Hand-in-Hand

Report on Aboriginal Traditional Medicine

Francesca Panzironi

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Printed version

ISBN: 978-0-9875311-0-0

PDF version

ISBN: 978-0-9875311-1-7

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Table of Contents

Acknowledgments

This report rests on an extraordinary web of relationships developed during the entire undertaking of the project.The report would not have been possible without the help of many people who have significantly supported my search for answers and the pursuing of the vision which underlines this report. I am deeply indebted to everyone who made the time to talk to me; to everyone who provided the logistical and travelling support across South Australia; to everyone who encouraged me to keep going, especially when it seemed there was no way to go.

Ceduna is where everything started. It was a chilly morning when my mobile rang. Tauto Sansbury, then CEO of the Ceduna Koonibba Aboriginal Health Service, was on the phone inviting me to go to Ceduna to discuss the project outline I had sent him a couple of weeks earlier. I was so happy that someone from the Aboriginal community was interested to discuss my thoughts and ideas. I would like to thank Tauto for opening the doors to me in the Aboriginal community controlled health sector and for providing ongoing guidance, especially in relation to the people who should be contacted, including CEOs, Directors and health professionals from the Aboriginal community controlled health services in South Australia. Thank you for making the time to meet a stranger that day and embrace this project since the very beginning. Since that day you haven't stopped supporting and encouraging me to keep going, especially when things seemed to go in the wrong direction. I am truly grateful for the friendship that we have developed over these years.

My deepest gratitude to John Singer who opened the doors to me in the Aṉangu Pitjantjatjara Yankuntjatjara lands. I would have never been able to embark upon this endeavour without your ongoing support and guidance. I am honoured to walk your country, to feel your land and breathe the sunlight that makes the land an ever-changing coloured living canvas. I am privileged to have met you that day in Alice Springs and, since then, shared every step of this project with you. Thank you for helping me liaise with the ngangkaṟi and to have supported our ngangkaṟi meetings. A special thank to Nganampa Health Council that has funded our ngangkaṟi meetings over the last two years. Nganampa Health Council's financial support has been vital to sustain the process of self-determination through which the ngangkaṟi from the APY Lands have developed and established their own Aṉangu Ngangkaṟi Tjutaku Aboriginal Corporation. A huge thank to Nganampa Health's staff for providing me with invaluable support every time I travelled to the APY Lands, particularly Dr Peter Bennet, David Busuttil, Markus Roth and Denise Smith. Many thanks to Robert Stevens, chairperson of Kaltjiti-Fregon community, who provided ongoing support to hold our ngangkaṟi meetings in the Council's community room. I would like also to thank APY for providing the venue to hold some of our ngangkaṟi meetings at Umuwa.

I am very grateful to everyone who helped me with accommodation and travelling across South Australia. This project has been conducted with very limited resources. None of the academic, research and governmental institutions approached provided the necessary funding to undertake this project. It is friends and people progressively met during the interview process that made this project possible by offering lifts and accommodation across the state. My deepest gratitude to David and Rochelle Baker who provided me with a home to stay in Adelaide for over four years; thank you for being a family to me. I will always cherish the time, chats, laughs and the beautiful dinners we had together. Thank you also to Noni and Matt Creasey for welcoming me in their place in Adelaide over the last year; you've always made me feel at home and made my stay very cheerful. A special thanks to Fiona and Cephas Stanley who

supported me every time I travelled through Port Augusta. Thanks Fiona for the numerous lifts you gave me to Coober Pedy and for introducing me to Gwen and Jack Crombie who provided extraordinary support with travelling and accommodation in Fregon. I am very grateful to Gwen and Jack for looking after me every time I travelled to the APY Lands; thank you for introducing me to community members and some of the ngangkaṟi from different communities. I will never forget the stories, chats and laughs we shared on the veranda and the long drives across the lands.

A special thanks to Rosanne McInnes for her unconditional support and significant contribution to this report. I remember when Rameth Thomas introduced us in Coober Pedy. At that time I wasn't really sure whether, and how, a magistrate could have any interest in what I was trying to do. But you believed in the significance of this project straight away and opened a window on an unexplored area worthy of thorough investigation. Always there for me – a friend to confide in, an expert to learn from, always providing invaluable support with accommodation and travel across the state by picking me up and dropping me off from one corner to the other of South Australia. I will always treasure the memories and friendship we share. And a heartfelt thanks to Michael Amos who has been an invaluable friend during our travels to the APY Lands, interpreting and helping me understand the multilayered depth of Aboriginal culture and languages.

A huge thank to Carole Varey for welcoming me in her place and continuing to provide me with somewhere to stay in Fregon. Thanks to Trish Jenner, Tom Redwood, Brian Dodson, Natalia Ipince for hosting me in their place during my visits in Fregon and Umuwa. A huge thanks to the APY's anthropologist team for helping me with travel and accommodation advice, particularly Andrew Cawthorn, Natalia Ipince, Caro Macdonald, Thiago and Belinda Oppermann.

I am very grateful to the Aboriginal Health Council of South Australia and its Aboriginal Health Research Ethics Committee to have accepted the project and provided the ethics clearance. A particular thanks to Alwin Chong who helped me through the application process and provided great support, especially in the first stages of the project. Thank you to Leonard Miller and Rameth Thomas for looking after me and driving me around to undertake the interviews in Coober Pedy. A huge thanks also to Patricia Gunter and her family to have always made feel me at home every time I travelled to Ceduna and stayed in your beautiful place.

The writing of the report has also had its challenges. I remember a day of great distress sitting in my office, headphones on to transcribe the interviews, a pile of assignments to mark, lectures to prepare, and one thought in my mind – "I won't make it, I can't make it, how am I going to do this? It's gonna take forever to transcribe all these interviews..." A knock on the door; two of my Master's students came in and it didn't take that long for them to realise how I was feeling that day. My deepest gratitude to Belinda Marchesiello, Stefania Bocchi and Tiffany Tan who volunteered to help me transcribe the interviews. Many thanks to Beth Norris and Nicoletta Romeo who also helped to transcribe some of the interviews; thanks to Joseph Spinella who helped me with the tables and graphs of the report. A special thanks to Dr Maureen Palmer who helped me during the transcribing process to better understand and clarify medical terms and concepts. Thank you all for your time and generosity, I will never forget it.

My heartfelt gratitude to Grace Nelligan who offered unconditional support throughout the entire development of this project. I am deeply grateful for the time and work you have generously donated to make this report come to life. Thank you for the design and formatting and proofreading of the report.

Thanks to Loris Armellini who designed the digital version of the logo of the Aṉangu Ngangkaṟi Tjutaku Aboriginal Corporation. A huge thank to Kim Spurway who read the draft report and provided useful feedback. A special thanks to Beatrice Rispoli for her unconditional support and encouragement, particularly in times of uncertainty. You helped overcome those setbacks that made this project seem impossible to realise. I am thankful to Joanna Richardson who provided legal advice during the development of the Rulebook of the Aṉangu Ngangkaṟi Tjutaku Aboriginal Corporation.

I am very fortunate to have a wonderful family who has always supported me in any possible way. Thanks to my mum and dad who are always there for me. A huge thanks to my brother Alberto who developed the website for the Aṉangu Ngangkaṟi Tjutaku Aboriginal Corporation despite his very busy life. My deepest gratitude to my sister Elisabetta for her unconditional love and support. I would have never been able to write this report without her emotional, moral and financial support. I will never forget what you did for me to make my dream come true.

Finally, my heartfelt gratitude to all the ngangkaṟi who participated and continue to be part of this endeavour. I am very grateful to all of you for welcoming me into your country, sharing your stories and continually teaching me your "way", Aṉangu way. This report speaks your truth and breathes your thoughts. This is our project. This is our vision. Thank you.

Acronyms

ACCHS: Aboriginal Community Controlled Health Service

ACT: Amazon Conservation Team

AHCSA: Aboriginal Health Council of South Australia

AHD: Aboriginal Health Division

AHF: Aboriginal Healing Foundation

AHS: Aboriginal Health Service

AHW: Aboriginal Health Worker

AWBSW: Aboriginal Well-Being Support Worker

AMA: Australian Medical Association

ANTAC: Aṉangu Ngangkaṟi Tjutaku Aboriginal Corporation

AO: Aboriginal Organization

APY: Aṉangu Pitjantjatjara Yankunytjatjara

ASOMI: Asociación de Mujeres de la Medicina Tradicional La Chagra de la Vida

CAM: Complementary and alternative medicine

CEO: Chief Executive Officer

CDHS: Ceduna District Health Services

CKAHS: Ceduna Koonibba Aboriginal Health Service

COAG: Council of Australian Governments

DoHA: Department of Health and Ageing

H: Hospital

HFA: Health Funding Authority

ICESCR: International Convention on Economic, Social and Cultural Rights

MHW: Mental Health Worker

NA: National Agreement

NAHO: National Aboriginal Health Organization

NAO: Non-Aboriginal Organization

NIRA: National Indigenous Reform Agreement

NP: National Partnership Agreement

OATSIH: Office of Aboriginal and Torres Strait Islander Health

OVHS: Oak Valley Health Service

PAHO: Pan American Health Organization

PLAHS: Port Lincoln Aboriginal Health Service

RAH: Royal Adelaide Hospital

RRMHS: Rural Remote Mental Health Service

SA: South Australia

TCAM: Traditional, Complementary and Alternative Medicine

THS: Tullawon Health Service

TM: Traditional Medicine

UMIYAC: Union de Medicos Indigenas Yageceros de la Amazonia Colombiana

UN: United Nations

UNCESCR: United Nations Convention on Economic, Social and Cultural Rights

UNDRIP: United Nations Declaration on the Rights of Indigenous Peoples

UTHS: Umoona Tjutagku Health Service Aboriginal Corporation

WHO: World Health Organization

WIES: Weighted Inlier Equivalent Separations

WPRO: Western Pacific Regional Office

List of Tables

Foreword
Tauto Sansbury

I have keenly followed Francesca's progress with the massive task of researching and producing this comprehensive report on Aboriginal traditional medicine since our initial meeting in 2009, when I was Chief Executive Officer of Ceduna Koonibba Aboriginal Health Service.

The research she has undertaken has been extensive, and I believe the findings of Hand-in-Hand and its recommendations, provide the foundation upon which we can build to ensure that ngangkari receive both long-overdue recognition for their expertise and inclusion in the mainstream healthcare system.

Nangkari play a significant role in meeting the health needs of Indigenous Australians, and the harmonisation and integration of traditional medicine in the provision of holistic health care to Indigenous peoples in South Australia and further afield must be a priority.

By committing to the above, we will be well placed to achieve the best possible health outcomes for Indigenous Australians and be further enabled to close the gap in Indigenous disadvantage.

Executive Summary

Notice

Aboriginal and Torres Strait Islander people are advised that this report contains references to people who have since passed away.

The United Nations Declaration on the Rights of Indigenous Peoples recognises that 'Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals' (art. 24.1). The World Health Organization (WHO) acknowledges that traditional medicine (TM) has played a fundamental role in primary health care for thousands of years and continues to be an essential component of public health around the world. Accordingly, the WHO has taken a leading role in setting international standards for the development of international and national health policy frameworks and implementation strategies on traditional medicine worldwide.

In light of the international policy development and increasing use of traditional medicine on a global scale, this report poses a fundamental question: what is the status of traditional medicine in Australia? The international literature ranks Australia as 'high' – in a scale of the global level of utilization of traditional medicine – and considered to be at an advanced stage of policy development in 'traditional, complementary and alternative medicine' (TCAM). This report disputes this positioning and argues that Australia sits at the end of that spectrum occupied by countries in which the policy process on TM has not yet started. This argument is grounded on the analysis of data provided in the international literature which exclusively refers to the legal recognition, regulation and financing of Chinese traditional medicine in Australia, but has no relation whatsoever to the only traditional medical system which fulfils the WHO's definition of TM in Australia, that is Aboriginal traditional medicine:

> Traditional medicine is the sum total of knowledge, skills and practices on holistic health care, which is recognised and accepted by the community for its role in the maintenance of health and the treatment of diseases. Traditional medicine is based on the theories, beliefs and experiences that are indigenous to the different cultures, and that is developed and handed down from generation to generation *(WHO/WPRO 2000a: 29)*

Thus, if 'traditional medicine exclusively refers to the indigenous health traditions of the world, in their original settings' *(Bodeker and Burford 2007: 9)*, what is the status of Aboriginal traditional medicine in Australia? This report examines the overarching Commonwealth and Council of Australian Governments' (COAG's) legal and policy framework to determine whether, and the extent to which, Aboriginal traditional medicine is recognised as a legitimate traditional medical system in Australia. The legal and policy analysis identifies a foundational flaw: the neglect of Aboriginal traditional medicine in the current national Aboriginal and Torres Strait Islander health policy agenda. This flaw requires investigation of the root causes which underly the neglect of Aboriginal traditional medicine. The report provides an in-depth analysis of the conceptual underpinnings on which the COAG's Closing the Gap health policy agenda rests and it identifies two root causes: a limited application of the human rights approach to the Closing the Gap Indigenous health policy agenda; and the predominance of the epistemological foundations of western medicine *vis-à-vis* Aboriginal traditional medicine.

The limited application of a human rights approach to the Closing the Gap Indigenous health policy agenda refers to the absence of key international standards defining Indigenous peoples' right to health, that is articles 24.1 and 31. Article 24.1 recognises that 'Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals'. The right of Indigenous peoples to practice their

traditional medicine is entwined with article 31 which stipulates that 'Indigenous peoples have the right to maintain, control, protect and develop their cultural heritage, traditional knowledge and traditional cultural expressions, as well as the manifestations of their sciences, technologies and cultures, including human and genetic resources, seeds, medicines, knowledge of the properties of fauna and flora, oral traditions...' and that '[i]n conjunction with indigenous peoples, States shall take effective measures to recognize and protect the exercise of these rights'.

Australia's disregard of Aboriginal traditional medicine in the national Indigenous health policy agenda contravenes articles 24.1 and 31. The current Australian government Closing the Gap policy reform agenda fails to acknowledge the same existence of Aboriginal traditional medicine; it dismisses the body of traditional medical knowledge embedded within the Aboriginal system of medicine passed down from generation to generation for thousands of years; it fails to consider the potential role that the promotion of Aboriginal traditional medicine can have on the health status of Aboriginal and Torres Strait Islander people and their communities; it does not consider the potential contribution that the inclusion of Aboriginal traditional medicine in a two-way health care model can make in 'closing the gap'.

The predominance of the epistemological foundations of western medicine *vis-à-vis* Aboriginal traditional medicine is identified as the second root cause underlying the disregard of Aboriginal traditional medicine in Australia's current Indigenous health policy. The report provides a comparative analysis of the epistemological foundations of western medicine *vis-à-vis* traditional medicine to demonstrate how the prevalence of western science-based medicine and the discount of Aboriginal traditional medicine are rooted in a process of colonization at the epistemological level. The creation of a temporal linear progression from a 'primitive' Aboriginal traditional medicine to the modern science-based biomedical model has crystallised, invalidated and relegated Aboriginal traditional medicine to a place of non-existence. The dismissal of Aboriginal traditional medicine replicates a process of epistemological colonization whereby a new *terra nullius* is created and reproduced in Australia's current Indigenous health policy, blind to the thousands-year-old Aboriginal medical system.

In light of the identified neglect of Aboriginal traditional medicine in Australia's current legal and policy frameworks, this report investigates whether, and the extent to which, Aboriginal traditional medicine is still practiced. The analysis adopts a statewide approach to provide a case study on whether, how, and the extent to which, Aboriginal traditional healers continue to practice their traditional medicine in their communities and within the mainstream health care system. The enquiry draws on a wide range of interview data undertaken across mainstream and Aboriginal community controlled health services in remote, rural and urban communities, federal and state government departments, the criminal justice system, and different Aboriginal and non-Aboriginal organizations and institutions in South Australia.

The findings of this enquiry identify key issues, challenges and advantages of current arrangements for the provision of ngangkaṟi[1] services across South Australia. Evidence demonstrates that the provision of ngangkaṟi healing services has a range of benefits. These include: positive health outcomes for patients; provision of a holistic two-way health care model and a collaborative team-based approach to Aboriginal health; building community trust in the western health care system; increasing cost-effectiveness of health care; reducing cases of misdiagnosis; enhancement of quality health care; calming effects on patients; enhancing compliance with western medical treatments.

1 Ngangkaṟi are the Aboriginal traditional healers – men and women – from the Pitjantjatjara, Yankunytjatjara, Ngaanyatjarra Aboriginal language groups from Central Australia. In this report the terms Aboriginal traditional healers and ngangkaṟi are used interchangeably as the ngangkaṟi from the APY Lands participated in this project. This report acknowledges other Aboriginal traditional healers from different language groups who practice their traditional medicine across Australia.

The key issues and challenges identified in current arrangements for the provision of ngangkaṟi interventions include: recognition of Aboriginal traditional healers as legitimate health practitioners; the need of a process of accreditation equipped with accreditation, qualifications and registration standards; need of a register of accredited ngangkaṟi; lack of a consistent payment schedule and payment process; need of educational programs for western health practitioners on the role and practices of ngangkaṟi; lack of a systematic data collection process and database on ngangkaṟi interventions; lack of a state-wide policy framework.

This report provides a systematic response to the issues and challenges identified in the current arrangements for the provision of ngangkaṟi services across South Australia. It proposes a new statewide policy framework which builds on the strengths of current arrangements and untangles the identified hindrances. The proposed policy framework establishes a two-way health care model to guarantee the systematic provision of Aboriginal traditional healing hand-in-hand with western medicine. The new statewide policy framework is grounded on six core constitutive components in line with the report's recommendations:

1. The Aṉangu Ngangkaṟi Tjutaku Aboriginal Corporation as the central body for the coordination, administration and delivery of ngangkaṟi services;
2. A ngangkaṟi accreditation process with qualification, accreditation and registration standards for the recognition of ngangkaṟi as legitimate health practitioners;
3. A Register of accredited ngangkaṟi;
4. A ngangkaṟi employment scheme grounded on a state-based model;
5. A systematic database on ngangkaṟi interventions;
6. Introduction of health professional training and development modules on the role of ngangkaṟi in health care.

This statewide policy framework builds on the body of evidence of this enquiry and encapsulates a new Aboriginal corporation established by the Aboriginal traditional healers from the Aṉangu Pitjantjatjara Yankunytjatjara Lands: the Aṉangu Ngangkaṟi Tjutaku Aboriginal Corporation (ANTAC). The Aṉangu Ngangkaṟi Tjutaku Aboriginal Corporation is founded on the principle of self-determination, embodies the voice of the Aboriginal traditional healers from the APY Lands and aims to operate within a two-way health care system.

This report establishes the foundations for the recognition of Aboriginal traditional medicine in Australia's Aboriginal and Torres Strait Islander health policy. The proposed statewide policy framework aims to consolidate a two-way health care model to ensure the systematic provision of Aboriginal traditional medicine hand-in-hand with western medicine. The policy framework not only aligns Australia with international legal standards and the international public policy agenda on Indigenous peoples' traditional medicine, but also advances current Australian governments' principles and strategies on Aboriginal and Torres Strait Islander health. In particular, it advances the development of a holistic *National Aboriginal and Torres Strait Islander Health Plan*; it integrates the Closing the Gap policy framework and potentially contributes to closing the gap in Indigenous health outcomes; it aligns with Australia's economic development and economic participation strategy for Aboriginal and Torres Strait Islander people; it provides a model to increase cost-effectiveness in Aboriginal health with the potential reduction in health care expenditure.

Recommendations

Closing the Gap and Aboriginal Traditional Medicine

Recommendation 1: It is recommended that Aboriginal Traditional Medicine be included in Australia's national Closing the Gap health policy agenda pursuant to articles 24.1 and 31 of the United Nations Declaration on the Rights of Indigenous Peoples.

Recommendation 2: It is recommended that Aboriginal Traditional Medicine be recognised as a legitimate system of traditional medicine based on its own traditional knowledge system, philosophical underpinnings, educational and training model. The legitimacy of Aboriginal traditional medicine should not be assessed against the criteria, conceptual underpinnings, educational and training model of western medicine.

National Aboriginal and Torres Strait Islander Health Plan and Aboriginal Traditional Medicine

Recommendation 3: It is recommended that Aboriginal Traditional Medicine be included in the *National Aboriginal and Torres Strait Islander Health Plan*. The integration of Aboriginal Traditional Medicine aligns with the fundamental principles of the *National Aboriginal and Torres Strait Islander Health Plan*.

National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well-Being and Aboriginal Traditional Medicine

Recommendation 4: It is recommended that the review of the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being 2004-2009* includes Aboriginal Traditional Medicine and Aboriginal traditional healers in the new national policy framework, strategies and implementation plans.

Commonwealth funding

Recommendation 5: It is recommended that the Commonwealth government strengthen funding agreements in partnership with the South Australian government to support the systematic provision of Aboriginal traditional healers interventions in the South Australian health care system.

South Australia: Policy development on Aboriginal Traditional Medicine

Accreditation, qualification and registration

Recommendation 6: It is recommended that Aboriginal traditional healers themselves determine the process of accreditation, qualification and registration according to their traditional medical knowledge system. Qualification, accreditation and registration standards should align with their traditional educational and training model, rather than the western bio-medical model.

Rates and payment schedule

Recommendation 7: It is recommended that a consistent fee-for-service payment schedule for ngangkari services be established and applied within the South Australian health care system. The fee-for-service payment schedule should be negotiated in partnership with the ngangkari, Aboriginal community controlled health services and mainstream health services.

Ngangkaṟi services in South Australia

Adelaide metropolitan area

A. Public Hospitals: Organization, coordination and management of ngangkaṟi services

Recommendation 8: It is recommended that the Aboriginal Liaison Units in Adelaide hospitals be directly involved in the organization, coordination and management of ngangkaṟi services. Aboriginal Liaison Units should be engaged in a substantial way to facilitate an effective and efficient provision of ngangkaṟi services to Aboriginal inpatients and Aboriginal discharged patients in their communities. The inclusion of ngangkaṟi in the *Aboriginal Patient Journey Program* should be considered as a potential strategy to strengthen the provision of culturally appropriate care to Aboriginal patients.

Recommendation 9: It is recommended that a central body be identified and endowed with the responsibility to coordinate, organize and manage the delivery of ngangkaṟi services across the hospitals in Adelaide metropolitan area. The central body should function as the primary interface between the Aboriginal Liaison Units and ngangkaṟi to ensure a systematic and coordinated provision of ngangkaṟi services to inpatients and discharged patients requesting ngangkaṟi health care.

Recommendation 10: It is recommended that Aboriginal Liaison Units establish a database to document patients' requests of ngangkaṟi and ngangkaṟi services provided. The database would provide a baseline to develop an evidence-based assessment of the demand for ngangkaṟi and typology of ngangkaṟi services provided. The database would also constitute a valuable resource for funding purposes.

Recommendation 11: It is recommended that a set of measures be established to improve Aboriginal Liaisons Units' access to Aboriginal traditional healers. These measures include: a) establishment of a consistent and systematic communication channel between the Aboriginal Liaison Units and the Aboriginal traditional healers; b) setting up of a Register of qualified ngangkaṟi available to provide ngangkaṟi services across hospitals in Adelaide metropolitan area.

Recommendation 12: It is recommended that Adelaide hospitals' Aboriginal Liaison Units be allocated adequate financial resources to provide a consistent ngangkaṟi health care service to Aboriginal and Torres Strait Islander patients.

The 30% Aboriginal WIES supplement could be considered as a potential source of funding to support ngangkaṟi services within the hospitals as part of hospitals' culturally appropriate health care support for Aboriginal and Torres Strait Islander patients.

B. Issues and challenges in Adelaide metropolitan area

Central body

Recommendation 13: It is recommended that a central body be established to coordinate the provision of ngangkaṟi services in Adelaide metropolitan area. The central body should ensure a coordinated and systematic approach to the provision of ngangkaṟi services across health care services and any other organizations requesting ngangkaṟi interventions. The central body should be identified in direct consultation with the ngangkaṟi.

Ngangkaṟi clinic

Recommendation 14: It is recommended that a ngangkaṟi clinic be established in Adelaide. The ngangkaṟi clinic should be structured in accordance with culturally appropriate criteria established by Aboriginal traditional healers. In the short term, existing facilities, such as Step Down units, could be used to accommodate ngangkaṟi during their visits in Adelaide metropolitan area.

Issues and challenges in South Australia

Qualification, accreditation and registration

Recommendation 15: It is recommended that a process of accreditation be established in order to ensure the identification of qualified ngangkaṟi who have acquired their knowledge and skills through the Aboriginal traditional educational and training system.

Recommendation 16: It is recommended that ngangkaṟi determine the process of qualification, accreditation and registration. The qualification, accreditation and registration standards should be in accordance with *ngangkaṟiku Tjukurpa* - ngangkaṟi Law - and its traditional education and training system.

Recommendation 17: It is recommended that a Register of accredited ngangkaṟi be established. The Register should include the ngangkaṟi who are accredited as legitimate health practitioners according to the qualification, accreditation and registration standards in accordance with *ngangkaṟi Tjukurpa* and its educational and training system.

The Register of ngangkaṟi should include all relevant information about the accredited ngangkaṟi as to allow individuals and organizations to make an informed choice about the most appropriate Aboriginal traditional healer to request.

Recommendation 18: Ngangkaṟi should hold the responsibility to develop and administer the Register of accredited ngangkaṟi.

Ngangkaṟi employment scheme and payment process

Recommendation 19: Ngangkaṟi employment scheme

It is recommended that a ngangkaṟi employment scheme be established within the South Australian health care system. The ngangkaṟi employment scheme should guarantee a fair remuneration for ngangkaṟi as legitimate traditional health care practitioners.

The ngangkaṟi employment scheme should be anchored to a three-fold structure:

1. Contract employees: remuneration based on a fee-for-service payment schedule;

2. Full-time employees: remuneration based on an employment standards scheme;

3 Part-time employees: remuneration based on a fractional employment standards scheme.

The ngangkaṟi employment scheme should be negotiated in partnership with the ngangkaṟi, relevant government departments, mainstream and Aboriginal community controlled health services.

Recommendation 20: Payment process

It is recommended that a consistent payment process be established to remunerate ngangkaṟi for the provision of their healing services. The payment process should be developed in line with the ngangkaṟi employment scheme and the financial requirements of the health care system.

The payment process should be negotiated in partnership with the ngangkaṟi, relevant government departments, mainstream and Aboriginal community controlled health services.

Recommendation 21: Ngangkaṟi employment scheme and payment process models

The establishment of a ngangkaṟi employment scheme and payment process can be based on two models: a state-based model and a federal-based model.

State-based model: Introduction of a ngangkaṟi employment scheme and payment process negotiated and agreed by ngangkaṟi, relevant federal and state departments, mainstream and Aboriginal community controlled health services. The state-based model could include the introduction of a 'ngangkaṟi provider number' for accredited ngangkaṟi to facilitate the application of a consistent and systematic statewide payment process.

Federal-based model: Introduction of a ngangkaṟi employment scheme and payment process within the national Medicare system. The Medicare model could entail the introduction of an 'Aboriginal traditional healer provider number' for accredited Aboriginal traditional healers and the development of a payment process in line with the Medicare system.

The state-based model could be introduced in South Australia in the short term and provide a pioneering model for the development of a federal-based model in the long term.

Recommendation 22: It is recommended that the introduction of a state-based or federal model should respect and align with a community-driven approach to the provision of ngangkaṟi services.

Database on ngangkaṟi interventions

Recommendation 23: It is recommended that a consistent database on ngangkaṟi interventions be developed within mainstream and Aboriginal health care services across South Australia. The database would contribute to create an evidence-based dataset on ngangkaṟi episodes of care; provide relevant information in relation to the role of ngangkaṟi in the health care system; develop a more comprehensive patient history according to a two-way culturally appropriate health care model.

Health professional training and development

Recommendation 24: It is recommended that educational programs on the role of ngangkaṟi in health care be introduced into health professional training and development statewide. Training modules for health professionals can contribute to bridge the 'knowledge gap' between western medical practitioners and Aboriginal traditional practitioners. An enhanced reciprocal understanding is fundamental for the delivery of an effective two-way health care model.

The new statewide policy framework

Recommendation 25: It is recommended that a new statewide policy framework be adopted to guarantee the systematic provision of ngangkaṟi services across South Australia. The policy framework establishes a two-way health care model based on six constitutive components:

1. The Aṉangu Ngangkaṟi Tjutaku Aboriginal Corporation as the central body for the coordination, administration and delivery of ngangkaṟi services;

2. A ngangkaṟi accreditation process with qualification, accreditation and registration standards for the recognition of ngangkaṟi as legitimate health practitioners;

3. A Register of accredited ngangkaṟi;

4. A ngangkaṟi employment scheme grounded on a state-based model;

5. A systematic database on ngangkaṟi interventions;

6. Introduction of health professional training and development modules on the role of ngangkaṟi in health care.

CHAPTER 1

Introduction

Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals

(United Nations Declaration on the Rights of Indigenous Peoples, art. 24.1)

1.1 Introduction: aims, scope and research questions

The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) recognises the right for Indigenous peoples to maintain and practice their traditional medicines under international human rights law. This report investigates the status of Aboriginal traditional medicine in Australia and assesses the extent to which Aboriginal traditional medicine is recognised and integrated in the health care system. The enquiry has a statewide focus and a defined scope: to provide an evidence-based analysis of whether, how and the extent to which Aboriginal traditional healers provide their healing practices within the health care system in South Australia. The state-based analysis establishes the foundations to further the status of Aboriginal traditional medicine in Australia and rectify the foundational gap in the current national Indigenous health policy: the neglect of Aboriginal traditional medicine.

