aboriginal Mental Health Cultural Competency Profile (**CCP**). The CCP is a culturally and psychometrically validated tool that measures the taker's Aboriginal mental health cultural competence. It was designed for the Aboriginal mental health workforce within Australia. The tool has been norm-referenced by the testing of thousands of people across Australia, meaning it is possible to compare individual results against the average level of cultural competence of the group of people who have taken it.

e. The General Cultural Competence Profile (**GCCP**) is based upon the CCP. The GCCP is designed to provide a measure of the cultural competence of those in the non-mental health related fields who work with Aboriginal Australians. It has undergone psychometric validation but the results of that validation are not yet published. To date, the tool has been norm-referenced with over 2,000 people across Australia.

f. The Cultural Competency Profile – Child Protection (**CCP-CP**). This tool is designed to provide a measure of the cultural competence of child protection workers in respect of Aboriginal Australians across the domains of: cultural knowledge, child protection skills and abilities (including culturally appropriate counselling and assessment and culturally specific parenting knowledge for example); awareness and beliefs; resources and linkages; and organisational cultural competency. To date, it has been validated with over 500 child protection workers across Australia. It is

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Diversity and Ethnic Minority Psychology, pp 74-81*;* Y Paradies, 'Colonisation, racism and Indigenous health', (2016), vol 33 (1), *Journal of Population Research*, pp 83-86.

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currently undergoing psychometrically validation; the holdup is that this has to be paid for by IPS.

g. The Cultural Needs Scale (**CNS**). The CNS is a tool designed to assess the cultural and personal barriers existing to workforce participation for Aboriginal individuals. It enables the development of a personal profile which can be used to create a personal or supervision plan to address those barriers. It is currently undergoing psychometric validation.

16. I am currently developing a Culturally Competency Assessment for Foster Carers, to enable measurement of the cultural competencies of potential foster carers for Aboriginal children, including in respect of their capacity to support cultural identity formation and the cultural needs of Aboriginal children during their development.

17. In 2003, the Canadian Government sent a delegation to Australia in 2003 to review my methods. The delegation recommended my work be replicated there. A copy of their report is annexed to this statement.

18. As part of my work with IPS, I train practitioners in the psychometric tests and assessments described above. To date, I have trained and accredited over 30,000 practitioners across Australia in these tools.

Background – culturally inappropriate testing and assessments for Aboriginal people

19. In psychological testing and assessment processes, *testing* refers to the administration of a test by an accredited professional. *Assessment* refers to the broader process by which diagnoses of mental health or cognitive capacity are determined (generally by clinical interview, direct structured observation, and gathering information regarding behavioural presentation from a variety of sources known to the person undergoing assessment). Testing is one tool available in the broader assessment process.

The history of inappropriate testing and assessments for Aboriginal people

20.   Research in psychology shows the pervasive influence of culture on the presentation of mental ill health.[3] For example, the Diagnostic and Statistical Manual of Mental Disorders acknowledges the potential influences of culture on the manifestation of psychological and cognitive assessment.[4] Because of the influence of culture on the presentation of mental ill health, in psychological literature, cultural bias in testing and assessment has long been addressed in research as a factor that may impact upon test result reliability and validity.[5]

21.   Generally, the focus is two-fold. First, bias in the manner in which the tests have been *constructed,* which impacts on test reliability and validity for particular cultural groups. Second, *practitioner 'bias' or lack of cultural competence* in both the administration of and interpretation of tests and within the assessment process itself (the interaction between tester and testee). In my view, and as argued by others, culture remains distal rather than central to psychological training, practice and research.[6]

22.   In respect of Aboriginal Australians, my own research, and other studies, have identified the risk of error in psychologists, psychiatrists and doctors applying mainstream psychological tests and assessment processes with Aboriginal clients which fail to recognise the role of culture in client presentation.[7]
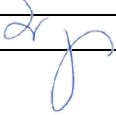
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[3] SR López, 'Patient variable biases in clinical judgment: Conceptual overview and methodological considerations' (1989), vol 106 (2), *Psychological Bulletin*, pp 184-203; AJ Marsella & AM Yamada, 'Culture and mental health: An introduction and overview of foundations, concepts, and issues', in IP Cuellar (ed), *Handbook of multicultural mental health* (2000), pp 3 - 26; S. Okazaki, 'Psychological assessment of Asian Americans: Research agenda for cultural competency', (1998), vol 70 (1), *Journal of Personality Assessment*, pp 54-70.

[4] Roberto Lewis-Fernández & Naelys Díaz, 'The cultural formulation a method for assessing cultural factors affecting the clinical encounter', (2002), vol 73 (4), *Psychiatric Quarterly*, pp 271-295*.*

[5] I Cuéllar, & FA Paniagua (eds), *Handbook of multicultural health,* Academic Press, 2000.

[6] M Cole, *Cultural psychology: A once and future discipline,* Harvard University Press, 1996.

[7] JM Kearins, 'Visual spatial memory in Australian Aboriginal children of desert regions', (1981), vol 13 (3), *Clinical Psychology*, pp 434-460; E Hunter, 'Aboriginal Mental Health Awareness: An overview, Part II', (1993), 17(1), *Aboriginal and Islander Health Worker Journal*, pp 8 - 10; Tracy Westerman, 'Development of an inventory to assess the moderating effects of cultural

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23. In 2016, the Australian Psychological Society issued a formal apology to Aboriginal and Torres Strait Islander people acknowledging psychology's role in contributing to the erosion of culture and to their mistreatment.[8] The Society specifically apologised for 'the inappropriate use of assessment techniques and procedures that have conveyed misleading and inaccurate messages about the abilities and capacities of Aboriginal and Torres Strait Islander participants'.

24. The factors associated with cultural bias that can impact upon test reliability and validity for Indigenous peoples include:

    a. The normative populations for thousands of psychological tests in existence are predominantly Caucasian Americans, in many instances men and/or middle class.[9] When minority populations such as indigenous people are assessed using these standardised norms, the relevance of those norms to them are questionable, raising the possibility of misdiagnosis.[10] Measures which have been developed within, used and standardised on, predominantly white, middle-class populations have questionable diagnostic reliability with Aboriginal youth, for example.

    b. The testee's emotional, spiritual and behavioural presentation is driven by a cultural context often not incorporated in the construction of psychometric tests.[11] Whether test performance represents everyday life
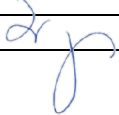
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resilience with Aborignal youth at risk of depression, anxiety and suicidal behaviours', PhD Doctor of Philosophy, Curtin University Curtin University, 2003; TG Westerman, 'Engaging Australian Aboriginal Youth in Mental Health Services' (2010), vol 45 (3), *Australian Psychologist*, pp 212-222; TG Westerman, 'Culture-bound syndromes in Australian Aboriginal Populations; where is the evidence?' (submitted).

[8] Australian Psychological Society, *Apology to Aboriginal and Torres Strait Islander People from the Australian Psychological Society*, media release, Melbourne, 15 September 2016. <https://www.psychology.org.au/news/media_releases/15September2016>

[9] RL Williams, 'The testing game', in R. L. Jones (ed) *Black psychology,* Cobb & Henry Publishers, 1991.

[10] JR Epstein, JS March, K Conners & DL Jackson, 'Racial Differences on the Conners Teacher Rating Scale', (1998), 26(2), *Journal of Abnormal Psychology*, pp 109-118.

[11] I Cuéllar, 'Cross-cultural clinical psychological assessment of Hispanic Americans', (1998), 70(1), *Journal of Personality Assessment*, pp 71 -86; RP DeShon, M. R. Smith, D Chan & N. Schmitt, 'Can racial differences in cognitive test performance be reduced by presenting problems in a social context?', (1998), vol 83 (3), *Journal of Applied Psychology*, pp 71 - 86*.*

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knowledge and ability, particularly in terms of cultural value, is also an issue of concern.[12]

c. Test instruments may not have been translated for indigenous people who often have English as a second language or dual language. Translation of tests provides construct equivalence or validity of test constructs through valid language, format and content.[13]

d. In respect of Indigenous Australians, the level of suspiciousness held by them of mental tests.[14]

25. From my own observation in applying psychological tests to Indigenous Australians in practice, I would add to those factors that Indigenous Australians are part of a collective culture in which the group is more important than the individual or 'self'. As testing is an individual process, this by itself can often present difficulties in my experience. For example, being individually spotlighted to provide a direct answer to a direct question has been identified as an issue in eliciting responses from students in classrooms.[15] My testing of Aboriginal people has always been undertaken in groups, thereby replicating the conditions of collectiveness to ensure individual testing compliance.
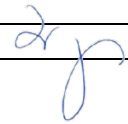
26. I would also add that Indigenous Peoples in Australia are not homogenous groups, being made up of many smaller groups with diverse beliefs, cultural practices and languages. However, what Indigenous Peoples do share which distinguishes them from other cohorts are the research supported negative effects of colonisation and

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[12] SE Cross, 'Self-construals, coping, and stress in cross-cultural adaptation', (1995), vol 26 (3), *Journal of Cross-cultural psychology*, pp 673 - 697.

[13] RH Dana, 'Multicultural assessment of personality and psychopathology in the United States: Still art, not yet science, and controversial', (1998), vol 14 (1), *European Journal of Psychological Assessment*, pp 62-70.

[14] GR Davidson, 'Fairness in a Multicultural Society: Reply to Dyck', (1996), 31(1), *Australian Psychologist*, pp 70-72.