Aboriginal traditional medicine consists of a complex and multilayered medical knowledge system passed down from generation to generation since time immemorial. It encompasses a holistic body of health-related knowledge, health belief system, educational and training model, methods of healing and treatment, and the use of medicinal plants. Aboriginal traditional medical knowledge and practices coexist in a web of interrelated relationships to maintain the health and well-being of individuals, families and communities. This report focuses on the role and practices of the Aboriginal traditional healers from the Aṉangu Pitjantjatjara Yankunytjatjara (APY) lands in the far northwest of South Australia. *Ngangkaṟi* is the term used to indicate Aboriginal traditional healers – men and women – from the Pitjantjatjara, Yankunytjatjara, Ngaanyatjarra Aboriginal language groups from Central Australia. In this report the terms Aboriginal traditional healers and ngangkaṟi are used interchangeably as the ngangkaṟi from the APY Lands participated and contributed to the development of this report.[1]

The aims of this report are as follows:

- document whether, how and the extent to which ngangkaṟi provide traditional healing services in the South Australian health care system;
- provide evidence of the current role of ngangkaṟi in clinical settings;
- identify the issues, challenges and strengths of current arrangements for the provision of ngangkaṟi services;
- develop a new statewide policy framework which establishes a two-way health care model to guarantee the systematic integration of Aboriginal traditional medicine hand-in-hand with western medicine;[2]
- propose the South Australian state-based model as a foundational platform for the recognition of Aboriginal traditional medicine as a legitimate complementary system of medicine in Australia.

There is a range of further research questions that have guided this enquiry. These include:

Legal and policy framework

What is the place of Aboriginal traditional medicine in Australia's legal and policy framework? Does the Closing the Gap Indigenous health policy agenda include Aboriginal traditional medicine and Aboriginal traditional healers?

1 This report acknowledges other Aboriginal traditional healers from different language groups who practice their traditional medicine across Australia.

2 In this report the term 'western medicine' is used interchangeably with 'allopathic medicine', 'mainstream medicine', 'science-based medicine' or 'bio-medicine'.

What is the current legal and policy framework in relation to the use of ngangkari in the South Australian health care system? Is there any state-based regulation or policy framework in regard to the provision of ngangkari services in South Australia? Does the South Australia Department of Health have a position on the current or potential provision of ngangkari services within the health care system?

Current data on ngangkari services

What data is available in relation to the provision of ngangkari services across South Australia? Do Aboriginal community controlled health organizations provide ngangkari services to their clients? Do mainstream health care services offer ngangkari services? Are there other organizations that provide these services? If ngangkari services are provided, is there any systematic data collection process? Is there any quantitative or qualitative data available on ngangkari services provided? Do health services or other organizations have specific resources allocated to provide ngangkari services? If so, what are the sources of funding and which are the funding bodies?

Current status of ngangkari in the South Australian health care system: perspectives from medical and health practitioners

Do medical and health practitioners know about ngangkari and their healing practices? Have there been any cases of collaboration between medical practitioners and ngangkari in clinical settings? If so, what is their perspective on the role and significance of ngangkari in the provision of health care to Aboriginal[3] people? What are the benefits and drawbacks? What is their perspective on a two-way health care model for the parallel provision of western medicine and Aboriginal traditional medicine?

Current status of ngangkari in the South Australian health care system: perspectives from ngangkari

Do ngangkari provide their healing services within the South Australian health care system? What is their level of engagement with western medical and health practitioners? What is their contribution to the health and well-being of Aboriginal people and communities? What kind of healing practices they provide and what are their methods of healing? What difficulties do they encounter in the delivery of their healing practices in clinical settings? How these difficulties can be overcome? What are their views on the development of a new two-way health care model whereby their healing practices are delivered hand-in-hand with western medicine?

Current status of ngangkari in the criminal justice system

Do ngangkari play any role in the criminal justice system? Do ngangkari provide healing services in correctional services? Is there a demand for ngangkari from Aboriginal people in custody? If so, are there any obstacles to provide prisoners with access to ngangkari? Are resources available to provide a fair remuneration to ngangkari for the provision of their healing services?

Patients' perspectives on ngangkari interventions

What are patients' experiences with ngangkari healing? What sorts of ailments have required ngangkari intervention? What are the health outcomes of ngangkari interventions? What are the benefits and the drawbacks experienced with ngangkari? What are Aboriginal community members' views on the role of ngangkari in their communities? What are their views and suggestions in relation to a new health care delivery model that could facilitate access to ngangkari?

A new statewide policy framework and two-way health care model

Drawing on collected data, would it be possible to develop a new statewide policy framework and two-way health care model to ensure the systematic provision of ngangkari services hand-in-hand with western medicine across South Australia? What would be the benefits of these policy framework and two-way health care model?

1.2 Methodology

The enquiry has adopted a methodology involving mixed methods research. This methodology entails the use of different data collection methods and the adoption of both qualitative and quantitative analysis to offset the weaknesses in the use of quantitative or qualitative methods alone *(Caracelli and Greene 1997; Tashakkori and Teddlie 2003; Creswell 2003; Creswell and Plano Clark 2007)*. The adoption of a mixed methods research is based

3 In this report the term 'Aboriginal' is used interchangeably with 'Aboriginal and Torres Strait Islander' and 'Indigenous'.

on three grounds: it offers a high degree of flexibility in order to address the multilayered set of research questions posed; it allows the ability to engage appropriately with the different research participants to capture their different perspectives; it allows the ability to analyse the range of different data gathered in this enquiry.

The methodology adopted in this enquiry includes legal research, policy analysis, qualitative interviews, quantitative analysis, focus groups, storytelling, and qualitative analysis of qualitative and quantitative data. This methodology has been primarily developed during the research process which dictated the most appropriate methods to tackle different issues, gather different typologies of data and engage with different participants.

1.2.1 Data collection methods

This enquiry has involved 145 participants from different backgrounds. A combination of data collection methods has been used to address the complexity of the research questions and to engage with the different participants involved in this enquiry. The methods of data collection have involved the gathering of secondary and primary data. These data collection methods include: a. *Primary data:* interviews; focus groups; storytelling; b. *Secondary data:* literature review.

Literature review

The literature review has provided an extensive range of secondary data. The literature review has involved an in-depth analysis of a wide range of sources, including books; academic journals; governmental and non-governmental reports; state, national, international legislative and policy documents, conference proceedings; case studies.

Interviews

This research has adopted qualitative unstructured and semi-structured interviews to collect primary data from different participants. Unstructured interviews have a flexible structure with minimal restrictions in relation to the wording and order of the open-ended questions contained in the interview schedule *(Sarantakos 2005: 268)*. Unstructured interviews were primarily used with the ngangkari in order to provide them with the opportunity to answer on their own terms and to raise any issues they may consider important. The interview schedule took the form of a concise list of key points of discussions. Semi-structured interviews contain elements of unstructured interviews and structured interviews *(Sarantakos 2005: 268)*. In this research, semi-structured interviews were based on the use of an interview guide with a list of questions and topics which needed to be covered during the interviews. However, semi-structured interviews allowed the ability to follow an open and informal interview style: the blending of set questions and open discussion provided interviewees with the opportunity to answer the questions while discussing and exploring new themes and ideas as they emerged. Semi-structured interviews were used with participants from mainstream health care service providers, Aboriginal community controlled health organizations, medical and health practitioners, senior administrators and policy officers in government departments and those no-health related organizations that had engaged with ngangkari for the provision of their healing services.

Focus groups

Focus groups, also referred to as 'focus group interviewing' *(Berg 1995)* or 'group discussion' *(Krüger 1998)*, were used to bring together the ngangkari from the APY Lands in order to facilitate group discussions among the ngangkari, brainstorm their ideas, create a mechanism of opinion formation and establish a decision-making process led by the ngangkari themselves.

The focus groups took the form of *ngangkari meetings* where several ngangkari from the APY Lands congregated. Numerous ngangkari meetings have been held in Fregon and Umuwa in the APY Lands. These meetings have provided a forum for dialogue, consultation and the vehicle for a ngangkari's decision making process. Ngangkari who participated in the ngangkari meetings have provided the foundations for the new statewide policy framework and two-way health care model proposed in this report.

Storytelling

The storytelling method was used to collect primary data on ngangkari interventions in clinical settings and communities. The storytelling method was used with three groups of participants: patients, community members, and ngangkari. Patients were asked to share their story of healing. Community members told their stories about the role of ngangkari in their community and the significance of their healing practices. Ngangkari

told their stories about their role and their healing in the communities and in clinical settings.

1.2.2 Data analysis methods

This research has primarily used qualitative analysis of qualitative and quantitative data. Qualitative data analysis embraces a wide range of different methods (Tesch 1990; Wolcott 1994; Fielding and Lee 1998). In this enquiry the qualitative data analysis was conducted during and after data collection. This combination has allowed conducting some basic analysis during the collection of data as to guide the research in the right directions and facilitate a comprehensive coverage of the issues and questions rose in the research. The qualitative analysis has utilised an open coding process that involves a flexible labelling of data to identify conceptual patterns and meanings. The open coding has been conducted utilising the computerised program NVivo 9.

1.2.3 Participants

This report has involved 145 participants. Participants were selected using a combination of purposive and snowball sampling processes. The author adopted a purposive sampling technique to select key participants who were relevant to the project based on their knowledge and expertise. Snowball sampling was utilised to reach out other people who could be willing to participate in the project. The author asked the key participants to recommend other people with knowledge and expertise in different aspects of the inquiry.

The enquiry has involved the following participants:

- Aboriginal Health Council of South Australia (AHCSA);
- Aboriginal Community Controlled Health Services members of AHCSA;
- Senior administrators and policy officers in relevant state and federal government departments;
- Western medical and health practitioners from mainstream health care service providers and Aboriginal community controlled health services;
- Ngangkari from the Anangu Pitjantjatjara Yankunytjatjara (APY) lands;
- Patients and community members;
- Officers in criminal justice system and correctional services;
- Officers in non-health Aboriginal and mainstream organizations providing ngangkari services.

The complete list of participants is shown in Appendix 1.

1.2.4 Ethics clearance

This research project was approved by the Aboriginal Health Research Ethics Committee of the Aboriginal Health Council of South Australia and the University of New South Wales Human Research Ethics Committee.

1.2.5 Funding

This project has been self-funded by the author except for an initial grant of $2,800 provided by the UNSW in 2009. This grant enabled the first round of consultations with some stakeholders across South Australia in 2009.

1.3 Structure of report

This report is structured into eight chapters, an executive summary and recommendations.

Chapter 1 provides an overview of the aims, scope, methodology and structure of the report. It introduces the key research questions that have guided this enquiry and it explains the data collection and data analysis methods.

Chapter 2 provides a comprehensive overview of the status of Traditional Medicine around the world and in Australia. It discusses definitional issues associated with Traditional Medicine (TM) in international public health. It provides evidence of the current role traditional medicine plays in public health care, and discusses the increasing demand and use of traditional medicine worldwide. The chapter provides a policy analysis of international, regional, national and local initiatives that integrate traditional medical systems with the western biomedical model. The chapter discusses the status of traditional medicine in Australia and denounces the neglect of Aboriginal traditional medicine in the international context and within Australia's domestic boundaries.

Chapter 3 analyses the legislative and policy framework of Aboriginal traditional medicine in Australia. It discusses the foundational causes of the neglect of Aboriginal traditional medicine in the current national Closing the Gap Indigenous health policy agenda and urges the Council of Australian Governments to rectify the disregard of Aboriginal traditional medicine. The chapter also provides a legal and policy analysis of the status of Aboriginal traditional medicine and Aboriginal traditional healers in South Australia. This analysis identifies the main issues and challenges of the current legislative and policy development.

Chapter 4 provides an in-depth analysis of the provision of ngangkari services in South Australia. The chapter is structured in four sections. Section one discusses the provision of ngangkari services in rural and remote areas; section two analyses the provision of ngangkari services in Adelaide metropolitan area; section three explores the provision of ngangkari services in the South Australian criminal justice system; section four identifies and discusses the issues and challenges of current arrangements for the provision of ngangkari services in South Australia.

Chapter 5 examines the relationship between western medical practitioners and ngangkari in clinical settings within the South Australian health care system. The chapter is structured in three main sections: the doctor-ngangkari relationship, the ngangkari-patient relationship, and the patient-doctor relationship. This tri-party relationship stands at the core of the encounter between western medicine and Aboriginal traditional medicine.

Chapter 6 provides a collection of stories of healing as told by Aboriginal and non-Aboriginal patients, community members, health professionals and staff from different organizations. The stories of healing have been reported in their full account as told by the interviewees. They include cases of reproductive and maternal health, child health, palliative care, grieving, physical pain, cancer, mental health, spiritual disorders and other episodes of care.

Chapter 7 provides an overview of *ngangkariku Tjukurpa*, that is the Law that governs ngangkari traditional medical knowledge system, its educational and training model, methods of healing and treatment, and the code of conduct by which ngangkari abide. It illustrates the role of ngangkari in health care, ngangkari's perspectives on western medicine and western health practitioners, and what ngangkari consider being the way forward for the actual implementation of a two-way health care model.

Chapter 8 proposes a new statewide policy framework which establishes a two-way health care model to guarantee the systematic provision of Aboriginal traditional medicine hand-in-hand with western medicine. The chapter explains the constitutive components of the proposed framework and elucidates its far-reaching benefits.

CHAPTER 2

Traditional Medicine

2.1 Traditional medicine in the international context

What is 'traditional medicine'? What does the term 'traditional medicine' encompass? What is the place of traditional medicine in the international public health policy agenda? The World Health Organization (WHO) has taken a leading role not only identifying the meaning and role of traditional medicine, but also assisting and guiding the development of policies, guidelines and research methodologies on traditional medicine worldwide (WHO 2000; 2001;2002a; 2002b; WHO/WPRO 2000a; 2000b; 2002; 2007; 2012). The World Health Organization defines traditional medicine as follows:

> Traditional medicine is the sum total of knowledge, skills and practices on holistic health care, which is recognised and accepted by the community for its role in the maintenance of health and the treatment of diseases. Traditional medicine is based on the theories, beliefs and experiences that are indigenous to the different cultures, and that is developed and handed down from generation to generation *(WHO/WPRO 2000a: 29)*

Further, in its attempt to articulate a comprehensive working definition of traditional medicine, the World Health Organization (2002a:7) emphasizes how the diversity of Indigenous knowledge systems requires to take into account the range of 'health practices, approaches, knowledge and beliefs incorporating plant, animal, and/or mineral based medicines, spiritual therapies, manual techniques and exercises applied singularly or in combination to maintain well-being, as well as to treat, diagnose or prevent illness'.

It is important to consider that 'traditional or Indigenous medicine' refers to a broad and diversified spectrum of traditional medical systems in terms of knowledge base, practices and training methods *(WHO 2000; 2002a; Martin-Hill 2003; 2010; Maar and Shawande 2010)*. At one end of the spectrum, traditional medicine can be formally and systematically codified and regulated; it can be openly practiced and publicly taught through specific medical institutions (eg Chinese medicine). At the other end of the spectrum, traditional medicine can be constituted of sacred knowledge passed on orally from generation to generation, such as in most of Indigenous peoples' medical systems. In this case, traditional medical knowledge has a secretive and mystical character; it can be geographically very localized, and it can incorporate physical and supernatural dimensions, such as physical symptoms and the intervention of supernatural forces *(WHO 2002a: 7)*.

In terms of terminology, 'traditional medicine' is used to 'exclusively refer to the indigenous health traditions of the world, in their original settings' *(Bodeker and Burford 2007: 9)*. However, in some countries the terms 'traditional medicine' *(TM)* and 'complementary and alternative medicine' *(CAM)* are used interchangeably or combined under the term 'traditional, complementary and alternative medicine' *(TCAM)*. The World Health Organization defines 'complementary and alternative medicine' *(CAM)* as 'a broad set of health care practices that are not part of the country's own tradition and are not integrated into the dominant health care system' *(Bodeker et al 2005: xii)*. Sometimes CAM is also referred to as 'parallel' or 'non-conventional' medicine *(WHO 2000a: 1; 2002: 7; Bodeker et al 2005: xii)*.

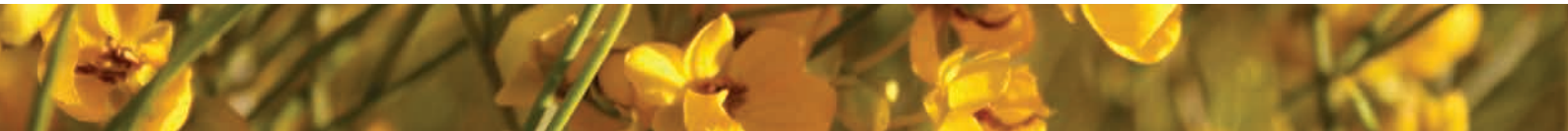
Traditional medicine plays a significant role in public health care worldwide. The WHO acknowledges that:

> Traditional medicine has an established promotive, preventive, curative and rehabilitative role with varying emphasis in different countries. It can be the main form of health care, or an integrated component of the mainstream health care, or an alternative or complementary to the main form of health care in the countries...*(WHO/WPRO 2000a: 30)*

Traditional medicine *(TM)* has played a fundamental role in primary health care for thousands of years *(WHO 2001; Bodeker et al*

2005; WHO/WPRO 2012). In the last decades, the use of traditional medicine has increased drastically worldwide both in developing and developed countries *(WHO 1995; 2000a; 2001; 2002a; Bodeker et al 2005)*. In particular, the 1990s have witnessed a twofold trend: in developing countries, TM has maintained its key role in primary health care. For instance, in Ethiopia 90% of the population still rely on traditional medicine for primary health care, followed by India, Rwanda, Benin with 70%, and Tanzania and Uganda with 60% *(WHO 2002b)*. In many developed countries, where western medicine is predominant in the national health care systems, the use of TM – also referred to as 'complementary or alternative medicine' (CAM) has expanded exponentially. On average, almost half of the population uses some form of CAM, including Canada (70%), Australia (48%), France (49%), US (42%), and Belgium (31%) *(WHO 2002b; Bodeker and Kronenberg 2002; Bodeker et al 2005; Bodeker and Burford 2007)*.

This trend in the expansion of traditional medicine has seen an unparalleled development of international standards and methodologies for the research and evaluation of TM. To remedy such a gap, the World Health Organization has taken a primary role in international standards setting for the development of national health policy frameworks on traditional medicine. As a result, the articulation and implementation of the *WHO Traditional Medicine Strategy 2002-2005 (WHO 2002a)* generated a widespread interest on the potential of traditional medicine in countries around the world as to have a significant impact on the development of national health policy frameworks. In 2005, the *WHO Global Atlas of Traditional, Complementary and Alternative Medicine (Bodeker et al 2005)* brought together a worldwide body of evidence-based information on the use and practice of traditional, complementary and alternative medicine. The current state of TCAM around the world shows a rapidly evolving situation in terms of policy development, regulation, education, research, use and practices *(WHO 2001; Bodeker et al 2005; Bodeker and Burford 2007; WHO/WPRO 2012)*. At the one end of the spectrum, many countries have established regulatory systems with formal recognition, promotion and financing of TCAM, while others are in the process of articulating legislative, policy and financing systems and different degrees of



autonomy for different TCAM professions. At the other end of the spectrum, there are countries in which the process of recognition and regulation has not begun yet *(Bodeker et al 2005; Bodeker and Burford 2007)*. In those countries where a process of recognition, promotion and financing of TM has started, the degree of integration or complementarity between traditional medicine and western medicine in health care systems varies significantly. The next section provides a snapshot of cases from different countries around the world in which traditional medicine and western medicine are integrated within the health care system.

2.2 Traditional medicine[4] and western medicine: case studies of integration and harmonisation

The integration[5] of traditional medicine and western medicine constitutes an expanding trend around the world to meet the aspiration of universal primary health care and tackle the issues of accessibility, availability and affordability across different countries *(WHO 1995; 2001; 2002a; 2002b; Bodeker et al 2005; Bodeker and Burford 2007)*. The development of health care models and service delivery strategies to harmonize western medicine and traditional medicine are testament of this trend. The few cases discussed in this section exemplify current regional, national and local efforts to balance traditional and western medical systems.

In the Americas, the Pan American Health Organization (PAHO)[6] has taken a leading role in developing strategies to harmonise Indigenous health systems with the mainstream health system. The incorporation of Indigenous medicines, perspectives and therapies into primary health care is one of these strategies and part of PAHO's *Health of the Indigenous Peoples Initiative*. Since the *Health of the Indigenous Peoples Initiative* began in 1993, the health of Indigenous populations in the Americas and the need to develop policy frameworks and strategies to harmonise Indigenous traditional medical systems and the western medical system in the Americas have begun a priority *(PAHO 1999; 2000; 2002; 2003a; 2003b; 2005).*

In Canada, the National Aboriginal Health Organization (NAHO) *(2008)* plays a primary role in promoting Inuit, Métis and First Nations' traditional medicine *(Martin-Hill 2010)*. The range of issues explored and discussed includes the epistemological foundations of traditional medicine *(Martin-Hill 2003: 3-8)*; recognition and integration of traditional medicine in national, provincial and territorial policies and strategies *(NAHO 2008)*; integration in clinical settings *(NAHO 2008: 12-14; Maar and Shawande 2010: 18-27; Walker et al 2010: 58-67)*; traditional medicine practice and specialized fields *(Martin-Hill 2003: 8-10)*; the impact of colonization on Aboriginal health and traditional medicine as a form of decolonization *(Skye 2010: 28-37; Mæller 2010: 38-47; Tobin et al 2010: 49-57)*; holistic, cultural and spiritual dimensions of traditional medicine *(NAHO 2007; NAHO 2008; Martin-Hill 2003: 10-13)*; misappropriation of traditional knowledge and intellectual property rights *(NAHO 2008; Martin-Hill 2003: 14-18)*; and the role of traditional healers and development of codes of conduct *(Martin-Hill 2003: 24-30; NAHO 2008)*.

Findings of numerous healing programs, practices and interventions demonstrate the successful outcomes of the adoption of traditional healing in Aboriginal communities *(AHF 2006: 45)*. It is reported that 85.4% of the health programs under consideration (103 programs) used traditional healing by adopting different traditional interventions and therapies *(AHF 2006: 55)*. These include ceremonies and spiritual healing *(AHF 2006: 55-57)*; circles *(AHF 2006: 57-60)*; medicine wheel *(AHF 2006: 60-61)*; counselling by healers and elders *(AHF 2006: 61-63)*. Evidence shows that the use and integration of traditional healing in conjunction with the biomedical model are central to the success of health programs and healing strategies *(AHF 2006: 175-192; Maar and Shawande 2010)*. Traditional healing practices are considered to

4 The terms 'traditional medicine', 'Indigenous medicine', 'Indigenous traditional medicine' are used interchangeably.

5 The term 'integration' as it refers to the integration of traditional medicine and western medicine does not indicate 'assimilation' of traditional medical systems within western medicine. The term integration indicates the *harmonisation* or *complementarity* of traditional medicine with western medicine; its *inclusion* or *incorporation* in the mainstream health care system.

6 The Pan American Health Organization is the WHO's Regional Office for the Americas and the specialised agency of the Inter-American System. It comprises 35 state members across North, Central and South America.

play a fundamental role because they restore balance and 're-enforce the stronger aspects of self; begin developing weaker aspects of self; revive a sense of clarity, strength, vitality, desire for life, increased cultural pride, improved self-care, parenting and leadership' *(AHF 2006: 177)*.

In Colombia and Suriname, the Amazon Conservation Team (ACT) promotes and supports innovative programs to support the integration of traditional medicine and western medicine and the transmission of traditional medical knowledge from generation to generation *(ACT 2007; 2008; 2009; 2010; 2011)*.[7]

In Suriname, the ACT's traditional medicine integration and promotion program exemplifies a successful initiative focused on the promotion of effective traditional medicine and its integration into the national health care model. This program includes the establishment and support of traditional medicine clinics and the *'Shaman and Apprentice'* program. Traditional medicine clinics have been constructed in four Indigenous communities in the Southwestern region of Suriname: Peleletepu, Kwamalasamutu, Apetina and Gonini Mofo. A traditional hospital – *Supeniime* – has also been constructed in the village of Kwamalasamutu to provide long term health care to patients of nearby villages and camps:

> The hospital is seen as a model to provide improved health care based on traditional methods; serves as a means for shamans to transmit their knowledge to their apprentices; and is serving as a prototype that ACT expects to see replicated in other Amazonian locales *(ACT 2007)*

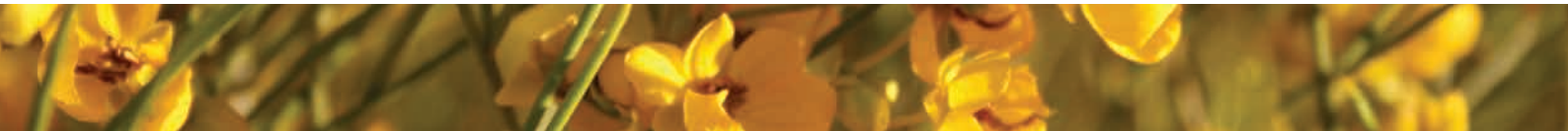
These traditional medicine clinics, built alongside western primary health care clinics, offer an unprecedented exchange for improving the healthcare of community members through the integration of traditional and western medicine. Tribal shamans (traditional healers) operate and direct these traditional medicine clinics in partnership with the western primary health care provider to the region. Since its inception in 2000, traditional healers have been restored to full honour in their communities.

The establishment of traditional clinics in these communities allows traditional healers to practice on equal footing with western-trained health workers and to play a fundamental role to maintain the health and well-being of their community members. The *Shaman and Apprentice* program is run in conjunction with the establishment and support of the traditional medicine clinics. The *Shaman and Apprentice* program prevents the disappearance of traditional medical knowledge by encouraging young apprentices to learn from the elder shamans and to preserve the knowledge of medicines from the Amazon rainforest. The program provides stipends and structured educational environments for younger tribal members to learn the ancestral medicinal practices of elder shamans and it enables elderly shamans to work with chosen members of their communities in the transmission of their healing knowledge. For instance, shamans and their apprentices participate in plant collection trips that result in the transmission of ancestral forest knowledge to younger generations as well as the renewal of forest as a repository of healing and place for learning. This longstanding traditional medicine integration and promotion program has been internationally recognised as a sustainable health care model operating at the interface between western medicine and traditional Indigenous healing.[8]

In Colombia, the *Shamans and Apprentices* program provides support for traditional healers and their apprentices in five tribes. This program supports and facilitates the restoration of ancestral medicinal practices in their communities and it enables elder shamans to pass their healing knowledge to the next generation. ACT provides scholarships for 40 apprentices and stipends to elderly shamans to cover their basic needs; it facilitates regular visits of shamans and their apprentices to remote communities

7 The Amazon Conservation Team is an NGO that works in partnership with Indigenous people of tropical America to maintain the biodiversity of the Amazon Rainforest and the culture and land of its Indigenous people. For more details, *see* www.amazonteam.org/

8 In 2002, this program has been recognised by UNESCO/NUFFIC as *Best Practice Using Indigenous Knowledge*. In 2003, as a result, the World Bank awarded a Development Marketplace grant to ACT's integrated medicine project, the first award for a Suriname-based initiative. In 2007, the program has been nominated as one of ten finalists for the global award for *Environment and Sustainable Development* by the UN Development Program (UNDP), UN Environment Program (UNDEP), and the World Conservation Union (IUCN). For more details, *see* act-suriname.org/



Support is also provided for the management of medicinal plant gardens, healers' gatherings, training of apprentices, and the renewal and strengthening of traditional medicinal practice

Shamans and Apprentices program, Colombia

that have little or no access to health care services. These groups of traditional healers that travel to remote villages are called 'health brigades'. Support is also provided for the management of medicinal plant gardens, healers' gatherings, training of apprentices, and the renewal and strengthening of traditional medicinal practice. This program is carried out in collaboration with two unions of traditional healers from the Colombian Amazon: the Union of Yagé Healers of the Colombian Amazon - Union de Medicos Indigenas Yageceros de la Amazonia Colombiana – (UMIYAC) and the Asociación de Mujeres de la Medicina Tradicional La Chagra de la Vida (ASOMI). UMIYAC is formed by the traditional healers of the Siona, Inga, Kofán, Koreguaje y Kametzá communities. ASOMI is the first formal alliance of female medicinal practitioners in the Colombian Amazon and includes female traditional healers of the Siona, Inga, Koreguaje y Kametzá communities. In 2010, the first large scale gathering of traditional healers brought together 74 medicinal practitioners of the UMIYAC and ASOMI healers' unions, including apprentices. The gathering focused on ways to improve healthcare and reinforce community strength. The UMIYAC and ASOMI Indigenous healer associations preserve the integrity and purity of traditional knowledge and strengthen respect for these ancient practices within their tribes *(UMIYAC 2000)*.[9]

In Perú, the Center for Drug Addiction Treatment and Research on Traditional Medicines, Takiwasi ('The House that Sings') offers an exceptional case of integration between western medicine and traditional medicine. Takiwasi was founded in 1992 by Dr Jacque Mabit, a French physician and trained traditional healer, to treat addictions using a combination of western scientific-based methods and shamanic healing methods based on the Amazon traditional medical model. The centre has also attended and treated patients with psychological disorders including depression, anxiety, and abnormal behaviour. Takiwasi is recognised by the Peruvian Ministry of Health and it is associated with the National Institute of Traditional Medicine within the Ministry of Health.

The therapeutic model developed and adopted in the centre is based on the core concept underlying Amazonian traditional medicine, that is the holistic nature of human being as body, mind and spirit. The therapeutic model is structured to tackle additions through a combination of western psychotherapeutic methods and the use of medicinal plants and shamanic healing practises that work on patients' physical, mental and emotional spheres. The therapeutic team comprises doctors, psychologists, technical nurse, ergo therapists, empiric ethno botanists, traditional healers (shamans) and therapeutic assistants. A fundamental pillar of Takiwasi is the scientific research on the clinical application of shamans' healing methods and their medicinal plants, including *ayahuasca* among many other plants from the Amazonia *(Giove Nakazawa 2002; Mabit 2001)*. The reported success rates for curing addicts at Takiwasi detox

9 For more details, *see* www.actcolombia.org

centre through the combination of psychological therapy and shamanic healing are quadruple the average in the western health care system.[10]

In the Western Pacific Region, the Regional Office of the WHO (WPRO), has played a leading role in developing, promoting and supporting an overarching regional strategic framework for the integration of traditional medicine in the national health care systems of its member states.[11] The WPRO's initiatives have focused on supporting regional conventions on the role of traditional medicine and development of national policies *(WHO/WPRO 2000a)*; the development of international standard terminologies on traditional medicine in the region *(WHO/WPRO 2007)*; harmonization of traditional and western medicines *(WHO/WPRO 2000b)*; the development and implementation of an overarching regional strategy on traditional medicine in the Western Pacific Region *(WHO/WPRO 2002; 2012)*. The need to harmonise traditional medical systems and the western allopathic medical system in the region is considered to be vital to ensure a higher degree of accessibility, availability and affordability of quality health care for all,

> ...a large proportion of the population in the Region use traditional medicine as a primary means of care. Traditional medicine will continue to exist as a separated medical system for some time... many users of traditional remedies also use modern medicine at the same time. Many medical doctors apply both traditional and modern medicine. Harmonization of traditional and modern medicine will, therefore, ensure that the two approaches work effectively side by side properly *(WHO/WPRO 2000b)*.

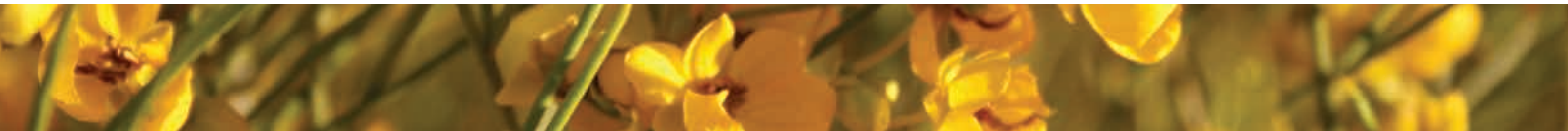
The level of integration of traditional and western medical systems varies significantly across countries in the region. In the last decade there has been a significant but variable progress in relation to the *Regional Strategy for Traditional Medicine in the Western Pacific 2001-2010 (WHO/WPRO 2002)*. Evidence shows that as of 2012, 18 countries have developed official governmental documents on traditional medicine, such as national policies, regulation or laws. For instance, Nauru adopted a national policy in 2009, Cambodia issued a policy on traditional medicine in 2012, while Fiji, Kiribati, Niue, New Caledonia and the Federated States of Micronesia are in the process of instituting national policies on traditional medicine. Increase in governmental initiatives on traditional medicine has been a widespread feature of the reported progress across the Western Pacific Region in the last decade *(WHO/WPRO 2012: 6-10,48-56)*.

In New Zealand, for instance, the re-emergence of traditional Māori medicine – rongoā Māori – in the last three decades has prompted the New Zealand's government to engage in a process of consultation regarding the place of rongoā Māori in the national health care system. Contemporary practice of rongoā Māori is significantly entrenched with the traditional beliefs still alive in today's Māori culture. Rongoā Māori traditional healing is formulated in a Māori cultural context, in which the health belief system, the ill causation process, ill health and its impacts are tackled through a range of culturally bounded responses. Despite the acceptance of western medicine and the use of the mainstream health care system, rongoā Māori traditional healing and Māori traditional healers – *tohunga* – continue to play an important role (Tipene-Leach 1994). In light of the increasing demand of traditional Māori medicine, discussions regarding ways to incorporate rongoā Māori and tohunga within the health care system have intensified within the national policy and political arena. Important developments can be traced back to the late 1980s when the Department of Health instructed medical practitioners and hospitals to interact with Māori traditional healers *(Salmond 1987)*. In 1995, the National Advisory Committee on Core Health and Disability Services (1995) recommended in its fourth report to the Minister of Health that:

> Regional Health Authorities purchase aspects of Māori traditional healing, to be provided in conjunction with other primary health services, where there is reason to believe this will improve access to effective services for Māori and lead to better health outcomes.

10 For more details regarding Takiwasi, its therapeutic method and current research on traditional medicine, *see* www.takiwasi.com/indexen.html

11 The Western Pacific Region of the WHO comprises 37 countries, including Australia, Brunei Darussalam, Cambodia, China, Cook Islands, Fiji, French Polynesia, Hong Kong, Japan, Kiribati, Lao People's Democratic Republic, Macao, Malaysia, Marshall Islands, The Federated States of Micronesia, Mongolia, New Caledonia, New Zealand, Nauru, Papua New Guinea, Philippines, Republic of Korea, Samoa, Singapore, Solomon Islands, Tonga, Vanuatu, Tuvalu, Viet Nam.



As a result, the Central Regional Health Authority purchased the first rongoā Māori service *(Jones 2000)* and the Ministry of Health acknowledged the legitimate place of Māori traditional medicine in the national health sector through the development of national standards for traditional Māori healing *(Ministry of Health, 1999)*. The standards have been developed in consultation with the National Organization of Traditional Māori Practitioners – Ngā Ringa Whakahaere o te Iwi Māori – and the Health Funding Authority (HFA) to ensure their alignment with the Health and Disability Sector Standards. The standards for traditional Māori healing establish fundamental principles aimed to guide health care services in the provision of quality of health care and ultimately ensure the health outcomes for their patients *(Ministry of Health 1999)*. In 2000, the Ministry of Health invited submission in regard to the future of primary health care *(Ministry of Health, 2000)*. Access to Māori traditional healers and traditional health services were recommended as additional services to be included in primary health care services. Further, the legitimisation of Māori traditional healing practices has also been supported by the Ministry of Māori development based on the increasing demand of rongoā Māori documented by the Māori Health Commission *(Harrison 2000)*. The development of adequate policies and strategies to incorporate Māori traditional healing continue to be central in New Zealand's political arena. In December 2011, a new national Rongoā governance body – Te Kāhui Rongoā Trust – has been established to protect, nurture and promote rongoā Māori. The national governance body Te Kāhui Rongoā Trust constitutes a key stakeholder in the current dialogue between Māori traditional healers, health care services and the New Zealand's government.

2.3 Traditional medicine in Australia

The international literature ranks Australia as 'high' – in a scale of the global level of utilization of traditional medicine – and considered to be at an advanced stage of policy development in TCAM *(Bodeker et al 2005: 185; Bodeker and Burford 2007: 8; WHO/WPRO 2002: 5-10, 34,37; WHO/WPRO 2012: 1-10, 47-48)*. Evidence shows that Australia has been developing a national policy on TCAM *(WHO 2001: 144-147; Bodeker et al 2005: 183-6)* and the Australian Government has funded traditional medicine practitioners to support the development and formalization of accreditation standards and appropriate participation processes *(Bodeker et al 2005: 183)*. The latest international study on the development of policies on traditional medicine positions Australia among the states with the most advanced policy development and supporting infrastructure for traditional medicine *(WHO/WPRO 2012: 47-48)*. It is highlighted that the 'Australian Government recognises the role played by traditional medicine and includes some forms of traditional medicine in its mainstream health services' *(WHO/WPRO 2012: 48)*. It reports on the introduction of a National Registration and Accreditation Scheme for health practitioners and the inclusion of traditional Chinese medicine in the scheme from 1 July 2012. As a matter of fact, traditional Chinese medicine was included in the new National Registration and Accreditation Scheme on 1 July 2012.[12]

This report disputes the positioning of Australia among the countries at an advanced stage of policy development in TCAM. It argues that Australia sits at the end of that spectrum occupied by countries in which the policy process on TM has not started yet. This argument is grounded on the basis that the data provided in the international literature exclusively refers to the legal recognition, regulation and financing of Chinese traditional medicine in Australia, but has no relation whatsoever to the only traditional medical system which fulfils the WHO's definition of TM in Australia, that is Aboriginal Traditional Medicine *(WHO 2001: 144-147; Bodeker et al 2005: 183-185; WHO 2002a: 12; WHO/WPRO 2012: 47-48)*.

Aboriginal traditional medicine is unquestionably a form of traditional medicine as recognised in the international public health arena, that is a medical system which 'exclusively refer to the indigenous health traditions of the world, in

12 As of 1 July 2010 a National Registration and Accreditation Scheme for health practitioners came into force and replaced the scheme operating in each Australian state. As agreed by COAG on 26 March 2008, health professionals in the following nine groups are covered by the national scheme. These include: physiotherapy, optometry, nursing and midwifery, chiropractic care, pharmacy, dental care (dentists, dental hygienists, dental prosthetists and dental therapists), medicine, psychology and osteopathy (COAG 2008).

their original settings' *(Bodeker and Burford 2007: 9)*. It is 'the sum total of knowledge, skills and practices on holistic health care'; it is 'based on the theories, beliefs and experiences that are indigenous to [the Aboriginal culture]'; it is 'developed and handed down from generation to generation'; and it is 'recognised and accepted by the community for its role in the maintenance of health and the treatment of diseases' *(WHO/WPRO 2000a: 29)*.

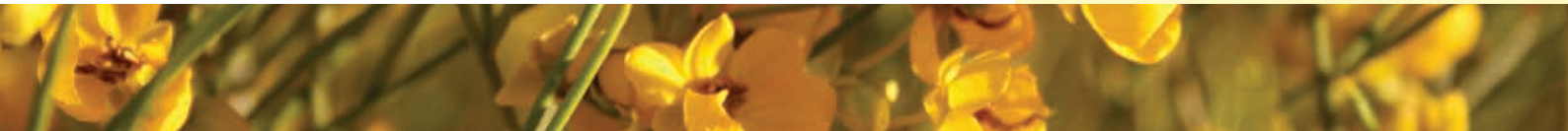
The disregard of the existence of Aboriginal traditional medicine in Australia constitutes a serious flaw in the international literature. The lack of consideration of Aboriginal traditional medicine skews the results and misrepresents Australia's position in the international arena. The reported lack of data on TM policy development and regulation in many countries of the Western Pacific Region where Australia is located *(Bodeker et al 2005: 184)*, does not justify the total absence of Aboriginal traditional medicine as a body of medical traditional knowledge still alive and practiced in Australia.

The disregard of Aboriginal traditional medicine in the international literature is reproduced within Australia. This absence is reflected in both the research and policy agenda on complementary and alternative medicine (CAM), and within the current Australia's national Indigenous health policy agenda.

Complementary and alternative medicine (CAM) constitutes an increasingly flourishing sector in the Australia's health care system *(McCabe 2005)*. The current research agenda explores the development of CAM in relation to regulation, education, professional representation, institutional recognition, and safety and efficacy issues *(Bensoussan and Myers 1996; Wooldridge 1996; Bensoussan et al 2004; Carlton and Bensoussan 2002; Bensoussan et al 2004; McCabe 2005)*. Interestingly, Australia's national research and public policy agenda on CAM does not include the traditional dimension ('T'), which is present in the international public health policy agenda on TCAM.

The gap identified in the international literature and in the Australian CAM sector, is replicated in the current Australia's national Indigenous health policy agenda. The next chapter explores the status of Aboriginal traditional medicine and Aboriginal traditional healers within the Commonwealth and South Australian legislative and policy framework.

The disregard of the existence of Aboriginal traditional medicine in Australia constitutes a serious flaw in the international literature



CHAPTER 3

Aboriginal Traditional Medicine: Legislative and Policy Framework

3.1 Introduction

This chapter analyses the Commonwealth, Council of Australian Governments (COAG) and South Australian legislative and policy framework on Aboriginal traditional medicine and Aboriginal traditional healers. The chapter integrates a legal and policy analysis of federal and state documents and an analysis of interview data from senior administrators and policy officers from the Commonwealth Department of Health and Ageing (DoHA), the Office for Aboriginal and Torres Strait Islanders Health (OATSIH) and the South Australian Department of Health. The findings are discussed to provide a comprehensive overview of the status of Aboriginal traditional medicine and Aboriginal traditional healers at the intersection between the Commonwealth and South Australian legislative and policy framework.

3.2 Commonwealth legislation on Aboriginal traditional medicine

The Commonwealth of Australia has never enacted legislation on Aboriginal traditional medicine. There are no federal legislative acts on the legal recognition, regulation and financing of Aboriginal traditional medicine, nor on the status of Aboriginal traditional healers.

3.3 Council of Australian Governments' 'Closing the Gap' Indigenous health policy framework

In terms of policy development, Aboriginal and Torres Strait Islander health policy constitutes a priority area in the current national health reform agenda (DoHA 2007; 2010; 2012; FaHCSIA 2009; 2011; AHMAC 2008; 2011; IERSC 2010; SCRGSP 2005; 2007; 2009; 2011; 2012; COAG 2009a; COAG 2009b; COAG 2009c; COAG 2009d; COAG 2009e; COAG 2009f; COAG 2011; NATSIHC 2003a; 2003b).

The launch of the Closing the Gap Campaign (2007) inaugurated a new era of policy reform in Aboriginal and Torres Strait Islander health. The *Closing the Gap Statement of Intent* signed in March 2008 by the Commonwealth, state and territory governments initiated a concerted whole-of-government policy-making process to overcome the health inequality between Aboriginal and Torres Straits Islander people and non-Indigenous Australians. The Council of Australian Governments' *National Indigenous Reform Agreement (NIRA)* and the *Closing the Gap National Partnership Agreements (COAG 2009a; COAG 2009b; COAG 2009c; COAG 2009d; 2009e; 2011)* constitute the backbone of the whole-of government approach to Closing the Gap in health outcomes for Aboriginal and Torres Strait Islander peoples.

What is the place of Aboriginal traditional medicine in the current Australian governments' Closing the Gap policy agenda, strategies and plans?

The *National Indigenous Reform Agreement*[13] *(COAG 2011)* establishes an integrated and multifaceted approach to the Commonwealth, States and Territory's efforts to close the gap in Indigenous disadvantage. The *Agreement* provides an overarching platform to coordinate and integrate the objectives, outcomes, outputs, performance measures and benchmarks agreed by the Council of Australian Governments through different *National Agreements* (NAs) and *Closing the Gap National Partnership* (NP) *Agreements*. The *Agreement* establishes seven 'Building Blocks' to integrate policy strategies and implementation plans to close the gap against the six COAG targets.[14] The 'Building

13 NIRA came into effect on 1 January 2009 and it was revised in February 2011.

14 In 2008, COAG agreed to the following six Closing the Gap targets: 1. to close the gap in life expectancy within a generation; 2. to halve the gap in mortality rates for Indigenous children under five within a decade; 3. to ensure all Indigenous four-year-olds in remote communities have access to early childhood education within five years; 4. to halve the gap in reading, writing and numeracy

Blocks' include: early childhood; schooling; health; economic participation; healthy homes; safe communities; governance and leadership. The NIRA's *National Integrated Strategy for Closing the Gap in Indigenous Disadvantage* (the *Strategy*) illustrates how the 'Building Blocks', COAG targets, outputs, *National Agreements* and *Closing the Gap National Partnership Agreements* are integrated *(COAG 2011: A17-41)*.

The *Strategy, National Agreements* and *Closing the Gap National Partnership Agreements* show no reference to Aboriginal traditional medicine, traditional healing or Aboriginal traditional healers *(COAG 2009a; 2009b; 2009d; 2009e)*. Likewise, the *Overcoming Indigenous Disadvantage* framework produced by the Australian Productivity Commission as part of the Australian governments' collective commitment to overcoming Indigenous disadvantage does not include Aboriginal traditional medicine or traditional healing as part of any strategies, outputs or indicators *(SCRGSP 2003; 2005; 2007; 2009; 2011)*.

The policy analysis of these documents identifies only two sporadic references to Aboriginal traditional healing and traditional healers. Traditional healing is mentioned as part of a case study on the benefits of participation in sport, arts and community group activities, that is the *Galiwin'ku Gumurr Marthakal Healthy Lifestyle Festival* held on Elcho Island in northeast Arnhem Land. The festival focuses on strengthening traditional understandings of health and healing through strong cultural frameworks and activities including traditional healing workshops *(SCRGSP 2009: 10.10)*. Traditional healers are included in the survey data from the National Aboriginal and Torres Strait Islander Health Survey 2004-05 which indicates what health care services Indigenous people sought when they had a health problem. Traditional healers are included in the category 'other' as part of all health services different form hospitals, doctors, and Aboriginal medical services *(ABS 2006: 9.63)*. However, these references to traditional healing and traditional healers have neither any policy implication, nor relation to the 'Closing the Gap' policy framework.

achievements for Indigenous children within a decade; 5. to halve the gap for Indigenous students in year 12 equivalent attainment by 2020; 6. to halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade.

3.4 'Closing the Gap' and Aboriginal Traditional Medicine

The policy analysis identifies a foundational flaw in the current Australian governments' Closing the Gap Indigenous health policy agenda: the complete disregard of Aboriginal traditional medicine *(FaHCSIA 2009; 2012; COAG 2009a; 2009b; 2009c; 2009d; 2009e; 2011a; Commonwealth of Australia 2010; 2011; 2012; DoHA 2007; 2012; SCRGSP 2003; 2005; 2007; 2009; 2011)*.

Why? What are the root causes that continue to fuel indifference toward Aboriginal traditional medicine in the current Closing the Gap policy agenda, strategies and implementation plans to overcome the health inequality between Indigenous and non-Indigenous Australians?

This section aims to untangle the root causes

that underlie the discount of Aboriginal traditional medicine. An in-depth analysis of the conceptual underpinnings on which the COAG's Closing the Gap health policy agenda rests identifies two root causes: the limited application of a human rights approach to the Closing the Gap Indigenous health policy agenda; the predominance of the epistemological foundations of western allopathic medicine vis-à-vis the epistemological foundations of Aboriginal traditional medicine.

3.4.1 Limited application of a human rights-based approach to the Closing the Gap Indigenous health policy agenda

In setting the core principles and objectives for a new Indigenous health policy agenda, the 2005 Social Justice Report *(2006: 9-98)* proposed that a human rights approach should be the core conceptual underpinning to guide the concerted effort to overcome the Indigenous health disadvantage. This involves applying foundational principles of international human rights law to the Aboriginal and Torres Strait Islanders' right to health within the Australian domestic jurisdiction. In this way, the Social Justice Commissioner's proposal anchored the 'Closing the Gap campaign and the Australian government' obligation towards Indigenous Australians' health status to the international legal standards defining the right to health *(ICESCR, art.12; UNCESCR 2000)* and to the internationally accepted human rights approach to policy making and development practice *(UN 2003)*.

The proposed human rights approach has become the fundamental underpinning of the Closing the Gap campaign and its non-governmental alliance in the ongoing monitoring function against the Australian government's commitments to achieve health equality between Aboriginal and Torres Strait Islander people and non-Indigenous Australians *(AHRC and SCIHQ 2008; ATSISJC 2009; CGSC 2010; 2011; 2012)*. The Australian government has also adopted a human rights approach in its commitment to achieve health equality between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians within a generation. In the *Closing the Gap Statement of Intent*[15] the Australian government commits '[t]o respect and promote the rights of Aboriginal and Torres Strait Islander peoples, including by ensuring that health services are available, appropriate, accessible, affordable and good quality'. The human rights-based approach to address the health inequality divide between Indigenous and non-Indigenous Australians has been embraced as the shared platform on which to found and develop the 'closing the gap' policy machinery *(FaHCSIA 2009; Commonwealth of Australia: 2010)*. Further, the Australian government's endorsement of the UN Declaration on the Rights of Indigenous Peoples (UNDRIP)[16] reinforces the adoption of a human rights approach in the Australian government's national Indigenous health policy reform agenda:

> The Australian Government has made a statement of support for the United Nations Declaration on the Rights of Indigenous Peoples and joined with the international community in affirming the aspirations of all Indigenous peoples *(Commonwealth of Australia 2010: 8)*
>
> In supporting the Declaration, the current government pledged to uphold the human rights of Indigenous peoples based on principles of equality, partnership and good faith. Through the Declaration, the Government also reaffirmed its commitment to upholding the rights of vulnerable people, including women and children, to live free of violence, abuse and neglect, and to the rights of all Indigenous people to lives that are safe, secure and free from intimidation *(Commonwealth of Australia 2010: 62)*

These statements, however, have not been translated into a clear indication of what are the UNDRIP's international legal standards relevant to the protection and promotion of Aboriginal and Torres Strait Islanders' right to health. In other words, there exists a weak connection between Indigenous peoples' right to health as recognized in the UNDRIP and the Australian government's Closing the Gap policy framework and strategies aimed at implementing the right to health for Indigenous Australians *(Commonwealth of Australia 2010: 8,12)*. Further, the Australian government's endorsement of the UNDRIP as a fundamental underpinning of its commitment to a human rights-based 'closing the gap' policy

15 *Closing the Gap Statement of Intent,* signed at the Indigenous Health Equality Summit, Canberra, 20 March 2008, available online at: www.humanrights.gov.au/social_justice/health/statement_intent.html

16 Hereinafter the UN Declaration or the UNDRIP.

agenda seems to have been diluted in favour of a more 'practical' and 'empirical' approach *(Commonwealth of Australia 2011*; 2012). As the Prime Minister (2012) states:

> Closing the Gap is a practical and empirical project and it is a project that should move us deeply, work which will make such a difference in so many individual lives

A 'partnership approach' based on 'a commitment to genuine engagement with the Indigenous community' to build 'new relationships based on trust and mutual respect' *(Commonwealth of Australia 2011: 6, 24)* seems to have superseded the lexicon of and commitment to international human rights standards. However, the human rights-based approach to the national Closing the Gap reform agenda continues to be upheld by the Closing the Gap Steering Committee *(2010; 2011; 2012)*. The Steering Committee reiterates the significance of the Australian government's endorsement of the UNDRIP and pinpoints the human rights standards relevant to achieving health equality. These include articles 18, 19, 23 and 24.2 which establish together the terms of the States-Indigenous peoples relationship in relation to the Indigenous peoples' right to health *(CGSC 2011: 7; 2012: 6)*.

Articles 18 and 19 recognise respectively the right of Indigenous peoples 'to participate in decision-making in matters which would affect their rights' and oblige States to 'consult and cooperate in good faith with the indigenous peoples concerned through their own representative institutions in order to obtain their free, prior and informed consent...'

Article 23 reaffirms the imperative of ensuring the full and substantive participation of Indigenous peoples in relation to their right 'to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health...',

Article 24.2 sanctions the core principles of international human rights law endorsed by the Australian government, which are the 'non-discrimination principle' and the 'progressive realization principle'. It states that 'Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right'.

These rights constitute the fundamental international legal standards defining Indigenous peoples' right to health. The UNDRIP, although not legally binding under international law, constitutes the most authoritative international legal instrument for the protection and promotion of Indigenous peoples' rights. As such, the international legal standards relevant to the right to health should continue to be adopted as the fundamental yardstick to guide Australia's Closing the Gap health policy reform agenda. As a result, the human rights-based approach to current Australia's Closing the Gap Indigenous health policy demands the integral adoption of the UNDRIP' s international legal standards relevant to Aboriginal and Torres Strait Islander peoples' right to health.

However, the legal and policy analysis identifies a limited application of the human rights-based approach to Australia's Closing the Gap Indigenous health policy. The integral adoption of the UN Declaration' s right to health requires the inclusion of articles 24.1 and 31. Articles 24.1 and 31 set the international legal standards that legitimise the claim to include Aboriginal traditional medicine in Australia's Closing the Gap Indigenous health policy agenda. Article 24.1 stipulates that

> Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals.

The right of Indigenous peoples to practice their traditional medicine is entwined with article 31 which stipulates that

> Indigenous peoples have the right to maintain, control, protect and develop their cultural heritage, traditional knowledge and traditional cultural expressions, as well as the manifestations of their sciences, technologies and cultures, including human and genetic resources, seeds, medicines, knowledge of the properties of fauna and flora, oral traditions, literatures, designs, sports and traditional games and visual and performing arts. They also have the right to maintain, control, protect and develop their intellectual property over such cultural heritage, traditional knowledge, and traditional cultural expressions

> In conjunction with indigenous peoples, States shall take effective measures to recognize and protect the exercise of these rights.

Australia's disregard of Aboriginal traditional medicine in the national Indigenous health policy agenda contravenes articles 24.1 and 31. The current Australian government Closing the Gap policy reform agenda fails to acknowledge the same existence of Aboriginal traditional medicine; it dismisses the body of traditional medical knowledge embedded within the Aboriginal system of medicine passed down from generation to generation for thousands of years; it fails to consider the potential role that the promotion and protection of Aboriginal traditional medicine can have on the health status of Aboriginal and Torres Strait Islander people and their communities; and it does not consider the potential contribution that the inclusion of Aboriginal traditional medicine in a two-way health care model can make in 'closing the gap'.

The identified flaw in Australia's current Closing the Gap Indigenous policy agenda can be rectified with the integral adoption of the UNDRIP's international legal standards on the right to health, that is article 24.1 and 31. These articles lay down the Australian government obligation and responsibility to take all necessary measures to ensure the exercise of Indigenous Australians' right to their traditional medicine, healing practices, and to maintain and protect their traditional medical knowledge and their intellectual property rights.

Recommendation 1:
It is recommended that Aboriginal traditional medicine be included in Australia's national Closing the Gap health policy agenda pursuant to articles 24.1 and 31 of the United Nations Declaration on the Rights of Indigenous Peoples

3.4.2 Epistemological divide between science-based western medicine and Aboriginal traditional medicine

The disregard of Aboriginal traditional medicine in Australia's Closing the Gap health policy agenda finds its counterpart in the predominance of the western allopathic medical system. What are the conceptual underpinnings on which the prevalence of the western allopathic medical paradigm rests? To answer this question it is important to consider the encounter between western medicine and Aboriginal traditional medicine from an historical point of view. The understanding of the current discount of Aboriginal traditional medicine cannot be explained without a sound consideration of the colonial context within which the encounter between western medicine and Aboriginal traditional medicine occurred. The process of colonization between western societies and non-western societies has had an indelible influence in crafting western and non-western societies' mutual understandings and relationships. As Shiva *(2000: vii in Dei, Hall and Rosenburg)* elucidates:

> ...under the colonial influence the biological and intellectual heritage of non-western societies was devalued. The priorities of scientific development...transformed the plurality of knowledge systems into a hierarchy of knowledge systems. When knowledge plurality mutated into knowledge hierarchy, the horizontal ordering of diverse but equally valid systems was converted into vertical ordering of unequal systems, and the epistemological foundations of western knowledge were imposed on non-western knowledge systems with the result that the latter were invalidated.

Knowledge systems are the backbone of any societies and cultures. Knowledge systems are characterized by key conceptual parameters: *epistemology*, *transmission*, *innovation* and *power*. The interplay among those parameters defines and differentiates diverse knowledge systems. In particular, *epistemology* identifies what is considered to be knowledge and how we know what we know; *transmission* defines how knowledge is taught and learnt; *innovation* captures how knowledge is renewed; and *power* refers to the relationships among different communities as well as different members of the same community *(Marglin 1990)*.

The colonial encounter exhibits a strong anti-pluralism towards those knowledge systems that are different from the dominant knowledge system. The colonial anti-pluralism entails the rejection of alternative epistemologies, that is, different modes of knowing and transmitting knowledge *(Whitt 2009)*. Central to the

tension between Indigenous and non-Indigenous epistemologies is the role of science. Particularly, a 'reductivist scientism' is considered the key element facilitating the tendency of the western knowledge system to discard and reduce alternative knowledge systems to 'superstition [and] the very antithesis of knowledge' *(Marglin 1990: 25)*. In 'reductivist scientism', science shifts from a field of enquiry to a methodology that can be applied to diverse areas of study; consequently, any discipline can potentially be scientifically based if the scientific method is adopted.

In this way, Indigenous knowledge systems whose epistemological foundations do not rely on the western scientific method and whose knowledge transmission is essentially in the forms of stories and ceremonies, are downgraded to 'factual propositions and are seen as "tainted" with a normative and spiritual component' *(Whitt 2009: 32)*. The anti-pluralism and scientific-based processes of knowing distinctive to the western knowledge system collide with the 'non-anthropocentric epistemological pluralism' typical of Indigenous knowledge systems *(Whitt 2009: 34)*. In other words, whereas western science 'discards anything that has a remote relationship with the subjective experiences of human being and other forms of life' *(Deloria 1992: 16)*, Indigenous knowledge systems accept different 'versions of existence' *(Dion-Buffalo and Mohawk 1992: 19)* and attribute a special place to visions, dreams and intra-species communications because they are 'a natural part of human experience' *(Deloria 1992: 16)*.

The western reverence towards a scientific-based process of knowing is replicated in the epistemological foundations of western medicine vis-à-vis Indigenous traditional medicine. The epistemological divide between a scientific-based medical model and Aboriginal traditional medicine constitutes a milestone factor in the development of Australia's Indigenous health policies.

Dr Thomas' *(2004)* ground-breaking analysis of doctors' writings in the first one hundred years of Indigenous health research *(1870-1969)* sheds light on the extent to which medical research about Aboriginal and Torres Strait Islander people 'encoded the way the colonisers dominated the colonised and how both parties imagined themselves, each other and colonialism itself' *(Thomas 2004: 6)*.

The in-depth analysis of doctors' writings at the colonial frontier demonstrates the significant role played by the social and political context within which Indigenous health research has been constructed and reproduced:

> Indigenous health research and the brutal history of colonialism in Australia are forever entangled: they are no identical, merged, parallel nor independent, but intricately and variously enmeshed *(Thomas 2004: xiv)*

The colonial encounter in medical research has had a profound impact on the way Aboriginal and Torres Strait Islander peoples have been represented and how their knowledge system considered. Medical representation of Aboriginal people as an inferior and primitive race, the description of Aboriginal individuals as passive and submissive research subjects during medical observations and trials *(Thomas 2004)* have fuelled the relegation of Aboriginal traditional medicine in a place of non-existence.

Aboriginal medicine, surgery and treatments were discussed in early medical journals *(Anon, Bennet G. 1873; Creed 1883; Stirling 1894-5; Manning 1889; Hogg 1902; Anon, MacPherson J. 1903; Cleland 1908; Cleland and Hickinbotham: 1909; Jackson 1911)*. Aboriginal medicine and its practices were mostly described as 'exotic' and 'primitive'. As this brief excerpt exemplifies:

> With regard to the surgery of the Tasmanian aboriginals, it was, as might be expected, of a most primitive character. Bleeding was stopped by the action of clay and leaves *(Hogg 1902: 176)*.