[15] M Malin, 'Invisibility in success, visibility in transgression for the Aboriginal child in the urban classroom: Case studies at home and school in Adelaide', PhD dissertation, University of Minnesota, 1989. See also: M Malin, 'The Visibility and Invisibility of Aboriginal Students in an Urban Classroom', (1990), vol 34(3), *Australian Journal of Education*, pp 312-329.

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oppression which reflects the realities of the impacts of 'black identity', racism and intergenerational trauma. The origins lie in the forced removal of Aboriginal children from their parents as part of the Australian Government's Assimilation Policy creating the Stolen Generations and resulting in disruption of attachment linked to increased likelihood of inherited or 'intergenerational trauma'. My research has indicated that the whole of Government denial of this trauma until the formal apology of 2007 resulted in the magnification of this trauma through the lack of validation of trauma.
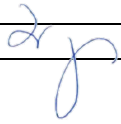
Impacts of inappropriate testing and assessments for Aboriginal people

27. The implication of Eurocentric cultural bias in psychological tests is that there are distinct group difference – or trends – in the test results for minority populations in comparison to Anglo-European populations.[16] For example, research has shown that cultural minority groups may show elevated patterns of symptomatology, in direction of pathology, in comparison to Anglo-European populations.[17]

28. Before my own research, Australian researchers have argued that Aboriginal people in Australia are often misdiagnosed or not diagnosed because their primary personality style is not one favoured or cultivated in the mainstream.[18] And, that

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[16] ML Lindsey, 'Culturally competent assessment of African American clients', (1998), 70(1), *Journal of Personality Assessment*, pp 43-53; S. Okazaki , 'Psychological assessment of Asian Americans: Research agenda for cultural competency', (1998), (70), *Journal of Personality Assessment*, pp 54 - 70; I Cuéllar, 'Cross-cultural clinical psychological assessment of Hispanic Americans', (1998), 70(1), *Journal of Personality Assessment*, pp 71 - 86; RP DeShon, MR Smith, D Chan & N Schmitt, 'Can racial differences in cognitive test performance be reduced by presenting problems in a social context?', (1998), vol 83 (3), *Journal of Applied Psychology*, pp 71 - 86; J Allen, 'Personality assessment with American Indians and Alaska Natives: Instrument Considerations and Service Delivery Style', (1998), 70(1), *Journal of Personality Assessment*, pp 17-42.

[17] J.N. Butcher, W.G. Dahlstrom, J.R. Graham, A. Tellegen, & B. Kaemmer, *Manual for administration and scoring: MMPI-2*, University of Minnesota Press, 1989. See also in respect of African Americans: Samuel B. Green & Crystal K. Kelley, 'Racial bias in prediction with the MMPI for a juvenile Delinquent population', (1988), vol 52 (2), *Journal of Personality Assessment*, pp 263 - 275; David A. Pritchard & Arthur Rosenblatt, 'Reply to Gynther and Green', (1980), vol 48(2), *Journal of Consulting and Clinical Psychology*, pp 273- 274.

[18] LA Clark & GS Halford, 'Does cognitive style account for cultural differences in scholastic achievement?', (1983), vol 14 (3), *Journal of Cross-cultural Psychology*, pp 279-296.
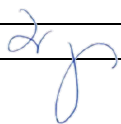
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the environment of many Aboriginal-Australians is likely to induce a different personality style to that of Anglo-Australians.[19]

29.   My own research, along with research conducted by others, has expressed concern that as a result of the application of culturally biased testing, minority populations (such as Aboriginal and Torres Strait Islander peoples in Australia) are set up for cultural differences to be assessed erroneously as mental health deficits.[20]

30.   Nevertheless, in my observation, the field of psychological and cognitive testing and assessment in Australia remains predominantly mono-cultural. By this I mean that researchers continue to use testing tools and assessment measures for Aboriginal and Torres Strait Islander groups that, in my view, inadequately account for cultural differences of Aboriginal and Torres Strait Islander peoples.

31.   Without the general availability of culturally valid tests by which to test Indigenous people in Australia, the key for practitioners is to be able to determine when test performance is the result of cultural difference rather than actual deficit.

32.   To determine this, in best practice, psychological and psychiatric diagnosis should follow a holistic assessment process in which application of an appropriate psychometric test is one part. In my experience of psychological practice, the perception sometimes remains among psychologists that psychometric testing is of paramount importance in making a diagnosis, as the only tangible component

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[19] R Morice, 'Depression before the white man', (1988), 12, *Aboriginal Health Information Bulletin*, pp 32-40.

[20] Tracy Westerman, 'Development of an inventory to assess the moderating effects of cultural resilience with Aborignal youth at risk of depression, anxiety and suicidal behaviours', PhD Doctor of Philosophy, Curtin University Curtin University, 2003; TG Westerman, 'Engaging Australian Aboriginal Youth in Mental Health Services' (2010), vol 45 (3), *Australian Psychologist*, pp 212-222; TG Westerman, 'Culture-bound syndromes in Australian Aboriginal Populations; where is the evidence?' (submitted); I Cuéllar, & FA Paniagua, (eds), *Handbook of multicultural health*, Academic Press, 2000; GR Davidson, *Ethnicity and cognitive assessment: Australian perspectives*, Darwin Institute of Technology Press, 1988; GR Davidson, 'Cognitive Assessment of Indigenous Australians', (1995), vol 30 (1), *Australian Psychologist*, pp 30-34.
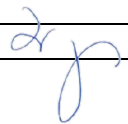
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of the decision-making process of assessment, without appropriate consideration of the possibilities of cultural bias.

33. Where psychometric tests are applied, in my view, clinical and cultural validation of test outcomes during assessment is best practice for Aboriginal and Torres Strait Islander peoples. For example, the WASC-Y and WASC-A incorporate clinical and cultural validation guidelines which aim to combat test error as a result of cultural bias. [21] Without adequate cultural competence, however, some psychologists might not understand the importance of cultural validation of test results for Aboriginal people.

34. From my research and practice with Aboriginal people, I have also come to the view that assessment methods of practitioners can impact upon the diagnostic data generated during the assessment process. Test performance and assessments, in particular when using structured interviews and clinical assessments, can be affected by the fact that the tester is from a different cultural background to that of the testee. In my view, more research is required into this interaction, in particular research conducted by Indigenous researchers.

35. In my view, reducing the impact of different cultural backgrounds between testers and testees who are Aboriginal requires cultural competence in respect of Aboriginal mental health on the part of testers. There is research showing that behaviours may be misdiagnosed as pathological without consideration of their appropriateness within their cultural context.[22] For example, the CCP seeks to

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[21] Tracy Westerman, 'Development of an inventory to assess the moderating effects of cultural resilience with Aborignal youth at risk of depression, anxiety and suicidal behaviours', PhD Doctor of Philosophy, Curtin University Curtin University, 2003.

[22] J Cawte, 'Australian ethnopsychiatry in the field: a sampling in the North Kimberley', (1965), vol 1 (13), *Medical Journal of Australia*, pp 467-472; Sandra Collard & Darren Garvey, 'Counselling and Aboriginal People: Talking about Mental Health', (1994), vol 18 (5), *Aboriginal and Islander Health Worker Journal*, pp 17-21.

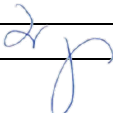| Signature		Witness	

address cultural competence in respect of the Aboriginal mental health workforce.[23]

Systemic implications of culturally inappropriate tools and assessment

36.   In my view, there are systemic ramifications of the unreliability and invalidity of the results of culturally inappropriate tests and assessments of mental health conditions of Aboriginal people.

37.   When psychological and mental health distress in Aboriginal and Torres Strait Islander peoples are assessed accurately, reliably and validly, causes of distress are measurable and lead to the proper identification of an individual's treatment and support needs. When assessment is inaccurate, a practitioner's design of treatment for an individual can be inappropriate as a result.

38.   Without appropriate assessment, treatment and support needs can go unrecognised and unmet. In my view, this is replicated systematically, in the sense that there is limited capacity to design and measure best practice in respect of treating mental health distress of Aboriginal and Torres Strait Islander peoples.

39.   Where mental health assessments are incorrect, this can also impact upon decisions in services systems that rely upon information from those assessments. For example, in the criminal justice system, mental health assessments are often used in consideration of offender sentencing, including to assess the risk of recidivism.[24]

40.   In my view, applying culturally inappropriate tools and assessments of Indigenous Australians is likely to impact on the reliability of data on the rates of prevalence

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[23] Tracy Westerman, 'Development of an inventory to assess the moderating effects of cultural resilience with Aboriginal youth at risk of depression, anxiety and suicidal behaviours', PhD Doctor of Philosophy, Curtin University Curtin University, 2003.

[24] In 2018, the Supreme Court of Canada held (by a majority of 7-2) that the Correctional Service of Canada had breached its statutory duty to an Aboriginal man, Jeffrey Ewert, by assessing his risk of recidivism using actuarial risk assessment tools that had not been proven to be accurate when applied to Indigenous offenders: *Ewert v Canada* 2018 SCC 30 (13 June 2018).

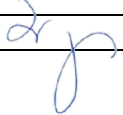| Signature		Witness	

of mental health distress among Indigenous Australians. [25] A lack of reliable mental health data impacts upon planning to address services needs on an evidence-based foundation (for example, in the Closing the Gap Strategy).[26]

Culturally appropriate assessment of disability for Aboriginal and Torres Strait Islander peoples

41. As a psychologist, in addition to my understanding of the assessment of psychosocial disability associated with mental health conditions, my understanding of disability assessment relates to testing of cognitive and intellectual disability.