Treatments used by Aboriginal people were also described and discussed in early medical journals. Some treatments were described as ineffective or even harmful whereas other treatments were considered as effective. Interestingly, when treatments were effective 'a Western biomedical explanation of the success (or an equivalent Western treatment) was usually provided' *(Thomas 2004: 17)*. The underlying superiority of the non-Aboriginal authors, who were writing to a non-Aboriginal audience, is evident in the exclusion of Aboriginal people's explanations of disease causation as opposed to lengthy discussions of their own scientific-based explanations. Despite references to the Aboriginal explanation of sorcery as the cause of some illnesses, scientific explanations were mostly tested and discussed *(Anon 1877; Stirling 1894-5; Ross 1870)*.

The disregard of Aboriginal medical knowledge is evident in the way some doctors and researchers promoted the use of local Australian therapeutic agents while dismissing the role and knowledge of Aboriginal people *(Ross 1872b: 166; Shepherd 1872: 130)*. It is reported how the botanist Shepherd, for example, explored the use of Indigenous and acclimatised medicinal plants and referred to Aboriginal people in very derogatory terms. Thomas *(2004: 17)* outlines how his emphasis was on 'their [Aborigines'] primitiveness whilst reluctantly explaining how even they [the Aborigines] had rendered poisonous cycad nuts edible'. Another example is Ross' dispute *(1872a)* against two French doctors in regard to the merits of the discovery of the therapeutic properties of eucalyptus. The dispute discounted Aboriginal people as the original holders of such traditional medical knowledge. Sometimes, the lexicon of western medicine was used to describe the practice and training of Aboriginal traditional healers to make those practices more understandable to a non-Aboriginal audience *(Anon MacPherson J.1903)*.

The medical descriptions and representations of Aboriginal medicine as a primitive version of western medicine contributed to create a temporal linear progression from a 'primitive' Aboriginal medical system to the 'modernist' system of western medicine. The modernity and strengths of western medicine were reinforced by the alleged backwardness of Aboriginal traditional medicine *(Thomas 2004: 18-19)*.

The backward/modern representation of Aboriginal traditional medicine/western medicine and the creation of a 'vertical ordering of unequal systems' *(Shiva 2000: vii in Dei, Hall and Rosenburg)* under the colonial influence demand a new understanding of Aboriginal traditional medicine, Indigenous traditional medicines generally, and their epistemological foundations. Traditional medicine or traditional healing encompasses the physical, mental, emotional and spiritual spheres of human nature. Traditional medicine tackles health from a holistic perspective grounded on knowledge systems different from the western scientific medical paradigm. The Canadian *Report of the Royal Commission on Aboriginal Peoples (1996: 348)* describes traditional healing as:

> The overall practices designed to promote mental, physical and spiritual well-being that are based on beliefs which go back to the time before the spread of western 'scientific' bio-medicine. When Aboriginal Peoples in Canada talk about traditional healing, they include a wide range of activities, from physical cures using herbal medicines and other remedies, to the promotion of psychological and spiritual well-being using ceremony, counselling and the accumulated wisdom of Elders.

It is important to consider that Indigenous traditional medicine is equated with the concept of 'healing'. The interweaving of 'healing' and 'medicine' within Indigenous knowledge systems has significant implications: from an epistemological point of view, it informs the foundations of what is considered to be medical knowledge and how this body of knowledge is attained; from a practical point of view, it informs the practices of healing and restoring well-being; further, it contributes to shed light on the key distinctive features of Indigenous traditional medicine vis-à-vis western scientific bio-medicine.

Traditional healing and medicine expand beyond a body of knowledge exclusively related to typologies of health issues, injuries, symptoms, remedies, and healing techniques. This is because 'medical knowledge never existed as an autonomous and formal body of knowledge as in modern Western Societies' *(Ootoova et al 2001: 1)*. In this regards, it has been pointed out that traditional healers are 'those individuals responsible [also] for the health of the community and their relationship to the supernatural world' *(UMIYAC 2000: 45)*. Traditional healing extends beyond the bio-medicine realm of individual health to encompass the realm of relationships among individuals, communities, land, environment, and the spirit world *(Cajete 2000)*. Traditional healing and medicine are intimately tied to land, language and culture; Indigenous medicine and healing practices are considered to be 'localized and culturally specific' *(Martin Hill 2003: 11)*.

The concept of 'ethnoscience' *(Cajete 1994)* and its application to traditional healing help understand the ecological nature of traditional medicine whereby the co-existence and interdependency between the natural world and human life are essential to secure a collective balance. Therefore, the source of disease and

different phases of sickness are directly related to the concept of balance which encompasses: individual balance, that is balance between mind and body as well as between different levels of bodily functions; balance between the individual and the community; balance between the individual or community and the environment; balance between the individual and the universe *(Bodeker and Burford 2007; Martin-Hill 2003: 24)*. Accordingly, healing practices and treatments are devised and delivered not only to restore the specific causes of diseases, but also to reinstate a status of balance between the individual and his/her internal or external environment *(Bodeker 2000)*; between the individual and community or family members *(Neumann and Bodeker 2007)*; or between the individual and specific sacred places *(Lebbie and Guries 1995)*.

It is evident that Indigenous traditional medicine and western allopathic medicine are constructed on very different epistemological foundations. Differences are so deep that western-based knowledge frameworks can be inadequate to grasp the holistic features of traditional healing *(Maar and Shawande 2010)*. Further, the complexity and diversity of Indigenous knowledge systems underpinning traditional medicines make it difficult for western-trained health professionals and researchers to navigate western and traditional medicine.

The comparative analysis of the epistemological foundations of western medicine vis-à-vis traditional medicine allows understanding one of the root causes of the disregard of Aboriginal traditional medicine in current Australia's Indigenous health policy. It demonstrates that the prevalence of the western scientific-based medicine and the discount of Aboriginal traditional medicine are rooted in a process of colonization at the epistemological level. The creation of a temporal linear progression from a 'primitive' Aboriginal traditional medicine to the modern science-based biomedical model *(Thomas 2004)* has crystallised, invalidated and relegated Aboriginal traditional medicine to a place of no-existence. The dismissal of Aboriginal traditional medicine replicates a process of epistemological colonization whereby a new *terra nullius* is created and reproduced in current Australia's Indigenous health policy blind to the thousands-year-old Aboriginal medical system.

The inclusion of Aboriginal traditional medicine within the current Australian governments' Closing the Gap health policy agenda requires a process of decolonization at the epistemological level. It demands to reposition the 'vertical ordering of unequal systems' to a 'horizontal ordering of diverse but equally valid systems' *(Shiva 2000: vii in Dei, Hall and Rosenburg)*. It demands the acknowledgment of Aboriginal traditional medicine as a different system of medicine, yet equally legitimate according to its own traditional knowledge system, philosophical underpinnings, and healing practices.

Recommendation 2:
It is recommended that Aboriginal Traditional Medicine be recognised as a legitimate system of traditional medicine based on its own traditional knowledge system, philosophical underpinnings, educational and training model. The legitimacy of Aboriginal traditional medicine should not be assessed against the criteria, conceptual underpinnings, educational and training model of western medicine

3.5 The *National Aboriginal and Torres Strait Islander Health Plan* and Aboriginal traditional medicine

Despite the lack of recognition and inclusion of Aboriginal traditional medicine in Australian governments' Closing the Gap policy agenda, fundamental principles to support the legitimate inclusion of Aboriginal traditional medicine in the existing Closing the Gap national policy framework and the forthcoming *National Aboriginal and Torres Strait Islander Health Plan* can be found in existing international and national health policy documents and strategies.

The development of a *National Aboriginal and Torres Strait Islander Health Plan* to guide governments in policy-making and program design is grounded on a comprehensive and holistic conception of health in accordance with the Declaration of Alma-Ata *(DoHA 2012: 2)*.

The Declaration of Alma-Ata provides the fundamental underpinnings not only for the adoption of a holistic understanding of health, but also for the understanding of health as a fundamental human right and the inclusion of 'traditional practitioners' as part of the health care workforce:

> ...health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right... (I)
>
> Primary health care: relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community (VI)

The need to adopt a holistic approach to Aboriginal health is ingrained in the *National Aboriginal Health Strategy (NAHSWP 1989)* and the *National Strategic Framework for Aboriginal and Torres Strait Islander Health (NATSIHC 2003a; 2003b)*:

> Health to Aboriginal peoples is a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity *(NAHSWP 1989)*
>
> For Aboriginal and Torres Strait Islander peoples health does not just entail the freedom of the individual from sickness but requires support for healthy and interdependent relationships between families, communities, land, sea and spirit. The focus must be on spiritual, cultural, emotional and social well-being as well as physical health *(NATSIHC 2003b: 4)*

These principles are adopted as foundational concepts in the development of the *National Aboriginal and Torres Strait Islander Health Plan (DoHA 2012: 2).* A holistic approach to health and cultural respect in the delivery of health services are also key principles of the *National Strategic Framework*:

> Cultural respect: ensuring that the cultural diversity, rights, views, values and expectations of Aboriginal and Torres Strait Islander peoples are respected in the delivery of culturally appropriate health services
>
> A holistic approach: recognising that the improvement of Aboriginal and Torres Strait Islander health status must include attention to physical, spiritual, cultural, emotional and social well-being, community capacity and governance' *(NATSIHC 2003a: 18)*

The significance of culture for a holistic emotional, physical and spiritual well-being is also upheld in the NIRA's *National Integrated Strategy for Closing the Gap in Indigenous Disadvantage.* Drawing on the *Overcoming Indigenous Disadvantage* framework *(SCRGSP 2007)*, it states that:

> Connection to culture is critical for emotional, physical and spiritual wellbeing. Culture pervades the lives of Indigenous people and is a key factor in their wellbeing – culture must be recognised in actions intended to overcome Indigenous disadvantage. Connection to culture is critical for emotional, physical and spiritual well being. Culture pervades the lives of Indigenous people and is a key factor in their wellbeing – culture must be recognised in actions intended to overcome Indigenous disadvantage...Efforts to close the gap in Indigenous disadvantage must recognise and build on the strength of Indigenous cultures and identities *(COAG 2011: A-20)*

In addition, the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being (2004),* designed to work in conjunction with the National Strategic Framework and currently under review, emphasises the holistic approach to Aboriginal health whereby health and well-being require the social, emotional and cultural well-being of the individuals and the whole community. It indicates the recognition and promotion of Aboriginal and Torres Strait Islander philosophies on holistic health as a key strategic direction to respond to the high incidence of social and emotional well-being problems and mental health issues among Indigenous Australians *(AHMAC & ATSIHC 2004: 15)*

The most important contribution in relation to the recognition and inclusion of Aboriginal traditional medicine as part of health care for Aboriginal and Torres Strait Islander peoples is affirmed in the *National Strategic Framework.* The National Aboriginal and Torres Strait Islander Health

Equality Council recognised the significant role of 'practitioners of traditional medicine' in relation to the development of a more effective and responsive health system for Aboriginal and Torres Strait Islander peoples *(NATSIHC 2003a: 13-23)*. Strategic actions to enhance service delivery to Aboriginal and Torres Strait Islander patients and communities within the comprehensive primary health care context include the following:

> Make non-Aboriginal and Torres Strait Islander health service providers aware of practitioners of traditional medicine in Aboriginal and Torres Strait Islander communities to foster recognition and respect for their role and skills and an understanding of the complementary roles of traditional healers and western-trained practitioners *(NATSIHC 2003a: 18)*

The *National Strategic Framework* includes Aboriginal traditional healers within the range of possible strategies to tackle health issues in the area of 'emotional and social well-being'. The recognition of the role of traditional healers is indicated as a potential strategy adequate to address population health issues *(NATSIHC 2003b: 57)*.

The *National Strategic Framework*'s references to Aboriginal traditional practitioners *(NATSIHC 2003a: 18; 2003b: 57)* seem to be forgotten in the subsequent policy-making process to overcome Aboriginal and Torres Strait Islander health disadvantage. In particular, the *National Strategic Framework*'s *Implementation Plan 2007-2013 (DoHA 2007)* does not include any reference to Aboriginal traditional healers or traditional healing. Nonetheless, the role of Aboriginal traditional practitioners for the health and well-being of Aboriginal

Recommendation 3:
It is recommended that Aboriginal Traditional Medicine be included in the National Aboriginal and Torres Strait Islander Health Plan. The integration of Aboriginal Traditional Medicine aligns with the fundamental principles of the National Aboriginal and Torres Strait Islander Health Plan

Recommendation 4:
It is recommended that the review of the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being 2004-2009 include Aboriginal Traditional Medicine and Aboriginal traditional healers in the new national policy framework, strategies and implementation plans

The National Strategic Framework includes Aboriginal traditional healers within the range of possible strategies to tackle health issues in the area of 'emotional and social well-being'

individuals and communities are in line with the holistic approach to Aboriginal health and the need to include culture for the attainment of a holistic emotional, physical and spiritual well-being.

3.6 Commonwealth funding: a keystone precedent

Despite the lack of a national legislative and policy framework on Aboriginal traditional medicine and Aboriginal traditional healers, the Commonwealth government provides funding for Aboriginal traditional healers' services in South Australia and across the country. In South Australia, federal funding is channelled through the Commonwealth Department of Health and Ageing (DoHA) and the Office for Aboriginal and Torres Strait Islanders Health (OATSIH).

> In OATSIH there is not a statement about ngangkari.[17] I suppose there is a precedent that it is something that OATSIH has funded around the country and there are a number of ngangkari services that we have signed off; we have signed off on the inclusion of ngangkari services in health plans. So it has been endorsed but it hasn't been endorsed in the sense of a definite policy position... but we have done it and it has happened all around the country... *(Interview Senior Administrator 1)*

> some of them [Aboriginal community controlled health services] have set funding, some have minimum state funding, but the majority of it is Commonwealth dollars through the Department of Health and Ageing (*Interview Senior Administrator 2*)

The Department of Health and Ageing does not have specific policies or guidelines on the financing of ngangkari services, nor does it have a defined funding stream to guarantee a systematic provision of these services. In South Australia, federal funding streams for ngangkari services are channeled as part of primary health care plans through OATSIH funding or the 'Regional Health Services Funding Agreements' for rural and remote areas.

> It is fair to say that there is no a single part of the Department which funds ngangkari, there is not like a line which says 'ngangkari services'. It doesn't exist as a program in and of itself. There are a number of programs in the Department that brings various packages and services and in some locations ngangkari has been picked up as one of those services *(Interview Senior Administrator 1)*

> We recognize there is not a single policy position on ngangkari. They have been supported as part of primary health care though, but it is not like GP funded through Medicare where there is one avenue of funding... In some places where OATSIH is funding services, that part of primary health care would include a ngangkari service; same for the RHS, there would be a part of services and ngangkari services are included as part of that *(Interview Senior Administrator 6)*

The 'Regional Health Services Funding Agreements' (Regional Health Services or RHSs) are devised specifically for rural and remote areas to meet 'community identified priorities for health and aged care services' *(DoHA 2000)*. In South Australia, the Commonwealth Department of Health and Ageing funds the Regional Health Services which are centrally administered through Country Health South Australia. The Commonwealth Department of Health and Ageing's federal funding channeled through the RHSs and OATSIH can be combined with state funding.

> It can be a combination of both Commonwealth and state, so some of those services would get funded blocks of money and then they have the opportunity to do things with that money with the services or part of the planning for services... so individual ngangkari programs and services are being run within those units *(Interview Senior Administrator 6)*

> Country Health SA funds NPY Women's Council and Nganampa Health Service, we fund both of them...We also fund them for ngangkari programs but we fund them a block of money for their ngangkari services and it's up to those services define how they use it *(Interview Senior Administrator 2)*

Both federal and state funding for ngangkari programs do not establish any requirement in relation to payment thresholds for ngangkari services. The need for a consistent process in relation to funding agreements is considered to be useful,

> we haven't got any hard and fast rules even with the organizations we fund that this is

17 The term ngangkari and Aboriginal traditional healers are used interchangeably in the South Australian context.

what their [ngangkaṟi] payments should be. We haven't stipulated that in any of our agreements because we have nothing to base it on... But we also need a consistent process for the way we fund. If we are funding them lump sums, we really need to stipulate with our lump sum payments and conform with payments that are set with our policy. Because otherwise, we're just giving them a bucket of money but at the same time, we are saying you need to do this but we don't... (*Interview Senior Administrator 2*)

Federal and state funding streams for mainstream and AHCSA's Aboriginal health services providing ngangkaṟi services across South Australia are detailed in Table 5.

The current DoHA allocation of funding for ngangkaṟi services is based on a community-driven approach whereby each health care organization determines what services are required in the community on the basis of their communities' health care needs,

...I think that's probably one of the reasons why it is hard to get a single story about the ngangkaṟi because the use of ngangkaṟi is tended to be driven by what the community on the ground wants...We got a process where we look at the community and [we say]...ok...what group of services do you need? The ngangkaṟi has been a part of that. That [ngangkaṟi services] can come up through any number of channels....so this is how it has evolved over time *(Interview Senior Administrator 1)*

The OATSIH's underlying philosophy of funding, particularly for community-controlled services, it is basically the WHO's view that best health outcomes involve people and what their health priorities are, and community-controlled are the natural extension of that where the organization working with the community determines their priorities *(Interview Senior Administrator 1)*

So to ensure that ngangkaṟi services can be delivered on the ground, the way it is at the moment is that individual services identify and they have their own local arrangements. This actually works reasonably well. My personal view is that those decisions about what level of involvement a ngangkaṟi should have in the service and how these arrangements should work are probably best worked out at the service level by each service...*(Interview Senior Administrator 1)*

There exists an increasing interest to develop a more integrated system to provide ngangkaṟi services through Commonwealth-SA partnerships. In particular, OATSIH and Rural and Population Health are interested in supporting the integration of ngangkaṟi services in collaboration with Country Health SA.

...we recognize there is not a single policy position on ngangkaṟi... I think right now it is a time that we are all saying that. There are rural programs looking at ngangkaṟi, OATSIH is looking at ngangkaṟi and so on.... (*Interview Senior Administrator 1*)

There is a huge interest in this project. Our section would be interested in looking at integrating the services of the ngangkaṟi in collaboration with Country Health SA into the rural projects that we have at the moment. It is mainly regional health services providing rural and primary health to people living in those rural areas. There are about 10 services at the moment and Ceduna is one of them. We also have other services which are not part of those rural and primary health services (*Interview Senior Policy Officer 1*)

The public financing of ngangkaṟi services as part of primary health care constitutes an important endorsement of the role of Aboriginal traditional healers within the Australia's health care system. Federal funding for Aboriginal traditional healers' services constitute a keystone precedent for the recognition of Aboriginal traditional medicine as a legitimate medical system and Aboriginal traditional healers as legitimate practitioners.

Recommendation 5:
It is recommended that the Commonwealth government strengthen funding agreements in partnership with the South Australian government to support the systematic provision of Aboriginal traditional healers interventions in the South Australian health care system

3.7 South Australia: Legislation on Aboriginal traditional medicine

The Government of South Australia has passed legislation that recognises the role of 'traditional healers' in the provision of mental health care to Aboriginal and Torres Strait Islander people. The *Mental Health Act 2009* recognises the significance of traditional healers and includes their involvement in mental health care among the fundamental principles that guide the administration of the Act. The recognition of traditional healers is articulated in section 7(1)(c)(iv) which stipulates that mental health services should:

> in the case of patients of Aboriginal or Torres Strait Islander descent, take into account the patients' traditional beliefs and practices and, when practicable and appropriate, involve collaboration with health workers and traditional healers from their communities.

This provision identifies Aboriginal patients' 'traditional beliefs and practices' and the involvement of 'traditional healers' as a key element to be considered in the provision of mental health services. The respect for 'patients' traditional beliefs and practices' and the 'collaboration with traditional healers' is to be applied across mental health services which include 'all services involved in the treatment, care and rehabilitation of persons with serious mental illness, including the making and carrying out of orders under this Act and services to assist the recovery of patients after the termination of the orders of the completion of treatment' *(Mental Health Act 2009, s(2))*. The broad definition of mental health services entails the collaboration with traditional healers throughout the overall treatment, care and rehabilitation process.

The inclusion of traditional healers in mental health care is reinforced by sections 7(1)(c)(i) and 7(1)(c)(iii) which respectively establish that services should:

> be governed by comprehensive treatment and care plans that are developed in a multi-disciplinary framework in consultation with the patients (including children) and their families or other carers or supporters; and
>
> take into account the different backgrounds of patients.

The normative recognition of traditional healers as a key component in the delivery of mental health services for Aboriginal people requires to be translated into operational terms. As a senior administrator highlights '...the next step is an implementation plan that goes alongside the *Mental Health Act* (*Interview Senior Administrator 3*).

The implementation plan in relation to the involvement of traditional healers in mental health services should take into account two key elements: where the onus to ensure the involvement of traditional healers lies and the acknowledgment of the need for a 'multi-disciplinary framework'. The onus to respect and infuse the principles set in section 7 of the *Mental Health Act* is shared among the key stakeholders involved in the administration of the Act, including '[t]he Minister, the Board, the Chief Psychiatrist, health professionals and other persons and bodies' (s7(1)). This provision places the responsibility across a broad spectrum of stakeholders, requiring politicians, policy makers and health professionals to actively engage in an implementation process guided by the stated principles. Secondly, the norm establishes three key interrelated principles whose combination and practical implementation have an important role for the health of Aboriginal people. These principles include the development of a 'comprehensive treatment' through a 'multi-disciplinary framework', and the need to take into consideration the 'different cultural background' of patients. The interplay of these elements and the inclusion of traditional healers in mental health care provide the legislative framework and conceptual foundation for a broader understanding of health care and health service delivery models for Aboriginal and Torres Strait Islander people.

The *Mental Health Act 2009,* s7(1) is a keystone for the normative recognition of Aboriginal traditional medicine and the development of a consistent statewide policy framework in South Australia.

3.8 South Australia: Policy development on Aboriginal traditional medicine

In South Australia, the *Overarching Bilateral Indigenous Plan* (OBIP) stipulated between the Commonwealth of Australia and the State of South Australia provides the foundational platform to integrate, coordinate and implement the new partnership to Closing the Gap in

Indigenous disadvantage *(Commonwealth of Australia and Government of South Australia 2010)* in accordance with the commitments made under the National Indigenous Reform Agreement. The implementation plan to Closing the Gap in Indigenous health outcomes *(Government of South Australia 2009)* set a package of health reforms grounded and integrated with the principles, targets and commitments made in the *Aboriginal Health Policy* (SA Health 2007a), the *South Australia's Health Care Plan 2007 – 2016* (SA Health 2007b), the *SA Health Strategic Plan* (SA Health 2008a), the *SA Health Statement of Reconciliation* (SA Health 2008b), the *Aboriginal Health Impact Statement the Aboriginal Workforce Development and Reform Strategy* (SA Health 2009), and the *Aboriginal Cultural Respect Framework* (SA Health 2004).

Aboriginal traditional medicine and Aboriginal traditional healers' services are not included in the South Australian Closing the Gap policy machinery. The lack of an overarching statewide policy framework on the role of Aboriginal traditional healers – ngangkari – and the delivery of their services in the health care system is widely acknowledged within the South Australian Department of Health:

> There is no statewide focus or statewide policy regarding the ngangkari programs so each area and each community-controlled health service, and each part of SA Health do it differently. And even within Country Health, some hospitals do it differently...*(Interview Senior Administrator 5)*
>
> there is no consistent process applied around the ngangkari programs across South Australia *(Interview Senior Administrator 1)*
>
> at the moment it's really open, we've got some individual units and separate policies...for example Ceduna Hospital will have its own policy for ngangkari, how you get ngangkari services, and what the pay schedule is *(Interview Senior Administrator 5)*

For over a decade, the South Australian Department of Health (SA Health) has been grappling with the issue of developing a statewide policy framework and service delivery model. Different branches of SA Health have engaged in a range of discussions: 'we've had several projects here in the Aboriginal Health Division, exploring ways of developing a service model for the utilization of traditional healers' (*Interview Senior Administrator 3*).

Preliminary discussions about the role of ngangkari and the search for an appropriate delivery model started around 1997-1999. Then a series of draft reports and discussion papers have been produced to explore the key issues around the recognition of ngangkari and their employment within the South Australia's health care system *(Interview Senior Administrator 3).*

3.8.1 The Browne's draft report

In 2000, the Aboriginal Services Division, Department of Human Services produced the first draft report on ngangkari and the South Australian health system. The Browne's draft report provides an overview of the key issues and challenges related to the recognition of ngangkari as 'specialist traditional doctors/ healers'; it discusses existing and potential employment arrangements; it proposes a range of policy options and objectives for a more consistent involvement of traditional healers in Aboriginal community controlled health organizations and other health related government agencies across South Australia *(Browne 2000).* The Browne's Report marks a significant step in the development of a statewide policy framework for the recognition of ngangkari and the inclusion of their healing treatments in the health care system.

The Report identifies the following key principles: the need to recognise ngangkari 'as specialist doctors/healers in their own right as an integral part of community health services'; the adoption of 'a holistic primary health care approach in a community development framework' *(Browne 2000: 3,9)*; the need to ensure that 'all Aboriginal people will have the opportunity to have access to traditional healers on request through all community controlled health services and health related government agencies in South Australia' *(Browne 2000: 3,14).*

In terms of policy guidelines, the report presents five possible service delivery models. Options 1 and 3 recommend the maintenance of the status quo whereby health services employ ngangkari based on need and demand. Option 1 suggests two employment arrangements: a long-term salary basis when the ngangkari reside in the same location of the health service; employment on a consultation basis and travelling allowance

in cases where ngangkaṟi don't reside in the same location of the health service. In option 3, each health service would act in complete independence in terms of potential cooperation with other services and the extent to which the ngangkaṟi services are provided. Options 2 and 5 indicate Pika Wiya Health Service and NPY Women's Council respectively as two potential central bodies that could be endowed with the responsibility to coordinate the provision of ngangkaṟi healing services across South Australia. Option 4 suggests to support a team of ngangkaṟi who could work as a consulting group and provide their healing services on a fee-for-service basis *(Browne 2000: 12,13)*.

The report indicates a two year timeframe for the achievement of a series of strategies that would potentially lead to the adoption of a statewide policy framework informed by the recommended measures. The Browne's Report indicates Option 2 as the preferred service delivery model whereby Pika Wiya Health Service would function as the 'State's Central Coordinating and Employment Agency to employ appropriate ngangkaṟi on behalf of Aboriginal community health services and allied health services to provide a traditional healing service to the Aboriginal community' (Recommendation 10) *(Browne 2000: 4,25)*.

3.8.2 The Burgoyne's draft report

In 2009, the Aboriginal Health Division (AHD) produced a draft report on the current status and historical development of service agreements for the employment of ngangkaṟi in health care services across the state. In this report the AHD endorses the vital role and respect enjoyed by ngangkaṟi in their communities:

> The AHD acknowledges that traditional Aboriginal Ngangkaṟi traditional health healers have been practicing for thousands of years, and are respected by their Aboriginal communities throughout Australia as traditional doctors. Ngangkaṟi play a vital role in shaping the lives of Aboriginal people, and play an important role on influencing and managing their spiritual and physical well-being. A qualified ngangkaṟi is a very knowledgeable person when determining a person's health status...' *(Burgoyne 2009: 6)*

The report highlights the significant role ngangkaṟi play for the well-being of Aboriginal people and their communities; it raises some key issues under discussion among different agencies, and it documents the development of funding and consultancy agreements between the Commonwealth and South Australian Health Departments and different Aboriginal health care services and other organizations *(Burgoyne 2009)*.

The role of ngangkaṟi is described in relation to the special skills and powers they have, the special training they need to follow to become fully-fledged ngangkaṟi, and some of the healing services they can provide (Burgoyne 2009: 6-9). It is evident that these sections, even if briefly articulated, intend to emphasise the existence of a different yet legitimate medical knowledge system based on Aboriginal law and culture. This can be considered the first attempt to articulate and endorse the 'traditional system of education and training' as an alternative educational system which runs parallel to the western educational system:

> A non-Aboriginal child is educated through the western education grading systems of studies each year through the different levels of primary school classes, before moving into high school, and then university to become qualified as a Doctor of their choice. This form of education is assisted with set criteria that are supported by numeracy, English, technology, literature and colonial history studies. An Aboriginal traditional Ngangkaṟi health healer's education and training is similar to the western process of education in their development of knowledge and understanding of medication and healing to become a qualified traditional Ngangkaṟi *(Burgoyne 2009: 9)*

The report considers some of the key issues under discussion, including the number of 'registered ngangkaṟi' and ngangkaṟi's service fees. Drawing on information gathered from Nganampa Health Council, the Ngaanytjarra Pitjantjatjara Yankunytjatjara Women's Council and the Aṉangu Remote Alliance Health (ARAH),[18] the report indicates a set of rates for ngangkaṟi services and associated costs as well as an estimated number of 12 ngangkaṟi employed through Nganampa Health Council and

18 The Aṉangu Remote Alliance Health (ARAH) is made up of Ceduna/Koonibba Aboriginal Health Service, Nganampa Health Council, Tullawon Health Service, Umoona Tjutagku Health Service and the Oak Valley Health Service.

NPY Women's Council and 4 other ngangkaṟi operating in their communities but not formally employed *(Burgoyne 2009: 10-13)*. The estimated number of ngangkaṟi to provide healing services across South Australia, Western Australia and the Northern Territory rises to 19 when considering the total number of ngangkaṟi who attended the first ngangkaṟi gathering at Muṯitjuḻu, NT.

In 2000, a ngangkaṟi meeting was organised by NPY Women's Council to provide a forum for ngangkaṟi to tell their stories about their way of healing so as to educate non-Aboriginal health workers about their healing practices. The Muṯitjuḻu ngangkaṟi meeting was attended by 19 ngangkaṟi from the Ngaanytjarra Pitjantjatjara Yankunytjatjara Lands. The gathering was very successful as ngangkaṟi could tell their own stories and it promoted a better understanding of the value and significance of ngangkaṟi practices in contemporary Aṉangu communities. The stories were recorded and collected in the book *Ngangkaṟi Work – Aṉangu Way: Traditional healers of Central Australia* (2003). Unfortunately, no follow up meetings were organized due to the high cost involved in the logistical arrangements that could not be met by the NPY Women's Council *(Burgoyne 2009: 11)*. The need for further ngangkaṟi meetings, however, has continued to be an ongoing urge. As a SA Health's senior administrator pinpoints:

> One of the things we're going to do with that particular project [Burgoyne's report]... was to actually sponsor the bringing together of ngangkaṟi...to coordinate this event because ngangkaṟi are saying that there are fake ngangkaṟi out there. They might be healers, but they're not ngangkaṟi. You got to get this gift from your family, your grandfather, your grandmother sees it in you as a child and you grow up with the skills *(Interview Senior Administrator 3)*

Notwithstanding a shared agreement on the need to sponsor other ngangkaṟi meetings to discuss the challenges and possible ways forward, no initiatives had been undertaken after the Muṯitjuḻu's meeting in 2000.

The Burgoyne's draft report briefly flags important issues that need to be addressed, including public liability and risk litigation, articulation of a consistent consultation fees schedule for ngangkaṟi and interpreters/ supporting workers, qualifications and registration of ngangkaṟi as health practitioners, availability of transport.

The report also provides a timeline of a range of specific agreements stipulated to provide ngangkaṟi healing services across South Australia. The report traced the way in which the Commonwealth and South Australian Health Departments have funded NPY Women's Council and Nganampa Health Council.

From 1997 to 2009 different funding agreements have been stipulated between the Commonwealth Department of Health and Family Services, through the Office of Aboriginal and Torres Strait Islander Health (OATSIH), and NPY Women's Council; the Department of Human Services and NPY Women's Council; the SA' Aboriginal Health Division and NPY Women's Council; Country Health SA and NPY Women's Council; the SA Aboriginal Health Division and Nganampa Health Council; Country Health SA and Nganampa Health Council. The report also indicates a consultancy agreement stipulated in 2006 to provide ngangkaṟi services in the metropolitan area of Adelaide. The 2006 consultancy agreement was initiated and coordinated by Nganampa Health Council in consultation with AHCSA. The agreement involved the provision of ngangkaṟi healing services for a period of 8 days across different health care services, such as the Central Northern Adelaide Service acute and primary care units, the Southern Adelaide Health services acute services, the Child, Youth and Women's Health Services.

Overall, the Burgoyne draft report touched upon important issues:

First, it highlighted how the success of NPY Women's Council ngangkaṟi program led other Aboriginal community-based services in South Australia to introduce similar programs on a continuing or needs basis. As a result, the demand for ngangkaṟi has steadily increased over the last decade both in rural and metropolitan areas *(Burgoyne 2009: 4,13)*.

> Due to the success of the ngangkaṟi service in remote areas, the service has been extended to urban and metropolitan Aboriginal communities in South Australia, because of the growth in demand and access to the oldest living form of health practice in the world *(Foreword by April Lawrie-Smith in Burgoyne 2009: 3)*

> With the success of the tri-state cross border ngangkaṟi's healing services, Aboriginal health services and communities are now placing a greater emphasis on traditional healing to address their health and wellbeing. Aboriginal people...believe that they {ngangkaṟi} should be included within medical and disease related health assessments and treatment of Aboriginal people, in consultation and coordination with health services and medical professionals *(Burgoyne 2009: 4)*

Second, it reported on the need for an ongoing and structured ngangkaṟi funded program across the state in regional and metropolitan areas:

> ...this service is growing in demand and Aboriginal services do not have specific budget allocations for this service *(Burgoyne 2009: 24)*

Third, it stressed that ngangkaṟi should be acknowledged as health practitioners:

> ...this recognition would be definitely a worthy acknowledgment for the work ngangkaṟi perform *(Burgoyne 2009: 24)*

3.8.3 Mental Health Unit: the Stewart's and Turner's draft discussion papers

The Mental Health Unit within SA Health developed two versions of a draft discussion paper titled *Ngangkaṟi: Practitioners in Medical and Mental Health Settings - A Framework Document.* The two versions, respectively developed by Harold Stewart (2009) and Mike Turner (2010), provide the same content with minimal stylistic and structural variations.

The purpose of these discussion papers was to explore key issues involved in accessing ngangkaṟi in mental health settings. These papers identify important issues in Aboriginal mental health care. First, a broader understanding of the concept of mental health is identified:

> In the Aboriginal community, mental health is considered in the broader holistic context of social emotional well-being. Social and emotional well-being is described as a state of spiritual, social, psychological and emotional well-being. Mental health is a positive state of mental wellbeing free of psychological and emotional distress and coping with the normal stressors of life *(Stewart 2009: 2)*

Second, the shortage of Aboriginal mental health workers both in mental health services and forensic mental health services urge the provision of access to ngangkaṟi to Aboriginal mental health sufferers. Third, it pinpoints the 'growing acceptance of the relevance of traditional healers in the hospital acute setting where there are significant numbers of Aṉangu and other traditional people in acute care for regular stays for chronic health conditions' (Stewart 2009: 4). Importantly, a strong claim is made for the need to recognise ngangkaṟi as 'legitimate practitioners' in mental health settings *(Stewart 2009: 2).*

The discussion papers draw on previous draft reports on ngangkaṟi in health care settings and reiterate most of the issues highlighted in those documents. A range of issues limiting access to and use of ngangkaṟi in mental health acute care settings include the high costs associated with consultation fees; transport and accommodation expenses involved for the provision of ngangkaṟi services in rural and urban areas across SA; lack of a consistent payment process within mainstream health services. In this regard, the lack of an ABN number or a Medicare provider number is considered as one of the major obstacles in the processing of payments to ngangkaṟi. Another important issue is the 'registration of ngangkaṟi': questions are raised about the possibility of having a formal recognition of ngangkaṟi, how to ensure professional standards, and whether an existing organization, such as AHCSA, would be willing to be responsible for the recognition of ngangkaṟi *(Stewart 2009: 5).*

In terms of a possible service model for ngangkaṟi practice, the four options replicate those presented in previous reports. These are:

1) to maintain the status quo whereby there is no coordination among health services and ngangkaṟi are engaged based on need and demand;
2) coordination by a central body in conjunction with an Aboriginal health service which has community and cultural links;
3) ngangkaṟi constituting themselves as a consulting group who would provide services upon invitation of the health services. This option is indicated to be very unlikely 'as ngangkaṟi act independently of each other, and are not interested in becoming consultants with an ABN or tax file number' *(Stewart 2009: 6)*;
4) the last option indicates NPY Women's Council as the more appropriate body

to coordinate ngangkari visits in South Australia given its experience in running and administering the ngangkari program for several years. Option 4 or a combination of options 4 and 2 are indicated as the most viable options.

The draft reports conclude with some recommendations on the following issues:

a) the need to recognise ngangkari as mental health practitioners: 'Ngangkari should be recognised as mental health practitioners that provide services in the primary health care setting at the request of the Indigenous consumer' *(Stewart 2009: 8)*;

b) the need to coordinate ngangkari visits: '[c]oordination of Ngangkari services through programmed visits might be the most cost effective and time efficient way to metropolitan and rural access when a Ngangkari is traveling from remote communities. This would enable Ngangkari to consult with a number of consumers in the same way that a specialist programs consultations' *(Stewart 2009: 8)*;

c) to endorse Aboriginal community controlled services with the coordinating role to arrange consultations and administer payment to ngangkari *(Stewart 2009: 8)*;

d) the possibility for clients to make appointments at the health services *(Stewart 2009: 8)*;

e) planning and organizing a ngangkari forum. It is recommended that the Aboriginal Health Division and Central Northern Adelaide Health Service convene a forum to bring together all stakeholders to consult with ngangkari on a range of issues raised in the discussion papers *(Stewart 2009: 8)*. These include: who is a ngangkari; who defines them and how they are recognised; who has the authority to endorse the status of ngangkari; what health service can they perform and where; whether ngangkari work with groups (eg cancer sufferers, elders groups), or with non-Aboriginal patients; whether they work alone. Also whether it would be appropriate to invite to the forum other healers using other techniques like Reiki and whether ngangkari need interpreters.

These documents provide the key points of discussion that continue to engage different divisions within DoHA, OATSIH and SA Health.

3.9 Challenges

The policy analysis and findings from interviews with senior administrators identify the key challenges in the development of a national or statewide policy framework that acknowledge Aboriginal traditional medicine as a legitimate medical system and recognise Aboriginal traditional healers as legitimate health practitioners. Those challenges are considered the primary stumbling blocks for the development and implementation of a health care service delivery model to provide ngangkari services in the South Australian health care system.

3.9.1 Bureaucratization and westernization

The idea of a national recognition of the role of Aboriginal traditional healers in the health care system is encountered with scepticism. These include the potential bureaucratization and westernization of the role of ngangkari, and the danger of superimposing a national framework on local-driven arrangements for the provision of ngangkari services.

> I can see a world of problems coming down that path of bureaucratizing the role of ngangkari, which is not to say that they shouldn't have national recognition but I think we've got a fairly narrow framework of what that actually means *(Interview Senior Administrator 1)*

> The more we try to formalize it and nationalize it, the harder it would be for those local service providers to have the arrangements that work for them with the ngangkari they recognize in their local communities *(Interview Senior Administrator 1)*

> If you try to impose a national framework it wouldn't work...I think the best kind of outcome you could get out of a national framework would be kind of: this is an OK item to fund and we consider it to be in scope with primary health care and I would not be inclined to push it beyond that... *(Interview Senior Administrator 1)*

3.9.2 Accreditation, qualification and registration

The recognition of Aboriginal traditional healers as legitimate health practitioners poses thorny issues in relation to appropriate accreditation, qualification, and registration standards.

Burgoyne (2009: 20) highlights how the lack of qualifications and training standards in line with the western bio-medical model constitute a serious difficulty for the recognition and registration of ngangkari as legitimate health practitioners:

> Dr ... explained that he could not see the medical board approving the registration of ngangkari as practitioners without having the Certified Doctors medical training and education qualifications. The reason behind his thought is that ngangkari have not gone through a western education system and completed an undergraduate qualification in the medical field.

The process of accreditation, qualification and registration for qualified ngangkari continues to be one of the most problematic barriers:

> Try to think about what it would be like to overlay a regulatory framework nationally on ngangkari... are you an accredited ngangkari? *(Interview Senior Administrator 1)*

> One other thing that you might have come across though is some of the blocks in the system with engaging ngangkari because the whole aspect of who's recognized as a professional? Do we employ them? That seems like a hard question for the department to actually address, that's right. By using the whole fee for service aspect, by bringing in someone and to do the work, like contracting for services, is probably the way we can actually get around it and engage ngangkari for that without coming across too many hurdles and barriers.

> They would argue and I would support this that they are medical practitioners in their own right and culturally they are medical practitioners. And while that might be a resource issue, certainly, the other has been whether western health systems, like our own SA health system, whether they would see traditional healers as being on an equal footing and would see them as going through all the rigor that they experience, you know, university, getting your accreditation, getting your qualifications, going through a board, and then you can get your certificate to practice *(Interview Senior Administrator 3)*

These points raised in relation to accreditation, qualification, and registration standards fail to take into account the existence of a specific Aboriginal traditional medical knowledge system equipped with a definite educational and training model to which fully-fledged ngangkari must adhere.

> ...ngangkari are highly skilled in providing spiritual, physical and emotional wellbeing support services...Ngangkari do not have western undergraduate tertiary qualifications; however, they have developed their skills and powers as an apprentice learning from their grandfathers over many years the art of becoming a qualified ngangkari...Both men and women ngangkari are seen by many Aboriginal communities and health professionals as equal to doctors in the health healing work they perform... *(Burgoyne 2009: 20)*

Recommendation 6:
It is recommended that Aboriginal traditional healers themselves determine the process of accreditation, qualification and registration according to their traditional medical knowledge system. Qualification, accreditation and registration standards should align with their traditional educational and training model, rather than the western bio-medical model

3.9.3 Rates and payment schedule

The issues of accreditation, qualification, and registration is closely linked to the issue of reimbursement of ngangkari services within the national and state health care system.

> if you were to look at say funding ngangkari through the Medicare stream, then you take it into a debate about equivalent qualifications of practitioners, if you only see the challenges ngangkari have, only to be reimbursed through the conventional financial system... (*Interview Senior Administrator 1*)

> Another issue that has been raised...was the issue of payment schedules and how do you? I mean it opens a very big can of worms. Because you have to talk about the

> accreditation, the registration of ngangkaṟi, how do you apply the western model to traditional use? (*Interview Senior Administrator 5*)

The provision of ngangkaṟi services within the health care system raises two key issues: a) what is the most suitable service model to ensure the reimbursement for ngangkaṟi services in line with the conventional financial system; b) what rates and payment schedule should be adopted.

The current service model is a fee-for-service contractual arrangement whereby ngangkaṟi are contracted as consultants and payed on a fee-for-service basis:

> At this point in time, that particular funding and services model is probably the best way at the moment we can do this: getting ngangkaṟi in, whether it's for client services or for the staff through the employee assistance program. So you know, we basically use those contractual arrangements to engage them as consultant, a provider, same thing... *(Interview Senior Administrator 3)*

Alternative options are suggested, such as the provision of a Medicare number or the inclusion of ngangkaṟi services in national and state health care packages.

> It'd be nice down the track that they [ngangkaṟi] can have a Medicare number. Talk about influencing national policy, about health access *(Interview Senior Administrator 3)*

> ...Or they can be a part of the mental health care packages that you can get. You can currently get mental health packages that give reduced fees to see psychologist, mental health care plan, you can access, I think it's five or ten visits to a psychologist at a reduced rate through Medicare *(Interview Senior Administrator 4)*

The second issue relates to what rates or payment schedule should be used for ngangkaṟi services. This issue entails determining what would be a fair remuneration and what parameters should be used. In this regard, it is noted that the role of ngangkaṟi extends beyond the individual-based health care model of the western system. Ngangkaṟi have the responsibility to provide healing not only to individuals, but also to communities and the land. In addition, the timeframe of their work is not limited to a timetable in the same way that western health practitioners operate within the health care system.

> In the western model we pay for a 'thing'... you pay someone to come in and do this activity, you don't pay for them to exist and to just do everything that they do from when they get up in the morning... a lot of the ngangkaṟi work is part of who they are and the way they move through their community, and I think we struggle to work out how that would be reimbursed...because it doesn't align to our way. Our doctors go home at the end of the day and they don't pick up the phone or whatever, and they can knock off. But it doesn't work that way for community stuff...it is day and night... *(Interview Senior Administrator 1)*

While the issue of what rates should be used remains open, there exists an overarching agreement around the need to adopt a consistent payment schedule.

> We've had several projects here in the Aboriginal Health Division, exploring ways of developing a service model for the utilization of traditional healers. But what we have always experienced is the resource issue. Because ngangkaṟi, and rightfully so, should be reimbursed for fee-for-service *(Interview Senior Administrator 3)*

> There needs to be more consistency on ngangkaṟi and interpreters' rates/fees agreed on and set by ngangkaṟi, in consultation and negotiations with Country Health SA, Aboriginal community health services, hospitals and departments to streamline fairness with all services *(Burgoyne 2009: 22)*

> whether you have policy around the payment of services to ngangkaṟi and something consistent across countries for us. Because some might get paid $40 and some $100... I don't think we've got any specific policy around that at the moment. It's all very *ad hoc (Interview Senior Administrator 5)*

> I think we need something, at least some basic framework to hold it into place because at the moment ngangkaṟi can be paid very little or a lot *(Interview Senior Administrator 5)*

Recommendation 7:
It is recommended that a consistent fee-for-service payment schedule for ngangkari services be established and applied within the South Australian health care system. The fee-for-service payment schedule should be negotiated in partnership with the ngangkari, Aboriginal community controlled health services and mainstream health services

3.10 Challenges: real or biased?

The policy analysis and interview data have raised compelling challenges. Are these challenges real or biased? There is no doubt that accreditation, registration and qualification standards and processes for the recognition of ngangkari as qualified Aboriginal traditional health practitioners pose thorny challenges. Yet, a foundational biased assumption undermines current efforts to overcome these challenges: the adoption of concepts and parameters grounded in the western biomedical health care model as the yardstick for the recognition of ngangkari as legitimate traditional health practitioners.

Evidence presented in the previous chapter demonstrates how the recognition and inclusion of Aboriginal traditional medicine and Aboriginal traditional healers in COAG's Closing the Gap and National Health Plan requires moving beyond the western allopathic medical paradigm. In this regard, a senior administrator observes:

> The treatments are... I guess you need to have a pretty open mind about some of the things that a lot of people experience because you can think that's just a magic or wonder how that actually happens... but it is not a rational model, it is very alternative *(Interview Senior Administrator 2)*

The development of an overarching statewide policy framework equipped to overcome existing challenges is considered a key priority to guarantee the consistent and systematic provision of ngangkari services to Aboriginal patients in remote, rural and metropolitan areas across South Australia.

> We want to make sure we have a consistent, overarching policy for the state. If there is going to be a policy, must be statewide... There should be some more formalized process around payments and accessing ngangkari services...you've got the Royal Adelaide and Flinders hospitals where you've got a lot of people from remote areas in those hospitals every day. So people would go and look for support...particularly for the use of ngangkari. So these kind of policies would have a statewide impact...that's why we are always reticent to say Country Health got this policy, because policy at Royal Adelaide, which has got 100 new people there at the moment, there's no policy for them... *(Interview Senior Administrator 5)*

This report aims to respond to the identified need for a statewide policy framework by developing a new statewide policy framework and two-way health care model grounded on the evidence-based enquiry presented in the following chapters.

CHAPTER 4

Ngangkaṟi Services in South Australia

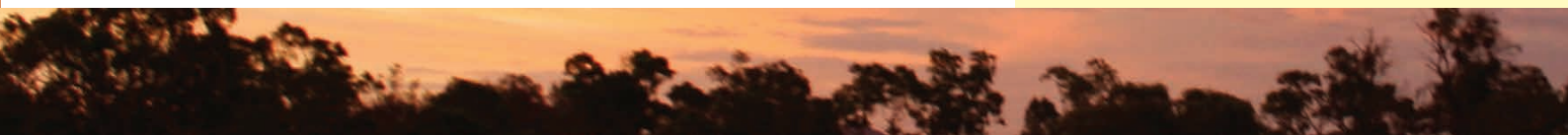
4.1 Introduction

This chapter provides evidence of ngangkaṟi services across South Australia. It includes evidence about the provision of ngangkaṟi services in four settings: mainstream health care services; Aboriginal community controlled health services (ACCHSs) members of the Aboriginal Health Council of South Australia; some Aboriginal and non-Aboriginal organizations outside the health care sector; and in the criminal justice system.

The chapter covers a number of findings from interviews with a range of health practitioners, directors and managers of mainstream and ACCHSs senior administrators and officers from a range of Aboriginal and non-Aboriginal agencies. The findings reveal a diversified picture in relation to the extent to which ngangkaṟi services are provided and accessed across the state. This chapter discusses and analyses the range of factors, issues and challenges that impact on current arrangements of ngangkaṟi services.

The chapter is structured into four sections. Section 1 discusses the provision of ngangkaṟi services across AHCSA's ACCHSs in rural and remote areas. The discussion also includes mainstream health care units that provide ngangkaṟi services in conjunction with the ACCHSs. Section 2 analyses the provision of ngangkaṟi services in the Adelaide metropolitan area. Section 3 discusses the provision of ngangkaṟi services in South Australia's criminal justice system. Each section identifies the key issues and challenges, discusses the key findings and recommends measures to improve current arrangements. Section 4 analyses the issues and challenges of the current arrangements from a statewide perspective.

This chapter discusses and analyses the range of factors, issues and challenges that impact on current arrangements of ngangkaṟi services



Section 1

NGANGKARI SERVICES IN RURAL AND REMOTE AREAS

This section analyses data on ngangkari services within AHCSA's Aboriginal community controlled health services in rural and remote areas. These services include: Nganampa Health Council (APY Lands), Umoona Tjutagku Health Service (Coober Pedy), Pika Wiya Health Service (Port Augusta), Nunyara Wellbeing Centre (Whyalla), Port Lincoln Aboriginal Health Service (Port Lincoln), Ceduna-Koonibba Aboriginal Health Service (Ceduna), Tullawon Health Service (Yalata), Oak Valley Health Service (Oak Valley Maralinga), Pangula Mannamurna Health Service (Mount Gambier), Kalparrin Community (Murray Bridge). The Umoona Aged Care Aboriginal Corporation in Coober Pedy, although not a member of AHCSA, runs a ngangkari program.

There exists a significant degree of variation in relation to ngangkari services provided by these Aboriginal community controlled health services within AHCSA. The degree of variations depends on several factors, including geographical location, availability of funds, demand for and accessibility of ngangkari, degree of urbanization and cultural resilience.

1.1 AHCSA's Aboriginal community controlled health services not providing ngangkari services

A few ACCHSs within AHCSA have never had a ngangkari program. These include *Pangula Mannamurna Health Service* at Mount Gambier, *Nunyara Wellbeing Centre* in Whyalla, *Port Lincoln Aboriginal Health Service* in Port Lincoln, *Kalparrin Community Inc.* at Murray Bridge.

However, most of those services have had occasional engagement with ngangkari, mostly when ngangkari have passed through for family visits or other reasons. On those instances informal visits to community members, staff or individuals have occurred. In a couple of cases, ngangkari have been occasionally engaged in the hospitals or in the Aboriginal health services to provide cleansing of the wards and other buildings.

> We never had a ngangkari program. We've only been running for 6 or 7 years though, so probably we aren't that strong, we haven't been up as long as others. There is no ngangkari here, not at all *(Interview Programs Manager 1-AHS10)*

> No, we don't have a ngangkari program. No, not formally. The community members have engaged them but it hasn't been an official engagement through the health service; but they have been visiting the community and community people *(Interviews CEO AHS4, Clinical Manager AHS4, Programs Manager 2-AHS4)*

> We've had a ngangkari visit though. I think the past CEO introduced ngangkari and the need for Aboriginal medicine to be introduced to the community. It wasn't sort of accepted... *(Interview CEO AHS4)*

The lack of ngangkari programs in these services is due to a range of factors such as geographical location, lack of funding, historical background and cultural resilience.

1.1.1 Geographical location

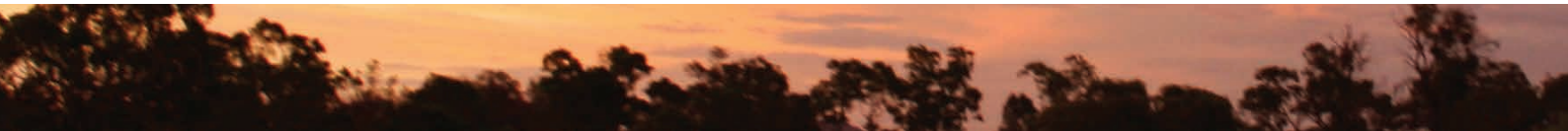
The geographical location of the ACCHSs has a significant impact on the potential operation and sustainability of ngangkari services. The relative distance from the Anangu Pitjantjatjara Yankunytjatjara lands (APY) - where most ngangkari live - makes accessibility more difficult and more costly.

> In Coober Pedy and Ceduna the ngangkari are fairly close by and they are part of the community and so the community would already be discussing them and their services, whereas for us, we would have to bring them here, it's a long way.... So if they were driving it's very long, if they flew it's really expensive...And then we would have to accommodate them for, they would probably need to stay for about a week. That's what they do when they come to Adelaide, they would stay for about a week or 10 days. And of course they need their accommodation and everything. If the community said 'we really need to have ngangkari' and if we had a ngangkari who was willing to come here, that would be great! *(Interview CEO AHS10)*

> Access is a problem *(Interview CEO AHS5)*

1.1.2 Lack of funding

The lack of funding is another important factor which influences ACCHSs' capability to offer ngangkari services to their clients.



No, no funding so far either by state or federal sources. If there were sources allocated and a systematic process we would definitely run a program on ngangkari *(Interview CEO AHS5)*

We don't really have any funds specifically targeted at utilising ngangkari. That's something that our organisation needs to look at and consider how to overcome whether we do or whether we don't utilise ngangkari *(Interview CEO AHS4)*

For us to go down the ngangkari path we would be looking for additional funding to do that, because we just don't have the funding to enable that to occur at the moment. We need to consider the travel requirements and the travel costs, the time cost and also staff cost in terms of doing promotion and education prior to them coming. And I must admit we haven't actually approached it with OATSIH before; we were of the opinion that it would be something that would be looked at down here by them *(Interview Programs Manager 1-AHS10)*

if we had the ngangkari here we would want them to get the same respect that anybody else gets, something to offer and to pay for that, and we also have to respect them *(Interview Programs Manager 1-AHS10)*

...there is no budget for them, no budget anywhere. In the mainstream hospitals all they worry about is credentialing and risk and insurance issues *(Interview CEO AHS10)*

1.1.3 Demand for ngangkari services

The lack of a ngangkari program in these ACCHSs, however, does not always reflect a lack of demand for ngangkari.

There have been requests for ngangkari, and particularly through the elders program *(Interview CEO AHS10)*

I've had a lot of white people asking whether we actually have ngangkari coming into our service, people who have lived up in Ceduna that are aware of the ngangkari model of practice, I suppose. I've had more white people actually requesting or asking than Indigenous people *(Interview Clinical Manager AHS4)*

There hasn't been a great demand of ngangkari mainly because there has never been a ngangkari program so that people don't know about this possibility; and because the population is very young. There have been requests from patients in palliative care *(Interview CEO AHS5)*

A couple of weeks ago two ngangkari in Port Augusta asked if we had a need, but I couldn't give them a definite yes or no because it's not a marketable service here at this place. It should be marketable...*(Interview CEO AHS4)*

The ACCHSs' capability to meet the demand is hindered by a lack of a consistent process to access ngangkari and coordinate their visits.

A few years ago if we wanted to get a ngangkari we needed to go to the Aboriginal Health Council and ask... probably about 2 or three years ago there was a request for ngangkari to come here but there's no kind of set pattern. The ngangkari would arrive and there would only be about one week notice, and then they would be here for about a week or 10 days...*(Interview CEO AHS10)*

Sometimes there would be a call come out from AHCSA to say "does anybody want to have an appointment?", and that made it difficult because there is no set way of where can we find ngangkari and how can we ring them and make bookings for them to come. There's often a big mob of people from here saying "yes, please come and see us", but it's partly to do with not enough time and also shortage of information basically. Probably if the ngangkari would have got here, then there would have been enough people for the person to see. Usually they travel male and female together so they mind men's and women's business as well *(Interview CEO AHS10)*

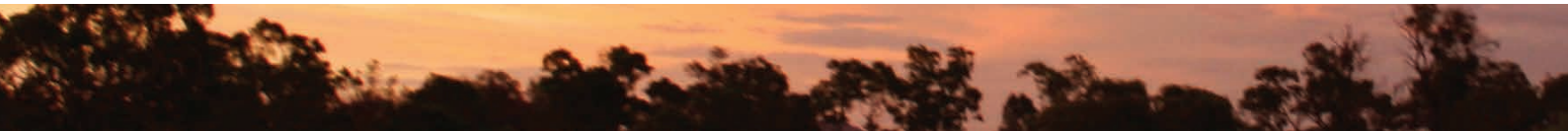
if you want to get one then you have to actually find it somewhere. So I think that is also an issue for services, it's an issue for us *(Interview Programs Manager 1-AHS10)*

Never had a ngangkari program so far. There have been instances where ngangkari have passed through... Access is a problem. They come from the North and when they passed by, there was none to cure. The hospital has allowed ngangkari to treat some patients *(Interview CEO AHS5)*

1.1.4 Historical background and cultural resilience

Historical background and cultural resilience are also important factors. In some areas, the disconnection with traditional ways, especially those related to traditional healing practices, requires the ACCHSs to undertake and engage in a process of consultation with their communities about the possibility and viability to introduce ngangkari services. The potential need for informational and promotional sessions about ngangkari are deemed an important requisite to be included in the consultation process.

> ...I think because of various different issues that have happened in this region over the years, some people in the community actually don't understand or know even within the Aboriginal community what a ngangkari is; and so to actually get a ngangkari program or anything or get them to visit we'd actually do a lot of promotion and actually see if it's fine for some of the community *(Interview CEO AHS10)*



And the other thing is the relationship between the ngangkari and the community, and those sorts of issues, would they want to come down here? In other areas communities know what the ngangkari does, they know what the strengths are of the ngangkari, so the community knows them and the ngangkari know the community; whereas here we don't know the ngangkari and the ngangkari don't know us *(Interview Programs Manager 1-AHS10)*

This is a really urbanised community. I don't want to disrespect anybody, but there are some people that believe in ngangkari and some that don't, so I think that because we are sort of urbanised that they may not prefer to see a ngangkari...So the community may be quite divided over whether they should be able to access them. If we as a health service made a conscious decision and came up with a model of practice to make ngangkari available, that may cause quite a divide within the community *(Interview Programs Manager 1-AHS4)*

It's difficult though, because it brings in that whole traditional, cultural, spiritual, much deeper connection with a spiritual realm that a lot of Aboriginal people are actually perhaps fearful of; and I would say that there is a large percentage of the community here that would be scared if a ngangkari came and started undoing, unearthing things; that it might create a lot of harm in the community. Now, some people may believe that that harm needs to be done in order to move forward and get healing but some would be really fearful of that happening *(Interview Programs Manager 2-AHS4)*

And I think some of the people in the community here... Look, we're all ancestral but we haven't been brought up traditionally so if you go to Ceduna that's different. They're semi-traditional up there and ngangkari, that's in there don't have a problem with it because they've still got both connections. Whereas here we are urbanised and because you've still got stolen generation issues where some of them haven't been able to deal with, which is their upbringing, I think, which is their traditional ties *(Interview Programs Manager 1-AHS4)*

There's a lot of, not dysfunction, but undercurrents in this community at the moment and if they were to start unravelling... I've said before it may be a good thing because it may lead to healing down the pathway. But at this time, it may cause harm for a lot of people...my concerns would be that a lot of that would need to be unravelled in order for that healing to happen is that you're not following traditional skin groups, people have intermarried, such a complex community now that it might start unravelling tensions *(Interview Programs Manager 2-AHS4)*

But there could be other effects too. I mean, I know my own views of ngangkari. My sister has the experience of one and swears by it and it's fine *(Interview Programs Manager 1-AHS4)*

Importantly, most of the ACCHSs that are not running a ngangkari program are keen to initiate a process of consultation both with the community and within their own service to explore the possibility of introducing and providing ngangkari services.