42. In practice, the Weschler Intelligence Scales is the mainstream cognitive test used to calculate an Intellectual Quotent (**IQ**) score and to determine intellectual ability and disability. The Weschler scales are mostly used to diagnose specific learning and reading disabilities (such as dyslexia, attention deficit hyperactivity disorder (ADHD) and the like).

43. There are concerns about cultural bias in the use of the Weschler Intelligence Scales.

44. Other tests used in assessing cognitive and intellectual disability include the Vineland Adaptive Scale, which determines individual adaptive functioning. The Vineland Adaptive Scale does not incorporate cultural context in determining how adaptive the individual is.

45. These all have cultural variants and cultural factors that are fully capable of conforming and confusing diagnosis; for example:

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[25] See also, for example: R.J. Velazquez, G.X. Ayala, S. Mendoza, E. Nezami, I. Castillo-Canez, T. Pace, et. al., 'Culturally competent use of the Minnesota Multiphasic Personality Inventory-2' in I.P. Cuellar (ed), *Handbook of Multicultural Mental Health*, Academic Press, 2000, p 425.

[26] Productivity Commission, *Mental Health*, Productivity Commission Inquiry Report, Report no. 95 vol 2, June 2020, p 110 fn 5.
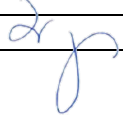
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a. ADHD is often confused with cultural differences in parenting. Specifically, Aboriginal people parent our children very differently than Eurocentric parenting styles. This can often be confused for a learning disability, and result in Aboriginal children being pathologized rather than a teacher understanding that these learning styles require teaching strategy adjustment.

b. Perceived reading disabilities can also often be the result of differences in learning style and the lack of face validity of the tests being undertaken (i.e. the verbal scales are predominantly used to screen for learning and reading disabilities and have the most cultural error out of all of the subscales on the Wechsler Intelligence tests).

c. Aboriginal English can be confused for learning disabilities.

46. Ultimately a lack of cultural appropriateness in assessment has a substantial impact on the results. As I have outlined above, these issues impact on the test validity itself. In addition, until tests have been determined as psychometrically sound with Aboriginal people we cannot comfortably say that they are valid or reliable measures. We also need to ensure that practitioner error is understood, including how it impacts on cultural competence, so that we can allow for this error in providing appropriate guidance for practitioners. Guidance should include:

a. Ensuring minimum standards of cultural competence;

b. Understanding the clinical and cultural differentials and manifestation of disability or disorder; and

c. Provide appropriate clinical and cultural validation guidelines that enable practitioners to address the specific test error associated with each test and based on cultural factors that confound item interpretation and/or testee performance.

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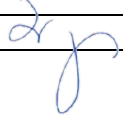## Culturally appropriate tools for the assessment and diagnosis of disability

47. There are several different approaches to the calculation of ability and IQ with Aboriginal Australian populations. All these approaches have significant limitations. For example:

    a. There have been a litany of attempts to adapt mainstream tests (most recently the attempted adaptation of the mainstream depression inventory the aPhQ). I carried out an analysis of this inventory. I am not aware that any simple adaptation has yet produced validated results.

    b. Developing unique tools. The Q-Test (previously the Queensland Intelligence Test) was developed as part of a PhD research project, and has since become utilised more in the recruitment industry. The limitations of this tool are that it focuses primarily on non-verbal intelligence, and does not generalise as a replacement for an IQ test.

    c. As I have outlined, I have developed various tests which have been both clinically and culturally validated in their field of operation.

48. I have recently had accepted for publication a paper setting out the validation of Culture Bound Syndromes for Aboriginal Australians. This is an extremely significant body of work due to the differential manifestation of Aboriginal mental health being confirmed empirically for the first time. It also validates the existence of culture bound syndromes which often conform to mainstream mental illnesses and are therefore often misdiagnosed. This then means that treatment is also compromised. It also resulted in an adaptation of the Diagnostic Statistical Manual Outline for Cultural Formulation which means that there will now be a requirement that those undertaking assessments of Aboriginal people will be trained and guided in accordance with the cultural factors in assessment.

49. At present, there is not enough data on any of these tools to be able to say to what extent they are valid with Aboriginal people.

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50. Generally, the field of cognitive assessment has failed to progress culturally over decades of the use of the Wechsler Scales. Predominantly psychologists will use only the performance subscales as a method of allowing for cultural bias. The argument being that the verbal subscales have more cultural bias. However, they are effectively then not providing a measure of verbal intelligence which is clearly a critical measure to gauge.

51. Where assessments lead to diagnoses that arise from culturally inappropriate tools, then the results will arguably always be problematic. It will have one of three outcomes – over diagnosis; misdiagnosis or underdiagnoses. Essentially there is more likelihood of chance than getting assessment correct with an Aboriginal Australian currently due to the complete failure to both acknowledge test and assessment bias and to address it nationally.

52. Where assessment is wrong, the wrong treatment results. Where treatment is wrong, there is no opportunity to gather evidence of what is working. Without data to help us understand program impacts, there is no proper measure of baseline risk, meaning that we cannot plan for and reduce the disadvantage gap – it is not being properly measured.

53. We currently have no data on prevalence across any of these issues that we can rely on as being accurate. This causes substantial difficulty in identifying and implementing appropriate interventions to assist in responding to mental health concerns, and possible cognitive and intellectual impairments.

Cultural competence of people applying disability assessment tools

54. In my view, and through my research, I consider that there is an inadequate understanding of, psychopathology, and what constitutes psychopathology, within other cultures. Past approaches to understanding the mental health needs of Aboriginal Australians has largely been through the application of generic

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(westernised) conceptualisations of health and well-being.[27] Often, such frameworks are inappropriate, primarily because they fail to recognise that both culture and spirituality have strong roles to play in the development and maintenance of mental health problems in Aboriginal people.[28]

55. Difficulty in detection has commonly centred on a lack of understanding of the manner in which mental health problems come to attention and the way in which cultural factors influence behaviour or presentation. The results of this are that those Aboriginal people who do come into contact with mental health services are more likely to be treated with higher doses of medication to ensure that their behaviour rapidly dissipates,[29] and are also more likely to be inappropriately diagnosed.[30] Those from remote areas in particular are more likely to be treated with medication rather than any other form of treatment. Even more concerning is that the prescription of medication likely to be inadequately supervised or understood by the client.

56. The result of these problems is that requests for help from mental health professionals by Aboriginals have always been considerably less frequent than by non-Aboriginals.[31] The problems associated with identification, isolation, and the lack of cultural understanding amongst many clinicians have led to the
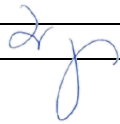
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[27] David Vicary & Henry Andrews, 'A model of therapeutic intervention with Indigenous Australians', (2001), vol 25 (4), *Australian and New Zealand Journal of Public Health*, pp 349-351.

[28] J Atkinson & C Clarke, 'The Indigenous Therapies Program: A student's perspective', paper, Western NSW Aboriginal Mental Health Seminar, Dubbo, 1997; C Waldegrave & K Tamese, 'Some central ideas in the "Just Therapy" approach', vol 14 (1), *Australian and New Zealand Journal of Family Therapy*, pp 1-8.

[29] E Hunter, 'The social and family context of Aboriginal self-harmful behaviour in remote Australia', (1991), vol 25, *Australian & New Zealand Journal of Psychiatry*, pp 203-209.

[30] JH McKendrick, M Thorpe, T Cutter, G Austin, W Roberts, M Duke, et al, 'A unique and pioneering mental health service for Victorian Aboriginal people', (1990), vol 13, *Aboriginal Health Information Bulletin*, pp 17 – 21.

[31] JH McKendrick, T Cutter, A Mackenzie & E Chui, 'The pattern of Aboriginal Psychiatric Morbidity in a Victorian Urban Aboriginal General Practice Population, (1992), vol 26, *Australian & New Zealand Journal of Psychiatry*, pp 40 – 47.

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fact that Aboriginal people only come to attention as a result of *severe behavioural disturbance* rather than with complaints of subjective distress.[32]

57. Difficulties with communication and problems associated with a foreign and sterile setting also mean that Aboriginal people often find it difficult to communicate their distress, and for professionals to question Aboriginal people about their feelings.[33]

58. The valid identification of mental health problems amongst Aboriginal people is perhaps the most significant issue facing mental health professionals in their desire to work with Aboriginal communities.

59. For clinicians specific information pertaining to culturally competent assessments of Aboriginal mental health clients is not forthcoming. In my experience, the result is that the engagement of Aboriginal clients is often rare, but also commonly at the extreme end of behavioural distress.

60. As a result of these problems there is in general a high degree of acceptance of abnormal behaviour within Aboriginal communities, which creates significant stress within these communities. Communities would only start to complain if the person was extremely violent, or if there were not enough people to care for the person on a shared responsibility basis.[34]

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[32] E Hunter, 'The social and family context of Aboriginal self-harmful behaviour in remote Australia', (1991), vol 25, *Australian & New Zealand Journal of Psychiatry*, pp 203-209.

[33] E Hunter 'Using a socio-historical frame to analyse Aboriginal self-destructive behaviour', (1990), vol 23, *Australian & New Zealand Journal of Psychiatry*, pp 191-198; E. Hunter, 'The social and family context of Aboriginal self-harmful behaviour in remote Australia', (1991), vol 25, *Australian & New Zealand Journal of Psychiatry*, pp 203-209; E Hunter, 'Out of sight, out of mind -1. Emergent patterns of self-harm among Aborigines of remote Australia', vol 6, *Social Science & Medicine*, pp 655-659.

[34] C Huffine, 'Social and cultural risk factors for youth suicide' in LDN Linnoila (ed), *Report of the secretary's task force on youth suicide*, Georgetown University Press (1989); E Hunter, 'Changing Aboriginal mortality patterns in the Kimberley regions of Western Australia. 1957-1980: The impact of death from external causes', (1989), vol 11, *Aboriginal Health Information Bulletin*, pp 27-32; Tracy Westerman, 'Development of an inventory to assess the moderating effects of cultural resilience with Aborignal youth at risk of depression, anxiety and suicidal behaviours', PhD Doctor of Philosophy, Curtin University Curtin University, 2003.

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Impacts of not having culturally appropriate disability diagnosis and assessment tools for Aboriginal and Torres Strait Islander peoples

61. Aboriginal Australians have less access to mental health services and are more likely to underutilise services.[35] In my experience, the access to and use of mental health services presents many challenges for Aboriginal Australians. A lack of cultural fit between the consumer and the available services has been identified as one of the main reasons for the underuse of mental health services by Aboriginal people in Australia and other minority populations.[36] My understanding of the research is that that a lack of fit leads to misunderstanding and miscommunication that hinders productive and effective service delivery and leads to negative outcomes for practitioner and patient alike. Consequently, a significant challenge for mental health practitioners who engage with Aboriginal people in Australia is developing and applying culturally competent service delivery.

62. One of the main explanations for this current situation is potentially the cultural inappropriateness of services, and their failure to accommodate Aboriginal conceptualisations of health and well-being.[37] In response, educational, professional and health care organisations alike have been determined to deliver culturally competent services to improve cultural fit.[38]

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[35] David Vicary & Henry Andrews, 'A model of therapeutic intervention with Indigenous Australians', (2001), vol 25 (4), *Australian and New Zealand Journal of Public Health*, pp 349-351.

[36] R Downing, E Kowal, Y Paradies, 'Indigenous cultural training for health workers in Australia', (2011), vol 23 (3), *Indigenous cultural training for health workers in Australia*, pp 247 - 257; P Memmott, R Stacy, C Chambers and C Keys, *Violence in Indigenous Communities*, Commonwealth of Australia, 2001; JR Betancourt, AR Green, JE Carrillo, *Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches*, A Field Report, The Commonwealth Fund, October 2002.

[37] Tracy Westerman, 'Development of an inventory to assess the moderating effects of cultural resilience with Aboriginal youth at risk of depression, anxiety and suicidal behaviours', PhD Doctor of Philosophy, Curtin University Curtin University, 2003.

[38] LM Anderson, SC Scrimshaw, MT Fullilove, JE Fielding & J Normund, 'Culturally competent healthcare systems: A systematic review' (2003) vol 24 (3 Suppl), *Amerian Journal of Preventative Medicine*, pp 68-79.

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63. Culturally competent services have many benefits including improved access and equity, cost-effectiveness and efficiency, and better service quality.[39] In Australia, there is initial evidence to support cultural competence initiatives.[40]

64. However, despite undertakings to improve cultural competence, cultural competence itself has not been consistently operationalized and defined.

65. The definition of cultural competence commonly accepted in health and educational settings is that cultural competence is a set of congruent behaviours, attitudes and policies that come together in a system, agency or amongst professionals and enables effective cross-cultural work.[41] A key element in the definition of cultural competence is the belief that cultural competence is multi-tiered and comprises integrated dimensions including the individual, professional, organisational, and systemic.[42] In other words, an individual practitioner's culture competence reflects that of the organisations, professions and systems in which they are positioned.[43]
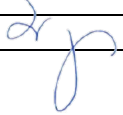
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[39] JR Betancourt, AR Green & EJ Carillo, 'Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care', (2003), vol 118, *Public Health Report*, pp 293-302; C Brach & I Fraserirector, 'Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model', (2000), vol 57 (1), *Medical Care Research and Review*, pp 181-2137.

[40] Tracy Westerman, 'Development of an inventory to assess the moderating effects of cultural resilience with Aborignal youth at risk of depression, anxiety and suicidal behaviours', PhD Doctor of Philosophy, Curtin University Curtin University, 2003; Y Paradies, 'A systematic review of empirical research on self-reported racism and health', (2006), vol 35 (4);, *International Journal of Epidemiology*, pp 888-901.

[41] TL Cross, BJ Barzon, KW Dennis & MR Isaacs, *Towards A Culturally Competent System of Care" A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed*, Washington D.C., 1989.

[42] R Bean, 'Cross-cultural competence and training in Australia', (2006), vol 14 (1), *The Diversity Factor*, pp 14-22; JR Betancourt, AR Green & EJ Carillo, 'Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care', (2003), vol 118, *Public Health Report*, pp 293-302; JR Betancourt, AR Green, JE Carrillo, *Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches*, A Field Report, The Commonwealth Fund, October 2002; J Bryson & C Hosken, 'What does it mean to be a culturally competent I/O psychologist in New Zealand?', (2005), vol 34(2), p 69.

[43] D Chrobot-Mason & BM Ferdman, 'Multicultural competences for IO psychologists: Why and how', (2001), vol 39 (1), *The Industrial-Organizational Psychologist*, pp 69-74; AJ Darnell & GP Kuperminc, 'Organizational cultural competence in mental health service delivery: A multilevel analysis', (2006), vol 34 (4), *Journal of Multicultural Counseling and Development*, pp 194-207.

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66. As part of my PhD, I expanded this definition of cultural competence and validated it for the Australian context. Since then, I have developed and validated three unique psychometrically determined tests of culturally competency which enable:

    a. An individual 'measure of cultural competence' which includes the individual's view of the organisations cultural competencies;

    b. A 'feedback' report or cultural supervision plan which enables the individual to improve their cultural competency over time;

    c. A mechanism to 'track' the improvement of organisational cultural competencies over time via trend analyses which provide an objective 'measure' of cultural competence.

67. In Australia, we also have the ability via the work of Paradies, IPS and the Jilya Institute to determine the cost of racism and also then arguably what improved cultural competency actually saves Australia and organisations.

Cultural competence of child protection systems

68. Aboriginal communities face a well-documented legacy of deep intergenerational trauma, resulting from experiences of colonisation and past government policies of separation and removal of children from their families. This trauma is extraordinarily complex and resonates across individuals and communities. Whilst there is an obvious need to have programs which are able to provide intervention and prevention around the transmission of trauma these have yet to be fully realised both in terms of empirical research and resultant evidence based, culturally specific programs which have determined their efficacy. This research has as its overall aim to address these gaps by developing an evidence base around the differential development and classification of attachment styles in Aboriginal parents and children.

69. The transmission of intergenerational trauma is multi-faceted, having a known phenomenology that includes physiological, genetic, psychological, social and

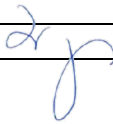| Signature		Witness	

spiritual elements. Caregivers who themselves experience complex trauma and/or PTSD may struggle to understand their children's behaviours and therefore have great difficulty providing essential attunement, consistency and discipline.[44] When a caregiver is attuned and consistent, the child develops 'secure attachment'. The child is then able to form healthy relationships with others into adulthood and mental health outcomes are generally positive. However, when caregivers have unresolved trauma, their capacity to be consistently nurturing can be impaired. Children can become traumatised in situations where this extends to family environments of violence and abuse. Attachment is very often damaged in these circumstances, which can be both a cause and an outcome of trauma.[45]

70.   In more serious cases, families may become involved with child protection services and children can end up in care. This is especially significant for Aboriginal children and young people, who are over-represented by about 10 times the rate of non-indigenous children in out of home care.[46] Children and young people who do not heal from developmental trauma can continue these patterns of dysregulation into adulthood and, when they themselves have children, the cycle is at risk of beginning again. Attachment theory is perhaps one of the best-understood mechanisms of transmission of trauma and is a target for effective intervention.

71.   An attachment-centred approach to intervention offers a critically important and effective means of restoring positive outcomes for families affected by trauma. Unfortunately, Western approaches to trauma treatment have shown limitations in efficacy, which highlight issues in assumptions of universality in the aetiology of attachment classifications across cultures. Unless programs are developed from

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[44] J Arvidson et al., 'Treatment of Complex Trauma in Young Children: Developmental and Cultural Considerations in Application of the ARC Intervention Model', (2011), 4, *Journal of Child & Adolescent Trauma*, pp 34-51.

[45] M Rahim, 'Developmental trauma disorder: An attachment-based perspective', (2014), vol 19 (4), *Clinical Child Psychology and Psychiatry*, 548-560.

[46] Australian Institute of Health and Welfare, *Child protection Australia 2018-19*, Final report, Report no. 72, 2020, p 44.

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within an Aboriginal context and are empirically tested there will remain limited opportunities for prevention and early intervention for at risk children and their parents.
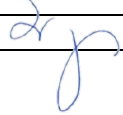
Cultural parenting differences

72. The research tells us that traditional Aboriginal Australian approaches to child-rearing create ideal conditions for secure attachment outcomes.[47] Aboriginal children traditionally have access to a greater number of primary attachment figures who persist throughout their lives and increase the likelihood that all of their emotional needs are able to be responded to in a manner that ensures secure attachment. The concept of a 'whole community raising a child' is consistent with Aboriginal parenting styles. It increases the likelihood of secure attachment, as there is an expectation that the emotional needs and therefore attachment bonds that develop are a shared community responsibility.[48] In addition to this, there is a greater focus on what has been termed 'attachment parenting' or, more accurately, 'cultural attachment parenting', in which the closeness between children and multiple carers occurs throughout their lives.