We haven't had the discussion, but if we had the discussion and the community said they're willing to try that, then we probably would explore it, and then we'd look at our budget of course *(Interview CEO AHS10)*

Personally I'd love to see ngangkari come down here, I really believe in their ability in terms of being able to provide a traditional aspect to care. I think that it's important for us down here because we are going through a rejuvenation of culture process, there's a revival of language down here as well as there's a lot of dreaming stories, creation stories and traditional kind of activities like bush medicine and things like that. There is a real revival happening down here and to be able to get ngangkari down here would be a real next step for all of those processes because what they provide, their traditional healing aspect, is really some of the most incredible part to Aboriginal medicine and Aboriginal culture, so for people to see that would be fantastic and to learn about it, and for those who are ill in some way, not terminal of course, but those who are ill would be able to see them and receive a fully Aboriginal form of care; that would be fantastic, it really would *(Interview Programs Manager 1-AHS10)*

I think anything that helps ngangkari to

broaden their range, increase funding and actually get western medical practitioners to believe in what they do, and that it is a legitimate form of medicine in some way would be ideal for all *(Interview Programs Manager 1-AHS10)*

The other thing of course is that we may have lost a lot of the culture and the information here, but sometimes there's sorts of things that come through in families and there would be people around who are healers, and maybe the ngangkari can heal with that too. I would think there would be people around here who can identify sometimes the different skills they have in the family, and some of that has been closed off or haven't had the opportunity, but if you've got a ngangkari there that can recognize that thing and help bring that up again, that would be another question that I'd ask, what is the opportunity if there are ngangkari here who don't know a ngangkari, how to help people? Not everybody can be a ngangkari. That person should have been a ngangkari if they have had a ngangkari to guide them. Is there a possibility or not? *(Interview CEO AHS10)*

It doesn't happen at the moment because there hasn't been one available. I would say that we would have to go through our Aboriginal liaison at the hospital when someone is sick in hospital, just have a simple question "if there was a ngangkari available, would you want that service or something? Or a plaque...*(Interview Programs Manager 2-AHS4)*

A lot of people don't know about them too *(Interview Programs Manager 1-AHS4)*

Something like a ngangkari service is valuable and if it was given a statewide visitation basis, a number of identified ngangkari that consistently travel to rural and capital cities where the access is less as in remote communities, then I think it's a valuable system and valuable resource...I certainly would speak with my board and staff to give our stamp of approval for something like this *(Interview CEO AHS4)*

I am always willing to talk and look into new opportunities *(Interview CEO AHS4)*

1.2 AHCSA's Aboriginal community controlled health services and mainstream health services providing ngangkari services

The Aboriginal community controlled health services that provide ngangkari services in rural and remote areas include: *Nganampa Health Council* in the APY Lands, *Umoona Tjutagku Health Service* and *Umoona Aged Care Aboriginal Corporation* in Coober Pedy, *Pika Wiya Health Service* in Port Augusta, *Ceduna-Koonibba Aboriginal Health Service* in Ceduna, *Tullawon Health Service* in Yalata, *Oak Valley Health Service* in Oak Valley Maralinga.

Findings from the interview data show a significant degree of variation in relation to service arrangements and use of ngangkari across different areas. Furthermore, it is indicated that most of the ACCHSs run their ngangkari services in conjunction with mainstream health care services, particularly public hospitals. In these cases, the degree of management, coordination and responsibility in the delivery of ngangkari services varies according to the service agreements between the ACCHSs and the hospitals.

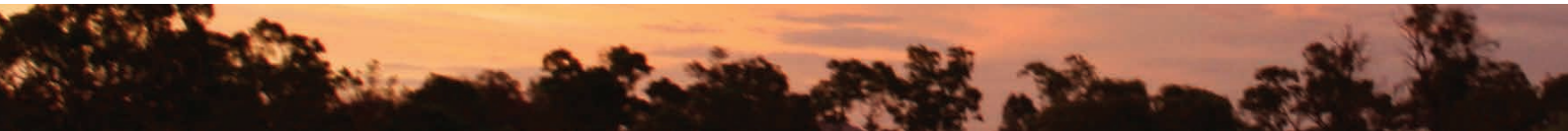
The following sections bring together and analyse the key issues and challenges identified by the interviewees across mainstream and ACCHSs in the remote and rural areas of South Australia. Drawing on the evidence-based analysis, recommendations are made for the improvement of current service arrangements.

1.2.1 Demand for ngangkari services

The provision of ngangkari services in ACCHSs and mainstream health services is a direct response to clients' demand to access ngangkari. Evidence from the interviews shows that there is an increase in the demand for ngangkari services in most ACCHSs in rural and remote area. The demand however is not steady: it fluctuates according to a combination of different factors, including the level of accessibility to ngangkari, availability and accessibility of funding. The interplay among these factors and the demand fluctuations will be discussed in the following sections.

> There's not enough ngangkari and there's too much demand on them *(Interview Hospital Manager 1-H7)*

> They have an increase about the work they



do and I have certainly seen them working mainly in the community. Several ngangkari I have fond relationships with, just from being here. When I sat down and talked to them and they will tell you about what they have been up to and they're always very very busy *(Interview Registered Nurse 3)*

We get a lot of requests, you see. And we get requests here in the health service, and we get a request at home, people request ngangkari at home *(Interview CEO 2-AHS6)*

I went to a meeting once with a couple of them and they spent most of their time treating people and very little time in the meeting because there was such a big need for them. When I talked to them that evening I said "where are you camping tonight?" and they said "out of the community so we can have some rest!" I think it's quite a busy role and demanding personally and time-wise on the ngangkari. There is a lot of demand from the community *(Interview Registered Nurse 3)*

They were here three weeks ago and some of the people that I have spoken to said that they were really helped by them, and I think that shows in the fact that when they came back the second time there were people that were seeking them out again *(Interview Programs Manager 1-AHS7)*

They are really good in the mental health area. And that's where a lot of city people get mental health problems that can use the ngangkari, a lot of young people... *(Interview CEO 1-AHS6)*

It is important that the choice of ngangkari is available for people. If people want to see a ngangkari either for individual healing or house cleansing, it's their personal choice. If patients feel comfortable with the ngangkari, then they will choose that person. We make sure that it's about personal choice *(Interview Director AHS1)*

There is a continuous demand for ngangkari... every week people call me also at ten at night that they need to see a ngangkari. The demand is very high. It is very tiring for me... I feel drained....sometimes I drive to the homelands with my car and the more people asking for ngangkari to go and see them and I don't go back home until 10 pm at night... The other day someone called me because their girl was scared to be in the house ....that something was there and they wanted to smoke their house. So I went there with the ngangkari and more people came and ask the same to smoke their place *(Interview Aboriginal Support Worker 2-AHS1)*

I have worked in different places. When I was at the hospital there have been requests from time to time. But these requests have been mostly led by families and depending on who is available. If a patient asked, I would refer the request to the community-based clinics *(Interview Clinician 1)*

I have always supported it if requested. If ngangkari are requested here at the General Practice, I would refer to the manager primarily mental health counselling *(Interview Clinician 1)*

There is an increasing demand for ngangkari also by non-Aboriginal people.

It's not happened here but there are lots of non-Aboriginal people who use ngangkari *(Interview Psychiatrist 2)*

I've had more white people actually requesting or asking than Indigenous people *(Interview Clinical Manager AHS4)*

Non-Aboriginal clients do use it. People have been using ngangkari, for sure *(Interview Hospital Manager 2-H7)*

There are some non-Aboriginal people who see ngangkari and I have seen ngangkari myself and I had true positive experiences with ngangkari. But I think the call on them is so huge already from their own people that to add the burden of seeing lots of non–Aboriginal people would be huge, maybe pay-wise it would be worse, I don't know. But it's hard enough to get people if they have to go to Adelaide to see somebody or there is a big call from other health areas because they don't have ngangkari in their area anymore; in lots of urban areas these people and their role has disappeared *(Interview Registered Nurse 3)*

For certain things I wouldn't hesitate to see them. They know...*(Interview Registered Nurse 3)*

... Fifty per cent of the consults in terms of that first meeting that I had with Kumanara Peters were with Caucasians, which I found really interesting *(Interview Psychiatrist 1)*

Usually it is on the client's request if they want to see a ngangkari and we organize

someone from Aged Care or someone from the Lands to come down... Sometimes clients have mentioned that there are a lot of people who have passed on in the hospital; they've seen the spirits in the hospital and a lot of people won't stay there. So we asked and organized for the ngangkari to come down and cleanse the hospital *(Interview CEO AHS7)*

1.2.2 Access to ngangkari

In the APY Lands ngangkari are relatively easily accessible either in the communities or through Nganampa Health clinics.

> Ngangkari is providing on call individual services, how that is organised I don't know. They are available, they don't have to be available, they generally are. They'll come anytime either day or night if people go and get them and they will come. So they don't have to be anywhere in particular or have hours or duties, so I just see them as being available when it's needed *(Interview General Practitioner 2)*

> Sometimes people would ask for a ngangkari to come to the clinic and they'd come to the clinic; but most ngangkari activity goes on outside the clinic. Of course the vast majority of it goes on outside the clinic *(Interview Medical Practitioner 3)*

> I would think about it myself because I am here. If I was in Brisbane I don't think I would, but here I have access and I know them so I wouldn't hesitate to access them *(Interview Registered Nurse 3)*

A factor that influences the accessibility to ngangkari is the availability of the 'right' ngangkari. The provision of the 'right' ngangkari means the accessibility to the ngangkari who is considered appropriate according to family kinship relationships and geographical locations.

> I think the difficulty is that there are not that many ngangkari around. So people will say "I want to see a ngangkari", but it's hard at times to find that right person...we don't say that the patients have to see this ngangkari or this other ngangkari. It has to be who that family grouping sees, who they are comfortable with. Also is that ngangkari comfortable seeing them? It's both ways *(Interview Registered Nurse 3)*

> But it's not always the appropriate ngangkari to see somebody anyway because the ngangkari see different people for different things so somebody may want to see a specific ngangkari if they've got a specific problem *(Interview Registered Nurse 3)*

The accessibility to ngangkari is also determined by the availability of the 'right' ngangkari when an episode of care is required. The high mobility across communities can make the accessibility more difficult.

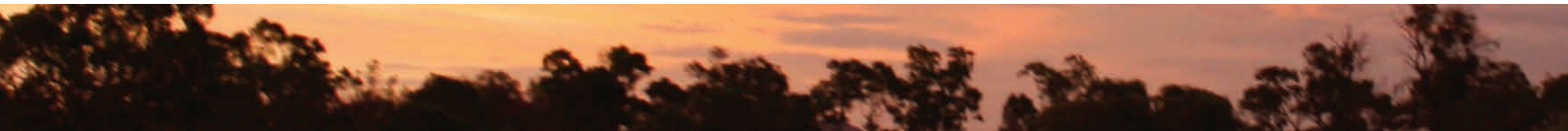
> We had a client, she was very ill and she wanted to see a ngangkari. Initially the family thought that he [the ngangkari] was here. So my colleague and I rang him and said "look, can you go and have a look to see if he can come here?" And you know, people were prepared to bring him down and everything. But he had gone to Adelaide. And that was the most appropriate person for that family *(Interview Mental Health Worker 1)*

Accessibility to ngangkari is also influenced by the travel distance from the health services where ngangkari interventions are required to the APY Lands or other locations where ngangkari can be based at the time of the request. On some occasions, clients are sent to the APY Lands to see a ngangkari; whereas other times the health services try to arrange for the ngangkari to travel to the health service.

> Sometimes when the clients ask and are in need of it, we send a client up there to the lands. Sometimes we try to get them to come down in a vehicle or a bus... *(Interview Hospital Manager 2-H7)*

> The distance is a problem. Most ngangkari don't live here, they live on the lands, we've got a ngangkari here, but most are land's people. Most times they come down on holiday time, most of them are sourced from Adelaide, and they will be called on the way through. They all come to me, but I don't keep a record of that, unless I remember a particular person *(Interview Programs Manager AHS6)*

There are different channels through which health services or other organizations access ngangkari. These include informal channels, such as personal connections and contacts, family and community relationships; more formal channels, such as through organizations that have had experience in providing or organizing ngangkari services. These include Nganampa Health Council, NPY Women's Council, or the Aboriginal Health Council of South Australia.



...one of the other big problems is knowing where to access a ngangkari. It's taken us a couple of years... Because before we found out about Better World Arts and Ngura Wiru, we used to contact Women's Council to know if any ngangkari were down in Adelaide *(Interview Psychiatrist 2)*

When we looked into ngangkari about a month ago we had to ask a wide range of people, and say "do you know of any ngangkari, how do we get hold of them?", so you have to know people who know where they are so if there's a central body that can assist with that it would be really helpful *(Interview Programs Manager 1-AHS10)*

We normally just go through the community because I know where some of these fellas live *(Interview CEO 1-AHS6)*

You can spend a lot of time looking for a ngangkari... a lot of time (*Interview Programs Manager AHS6*)

We contact them or ngangkari will contact us. So, it's a bit of both. Or we'll hear they're in town through the Aboriginal health service or the Aboriginal health services have actively gone up and engaged them and brought them down for a specific purpose. Or their family members have let them know they are here. So really informal contact and a number of times they've rung and said "we're coming down, see you next week", and we haven't seen them *(Interview Hospital Manager 1-H7)*

Maybe they come twice in one quarter or none in the next quarter. We grab what we can. There's no plan at all *(Interview Hospital Manager 2-H7)*

Most Aboriginal and non-Aboriginal health services across the state, except in the APY Lands, can access ngangkari only when they are in town, either for personal reasons or because someone has organised a visit.

Ngangkari are employed occasionally when they are in Ceduna. People are advised through the Aboriginal health service so that they can ask to receive a treatment by the ngangkari in town. *(Interview Hospital Manager 1-H7)*

1.2.3 Funding

1.2.3.a Funding streams for ngangkari services

The Commonwealth Department of Health and Ageing funds the majority of ngangkari services in South Australia. Most of that funding is administered through Country Health SA.

In terms of funding agreements, in rural and remote areas most ngangkari programs are funded through the 'Regional Health Services (RHS) Funding Agreements'. The Aboriginal community controlled health services funded through the RHS include: *Umoona Tjutagku Health Service Aboriginal Corporation* and *Umoona Aged Care Aboriginal Corporation* in Coober Pedy; *Oak Valley Health Service* (OVHS), *Tullawon Health Service* (THS), and *Ceduna-Koonibba Aboriginal Health Service* (CKAHS) in the south-west region.

The RHS funding agreements are devised specifically for rural and remote areas to meet 'community identified priorities for health and aged care services' (DoHA 2000). The RHS funding agreements are based on a close partnership between the mainstream health services and the Aboriginal community controlled health services.

In Coober Pedy, the Coober Pedy Hospital Health Services receives the funding for RHS programs. A service agreement is then stipulated between the Coober Pedy Hospital Health Services, Umoona Tjutagku Health and Umoona Aged Care for the provision of the ngangkari program and a number of other services. Umoona Tjutagku Health Service has the responsibility to manage and administer the ngangkari service in close collaboration with Umoona Aged Care. The funding for the ngangkari program is part of a larger funding application, which is submitted by the Coober Pedy Hospital Health Services to the Department of Health and Ageing through Country Health SA.

There isn't a specific and separate ngangkari funding application. The ngangkari service was one of the areas that was identified as a need for Coober Pedy because prior to that, there was no formalised ngangkari service. The ngangkari service certainly happened but it was nothing formal. The program started in 2005 through the Regional Health Services funding. So this is Commonwealth

> funding that has been given to support health promotion and any intervention activities. Ngangkari service is only one of the programs in Aboriginal health. We have identified there is a need for the ngangkari service in the community to support the Aboriginal culture in their spiritual beliefs...We've just acknowledged the cultural and spiritual beliefs of the Aboriginal people and contract the services of traditional ngangkari. I've submitted a new funding application to the Commonwealth through Country Health SA and the ngangkari service is a continuing part of that funding application. So the expectation is that the dollars will continue, therefore the service can continue. We're just sort of the conduit for the financial component of it *(Interview Hospital Manager 3-H8)*

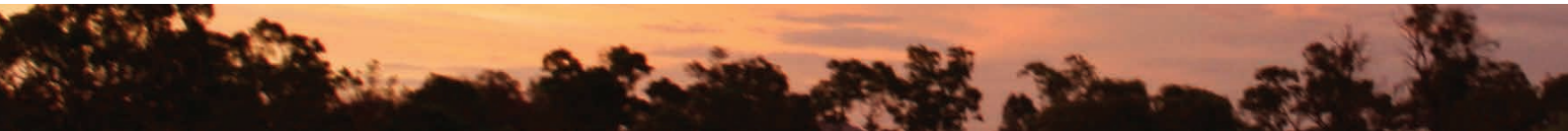
In the south-west region, the Ceduna District Health Service (CDHS) receives the funding for ngangkari services as part of the RHS funding agreement stipulated with the Department of Health and Aging through Country Health SA. The funding request for the provision of ngangkari services is included within the 'Service Delivery Plan' for the communities of Ceduna, Koonibba, Yalata, Oak Valley and surrounding towns. The Service Delivery Program comprises four Remote Health Services Program goals, that is to 'enhance access to quality, multi-disciplinary, comprehensive primary health care services'; 'establish and maintain mechanisms for effective community participation in the ongoing review, planning and management of health services'; 'adopt integrated approaches to planning and delivery of health services to maximise health gains for consumers'; 'manage services in accordance with a quality improvement framework including organisational and cultural change' (DoHA 2010).

The funding request for ngangkari services is embedded within the *Enhanced Primary Health Care Program*. The provision of ngangkari services is among the key activities to be pursued for the achievement of the service outcomes stated in the primary health care program, that is 'improved management of social, emotional, physical and environmental health'. The RHS funding for ngangkari services is received by the Ceduna District Health Service and then equally distributed between Oak Valley Health Service, Ceduna Koonibba Aboriginal Health Service, Tullawon Health Service and Ceduna District Health Services.

> There are RHSs funded by the Department of Health and Ageing around the state within Country Health SA; so we're not the only one, different health units have RHSs. It's specifically for areas that may have particular programs they want to run because they're regional and outreach type areas. Here the RHS has been going on for six years. Before ngangkari services were formalised in the RHS, we still would have ngangkari here and we would pay them with state funds. Yes, before the RHS we would fund ngangkari services through the general operating budget. They were infrequent and once the RHS was funded, ngangkari services were included within the RHS programs *(Interview Hospital Manager 2-H7)*
>
> We're a state organisation but the Commonwealth funds us and then we give $5,000 to Oak Valley Health Service, Ceduna Koonibba Aboriginal Health Service, Tullawon Health Service and $5,000 to us. So it's $20,000 all up. We each have $5,000 to spend on ngangkari services...Our funding has stayed static at $5,000 for health service *(Interview Hospital Manager 1-H7)*

In Port Augusta, Pika Wiya Health Service receives funding for the ngangkari program by the Commonwealth Department of Health and Ageing. There is also an agreement between Pika Wiya and the Port Augusta Hospital whereby patients can be referred to Pika Wiya to access ngangkari services. The Office for Aboriginal and Torres Strait Islander Health (OATSIH) provides the funding through Country Health SA.

> ...the funding comes through Country Health. It's Commonwealth money: OATSIH provides the funding, they give it to Country Health, then it gives it to us *(Interview Financial Manager AHS6)*
>
> We are still funded by Country Health SA, but our main partner now is OATSIH, it's Commonwealth. It's about 3/5 Commonwealth and 2/5 state, generally. Now we are community controlled with our own board with OATSIH our main partner, Country Health as secondary partner *(Interview CEO 3-AHS6)*
>
> We've got an agreement between Pika Wiya and ourselves: Pika Wiya acquires the money; so they've got a bucket of money and it's never enough...The Aboriginal liaison officer would refer the patient to Pika Wiya to check



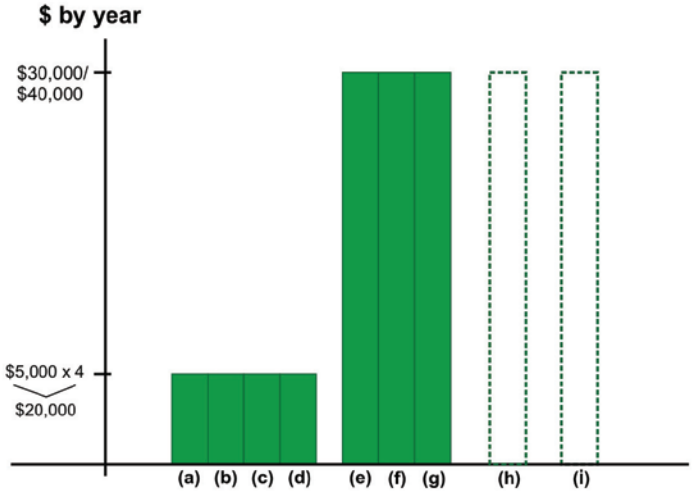
if there is a traditional healer available. So the funding for patients in the hospital comes from Pika Wiya *(Interview Aboriginal Liaison Manager H9)*

In the APY Lands, Nganampa Health Council's ngangkari program is funded by OATSIH through Country Health SA, Department of Health of South Australia.

> Country Health SA funds NPY Women's Council and Nganampa Health Service, we fund both of them...We also fund them for ngangkari programs but we fund them a block of money for their ngangkari services and it's up to those services define how they use it *(Interview Senior administrator 2)*
>
> We get some specific funding which I guess... it's probably about around 10 years we've been getting a small amount of money from the South Australia's Department of Health *(Interview Programs Manager 1-AHS9)*

Table 1 illustrates the funding bodies and funding streams for ngangkari services in rural and remote areas of South Australia.

Table 1: Funding streams for ngangkari services in rural and remote areas in South Australia



Funding bodies:

= Commonwealth Department of Health and Aging (DoHA)

= Office for Aboriginal and Torres Strait Islander Health (OATSIH)

Health Care Services:

(a): Ceduna District Health Service (CDHS), Ceduna
(b): Ceduna - Koonibba Aboriginal Health Service (CKAHS), Ceduna
(c): Tullawon Health Service (THS), Yalata
(d): Oak Valley Health Service (OVHS), Oak Valley, Maralinga

(e): Umoona Tjutagku Health Service, Coober Pedy
(f): Umoona Aged Care Aboriginal Corporation, Coober Pedy
(g): Coober Pedy Hospital Health Services, Coober Pedy

(h): Nganampa Health Council, APY Lands

(i): Pika Wiya Health Service, Port Augusta

1.2.3.b Adequacy of funding: demand, availability and accessibility

The adequacy of current funding allocations to meet the demand for ngangkari services across AHCSA's Aboriginal community controlled health services in rural and remote areas is strictly connected to the simultaneous interplay of three factors: the fluctuation of demand, the availability of ngangkari and their accessibility. The relation between these factors and the adequacy of current funding allocations operates in two directions: on the one hand, demand, availability and accessibility of ngangkari impact on the adequacy of current funding to meet the demand; on the other hand, current funding allocations impact on the demand and accessibility of ngangkari.

1.2.3.c Impact of demand, availability and accessibility on funding

In most cases, when the demand is high or very high and ngangkari are available, current funding is not sufficient to meet the demand in the long term. The yearly amount of funding can be spent in a few months so that the health services are unable to guarantee the delivery of an ongoing and consistent ngangkari service to their clients.

> Funds are the biggest problem because $5,000 per year doesn't cater for what is required. I would recommend $25,000-30,000 a year *(Interview CEO AHS-1)*
>
> It's not enough at the moment for ngangkari. We get funding on a financial basis. It is not enough to meet the demand for ngangkari *(Interview CEO AHS7)*
>
> The budget is very small at the moment but we are looking to invest more within our own programs and add more to that budget of $5,000 *(Interview Director AHS1)*
>
> Funding is really difficult for anything and we struggle with getting funding, so it's always hard and then you got a lot of problems in administrating that, which can create huge difficulties, and who does that and how it's done *(Interview Registered Nurse 3)*
>
> Ngangkari are in high demand but sometimes we cannot pay them so patients have to pay and this is sometimes a big problem...yeah, 'cause if the service doesn't have the money they have to pay themselves *(Interview Aboriginal Support Worker 2 AHS1)*

At some one stage we had $20,000 a year and that was about gone in six months. So it depends on what's happening in the community too. It's safe to say sometimes it's seasonal sickness. Could be a lot more asthma during the colder months or scabies during warmer weather, so it depends on what's happening. That's what we call the seasonal sicknesses. So during that time, there could have been a lot of death in the community, around loss and grief, around drugs and alcohol, so that younger people or parents are requesting the services of a traditional healer *(Interview Aboriginal Liaison Manager H9)*

We haven't got any money at the moment... there are lots of request but we've spent already the budget...yeah, now we have to wait until next year...and this is a problem for our clients *(Interview Aboriginal Support Worker 2 AHS1)*

Sometimes, the demand is high but ngangkari are either unavailable or inaccessible. At other times, the demand is either low or there is no demand. On these occasions, funding is only partially utilised. At times, this can result in accumulation of surplus.

People say they need to see ngangkari, especially in mental health, social and emotional area. They are always looking for ngangkari. But they are not here, and I can only ring a couple of people to find out. Most of times no one is here. Patients say "I want them now!" *(Interview Programs Manager AHS6)*

We're struggling to find ngangkari because there's too much demand on their time. So we've traditionally used different ngangkari... bits and pieces. Mr ... is here and then he's gone and he's all over the shop. He was the last person we used *(Interview Aboriginal Support Worker 1 AHS1)*

In a few services, particularly those in remote areas far away from the APY Lands, the funding has not been utilised due to a combination of scarce demand for ngangkari and inaccessibility of ngangkari.

No, I haven't had anyone asking for that service here. I think it's largely due to the fact that there isn't one [ngangkari] around. I don't think there is many left, just anecdotally. They are not here where we are *(Interview CEO AHS10)*

The funding has not be used mainly because we don't know who the ngangkari are and how to contact them...We haven't used the funding for a few years now... *(Interview CEO AHS-11)*

In services where ngangkari are more easily accessible and when the demand is not too high, most of the time funds have been sufficient to provide ngangkari services when requested.

We don't hold the bucket of money but I've never been denied access to funding, so that would tell me that there is enough there for our service. But I think it fluctuates because it has its moments where some years would use more than others. I think they do get enough to cover; in particular, because we have access to ngangkari here, there's less travel requirements and stuff. But if you're in Adelaide and someone needed a ngangkari from the APY Lands, that's probably when there is not enough money because of the cost of getting the ngangkari down, getting accommodation, getting them home, feeding them, as well as paying them *(Interview CEO AHS-8)*

We usually refer patients to the community health service and we haven't had problems to pay ngangkari to assist our clients... *(Interview Clinician 1)*

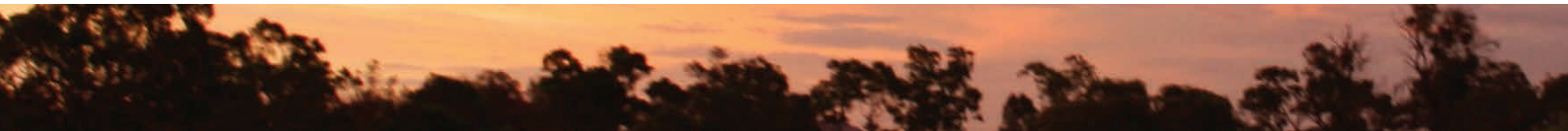
1.2.3.d Impact of funding on demand and accessibility

The current allocation of funding does impact on the demand of ngangkari services, its fluctuation over time and the degree of accessibility. In most ACCHSs current funding contributes significantly to adopt a reactive rather than a proactive approach in the provision of ngangkari services.

The money is certainly a factor because if we had access to more money, then we would be able to promote ngangkari services. You see what I mean? So while we got a very minimal budget, you wouldn't go out and advertise it *(Interview CEO 2-AHS6)*

The number of visits also depends on the resources available to pay the ngangkari *(Interview Aboriginal Support Worker 2 AHS1)*

We do get requests by in-patients but if the service was more regular, I think it would create more demand. So because of the *ad hoc* nature of it, it's only occasional, when people that are in hospital on the day the



> ngangkaṟi are here that get to see them. There are no planned, scheduled visits or arrangements *(Interview Hospital Manager 1-H7)*

Current allocation of funding limits the extent to which ngangkaṟi can attend to patients' requests, especially when long distance travel is involved. This factor impacts negatively on the demand and on the extent to which the service is delivered. This is particularly significant to meet the demand across different communities in the APY Lands, and in rural or metropolitan areas like Adelaide far away from the APY Lands.