Desired attachment outcomes can differ across cultures

73. In looking more closely at the strengths that are evident in Aboriginal parenting practices, we need to better understand how these differ compared with more Westernised styles of parenting. Broadly speaking, in Western societies development of the self is dependent on being individually and task-oriented. These cultures value adults who display autonomy, independence and

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[47] J Kearins, *Child-rearing practices in Australia: a variation with life-style*, University of Western Australia, 1984; JJ Goodnow, in GR Davidson (ed), *Ethnicity and Cognitive Assessment: Australian perspectives*, Darwin Institute of Technology, 1988; Fiona Ryan, 'Kanyininpa (Holding): A Way of Nurturing Children in Aboriginal Australia', (2011), vol. 64 (2), *Australian Social Work*, pp 183-197; S Lohoar, N Butera & E Kennedy, 'Strengths of Australian Aboriginal cultural practices in family life and child rearing', *Child Family Community Australia Paper No. 25*, Melbourne, 2014; Soo See Yeo, 'Bonding and attachment of Australian Aboriginal children', (2003), vol 12(5), *Child Abuse Review*, pp 292-304.

[48] Tracy Westerman, 'Development of an inventory to assess the moderating effects of cultural resilience with Aborignal youth at risk of depression, anxiety and suicidal behaviours', PhD Doctor of Philosophy, Curtin University Curtin University, 2003.

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competence. On the other hand, many Aboriginal Australian cultures emphasise experiential learning, interdependent relationships, honouring spiritual and cultural connections in the community and group cohesion.[49] Prior to two years of age, children from a mainstream Western background are likely to be comforted by caregivers after they become distressed. Aboriginal caregivers, however, more often aim to prevent their child's distress before it occurs. Older children in Aboriginal societies tend to be more self-reliant and may play a significant role in the upbringing of other children in the family.[50]
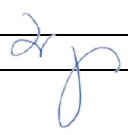
74. These cultural differences present a challenge to typical assessment of attachment and bonding in Aboriginal clients.[51] For example, infants or young children may be observed to seek out multiple caregivers and be capable of organising a complex array of attachment figure/s depending upon the emotional and/or practical needs they fulfil. An Aboriginal parent will not be directive or autocratic (concertive) in their parenting behaviour with a child as the expectation is that the child needs to learn skills by group and not through a sole focus on an individual parent. Further, children are taught from a young age to look more to siblings and same aged peers than adults to learn and provide emotional regulation to them.[52] While culturally appropriate for an Aboriginal family, these behaviours could be perceived through a Western lens as representing disrupted

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[49] Fiona Ryan, 'Kanyininpa (Holding): A Way of Nurturing Children in Aboriginal Australia', (2011), vol. 64 (2), *Australian Social Work*, pp 183-197; S Lohoar, N Butera & E Kennedy, 'Strengths of Australian Aboriginal cultural practices in family life and child rearing', *Child Family Community Australia Paper No. 25*, Melbourne, 2014; Soo See Yeo, 'Bonding and attachment of Australian Aboriginal children', (2003), vol 12(5), *Child Abuse Review*, pp 292-304.

[50] Fiona Ryan, 'Kanyininpa (Holding): A Way of Nurturing Children in Aboriginal Australia', (2011), vol. 64 (2), *Australian Social Work*, pp 183-197.

[51] Soo See Yeo, 'Bonding and attachment of Australian Aboriginal children', (2003), vol 12(5), *Child Abuse Review*, pp 292-304.

[52] Judith Kearins, Child-rearing practices in Australia: Variation with lifestyle, Education Department of Western Australia, 1984; Tracy Westerman, 'Development of an inventory to assess the moderating effects of cultural resilience with Aborignal youth at risk of depression, anxiety and suicidal behaviours', PhD Doctor of Philosophy, Curtin University Curtin University, 2003.
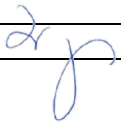
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attachment patterns.[53] In addition, culturally there are significant problems with the classification of attachment disorders.

75. Measures such as the Adult Attachment Interview and the Strange Situation Test have been developed around Western populations and their observed attachment patterns. More culturally appropriate assessment tools are needed to better account for the dynamics in Aboriginal Australian communities. Further investigation is also required to understand the specific manifestations of attachment disruption in Aboriginal populations. This includes assessment of caregivers' early attachment experiences and descriptions of current caregiver-child bonding.[54] There is a danger of seeing cultural differences in parenting as a deficit. The reality of looking at cultural parenting through a mainstream lens increases the likelihood of misdiagnosis of attachment disorders and therefore limits the capacity to determine appropriate treatments and interventions.

76. A great risk in uncritically applying non-Indigenous paradigms such as attachment is that we colonise the knowledge systems around child-rearing already present within Aboriginal cultures. When working from our own cultural reference points, both personal and professional, we can easily fail to understand that there are multiple constructions of child rearing, some aspects of which are similar to ours and some which are not. This highlights our need to scrutinise the fundamental design of child protection systems, their decision-making frameworks and their position within a broader set of colonising structures. Further, we are challenged to genuinely situate conventional Western and Indigenous knowledge together. In this, each system seeks to understand the other, traversing often foreign conceptual territory and unpacking hidden assumptions about the worlds in which we and the other live.

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[53] Fiona Ryan, 'Kanyininpa (Holding): A Way of Nurturing Children in Aboriginal Australia', (2011), vol. 64 (2), *Australian Social Work*, pp 183-197.

[54] Soo See Yeo, 'Bonding and attachment of Australian Aboriginal children', (2003), vol 12(5), *Child Abuse Review*, pp 292-304.

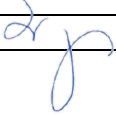| Signature		Witness	

Differential cultural diagnosis issues: Cultural differences presenting as 'attachment disorders'

77. Many aspects of Aboriginal kinship systems have significant potential to be viewed as attachment disorders when referencing the DSM criteria of inhibited and disinhibited outcomes. The nature of attachment assessment is a combination of assessment protocols and direct observation of the caregiver-child bond. The structure of kinship, gender relationships, skin relationships and hierarchies within Aboriginal communities all affect individuals' social behaviour. The rules governing these relationships may be invisible to those unfamiliar with it; as such, a person's social behaviour can be viewed out of its context and attributed to attachment outcomes.

78. First, kinship relationships are structured very differently in Aboriginal Australian societies compared with Westernised ones. Relationships are based on this unique structure rather than a subjective sense of 'bond'. For example, gender is a 'subculture' in Aboriginal communities and gender-directed relationships strongly influence the nature of individuals' interactions with each other. This separation ensures that the cultural decision making specific to 'men's and women's business' remains secret or sacrosanct. The natural separations between people created by this structure could be misinterpreted as 'inhibited attachment', as children may indiscriminately attach to those individuals who are an accepted source of affection and support. On the other side of the coin, to make up for this separation of the genders, Aboriginal children are established into hierarchies very early. They look more to peers for direction as opposed to looking to adult 'authority' figures. In school-age years this can be misinterpreted as behavioural issues and, due to the encouragement of close, often more tactile relationships within the same gender, can also look like disinhibited attachment.[55]

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[55] Tracy Westerman, 'Development of an inventory to assess the moderating effects of cultural resilience with Aborignal youth at risk of depression, anxiety and suicidal behaviours', PhD Doctor of Philosophy, Curtin University Curtin University, 2003.

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79. A further complicating factor is the formulation of skin groups and associated relationships in many Aboriginal communities. Skin relationships (or 'skin system') refers to the complex system that determines how people relate to each other. It encompasses their societal roles, responsibilities and obligations. The kinship system determines who marries who, ceremonial relationships, funeral roles and behaviour patterns with other kin.

80. The behavioural outcomes of skin relationships could lead to a differential diagnosis of attachment disorder. For example, a child may eschew direct contact with various people in his or her community due to skin relationships which forbid close or direct contact between individuals. These are known as *avoidance relationships.* As these interactions can appear similar to attachment dynamics, observation must occur either by or with a cultural consultant who is 'vouched' for by the community as having essential cultural knowledge of these dynamics. This is essential in order to ascertain whether or not behaviours are culturally appropriate. Unfortunately, what further complicates this picture is that not all communities continue to operate within a 'skin system'. The assessor must then have the capacity to undertake a comprehensive and objective *cultural map* of the kinship structure operating within the community and the extent to which individuals have chosen to live within this structure. There may be many instances in which an individual has 'unwittingly' married someone for whom they are 'wrong way' (i.e., the 'wrong skin group') and may not have an awareness of this. The previous generation, who are aware of this 'taboo', may in turn have views about the relationship and particularly 'shun' the children of these relationships. Again, it is important to consult with a vouched-for consultant to determine if wrong way skin may be implicated in attachment assessment.

81. Aboriginal culture is hierarchical. Power and knowledge are not something that everyone simply has a 'right' to. Knowledge is looked after by certain people, which includes maintaining the secret nature of many ceremonial and other practices. It is taboo for someone of a lower level of power to approach a person of a higher
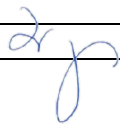
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hierarchy or attempt to question or converse with particular individuals who hold more knowledge and/or power. To attempt to do so often elicits 'avoidance language', which can persist within communities and give an impression of a disordered or avoidant attachment style. For example, an Aboriginal male who has gone through initiation will have a greater level of 'power' than a non-initiated male and this dictates relationship dynamics, including those between young people and classroom teachers.

What value does exploring attachment specific to Aboriginal people provide?

82.   The need for empirical testing of an Attachment Model and developing and testing of an attachment program specific to Aboriginal people is vital for a multitude of reasons. For professionals who provide programs (e.g., counselling, family support, parent education, childcare) for families with children under the age of three from many cultures and contexts, and who promote care-giving practices that encourage positive parent-infant relationships, there is a need to understand different cultural views of attachment and bonding to ensure that misdiagnosis of attachment disorders do not occur. In addition understanding the focus of attachment treatment intervention should be free of cultural bias. Importantly though there is a very clear ethical consideration in being able to adopt a culturally inclusive set of attitudes, knowledge and skills when promoting culturally appropriate attachment-based parenting behaviours (i.e., best practices) in research and intervention.[56] It is essential that infant mental health professionals provide culturally sensitive services by learning how different care-giving practices fit into the cultural contexts that they work in.[57] Promoting practices based on one culture may lead to under- or over-referrals based on diagnoses of inhibited and disinhibited attachment, due to a number of cultural

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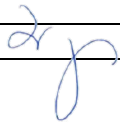[56] J Bowlby, *Attachment and loss: Vol 1. Attachment 2.* Basic Books, 1969.

[57] I Barrera, RM Corso, D Macpherson, *Skilled Dialogue: Strategies for Responding to Cultural Diversity in Early Childhood*, Brookes Publishing, 2003.

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issues (i.e. skin relationships; gender issues; hierarchy issues) which can result in differential diagnosis.

83. In addition, if parenting practices are only understood from one cultural viewpoint there is a risk of under-serving populations that have different cultural backgrounds over-identifying parents as having poor attachment relationships with their children and/or castigating them for their cultural beliefs and practices.[58] This has certainly been the case in Australia with policies of assimilation specifically focusing on parenting of Aboriginal children and removing them specifically for these parenting differences and creating the stolen generations of Aboriginal people. These impacts continue until this day, whereby Aboriginal children continue to be grossly over-represented in the out of home care and child protection system.

84. Securely attached children have better health, education, employment and mental health outcomes than children with disrupted attachment. Placement instability has significant adverse effects on children. On the basis of my overall understanding of the literature, I am aware of a number of studies that have found associations between continued instability and adverse psychosocial outcomes, such as emotional difficulties, behaviour problems and poor academic performance. What is clear is that within Australia there has been a virtual absence of 'testing' of conventional Attachment Theory and its relevance for Aboriginal Australian families. There is, however, some emerging research which both challenges and supports a Cross Cultural Model of attachment which provides an important basis for program development and which will be explored here.

85. There are three main attachment styles that are generally accepted: secure (type B), insecure avoidant (type A) and insecure ambivalent/resistant (type C). It is

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[58] Soo See Yeo, 'Bonding and attachment of Australian Aboriginal children' (2003), vol 12(5), *Child Abuse Review*, pp.292-304.

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generally believed that these attachment styles were the result of early interactions with the mother. A fourth attachment style known as disorganized was later identified.[59]
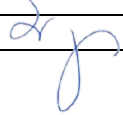
86. Whilst attachment theory has mostly stood up to empirical validation and testing, there are of course, opponents of this approach.

87. In my view, the most complete explanation of why children develop different attachment types would be an interactionist theory. This would argue that a child's attachment type is a result of a combination of factors – both the child's innate temperament and their parents' sensitivity towards their needs.

88. I am aware that a study in 2012 noted evidence that Indigenous children experienced higher levels of emotional and behavioural problems.[60] In my view, it would certainly be interesting to explore the origins of this. Those communities that remain relatively culturally 'intact' in comparison to those communities who have experienced higher levels of acculturation and acculturative stress may have more resilience to the development of emotional and behavioural disorders and to the intactness of parental bonds and security that this offers both the child and the parent.

Relevance of attachment to cultural differences in parenting

89. The term 'Aboriginal' refers to all original peoples in Australia. Three separate groups are recognized within this context including those who identify as Aboriginal Australian, Torres Strait Islanders and South Sea Islanders. It is important to note that these groups are made up of diverse peoples, each with their own unique histories, spiritual beliefs, languages and cultural practices. Further, parenting practices and parenting styles among different Aboriginal

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[59] Mary Main & Judith Solomon in 'Procedures for identifying infants as disorganized/disoriented during the Ainsworth Strange Situation' in Mark Greenberg, Dante Cicchetti, & Edward Cummings (eds), *Attachment in the preschool years: Theory, research, and intervention*, University of Chicago Press, 1990, pp 121–160.

[60] Keriann Little, Ann Sanson & Stephen Zubrick, 'Do individual differences in temperament matter for Indigenous children?' (2012), *Family Matters*, vol 91 (1), pp 92-105.

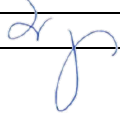| Signature		Witness	

groups, communities or families should not be considered to be homogeneous. It is also clear that culture changes over time and parenting practices within each culture also change slightly over each generation. However, there is good evidence that the biological function of the attachment relationship is the same across cultures and generations and serves to provide safety, comfort and stress reduction to the infant. For example, some evidence shows that the quality of the infant's attachment relationship influences the level of cortisol secretion in response to stress.[61] Infants who are in reliable healthy relationships show lower increases in cortisol in response to a stressful situation compared to infants in less healthy relationships.

Culture and Attachment

90. While research on the appropriateness of attachment theory outside of Western cultural parenting practices has been limited, attachment is not about parenting styles, values, or even about different parenting behaviours. [62] Attachment behaviours may look different across different cultures but they achieve the same function.

91. Based upon my review of all the available literature (all of which is international), there are some aspects of attachment which are considered to be consistent or universal between cultures while some appear to be more culture specific. Although there is sufficient evidence that the distribution of attachment classifications is consistent between cultures (i.e., 60% secure, 40% insecure), it is perhaps more worthwhile to the culture specificity argument that it is the expression of attachment in terms of parent and child behaviour which is the most

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[61] Rena L Repetti, Shelley E Taylor & Teresa E Seeman, 'Risky families: family social environments and the mental and physical health of offspring', (2002), vol 128 (2), *Psychological Bulletin*, pp 330-366.

[62] Michelle Christensen & Spero Manson, 'Adult attachment as a framework for understanding mental health and American Indian Families: a study of three family cases', (2001), vol 44 (9), *American Behavioral Scientist*, pp 1447-1465; Raymond Neckoway, Keith Brownlee & Bruno Castellan, 'Is attachment theory consistent with Aboriginal parenting realities', (2007), vol 3 (2), *First Peoples Child & Family Review*, pp 65-74.

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likely to vary between cultures and the quality of the different expressions of attachment styles. It is my understanding that secure infant attachment is the most adaptive and prevalent form of attachment, but the variability in the rates of insecure classifications in diverse contexts suggests a closer look at both infant and maternal behaviours warrants exploration.

Factors shown to impact on attachment

92. Low socio-economic status has been associated with higher rates of insecure attachment in children due to the risk factors associated with poverty which have been shown to negatively impact on the parent-infant relationship. 63 These factors include racism which will be considered here as a number of different components. These include acculturation, identity formation and acculturative stress as variants in the parental bond and parenting style. These factors will be explored in terms of the individual, the collective as well as external variables. It is argued that there is a significant role in the realities of cultural change and adaptation to external factors such as policies of removal and assimilation. The question then becomes – are current 'Aboriginal parenting practices' a representation of traditional parenting practices or the result of loss of primary attachment figures and parental models? The section on acculturation discusses this issue.

The group versus the individual in attachment theory

93. Attachment theory is often criticised for its emphasis on the independence for the purpose of achieving the future goal of separation and autonomy. However, those in collectivist societies may actually have different parenting goals.

94. In addition, it is well accepted that most research has explored attachment between a child and one parent; there has been very little exploration of the child's

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63 Jay Belsky, & Pasco Fearon, 'Infant-mother attachment security, contextual risk, and early development: A moderational analysis', (2002), vol 14(2), *Development and Psychopathology*, pp 293–310.

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ability to form multiple attachments from a very early age. Although early attachment writing emphasised an infant's preference for a primary caregiver, subsequent reviews have challenged this idea.[64] This research suggests that very young children can form attachment bonds to multiple caregivers simultaneously. The literature on cultural expression of attachment,[65] on shared caregiving,[66] and on attachment in middle childhood also questions the notion of a primary attachment figure.[67]
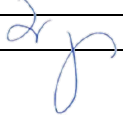
95. When considering the attachment needs of Aboriginal and Torres Strait Islander children and their caregivers, it is important to look beyond the dyadic model of attachment and consider the broader importance of multiple attachment relationships for children, and the significant importance of extended family and kinship networks for children. Therefore, it is important to be aware of cultural values and ideals regarding parenting when considering if a child's attachment experience has been compromised.

96. Amongst Indigenous groups generally, there are a complex system of relationships that exist and which are specific to the attachment needs of the child. It is often then the case that the child is taught to organise a whole range of attachment figures specific to emotional needs and this is consistently reinforced throughout the life of the child via the kinship structures. The commonality amongst Indigenous groups lies in the importance of the extended family and the unity of the relationship to the land and to kin.

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[64] Michael Lamb, 'A wasted opportunity to engage with the literature on the implications of attachment research for family court professionals', (2012), vol 50(3), *Family Court Review*, pp 481–485.

[65] Fiona Ryan, 'Kanyininpa (Holding): A Way of Nurturing Children in Aboriginal Australia', (2011), vol 64 (2), *Australian Social Work*, pp 183-197.

[66] Carollee Howes & Susan Spieker, 'Attachment relationships in the context of multiple caregivers' in J. Cassidy & P. R. Shaver (eds), *Handbook of attachment: Theory, research, and clinical applications*, The Guilford Press, 2008, pp 317–332.