> Sometimes they need transport and it makes it really difficult; that's a huge problem with maintaining vehicles and fuel, that's another administrative cost. Often people can't. Maybe they want a particular ngangkaṟi, but they can't get from their community to the community where the ngangkaṟi are at, or the family can't get to them, so that makes it difficult *(Interview Registered Nurse 3)*

There are calls for ngangkaṟi to go down to Adelaide and work not only with Aṉangu but other Aboriginal people. Again I think that's all very difficult because the amount of money they get for the travel allowance, it doesn't always meet the needs; there is a huge cost to getting them there, putting them up and sometimes the actual money you get for doing that, it can't cover the costs *(Interview Programs Manager 1-AHS9)*

There is not adequate funding. They usually always want a Toyota but it's hard to maintain them because people travel so much and to maintain a vehicle on this road, it is always a lot of costs in fuel and maintenance... *(Interview Programs Manager 2-AHS9)*

The bulk of the funding is set to support the ngangkaṟi program and it's set to pay the ngangkaṟi themselves and the anticipated expenses or costs incurred *(Interview Hospital Manager 3-H8)*

Section 2

NGANGKARI SERVICES IN ADELAIDE METROPOLITAN AREA

2.1 Introduction

In Adelaide, the provision of ngangkari services has occurred for about a decade on an *ad hoc* basis. During their visits, ngangkari have provided their healing services to a broad range of mainstream health care services as well as Aboriginal and non-Aboriginal organizations. In the area of mental health the Rural and Remote Mental Health Service (RRMHS) has played a pivotal role in engaging with ngangkari for the diagnosis and treatment of mental health patients. RRMHS has pioneered a two-way mental health care practice within the mainstream health system initiating collaboration between ngangkari, psychiatrists and other mental health professionals.

Ngangkari visits in Adelaide have been arranged and coordinated by three organizations: the Aboriginal Health Council of South Australia, Nganampa Health Council and NPY Women's Council. Most of the times AHCSA has coordinated the provision of ngangkari services through its workforce team in conjunction with Nganampa Health and NPY Women's Council. AHCSA doesn't have an official policy on ngangkari. However, it has always been supportive to arrange and contribute to the costs associated with ngangkari visits in Adelaide.

> People keep ringing AHCSA to see ngangkari. Other people ring the Aboriginal Health Division and ask for ngangkari. The workforce team in the AHCSA has coordinated ngangkari visits in conjunction with Nganampa Health and NPY Women's Council in the past *(Interview Senior Officer AO4)*

> ... certainly it [AHCSA] is always supportive of the idea of bringing ngangkari down. Sometimes we have set up a room at the Aboriginal Health Council for ngangkari to work there *(Interview Medical Practitioner 2)*

The client base in the Adelaide metropolitan area is quite broad: it includes patients from hospitals, staff from government departments and non-governmental organizations; and the general public. The majority of patients requesting and accessing ngangkari are Aboriginal and Torres Strait Islander people. However, it is reported that non-Aboriginal people are increasingly requesting to be visited by ngangkari.

The provision of ngangkari services in the Adelaide metropolitan area presents specific features and raises several issues. This section discusses the issues and challenges emerging from current arrangements in the delivery of ngangkari services within Aboriginal and non-Aboriginal health care services and different non-health related agencies and organizations.

2.2 Public hospitals: issues, challenges and ways forward

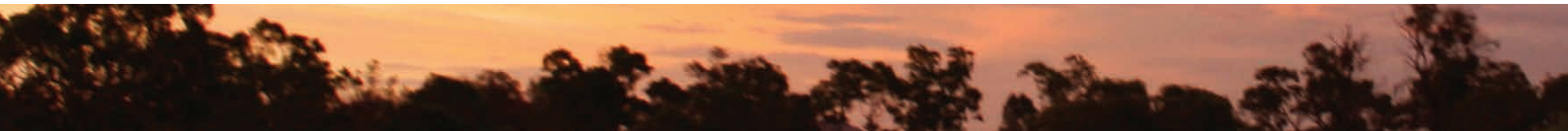
This section covers a number of findings from interviews with health professionals from the Aboriginal Liaison Units and clinical managers of the six hospitals in Adelaide: the Women's and Children's Hospital, the Royal Adelaide Hospital, the Queen Elizabeth Hospital, the Flinders Medical Centre, the Lyell McEwin Hospital and the Noarlunga Health Centre.

The findings indicate common issues and challenges faced by the Aboriginal Liaison Units in facilitating the provision of ngangkari services across the hospitals. Notwithstanding differences in the degree of engagement in the provision of ngangkari services, there exists a unanimous recognition of the significance and pivotal role ngangkari play in the provision of quality health care to Aboriginal patients in hospital settings.

> They play a very vital role in the health care and better outcomes for our Aboriginal clients. I've been in Aboriginal health for 40 years and I can say that ngangkari play a pivotal role for our Aboriginal patients *(Interview Aboriginal Liaison Manager H1)*

> On occasions when we had ngangkari it has been useful; we find ngangkari have a major role to play, in particular with social, emotional and spiritual well-being of some of our clients who access the psycho ward *(Interview Aboriginal Liaison Manager H4)*

The following analysis focuses on the challenges encountered in the provision of ngangkari services across the hospitals in the Adelaide metropolitan area in relation to the following key issues: organization, coordination and management of ngangkari services; demand for ngangkari; access to ngangkari; funding; policy and guidelines; safety and risk issues.



2.2.1 Organization, coordination and management of ngangkaṟi services

The Aboriginal Health Council of South Australia, Nganampa Health Council and NPY Women's Council have been the three bodies that have organized, coordinated and managed ngangkaṟi's visits across the hospitals in Adelaide. The actual delivery of ngangkaṟi services in the hospitals has occurred through the Aboriginal Liaison Units of each hospital. The Aboriginal Liaison Units play a central role in supporting Aboriginal patients admitted to hospitals and they function as an indispensable bridge between the delivery of mainstream health care and Aboriginal patients. As such, their insights are valuable to gain an in-depth understanding of the way in which ngangkaṟi services have been provided, what are the issues and challenges they have been facing, and how the delivery of these services can be improved to meet Aboriginal patients' demand for ngangkaṟi and contribute to enhancing their health outcomes.

There are three key issues hindering the current process of organization, coordination and management of ngangkaṟi services across the hospitals in Adelaide. These include: a) lack of or limited consultation; b) lack of or limited coordination; c) *ad hoc* nature of the services; d) lack of a central body and of a systematic approach.

2.2.1.a Lack of or limited consultation

The Aboriginal Liaison Units of the hospitals report either a lack of or limited consultation with AHCSA in relation to the timing of ngangkaṟi visits and patients' demand of ngangkaṟi; funding arrangements between the hospitals and the organizing body; and uncertainty of costs associated with the actual number of patients treated by ngangkaṟi. These issues are directly intertwined:

> AHCSA organised it to bring them down and then there is an expectation that they'll visit the hospital and we will contribute to their cost. But the way it has happened in the past is that it's not been a consultative process, we have not been included; the hospitals have not been included in discussions with AHCSA about when to bring them, when they arrive. We are just told when they are here: "they are here now, they are coming to your hospital". It is not very appropriate. When they've been here, they'll go and visit people on the wards and they don't always do a service to a patient, but they'll actually go and visit with everybody and talk and one or two people may receive their service, but they don't come here and treat everybody; they will visit most people that want a visit from the ngangkaṟi...if they know that the ngangkaṟi are in the hospital even if they can't get a treatment, they all want to see them. And if they are doing treatments, there is a cost associated with that as well, that you've got to come up with *(Interview Aboriginal Regional Manager H4)*

> They came here from the Aboriginal Health Council when they sent them out, but there were no requests for them to be sent. And we've asked the people if they want to see ngangkaṟi. So the Aboriginal Health Council does have ngangkaṟi but just from the APY Lands and that's not always appropriate. It's a choice, we let them know if anyone wants to see a ngangkaṟi *(Interview Aboriginal Liaison Manager H1)*

2.2.1.b Lack of or limited coordination

The lack of, or limited coordination between the organizing bodies and the Aboriginal Liaison Units in the hospitals impacts on the degree of efficiency and effectiveness of ngangkaṟi services to meet patients' demand for ngangkaṟi treatments:

> In the past AHCSA and NPY Women's Council have arranged visits. But...it would be good to have more coordination; yeah, coordination through a central body...Most of times we know that ngangkaṟi are in Adelaide with short notice. The AHCSA advises us only a few days before, and we don't have much time to organize and tell patients....yes, it's not coordinated and *ad hoc (Interview Aboriginal Liaison Manager 2-H2)*

> It's not coordinated, I don't think it's planned enough, looked at enough *(Interview Aboriginal Liaison Manager H1)*

> As for coordination in the metropolitan area each organization or division organizes it separately *(Interview Senior Officer AO4)*

2.2.1.c Ad hoc nature of ngangkaṟi services

The limits identified in terms of consultation and coordination between the organizing bodies and

the Aboriginal Liaison Units contributes to make the delivery of ngangkaṟi services an *ad hoc* service provision:

> ... AHCSA brought them down and spent a couple of weeks down here. They have done it a few times but to me that's not really... it's good but it's not good enough because I want somebody on tap. I want to be able to ring up the database, whatever it's going to be, and say "look, we've got James and he would love a ngangkaṟi". That's the way it should run, that it'd be successful. This bringing them down, you know, and then "oh this is the hospital...", all I can do is take them ward by ward and introduce them, explain these are the traditional healers, they are here from the Lands, they are here to see patients. Someone can have a relation, but this is not what we are after. What we are after it's when we need one we should be able to get one *(Interview Aboriginal Liaison Manager H3)*

Recommendation 8:
It is recommended that the Aboriginal Liaison Units in Adelaide hospitals be directly involved in the organization, coordination and management of ngangkaṟi services. Aboriginal Liaison Units should be engaged in a substantial way to facilitate an effective and efficient provision of ngangkaṟi services to Aboriginal inpatients and Aboriginal discharged patients in their communities. The inclusion of ngangkaṟi in the Aboriginal Patient Journey Program should be considered as a potential strategy to strengthen the provision of culturally appropriate care to Aboriginal patients

2.2.1.d Lack of a central body and a systematic approach

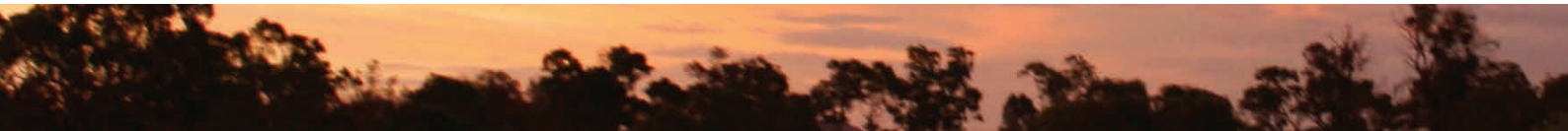
It is indicated that the lack of a central body and a systematic approach to the organization, coordination and delivery of ngangkaṟi services constitutes the greatest challenge in past and current arrangements. None of the bodies that have been organizing and managing ngangkaṟi's visits in Adelaide is endowed with a formal responsibility to operate as the central body for the provision of ngangkaṟi services in the Adelaide metropolitan area. The need for a central coordinating body and a systematic approach is strongly identified as a way forward to overcome current hindrances and improve the delivery of ngangkaṟi services within the health care system.

> People keep ringing AHCSA to see ngangkaṟi. Other people ring the Aboriginal Health Division and ask for ngangkaṟi. The workforce team has coordinated ngangkaṟi visits in conjunction with Nganampa Health and NPY Women's Council in the past, but there isn't a defined central system *(Interview Senior Officer AO4)*

> In the past AHCSA and NPY Women's Council have arranged visits. But we really need a more systematic approach. It needs to be formalised with funding attached. It would be good to have more coordination; yeeh, coordination through a central body, maybe AHCSA and the hospitals...*(Interview Aboriginal Liaison Manager 2-H2)*

> It has to be something like a health centre or central body but I don't think it should be tied to us. It shouldn't be attached with the hospital, hopefully AHCSA could...I am trying to think where it could sit. I wouldn't like to see it in the hospital, but I would like to see it set up somewhere *(Interview Aboriginal Liaison Manager H3)*

> We need to have an easy way of contact, to be able to ring up and ask when they are coming down and in what times. Because when they arrive here there is nobody who wants to see a ngangkaṟi. But if we had somebody on tap basically that we could ring up if they are in intensive care and say "we've got this baby and the parents want to see a ngangkaṟi, ring them up". And maybe through the Health Council, they can contact them and maybe the Health Council pay them...I am not sure how, but some kind of arrangement. Because people wait, they wait today and tomorrow and say "when are they coming?" and that patient could be dead, too late. We need access, immediate access.



Not wait until next week or the month after, it may be too late. And when they do get in, nobody is here to be seen, so it's a waste of resources *(Interview Aboriginal Liaison Manager H1)*

The costing was quite expensive because we brought them from the Lands, but the Aboriginal Health Council paid the bulk of it and the various hospitals contributed. But I don't think was satisfactory enough because patients used to ask them and we couldn't always have access to them, especially when Aṉangu came in; but it's not just Aṉangu patients who wanted to see ngangkaṟi *(Interview Aboriginal Liaison Manager 1-H2)*

We need a systemic approach; if I had to leave I want to be sure that there is a system in place *(Interview Aboriginal Liaison Manager H9)*

Recommendation 9:
It is recommended that a central body be identified and endowed with the responsibility to coordinate, organize and manage the delivery of ngangkaṟi services across the hospitals in Adelaide metropolitan area. The central body should function as the primary interface between the Aboriginal Liaison Units and ngangkaṟi to ensure a systematic and coordinated provision of ngangkaṟi services to inpatients and discharged patients requesting ngangkaṟi health care

2.2.2 Demand for ngangkaṟi

Findings show a widespread demand for ngangkaṟi across the hospitals in Adelaide. Regrettably, there has not been a systematic collection of records in relation to ngangkaṟi visits in the hospitals.

The demand for ngangkaṟi across Adelaide's hospitals varies according to three main factors. The first factor relates to Aboriginal patients' age and place of origin. Adults and old people are more likely to request ngangkaṟi than children or young people. The place where patients come from also contributes to the level of request for the ngangkaṟi from the APY Lands. These have been the Aboriginal traditional healers more involved in the Adelaide metropolitan area. Second, the availability of a ngangkaṟi program within the hospitals influences the demand for ngangkaṟi. Hospitals can receive requests but the lack of an established ngangkaṟi service contributes to the decline of potential and future demand. Third, the availability of funds to offer a ngangkaṟi service has a significant impact on the extent to which the service can be offered and promoted. Finally, the timely accessibility of ngangkaṟi can determine the variations of patients' demand for ngangkaṟi.

We don't have a ngangkaṟi program but we do have people who request ngangkaṟi, but we don't have funding to support this service and to give this service to our clients *(Interview Clinical Manager H5)*

We don't have a lot of requests for ngangkaṟi mainly because in the other major hospitals patients are all adults and middle-aged or old people that ask more to see ngangkaṟi. And the ones that we have had here, I can recall about four of the ngangkaṟi that I know of, they were from the APY Lands. But because here we have so many different people from different tribes, sometimes NT mob doesn't like using SA ngangkaṟi, they want their own ngangkaṟi who they know and who they trust, and of course that's impossible to provide that, you know? And they'll say "where are they from?" We have patients from different groups, some ngangkaṟi can't touch you for different reasons, cultural reasons. There are similarities but there are differences *(Interview Aboriginal Liaison Manager H1)*

Rural patients ask for ngangkaṟi from specific areas and they may not want ngangkaṟi who are here in Adelaide because they come from different tribal areas *(Interview Aboriginal Regional Manager H4)*

...we have used ngangkaṟi in the past. I can recall five patients. Two were in IC, and the rest were in the ward and that was a teenage boy from Kintore up closer to Alice Springs than SA. But when you ask where they are from, they are Pitjantjatjara people. They

prefer, I reckon, them coming from their own area *(Interview Aboriginal Liaison Manager H1)*

The liaison worker talks to the patients saying that the ngangkaṟi are coming. Some patients are enthusiastic, others no. Interest depends sometimes where they come from. Young patients are more interested. Sometimes there are issues of gender and cultural stuff *(Interview Aboriginal Liaison Officer H2)*

...we haven't any record of ngangkaṟi visits, it's just who remembers what... we recall maybe five visits and a couple of cleansing ceremonies in key areas of the hospital *(Interview Aboriginal Liaison Manager 2- H2)*

Recommendation 10:
It is recommended that Aboriginal Liaison Units establish a database to document patients' requests of ngangkaṟi and ngangkaṟi services provided. The database would provide a baseline to develop an evidence-based assessment of the demand for ngangkaṟi and typology of ngangkaṟi services provided. The database would also constitute a valuable resource for funding purposes

2.2.3 Access to ngangkaṟi

The accessibility of ngangkaṟi is identified as a major issue in the setting up and delivery of consistent and effective ngangkaṟi services across the hospitals. Access to ngangkaṟi is considered to be difficult due to a range of factors.

First of all, the timely availability of ngangkaṟi from the APY Lands or from other areas such as the Northern Territory, makes their accessibility very difficult in the Adelaide metropolitan area. Most of the times, ngangkaṟi are accessed when they are brought down by other organizations or they are in town for personal reasons. Further, the high level of mobility heightens the degree of accessibility.

If someone asks to see ngangkaṟi, we ask if they are around, but most of the time it's difficult to access them or they can't come *(Interview Aboriginal Liaison Manager 2-H2)*

We only use them when they are brought down *(Interview Aboriginal Regional Manager H4)*

We had some successful stories, but unfortunately it's not easy to access ngangkaṟi. In particular, different groups from different areas do prefer ngangkaṟi from their own region or tribe, or community. We cater for Aboriginal clients who come from a large geographical area, from the Tiwi Islander down the bottom of SA...So we have a very large area with Aboriginal clients accessing the hospital. When we need ngangkaṟi it's very hard to access them or even to find one in metropolitan Adelaide... *(Interview Aboriginal Liaison Manager H1)*

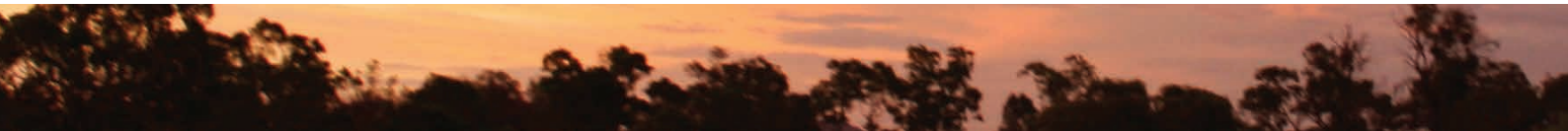
We asked people if they want to see a ngangkaṟi when they come down. Since I've been here I reckon about five times... They are either in the APY Lands or over the west, west coast. In an emergency you need somebody from here, it's a big thing to get somebody down to do it *(Interview Aboriginal Liaison Manager H1)*

With the issue of ngangkaṟi, unfortunately it's been difficult at times for us to access ngangkaṟi when people have requested it because of the nature and the diversity of the area they come from. On occasions when we had ngangkaṟi they have been resident in the metropolitan area. It has been useful; we find ngangkaṟi have a major role to play, in particular with social, emotional and spiritual well-being of some of our clients who access the psycho ward *(Interview Liaison Manager H1)*

Yeah, they're not on tap as easy, you know what I mean? I've got a couple in Adelaide that I know and I tried to get one today, actually. A young girl, heroin overdose. And she was telling us that when she was younger, somebody sung her and I said "you wanna see a ngangkaṟi?" And she said "yea". I went there early this morning to see her in the psych ward but they already sent her home *(Interview Aboriginal Liaison Manager H1)*

... also they're not always stable here in Adelaide, they are so on the move all the time, men and women...*(Interview Aboriginal Liaison Manager H1)*

Access to ngangkaṟi is also made difficult



by the lack of a consistent and systematic channel of communication between the Aboriginal Liaison Units and the ngangkaṟi. The difficulties in accessing ngangkaṟi in a timely fashion have profound impacts in cases of emergency or patients in intensive care; sadly, at times it can be too late for a ngangkaṟi intervention.

> It's complicated, and sometimes it's too late. Tomorrow we can have someone in intensive care who would like to see a ngangkaṟi, where and how are we gonna get a ngangkaṟi? Do you know what I mean? *(Interview Aboriginal Liaison Manager H1)*

> ...it would be good if we could have some type of register of accepted ngangkaṟi around from different regions if possible. How that would work, I don't know. But it would be good to have easier access to ngangkaṟi when needed, not wait two, three days or wait until next week to come down. It could be too late at times *(Interview Aboriginal Liaison Manager H1)*

> ...there is no one person permanent here that you can call on... it's just by word of mouth and who knows who in the communities... Yeah, often it's just about a few phone calls to people in the communities and find a ngangkaṟi to come down...*(Interview Aboriginal Liaison Officer H2)*

> ... they're not always easily accessible; they only come down in certain times, the Pit ones. And in emergencies and things like that it's really hard to find somebody *(Interview Aboriginal Regional Manager H4)*

> if a patient asks for a ngangkaṟi today we can't have them here and if then we get them tomorrow it may be too late *(Interview Aboriginal Liaison Manager 2-H2)*

It is indicated that improving the level of accessibility would allow Aboriginal Liaison Units to provide more efficient and effective ngangkaṟi services to their Aboriginal clients. A more consistent access to ngangkaṟi would reduce the time gap between the request for ngangkaṟi intervention and its delivery; also it would increase the number of patients who could access ngangkaṟi treatments.

> The use of ngangkaṟi is very important, we would love to have them, I would love to have a ngangkaṟi here sitting in the hospital. I would like to have access to a ngangkaṟi every day to be able to talk with people. The ngangkaṟi came up yesterday in our managers' meeting because I said "I want to have more access to ngangkaṟi within the hospital" and then when they said "No, I think AHCSA is working on that..." *(Interview Aboriginal Regional Manager H4)*

> Sometimes when they come, they can see on average 25-30 patients. Last time they saw six patients. They don't have much time, if they could stay longer we could provide a better service to our clients *(Interview Aboriginal Liaison Manager 2-H2)*

Recommendation 11:
It is recommended that a set of measures be established to improve Aboriginal Liaisons Units' access to Aboriginal traditional healers. These measures include: a) establishment of a consistent and systematic communication channel between the Aboriginal Liaison Units and the Aboriginal traditional healers; b) setting up of a Register of qualified ngangkaṟi available to provide ngangkaṟi services across hospitals in the Adelaide metropolitan area

2.2.4 Funding

All Aboriginal Liaison Units within Adelaide's hospitals do not have a specific stream of funding for the provision of ngangkaṟi services to their Aboriginal clients.

> We don't have resources specific for ngangkaṟi. We don't have an allocated budget, it's just a one-off expense. We get whatever amount we can from the running budget. In the past we have shared part of the funding with Safety and Quality and AHCSA *(Interview Aboriginal Liaison Manager 2-H2)*

> In the Adelaide metropolitan area hospitals have no funds for ngangkaṟi. The organizations draw it out of their running budget *(Interview Aboriginal Regional Manager H4)*

No, we don't have specific funds. Those that we did have in IC were paid by 'social work', 'cause that baby was going to die. That was paid by 'social work', it was a one-off expense basically. And I do know another one where the family sent him down themselves. Patient and parents that were here rang Alice Springs, to family, and told them they wanted to see this ngangkari – special one in Alice Springs – and the family paid for the old man's fare to Adelaide. That was a private arrangement *(Interview Aboriginal Liaison Manager H1)*

It is indicated that the provision of ngangkari services is expensive due to a range of costs involved. These include travel, accommodation, meals, and fees for service. Past and current arrangements have involved a shared contributions from AHCSA, Nganampa Health, NPY Women's Council, and the hospitals accessing the ngangkari. Hospitals' contributions have generally been drawn from the Aboriginal Liaison Units' running budgets or from other branches within the hospitals. It is reported that at times there has not been any financial contribution from some hospitals due to a lack of consultation, reciprocal agreements or lack of resources.

It is a very costly business because we can't expect them to come and not be paid. Traditionally they are in a community and people would go and see them, and there would be a swapping of something. Something would be given, it might be kangaroo tail or whatever, there is a payment in kind for the ngangkari services. When we move into the western world it's all about dollars, it's all about money so it has to be compensated in that western model and fitting into that, and it doesn't fit very well. It is a difficult one! *(Interview Aboriginal Regional Manager H4)*

We would like to use ngangkari but it's so expensive. We don't have any funds to pay for ngangkari services. We don't get any support from the Department of Health and AHCSA to provide ngangkari services. You have to find it out of what you've got, pull it from something else if you want to have that service *(Interview Aboriginal Regional Manager H4)*

AHCSA never had a specific bucket of money for ngangkari; you just got to grab it from wherever else. Yes, it has always done in that way, AHCSA organising the ngangkari visit in conjunction with Nganampa. And only three are paid through the Women's Council *(Interview Aboriginal Regional Manager H4)*

AHCSA did it and no, I didn't contribute because I thought "well, AHCSA doesn't contribute anything to this hospital, they contribute to all other hospitals except this one". So I said, "well I am not prepared to do much because there isn't a reciprocal thing"... *(Interview Aboriginal Regional Manager H4)*

The funding came from AHCSA. They brought them down and spent a couple of weeks down here. They have done it a few times... *(Interview Aboriginal Liaison Manager H3)*

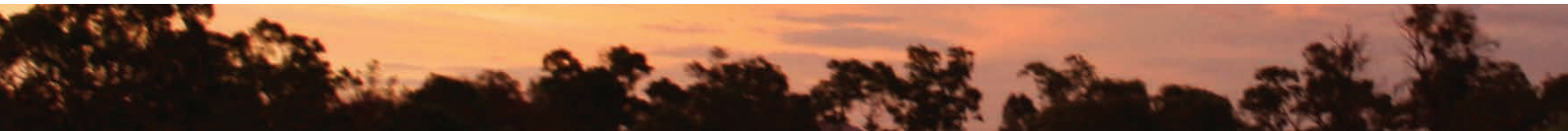
We didn't contribute to these costs even if the ngangkari came here and the other part that annoys me is that it's not a consultative process when it comes to AHCSA organizing it, and they expect to fall in and along with that and make ourselves available on those days; and it doesn't always fit, so I would like it to be more consultative across the regions, in the southern region, all of us who are in health services working with Aboriginal people need to be involved in when it's the best time to bring them and know how many clients we've got between ourselves we would like to see, work out the cost of what that may be, given on a rate of $90 for treatment or whatever it is and work from there. *(Interview Aboriginal Regional Manager H4)*

The lack of specific funding impinges upon the extent to which ngangkari services can be provided to Aboriginal patients.

Unfortunately we can only provide a few services because of limited resources *(Interview Aboriginal Liaison Manager 2-H2)*

When they do come down there is all the cost involved and they wanna be paid wages and it's getting them down, the hospital doesn't cater for that. We don't have funds for ngangkari. Sometimes people want to see ngangkari from a certain area but nobody has got that type of funding *(Interview Aboriginal Liaison Manager H1)*

The Aboriginal Liaison Units unanimously agree on the need to have a specific allocation of funding to be able to guarantee the provision of ngangkari services on a consistent and long term basis. It is emphasized that each service provider and agency should strongly advocate for the



allocation of funding to supply a ngangkari service. Some Units have requested specific funding for ngangkari services but there exists some confusion and uncertainty about what government institution or Aboriginal body is dealing with the allocation and management of money for ngangkari services.

> We need specific funding for ngangkari: each Aboriginal Liaison Unit should have a bucket of money to pay for them *(Interview Senior Officer AO4)*
>
> This is the only way it's going to survive, it's to have seed funding, a specific bucket of funding at the hospital that we could justify *(Interview Aboriginal Liaison Manager H3)*
>
> We don't have a ngangkari program but we do have people who request ngangkari but we don't have funding to support this service and to give this service to our clients. I would love to have some funding for ngangkari programs *(Interview Clinical Manager H5)*
>
> ...It's up to the services and up to other agencies supporting Aboriginal people and communities to argue for the need and the funds to supply such a thing. When we have immunization days in the communities you could also incorporate the ngangkari coming on all those days, so people coming for their flu vax or whatever immunization they are due for, and they could also see a ngangkari while they were there. So there wouldn't be a fee because we would be paying for the ngangkari to come. We have immunization days a couple of times a year in communities. Have to talk to the community health team and the family clinics *(Interview Aboriginal Regional Manager H4)*
>
> I had a wish list yesterday, that I wanted to have more access to ngangkari; so I need more funds for that, but they said "well, that's part of SA Health". Because state and Commonwealth fund it, they get some money as well. I said "no, in my wish list I want access ngangkari more often in the hospital." And they said "no, that's in the plan with AHCSA or SA Health....". Yes, because we had a bit of extra money and in the meeting they were saying "what do you want?" and I said "That money, I wanted it for ngangkari", but that money wouldn't fit for the ngangkari because there is already someone doing something about it... ACHSA, I think, were the ones who already were doing a plan around the ngangkari... but I am not sure. *(Interview Aboriginal Regional Manager H4)*

2.2.4.a The Aboriginal Weighted Inlier Equivalent Separations (WIES) supplement

The Aboriginal WIES supplement is the government funded payment to hospitals for Aboriginal and Torres Strait Islander inpatient health services. The Aboriginal WIES supplement is established at 30% to provide Aboriginal and Torres Strait Islander inpatients quality health care within Australia's hospitals. It is suggested that the 30% loading for Aboriginal and Torres Strait Islander patients could be a potential source of funding to support ngangkari services within the hospitals:

> The 30% loading is an extra amount which is added to medical expenses for medical procedures for Aboriginal inpatients. It's used to cover extra costs and it goes into the general revenue here at the hospital...Certainly, a percentage of that loading could be something that we could be using in terms of our ngangkari to create that pool of money. If we deem that to be a useful resource for all hospitals to access, maybe a part of that 30% loading go into a specific portfolio for ngangkari or traditional healing methods *(Interview Aboriginal Regional Manager H4)*

Recommendation 12:
It is recommended that Adelaide hospitals' Aboriginal Liaison Units be allocated adequate financial resources to provide a consistent ngangkari health care service to Aboriginal and Torres Strait Islander patients.

The 30% Aboriginal WIES supplement could be considered as a potential source of funding to support ngangkari services within the hospitals as part of hospitals' culturally appropriate health care support for Aboriginal and Torres Strait Islander patients

2.2.5 Employment opportunities

There is an overarching agreement that ngangkari should be considered as part of the health workforce and ngangkari interventions offered as an optional service to Aboriginal patients. In terms of employment of ngangkari in the hospitals there are two positions: a) to employ ngangkari on a full time basis; b) to employ ngangkari on a fee-for-service basis. Ngangkari are considered very important not only in providing treatments to patients in the hospital and outside the hospital once they are back home, but also in enhancing patients' trust in the western medical system and increasing compliance with medical treatments.