[67] Roger Kobak, Natalie Rosenthal, Kristyn Zajac, & Stephanie Madsen, 'Adolescent attachment hierarchies and the search for an adult pair bond', (2007), vol 117, *New Directions for Child and Adolescent Development*, pp 57–72; and Deborah Laible, 'Measuring attachment in middle childhood: Challenges and future directions', (2005), vol 48, *Human Development*, pp 183–187.

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Relationships with people are considered to be structured and based in Aboriginal Law and the Dreaming. Children are taught about mutual co-operation, about special duties to some extended family group, about taboos and about relationships which have special ritual significance. Behaving properly within the cultural context to other people is an important aspect of Aboriginality and important to the development of 'cultural attachment behaviours'.

97.   In terms of attachment classification then these cultural differences can be the source of misdiagnosis of the different attachment types. For example, skin relationships which also determine avoidance relationships amongst Aboriginal people and dictate contact due to cultural issues can be misclassified as Insecure Ambivalent / Resistant. It can also be the source of misunderstanding and misrepresentation (i.e. behaviour considered to be inappropriate in one culture but appropriate in another). For example, the family home may be the scene of many comings and goings where people move around, and numerous people may pick up a child from school/ day-care etc. Collectivist cultures such as Aboriginal cultures in which parenting is a 'shared' or community responsibility understandably increase the likelihood that secure attachment will be developed in the child.

98.   For example, part of growing up in a collectivist culture means that Aboriginal infants may be breastfed and cared for by several women interchangeably. Under bonding and attachment theory, the practice can be viewed negatively as indiscriminate attachment.[68] Skin and avoidance relationships can be seen as inhibited attachment. Similarly, issues of child neglect can often be considered as a matter of parental culpability, rather than as a shared responsibility between parents, families, community and society.[69]

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[68] Soo See Yeo, 'Bonding and attachment of Australian Aboriginal children' (2003), vol 12(5), *Child Abuse Review*, pp 292-304.

[69] Debbie Scott, Daryl Higgins & Richard Franklin, 'The role of supervisory neglect in childhood injury', (September, 2012), Paper No. 8, *Australian Institute of Family Studies: Child Family Community*, <https://aifs.gov.au/cfca/publications/role-supervisory-neglect-childhood-injury/child-injury>; Soo

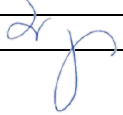| Signature		Witness	

Material sensitivity

99.   In relation to attachment type, however, the emotional responsiveness of the mother to the child's specific needs (attachment type) is a further area of cultural difference that has been demonstrated to impact upon attachment expression. The main difference that has been seen in maternal sensitivity in non-Western studies seems to be the issue of maternal control. This refers to the extent to which a parent either directs ('interferes' with) or allows the infant to control his or her own actions (i.e. cooperation). Aboriginal parenting styles allow for 'natural growth' – which is specific to allowing independence in learning, or less boundaries and control on behalf of the parent.

100. In families, it is often assumed that babies and children are best able to express their own needs and that adults are there to attend to those needs. Among traditionally oriented and some suburban families there is group care of babies and young children. This means that a baby is likely to be held by someone nearly all of the time. A child may relate to several aunts as 'Mum' and be fed or put to bed in several different households as a normal experience.

Independence, interdependence care and autonomy

101. One of the strengths of a collective community approach to raising children is that parents and carers have the security and confidence to allow their children the freedom to explore the world on their own terms. For Australian Aboriginal families, the risks associated with children's activities are accepted as a natural part of growing up.[70] Aboriginal carers actively encourage independent play so that children can learn a range of important life skills, including the capacity to learn

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See Yeo, 'Bonding and attachment of Australian Aboriginal children' (2003), vol 12(5), *Child Abuse Review*, pp 292-304.

[70] Secretariat of National Aboriginal and Islander Child Care, 'Growing up our way: Practices matrix', (2011), Melbourne, <https://www.snaicc.org.au/wp-content/uploads/2016/01/02802.pdf>.

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responsibilities to care for and protect one another.[71] To deny a child this independence would be considered a breach of parental responsibility under traditional Aboriginal culture and Law (Lore/The Dreaming/Dreamtime).[72]
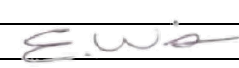
102. One of the more notable differences between Aboriginal and White Australian reared children is interdependence on other caregivers. The focus of this type of parenting is on the future competence of the child around self-expression and social interaction as well as autonomy. The group harmony and cohesion becomes more essential to individual caregiver bonds.

Kinship attachment and hierarchical organisation of attachment

103. The peer group then becomes the most important source of attachment development for the child as soon as they are 'capable' or independence, generally around 18 months to 2 years of age. Hierarchies are established early to ensure that there is independence in learning but safety in the group providing a secure base. The infant caregivers then naturally anticipate infant's needs by what seems to be a biologically based inclination to respond in accordance with kinship but importantly emotionally simpatico between caregivers and infant. Aboriginal communities believe that it takes a whole community to raise a child and this means that it is commonplace for different caregivers to respond to the different emotional needs of the child – the collective arguably making it more likely that the child's innate temperament and personality style which is of biological and genetic origin can then be 'assisted' or responded to by a range of external caregivers. This arguably increases the likelihood that temperaments that are difficult or hard to warm up will be

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[71] Soo See Yeo, 'Bonding and attachment of Australian Aboriginal children' (2003), vol 12(5), Child Abuse Review, pp.292-304.

[72] Secretariat of National Aboriginal and Islander Child Care, 'Growing up our way: Practices matrix', (2011), Melbourne, <https://www.snaicc.org.au/wp-content/uploads/2016/01/02802.pdf>; Soo See Yeo, 'Bonding and attachment of Australian Aboriginal children' (2003), vol 12(5), Child Abuse Review, pp.292-304.

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managed or 'altered' by the environments increased capacity to respond to their entire range of emotional needs of the child.

104. Since the child does not attach exclusively to the mother, nor equally to each member of the group, a kind of balance then starts to emerge between the child as a separate individual in relation to its mother and as a member of a group.
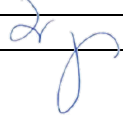
Ways of passing the spirit of Aboriginal culture to children

105. I am aware of some evidence which suggests that engaging in spiritual practices is associated with improved physical and mental health. Improvements in immune system function, lower blood pressure and lower rates of heart disease, stroke and kidney failure are just some of the physical benefits from engaging in spiritual practice. Mental health benefits include a greater sense of responsibility, increased self-control and greater tolerance.[73] Spiritual engagement is also shown to be a protective factor against adolescents' risky behaviours.[74]

106. For Aboriginal families, spirituality is a key cultural characteristic that embodies the interconnectedness of life's dimensions. The sacred connection to the Dreaming provides guidance for families and communities in raising children and helps to instil the shared values of interdependence, group cohesion and community loyalty. These qualities help to provide a safe environment for raising children and help both adults and children to understand the importance of caring for and protecting one another.
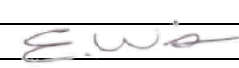
Measuring cultural competence of individuals and workforce services

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[73] Alexandra McEwan and Komla Tsey, 'The Role of Spirituality in Social and Emotional Wellbeing Initiatives: The Family Wellbeing Program at Yarrabah' (2009), *Cooperative Research Centre for Aboriginal Health*, < https://core.ac.uk/download/pdf/30684294.pdf>.

[74] Sharon Rostosky, Fred Danner and Ellen Riggle, 'Is Religiosity a Protective Factor Against Substance Use in Young Adulthood? Only If You're Straight!', (2007), vol 40 (5), *Journal of Adolescent Health*, pp 440-447.

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107. Traditionally, society has placed greater importance on clinical than cultural competence. It has been ill defined, inconsistent and ambiguous which in and of itself has significant impacts on the ability to address many of the issues noted in this statement. In 2002 as part of my PhD research I aimed to correct that issue and started to explore this notion of cultural competency within the mental health field and with Indigenous mental health consumers. The predictors of cultural competence in mental health were therefore determined via focus groups and through the use of thematic analysis.

108. This led to the initial design of a cultural competency 'test' known as the Cultural Competency Questionnaire. Over time this became more refined through the use of the tool in training and audits of organisations and now has been normed Australia wide on practitioners. This provides a number of unique outcomes:

   (a)   That the predictors of cultural competence is now no longer ambiguous as they have been clearly defined through rigorous methodology that ensured Aboriginal voices were front and centre of this;

   (b)   That the tool has also undergone psychometric validation. This has ensured the dual outcome of tests being both clinically and culturally valid;

   (c)   It provides us with a measurability component to cultural competence which is the ideal position to be able to ensure;

      (i)   that cultural competency can be improved over time;

      (ii)   that programs can target those factors were understand to provide our best opportunity for practitioners and organisations to be culturally competent;

      (iii)   it enables us to demand universities and organisations meet minimum standards of cultural competence;

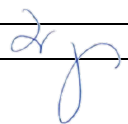   (iv)   it enables us to measure the impacts of cultural competency and awareness type programs; and

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(v)   it provides an opportunity to address all of the significantly poor statistics we are seeing across Australia in terms of Aboriginal over-representation by contributing clearly to the 'why' of this over-representation, I have just launched the non-profit Westerman Jilya Institute for Indigenous Mental Health ('Jilya'). IPA are currently seeking research partnerships to assist with this.

109.   Following the development and validation of the Cultural Competency Profile - Mental Health (CCP-MH); the General Cultural Competency Profile (GCCP) was validated in 2012, followed by the Cultural Competence Profile – Child Protection (CCP-CP) in 2018 both of which were adapted from the original CCP but involved significant focus groups, piloting and norming.

110.   The CCP-CP assists those who work specifically with Aboriginal people in the child protection context. The aim is to help individuals identify personal strengths and limitations in providing culturally appropriate child protection services to Aboriginal people. The CPP-CP is designed to facilitate and ensure ongoing "critical self-reflection" or insight to ultimately ensure skills, knowledge, attitudinal and organisational improvement. That is, the tool seeks to promote a process whereby those who work with Aboriginal people are encouraged to look closely at how they interact with Aboriginal people and to think about how they might improve their ability to be culturally appropriate. The CPP-CP incorporates five domains of cultural competency and 16 subdomains which have been supported in previous literature. They can be seen in Table 1 provided below:

Table 1: The domains and subdomains of the Cultural Competency – Child Protection Profile (CCP-CP: Westerman, 2019)

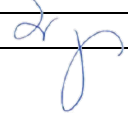| DOMAIN	SUBDOMAIN
1. Cultural Knowledge	Local Cultural Knowledge
	General Child Protection Knowledge
	Application of Knowledge
	Cultural Parenting & Child Development Knowledge

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2. Skills & Abilities – Child Protection	Training Access
	Culturally Appropriate Counselling & Assessment
	Culturally Specific Parenting Knowledge
	Assessment & Intervention
	Engagement & Contact
3. Awareness & Beliefs	Cultural Empathy
	Emotional Stability & Flexibility
	Personal Identity
4. Resources & Linkages	Interactions & Awareness
	Links & Referrals
5. Organisational Cultural Competency	Implementation
	Capacity & Commitment

1. Cultural Knowledge: Gauges individual's local, general, applied, and child development specific knowledge in working with Aboriginal clients.
2. Skills & Abilities: Determines your culturally relevant training, counselling, assessment and general practice skills.
3. Awareness & Beliefs: Provides an indication of the extent to which your prevailing beliefs are consistent with working effectively with Aboriginal people in the child protection context.
4. Resources & Linkages: Examines the extent to which your networks, community and agency links as well as culture-specific resources are sufficient across child protection notifications, assessments child removal and interventions.
5. Organisational Cultural Competency: Gauges your views on how your Organisation supports the cultural competencies of its staff through organisational and staff development.

112. As far as I am aware, this is the first time in which cultural competencies have been empirically determined for the child protection workforce and so has not only departmental, but also national and international implications and interest. This analysis represented a first 'look' at what cultural competencies are able to tell us about the nature of the child protection workforce but also what cultural competencies are best addressed in order to ensure that child protection workers have appropriate cultural skills to work in a more effective manner with Aboriginal children and their families.

113. In June 2020 I launched the Westerman Jilya Institute for Indigenous Mental Health ('Jilya') to address the significant gaps across justice (criminogenics); suicide prevention; child protection, mental health and educational outcomes. The essence of this lies in the unique psychometric tests I have developed and including significant data that is being captured everyday across Australia on these tests. I have donated the intellectual property of these tools to Jilya for research

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purposes. In combination they give us the ability to answer the causal pathways questions (or the 'why') associated with all of these poor outcomes but in a way in which programs are able to be more reactive to what is feeding into these hard statistics (ie, child removal of 54%; incarceration of 34%; highest suicide rates in the world etc). The essence of the model is that the continuous data gathered by the WASCY&A and cultural competency tests can be used to determine causal pathways to enable us to determine the following:

(a)   Do improvements in cultural competency in child protection result in lower rates of child removal?

(b)   Do improvements in cultural competency in police result in lower rates of incarceration?

(c)   Do improvements in teacher cultural competency predict better educational outcomes?

(d)   Does reduction in risk determined by the WASCY&A predict lower incarceration rates; lower risk for mental health and suicide and therefore lower risk for recidivism?

(e)   Does responsiveness to risk measured by the WASCY/A result in lower rates of suicide?

The possible consequences of the statutory child protection workforce not being culturally competent for Aboriginal and Torres Strait Islander peoples with disability
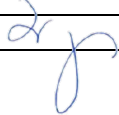
114.   The over-representation of Indigenous people in the child protection system, the justice system, higher rates of suicide, mental ill health, and poor education outcomes. Despite this over-representation the contribution of racism has never been appraised in a manner that is long term, trackable and measurable over time. The work of IPS and Jilya Institute will allow that to occur amongst many other outcomes.

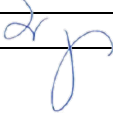| Signature		Witness	

115. As I have referenced above, the cost of racism has been quantified and it is significant.

116. The work of IPS however, enables this cost to be measured and therefore we would be (the big picture thinking) able to demonstrate that improvements to cultural competence saves organisations. For example, from what I have read I understand that Nextel found that for every dollar they invested in cultural competency, they received 163% return on their investment. This has yet to be demonstrated in Australia but at the very least has to be explored as a significant factor otherwise we are destined to continue down a similar path of racism not being looked at in a rigorous way to determine its impacts but also not looking at what improvements to cultural competency actually lead us to.

Recommendations

117. It is my recommendation that the Royal Commission consider this globally significant opportunity provided by IPS and the Westerman Jilya Institute for Indigenous mental health to address the significant and unacceptable gaps that continue to contribute to the over-representation of Aboriginal people across justice, child removal, mental health, education and suicide prevention outcomes by:

    (a) Investing in the national research validation of the WASCY, WASCA to following significant gaps are addressed:

    (b) Developing a robust national database of mental health prevalence to ensure that we are nationally able to:

        (i) determine the nature and extent of mental health and suicide risk for Indigenous adults and youth;

        (ii) determine a baseline of prevalence against which to measure program and funding impacts and success;

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(iii)   determine unique risk factors and causal pathways for Indigenous mental health, suicide and criminogenics;

(iv)   That we are able to develop unique intervention and prevention programs based upon unique causal pathways for Indigenous people.

(v)   screen for early stages of risk and undertake measured and targeted prevention;

(vi)   gather evidence of what is needed and what is working, and

(vii)   determine mental health comorbidity to better understand treatment focus and research priorities.

(c)   Validate the Acculturation and Acculturative Stress scales nationally to ensure that capacity to moderate potential risk for the development of suicide, mental ill health, health and poor educational outcomes are able to be managed and addressed;

(d)   Facilitate the national roll out of the CCP-MH, GCCP and CCP-CP to provide our best opportunity to address the contribution of racism, or a lack of cultural competency and improvements to the same on incarceration rates, child removal rates, mental health prevalence, and suicide rates.

118.   In addition, I recommend that the Royal Commission actively encourage Federal and State education departments to consider the wide scale norming of the Weschler Scales with Aboriginal people. That this should occur in conjunction with;

(a)   The administration of the Acculturation Scale for Aboriginal Australians – Youth version. This will enable the determination of the interaction between cultural connection and intelligence which enable us to 'correct' for cultural difference or diversity. The major argument with the validation of a single tool for Aboriginal people is that the culture is so diverse that this is impossible to apply a single tool. However, acculturation enables us to
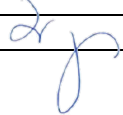
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determine the extent of individual cultural error and statistically correct for this but we need good solid normative data to enable this;

(b)   The use of the CCP-MH to ensure the cultural competency of those who administer the scales with Aboriginal children;

(c)   That a determination of Aboriginal English usage be made at the commencement of test administration for the purposes of departing from standard Australian English Administration to ensure tests are administered in a more valid way.

119.   I recommend that the Royal Commission encourage the funding of an adaptive scale for use with Aboriginal Australians to ensure that functional capacity is assessed in the most culturally fair manner.

120.   I invite the Royal Commission to recommend funding to determine the relevance of mainstream attachment theory and a unique attachment classification for Aboriginal Australians given the different cultural parenting styles and contexts that can lead to differential diagnosis, including exploration of whether there is a universal attachment aetiology or if there are unique attachment types, and related research questions, which must include in combination:

(a)   Determining the relevance of the classification of attachment disorders and types given the range of cultural factors that complicate the cultural validity of such diagnoses;

(b)   Exploring the utility of existing measures in use for the assessment and diagnosis of PTSD and attachment disorders with the view to the development of unique assessment tools;

(c)   Determining the impacts of acculturative stress on the presentation of PTSD and individuals' resilience to it through the use of the Acculturative Stress Scale for Aboriginal Australians.

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121. I recommend that the Royal Commission recommend funding be directed to an Indigenous led organisations that has pre-requisite expertise and track record in psychometric test development with Indigenous people to enable the national determination and tracking of causal pathways for suicide, mental health, criminogenics. This data can then be used to inform program impacts, program content, program outcomes and funding determination. A national data base of program outcomes currently does not exist which prevents any opportunity for developing robust evidence of what is working to reduce suicides, mental health prevalence, criminogenic risk and poor educational outcomes.

122. I believe that we presently have a very exciting opportunity to address significant gaps in our knowledge of causal pathways across child protection, suicide prevention, incarceration and educational outcomes with the work of IPS in combination with the Jilya Institute. It is essential that the Royal Commission makes recommendations that are specific rather than general due to the high level of complexity of this area and the urgency of the need for these issues to be addressed to ensure that the needs of Indigenous Australians are understood. This is also essential so we do not continue down the path of non-evidence based approaches that fail to demonstrate impacts and fail to do so in a way that is objective, irrefutable and measurable. As a non-profit driven charity Jilya will ensure that the work of IPS is expanded where it is able to provide our best opportunity for prevention. It is a model that exists nowhere else in the world and provides an opportunity to not only prevent but measure impacts of funding distribution.

Signed: _____

Date: 25/11/2020 _____

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Date: 25/11/2020 _____

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