> I would employ a person who is a ngangkari. If I could, I would *(Interview Aboriginal Regional Manager H2)*

> You have to have specific funding to employ a ngangkari; you need to employ them as an employee and give full time job to do what they need to do, because if you had a ngangkari here we could actually use them to go not only in the wards, but you could also have them to go out into communities once people have gone home and maybe cleanse their homes and things like that. We need cleansing here in the hospital because there are some spirits who are caught here that people see when they come, that need the ngangkari to come and take them home. There are things that need to be done that are culturally appropriate for the safety of other people coming because when you get other people who come and say "No, in that room there is spirits there", then we don't see them but those people are seeing them, so they are there and that can be conducive to clients say "no, I am not staying, I am not gonna have the treatment". Also, we have people come down and when they find out what's going to happen – they might be cut open here and there – because I have to explain risks and also the risk that you might die, because there is always a risk of death under any anaesthetic or any procedure. But for Aboriginal people that's all they are hearing, they are gonna get cut open and might die so that people have said "no, I am not gonna do it then" and they leave and go home. They live as long as they live at home. Ngangkari can talk to them, make them comfortable and explain they need also whitefella medicine...*(Interview Aboriginal Regional Manager H4)*

> I just would like someone on tap, on call. I don't want them to station in the hospital because we couldn't justify having somebody here full time, truly couldn't. But ngangkari should sit somewhere outside the hospitals and we should be able to call them when needed *(Interview Aboriginal Liaison Manager H3)*

> It would be very helpful to have some ngangkari on tap... *(Interview Aboriginal Liaison Manager H1)*

> My thing would be to do a study of what ngangkari are in Adelaide, which would make it easier for us to access them if we need it; but they have to look at the different groups, and in and around the centre of Australia and the APY Lands you have a mixture of groups. Then they should be employed by the hospital on a contractual basis, so that they can be called in. You can't say to put them on full time employment because they could be here today and gone tomorrow because of ceremonies or other things *(Interview Aboriginal Liaison Manager H1)*

2.2.6 Policy and guidelines

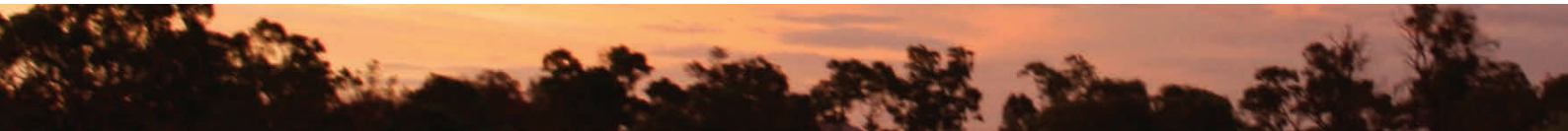
Hospitals and Aboriginal Liaison Units do not have any formal policy or guidelines in regard to the use of ngangkari within hospitals. However, practice has developed over time whereby the provision of ngangkari to inpatients who request them is sought through informal channels or when visits are facilitated by organizations such as AHCSA, Nganampa Health or the NPY Women's Council.

There have been different initiatives initiated within SA Health in conjunction with some hospitals. Some hospitals are determined to provide a ngangkari service to their clients only once a set of policies and procedures is articulated and implemented.

> We haven't used ngangkari. I personally haven't been asked for. But I know it's a policy, we have to provide one if patients ask *(Interview Aboriginal Project Officer H6)*

> The General Manager has been very supportive. Usually you would go for that channel *(Interview Aboriginal Liaison Officer H2)*

> At the moment we are not using ngangkari



but we will. There are some families who use ngangkari on their own. We need to develop some policies around that. We are working in conjunction with the Aboriginal Health Division to develop consistent procedure and policies to contact the accredited ngangkari. Once we develop the procedure we will engage with ngangkari. We need to make sure that it must be done strategically. At the moment we are still at the infancy stage in terms of procedures and policies. Until such time in which the correct procedures are completed we won't use ngangkari *(Interview Aboriginal Regional Manager H5)*

In terms of policy development, the adoption of a bottom-up approach is strongly advocated in order to avoid the replication of policy frameworks articulated without adequate consultation with the parties involved and consequent failure of following programs in the long term.

We are the most researched people in the world, there wouldn't be nobody else in the bloody whole world which has been researched more than us and nothing becomes better, just becomes dust collectors upon the shelf. It is very rare that something comes through; nothing is sustainable either. I think it may be they don't go there on the ground to find out what's happening. I am quite vocal about it. You create a policy up there and you come down and say "implement it"; you really need to come down here, find out what doesn't work, then going up there and create a policy and say this is streamline and this is what we do. This business of coming down and telling us "we have designed this and this is what you have to do", it doesn't work! It doesn't work, it just goes in the basket. But if this project has been chip it away for 2 years, it may happen *(Interview Aboriginal Liaison Manager H3)*

2.2.7 Safety and risk issues

No adverse event or risk issues have ever been reported in the provision of ngangkari services within the hospitals. However, potential safety and risk issues are identified as an area that should be taken into account in the implementation of any policy framework adopting the provision of ngangkari services.

No, never had an adverse event. It's a very tricky area, one that probably needs to be considered if they are developing some module around what the services may look like in acute care, then you need to have some cover for that question because other people would think of it, I haven't thought of that; I guess no one is forcing people to see ngangkari, it's a personal choice so maybe it's a personal thing, maybe it doesn't reflect on the hospital...mmm...tricky one! Nothing ever happened, never, nothing hasn't... but it's not to say something might or if an Aboriginal person had a treatment by a ngangkari, then collapse and say "oh, that's the ngangkari who did it!" How do you cover that part? I am not sure, but there must be similar policies to doctors when they are employed by the hospital. If you had one employed by the hospital that should be those rules and things; bringing a non-employee into the situation could be a bigger problem, hadn't thought about that. One to remember: how that is dealt with on the terms of safety, industrial relations, all those sorts of things *(Interview Aboriginal Regional Manager H4)*

No, any disadvantage. We had all positive experiences. Ngangkari help the healing process *(Interview Aboriginal Liaison Manager 2-H2)*

As for patients' feedback, we got a lot of verbal feedback, smiles and tears. We never heard negative comments. It's very low key... *(Interview Aboriginal Liaison Officer H2)*

2.2.8 Cases of ngangkari interventions in public hospitals

This section collects a small sample of stories about ngangkari interventions within public hospitals. Health professionals highlight the positive health outcomes for patients.

Lots of stories! I have seen them doing good healing with one girl who came and was really sick, and there was a group of women ngangkari that came that time, not men, they were all women, and I didn't know them; and they worked on this girl, it was up in the ward and she got better real quicker after that and didn't need the surgery, so that was great...*(Interview Aboriginal Regional Manager H4)*

Definitely, ngangkari interventions have effects on people at the psychological and emotional level for what we can see and from our

observations. A guy was in a coma, the ngangkari visited him and said that he will be all right, he had brain damage, but after he woke up *(Interview Aboriginal Liaison Manager 2- H2)*

Usually ngangkari don't give outcomes of their healing, but we see that clients feel much better... I remember on one of their visits, they treated a manager who had a chest infection. In half an hour she could feel better *(Interview Aboriginal Liaison Manager 2-H2)*

I see them play a very vital role in mental health and also I see them playing a major role with our kids...I have seen patients using ngangkari, especially when I was in Fregon. A friend of mine had a ngangkari do her leg; she had to have an operation on that leg and they wanted to bring her to Royal Adelaide. She went to a ngangkari there in the APY Lands and they've done a physio on her leg and ankle and they fixed her leg: she never had to have the operation, they fixed her leg and ankle *(Interview Aboriginal Liaison Manager H1)*

One of the stories, we had a European nurse who had to have a surgery on her ankle and a ngangkari worked with her doing physiotherapy and massage and ended up that she didn't have to have surgery. So that was very successful *(Interview Aboriginal Liaison Manager H1)*

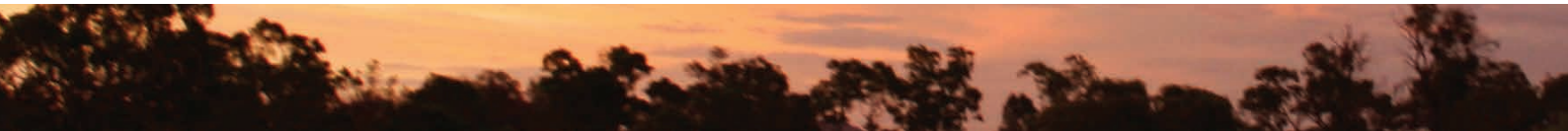
We also had a doctor down here and an Aboriginal Liaison Officer who had problems. The ngangkari worked in our office here in the hospital and the two came out very successful with what their medical complaints were. And also in the paediatric intensive care unit, we had a seriously ill child and the ngangkari came, was a female ngangkari. She knew exactly what was wrong with that child before I was telling her. She told us what was wrong with that child and thankfully the little one end up surviving after the ngangkari did come...yeah, that was in the paediatric intensive care unit *(Interview Aboriginal Liaison Manager H1)*

I have to tell a story about my experience with ngangkari in the APY Lands. I had to go back to the APY Lands back in the 1980s because I couldn't get a registered nurse to cover the community, so myself and the local traditional health worker. But on my journey up to the APY Lands to that local community, I had to escort a patient who was discharged from Royal Adelaide Hospital and he had a kidney removed and he was flown up with me. All being that he came out of the hospital a bit quicker after having an operation like that and back into the community where I was going to be running the clinic; and I was only an Aboriginal health worker at that time. So when we got back to that community, he became ill and during the evening the family brought him over to the clinic and I was concerned and rang the Alice Springs' hospital. I was under instructions from the hospital, what to do, his observations every hour and whatever, whatever...I said to the family "Would you like him to see a ngangkari?" They agreed, they went off and got the ngangkari. She came back and she was my friend from many years and I didn't know she was a ngangkari. I thought I leave her in the ward with the patient and the family around, but she insisted that I stayed there with her and I experienced something really fantastic there, being present while she was attending to the patient. When she finished doing what she had to do, he went off to sleep and we observed him all night; the clinic took him to another community the next morning and everything was well with the Flying Doctors who examined him. But if it wasn't for that ngangkari who was there, I don't know what would have happened during the night with that particular patient. So what it was, what she had done was very successful and it was an experience that I never forget *(Interview Aboriginal Liaison Manager H1)*

2.3 Other organizations accessing ngangkari

Beside the hospitals, a range of other health services and non-health based organizations request and access ngangkari in Adelaide. These include the Rural Remote and Mental Health Service, GP Plus Super Clinic Noarlunga, Nunkuwarrin Yunti, Kanggawodli Caring House, South Australian Native Title Services, Relationships Australia SA, Statewide Gambling Therapy Service-Flinders Human Behaviour and Health Research Unit, Department of Families and Communities SA, Public Trustee.

These are only some of the agencies that have been accessing ngangkari. Interview data



indicate that other government departments have occasionally accessed ngangkaṟi, mainly to undertake cleansing of their buildings upon request of some staff members. Some of these agencies include the Department of Premier and Cabinet, Aboriginal Affairs and Reconciliation Division, Housing SA, Disabilities SA and the Department of Environment.

The use of ngangkaṟi services by these agencies varies in terms of timeframe and regularity. Some agencies have been accessing ngangkaṟi for a long period of time and on a regular basis. The South Australian Native Title Services (SANTS), for example, has been facilitating the service for about 10 years with an average of two visits per year. Others have been using ngangkaṟi for a shorter period of time and on a more sporadic basis depending on demand.

The rationale behind the provision of ngangkaṟi within these agencies is to respond to the demand of culturally appropriate healing treatments from staff members and clients. Ngangkaṟi services have been requested for individual healing and cleansing of buildings. The cleansing of buildings and individual healing are considered very important to guarantee a duty of care toward clients' and employees' health and well-being and to ensure Aboriginal staff are comfortable in the work environment. In some cases, ngangkaṟi treatments have been offered to staff's family members.

> It is really a tool to reduce potential problems for staff or for the place we work in *(Interview CEO AO1)*

> It's in our line of work because we are going out on country quite a lot. Sometimes you can pick up things or come across things that are on a spiritual level rather than on a physical level. So we started bringing in ngangkaṟi and they would clean the office and also doing staff and family members as well. It is not just about you, it is also about you going home to your family and taking those things back to your family. It also helps with your health and well-being *(Interview Senior Officer AO1)*

> It is like going to your GP and he will give you a tablet, whereas ngangkaṟi will not give you a tablet. So it has been beneficial and works support it highly *(Interview Senior Officer AO1)*

In other organizations access to ngangkaṟi is offered to clients as an optional complementary therapy to mainstream health care treatments. Other times, some organisations facilitate ngangkaṟi in hospitals or other health care units to assist staff's family members or friends.

> We do have Aboriginal people coming here and a lot of Pitjantjatjara people who come through this service. Sometimes they will turn up and there would be another issue and it was something that was more in the province of a ngangkaṟi. We thought that maybe we should offer ngangkaṟi treatments here as an adjunctive therapy. So they are doing their therapy here, but if there was another problem that they were willing or wanting to seek a ngangkaṟi for, we could access a ngangkaṟi *(Interview Senior Project Officer 1-NAO3)*

> ...So we get Aboriginal clients in here but a lot wouldn't be seeking a ngangkaṟi and that's where I think budget-wise we can manage it. We had another person enquire but they decided against it. That was an Aboriginal person from Victoria. We said that we could set up a ngangkaṟi for you if you like... *(Interview Senior Project Officer 1-NAO3)*

2.3.1 Funding

These organizations do not have a specific funding to provide ngangkaṟi services to their staff or clients. Some agencies draw it from the organization's miscellaneous funds, others draw it from their running budget; others incorporate the expense within their existing health programs.

> No, we don't have a bucket of funds for ngangkaṟi, we have miscellaneous funds that work puts aside where we will engage them *(Interview Senior Officer AO1)*

> Funding is pretty limited and I guess if I did it too much they would scream a lot. Because we run a therapy program and it's getting the ngangkaṟi treatments as an adjunctive, there isn't another way. If there was a Medicare way or something like that, we would use it. I just got off the phone with this lady, for example, that needs a referral, and I need to find someone who is a bulk billing psychologist, and a bulk billing psychiatrist for this particular woman because there is no way that we can pay for this sort of thing; but there is no other way for us to actually get someone a ngangkaṟi service unless we pay ourselves *(Interview Senior Project Officer 1-NAO3)*

No, we don't have a budget. The last time we accessed ngangkaṟi we were lucky because Remote Rural Mental Health offered to pay for one, but we funded the other one... *(Interview Senior Project Coordinator 1-NAO5)*

Some organizations use their funding to cover travel, meals, accommodation and fees to provide ngangkaṟi treatments to their clients or staff.

We pay for the ngangkaṟi to come down because it is for us. We pay for their travel down here, whether it is flight or bus or car fuel. We pay for their meals and accommodation while they are here. We pay for the support worker and the organization provides the car and fuel. We have also opened it up for them to stay another two or three days outside of our consultation at work so the community can have access to them as well, although we won't pay for the consultation, but the individuals will have to pay for their own consultation fee which can be quite costly *(Interview Senior Officer AO1)*

2.3.2 Positive health outcomes

None of the interviewees indicate adverse events caused by, or related to, ngangkaṟi interventions. On the contrary, positive health outcomes and benefits are highlighted as a result of ngangkaṟi treatments:

In all of the cases that I have worked with them, there seems to have been some benefit to access the service whatever it is that the person has come in wants assistance with. They say that they feel better about that thing. There might be something I don't really feel I need to be treating. Normally it could be something that I would refer to another psychologist or refer to another service and they say no, they want a ngangkaṟi. So, "Ok, we'll get you a ngangkaṟi. And how was the ngangkaṟi, was the ngangkaṟi helpful?" "Yes, thank you the ngangkaṟi was very helpful" *(Interview Senior Project Officer 1-NAO3)*

The advantages are enormous, mental health people at Glenside say that there is no doubt that it works. That is from their experience. So obviously they can probably do things that normal psychiatrists can't do and maybe particularly with Aboriginal people. That works with other people as well but I think Aboriginal patients might be much more open to ngangkaṟi than they are to some of the other sort of medicine, so that is huge advantage they have the ability to heal and they do that *(Interview Director NAO1)*

That's fine if it makes people feel better... *(Interview Senior Project Officer 1-NAO3)*

Ngangkaṟi attend to a wide range of physical, mental and spiritual complaints. These include cases of assisting dying people and their families in their grieving; assisting children in distress; providing pain relief for a range of complaints; and different forms of spiritual healing. Chapter 6 provides a sample of stories of ngangkaṟi healing that occurred to clients and staff from these organizations.

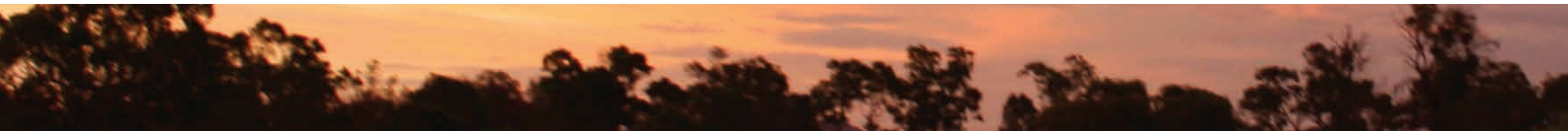
2.4 Issues and challenges in Adelaide metropolitan area

This section discusses the key issues and challenges encountered by health care services and other organizations in the provision of ngangkaṟi services in the Adelaide metropolitan area. These include: coordination, logistical support, accommodation, travel arrangements, need for a ngangkaṟi facility. Additional issues and challenges common to mainstream health care services, Aboriginal community controlled health services, correctional services and other agencies providing ngangkaṟi services across South Australia will be discussed in section 4 of this chapter.

2.4.1 Coordination: a central body

There is an overarching consensus across mainstream and Aboriginal health care services, public hospitals, and other organizations on the need of a coordinating central body to provide a coordinated and systematic response to the demand for ngangkaṟi services in metropolitan Adelaide.

Health care services and other agencies operate independently in regard to the provision of ngangkaṟi services. The only exception is when ngangkaṟi visits have been organized by AHCSA, Nganampa Health or NPY Women's Council. In those cases coordination efforts have been made to provide ngangkaṟi treatments to as many health care units, agencies or private clients as possible. Some interviewees have indicated AHCSA, Nganampa Health Council or NPY Women's Council as potential coordinating bodies.



In Adelaide each organization does it independently... *(Interview Senior Officer AO4)*

There is no actual program set up for people to see a ngangkaṟi. I refer them to the Arts centre in Adelaide to see a ngangkaṟi or I will tell them to ring NPW Women's Council. I do all the coordination for our office and if they are down here for a couple of extra days, work allows me to work with them until they go home*(Interview Senior Officer AO1)*

I think Nganampa Health is the right place for at least the ngangkaṟi from the APY Lands, that they keep the register and maybe the Women's Council register needs to be set...I think that they are the right bodies at least for that area and people coming down here who want to access them. That information could go to the Aboriginal Health Council so anyone can access that information. Maybe there is a body that is working in Oak Valley or Yalata and places like that. Maybe whatever they get together, that could be sent to the Aboriginal Health Council so it can be the place where anyone can find out. They can be the central point of knowing whether [he] is a ngangkaṟi and that allows for any community such Coober Pedy or Port Augusta, they can do a similar thing to Nganampa Health or the Women's Council [so] that it keeps getting sent to somewhere central like the Aboriginal Health Council *(Interview Senior Project Officer 1-NAO3)*

We pay for our staff, everyone else pay for themselves; other organisations pay for themselves. We deliberately did that. It wasn't until talking with people from Alice Springs and other places that we realised that the ngangkaṟi were being used in other areas in other services. Before then we were using them solely for us and families of staff *(Interview CEO AO1)*

In May 2011, the Adelaide Health Service and Ngura Wiṟu Winkiku Indigenous Corporation submitted a service provision proposal to support the delivery of ngangkaṟi services and cultural exchange in the Adelaide metropolitan region. The proposal aimed 'to provide a coordination of ngangkaṟi services through regular programmed visits across the metropolitan health settings within the Adelaide Health Service' (Adelaide Health Service 2011: 5). The collaborative arrangement had a two prolonged approach: to strengthen Ngura Wiṟu's capability to facilitate the provision of ngangkaṟi services and to provide 'a two way education and engagement arrangement between ngangkaṟi and western medical practitioners to ensure that the health and wellbeing of Aboriginal clients is culturally, spiritually and medically addressed with improved health outcomes for those clients' (Adelaide Health Service 2011: 5).

If the government supports this proposal it means that ngangkaṟi will be rolled out all through the health services when they are demanded. This would be a major thing because it is recognising that ngangkaṟi are up there with other alternative or natural therapies... *(Interview Senior Project Officer AO2)*

That's a business opportunity for them but there needs to be some seed funding to get it going and potentially even some ongoing funding in regards to administration because again it comes down to, if you've got a ngangkaṟi working full time, they also need a PA or an administrator to take the bookings, do the invoicing, remind them to get to the appointment, book taxi, do all of those things *(Interview Director NAO1)*

There needs to be someone to take the bookings and work out which ngangkaṟi is the best one to talk to. They do that themselves. I need to take all the information I can and find out a little about what the person is looking for to ascertain which ngangkaṟi is the right one. If they are not the right one then they sort it out. There is a lot of preplanning that goes into this, yes there is a lot of coordination in terms of what you have to do from the phone call. Some ngangkaṟi say "I am not the right person for that" and you will have to start over again. And the price schedule reflects that. It is not just about going on the job *(Interview Senior Project Officer AO2)*

I started working on a proposal looking at the costing, bringing them down from the Lands, looking at whether they drove or flew, whether was one male, one female and one support worker, or two male, two female, two support workers... and I wanted to have three prolonged approach: seeing patients, cleansing of hospital or various sections as well as providing a cultural exchange because when we had them in the past medical staff began to ask me – because I did the cultural,

the nursing professional development sessions for all the nurses. They wanted me to do a session for the medical staff on ngangkaṟi and I said it's inappropriate that I do that; but when we had some of the senior ngangkaṟi here I spoke to them to see if they would come and give a talk. So that was the three pronged approach: seeing the patients, cleansing, and to have that cultural exchange where they would come here or go down to Flinders so that nursing and medical staff can hear for themselves from the ngangkaṟi, their role, what they do and exchange information, ask questions... So we were having discussions with our Steering Committee here but in the meantime more Aṉangu moved to Adelaide and I found out about an organization set up in Port Adelaide called Ngura Wiṟu. So I worked with them and we had a lot of meetings and discussions with Andy as well. His involvement and input, and also Rama two of the senior ngangkaṟi because more Aṉangu moving into Adelaide, so that organization was set up to support and assist Aṉangu relocating and moving into Adelaide, just happened that they have four ngangkaṟi on their books; so we worked together, we were putting that proposal, the costing but the cleansing wasn't part of it, it was just the other two sides for the initial stage then I was going to do another one to do the cleansing *(Interview Aboriginal Liaison Manager 1-H2)*

Follow-up interviews in 2012 indicated that such a service provision proposal was not accepted and funding was not allocated to Ngura Wiṟu Winkiku Indigenous Corporation.

The establishment of a central body is considered a cornerstone provision to centralise all relevant information regarding the running of a consistent and systematic ngangkaṟi program in Adelaide metropolitan area. A central body would facilitate access to ngangkaṟi on a continuing basis and enhance health care services' and other agencies' capability to provide ngangkaṟi services to their clients. This is particularly important considering that numerous diverse groups of Aboriginal and Torres Strait Islanders from different parts of Australia access health services in Adelaide.

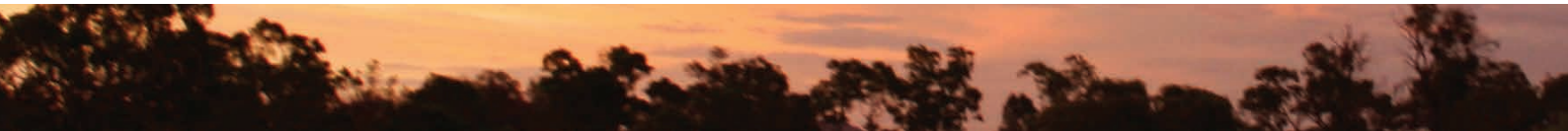
I mean people have to be able to access the information easily and because I hear of Aboriginal people coming from all different areas, they don't necessarily come from the APY Lands, I get people from Western Australia, I get people from Northern Territory so maybe it needs to sit at one place down here but all these different bodies can have a way of channelling in *(Interview Senior Project Officer 1-NAO3)*

I had someone recently who wanted someone to go out and do a smoking ceremony, one of the age funds, I can't remember, and on top of the ngangkaṟi's healing stuff but also to have that sort of thing. Sometimes people want a function but other times they want a healing capacity to go to an aged care home where there are some old Aboriginal people even if it is not an Aboriginal aged care home they might want for their residents. So to know that there was a place that was reasonably accessible that had that knowledge about how to do these things. That would be a really good thing for the Aboriginal Health Council to do *(Interview Senior Project Officer 1-NAO3)*

If they can coordinate things like a smoking ceremony or an opening, to know who they should go to. Should I go to this group or that group? And people don't know, but if it is there and it is listed, you know. You are confident that this is the place they could go and get a genuine service. Do you know what I mean? *(Interview Senior Project Officer 1-NAO3)*

I got someone else at the moment but they wouldn't use someone that is Pitjantjatjara but if there were someone from a region closer to their home they would probably use it. So the more we can make the service easy to tap into and I guess ngangkaṟi who travel down and do stay for a period if they get into the habit of notifying this body and saying I am in town for about six weeks, they could get some work while they are here. That would be a very good way for people who had to be forced to leave their community and can't go back up *(Interview Senior Project Officer 1-NAO3)*

I think there is room for both approaches, that is providing ngangkaṟi interventions in the hospitals and having a clinic where people can come, because this is essentially what is already happening, it is just happening in such a small scale that is not doing much. It provides a service to few people but there is a lot people stuck in the hospital and



obviously that is the right place to provide them a service; but having a clinic that people could come to, it's an equally viable thing *(Interview Director NAO1)*

Recommendation 13:
It is recommended that a central body be established to coordinate the provision of ngangkaṟi services in Adelaide metropolitan area. The central body should ensure a coordinated and systematic approach to the provision of ngangkaṟi services across health care services and any other organizations requesting ngangkaṟi interventions.

The central body should be identified in direct consultation with the ngangkaṟi

2.4.2 Logistical support: accommodation and travel arrangements

The provision of ngangkaṟi services in the Adelaide metropolitan area requires coordination also in terms of logistical support, particularly in regard to travel and accommodation arrangements. A central coordinating body could coordinate the logistics associated with travel and accommodation arrangements.

In relation to accommodation options, some interviewees have suggested the adoption of the Kanggawodli's model to provide logistical support to ngangkaṟi and manage ngangkaṟi's visits in Adelaide. Kanggawodli – which means 'Caring House' in Kaurna language – is a residential facility that provides a culturally appropriate place for Aboriginal patients to recover after their initial discharge from hospital and while they are receiving treatment. It is suggested that this model could be adopted to provide logistical support to ngangkaṟi during their visits as to make the provision of ngangkaṟi services in Adelaide more coordinated and cost-efficient.

...the issue is always gonna be their accommodation and their travel, and I truly believe this could be in a way similar to the PATS scheme, that is the Patients assistance where they provide accommodation for patients. I am talking about the patients at the moment, but I think it could be turned around for ngangkaṟi. In the Lands it would be just a telephone call to the central body, say Nganampa Health... but still to get them down you have to pay their accommodation and the transport down and once you go into a hospital, you have to pay three meals a day... *(Interview Aboriginal Liaison Manager H3)*

...Step Down Units and here Kanggawodli offer accommodation for patients. It could also be used for ngangkaṟi... Or have something similar just for the ngangkaṟi *(Interview Senior Officer AO4)*

2.4.3 Ngangkaṟi clinic

Ngangkaṟi services are provided on-site within the facilities of the requesting health services or agencies. In this regard, interviewees have identified some key issues that need to be considered. First, most of the services and agencies accessing ngangkaṟi do not have a specific space for the ngangkaṟi to provide their treatments. Office rooms or *ad hoc* space within facilities are temporarily allocated to allow clients to consult or receive treatments by ngangkaṟi. The availability of proper space can be problematic in two ways: to provide clients with the necessary privacy; and it can impact on the demand for ngangkaṟi services.

Ideally what this organisation requires in terms of making the transaction easier is a treatment area. Now when people come for private consultations there is no private area and that is a problem *(Interview Senior Project Officer AO2)*

We don't have a specific place, there isn't a private and open space for their healing. We are reacting more than leading and this leads to less income for Aṉangu. Demand is there, but not ability to meet the demand. There is an income stream that has the potential to help Aṉangu, a potential for Aṉangu to earn a living. There could be an on-site service say for five days a week. The biggest issues are personnel and facility. Staffing is a big issue, we would need at least one ngangkaṟi full time *(Interview Director NAO1)*

> It would be great to have a place where we can find the ngangkaṟi here in Adelaide, and be sure they are there if we want to call them for our clients...we don't know where they are, where to go to access them when patients ask for the healers *(Interview CEO AHS3)*
>
> ...a specific space for ngangkaṟi is what we need. You go there, you know that ngangkaṟi are there and everything is much easier. You need some privacy when people are treated... *(Interview Director AO2)*
>
> I truly believe that if people, general public, or anyone knows that there is a place where to access ngangkaṟi, this would increase the demand and the use of traditional healing for our people and also whitefella... Yes, no doubt about it... *(Interview Aboriginal Liaison Manager H3)*
>
> If we could have a ngangkaṟi clinic, there is a need of an integrated approach: Housing SA, AHD, AHCSA, RTO, OATSIS *(Interview Aboriginal Liaison Manager H9)*

The setting up of a ngangkaṟi clinic is indicated not only as a solution to these issues but also as a cost effective arrangement to tackle the logistical issues related to the provision of ngangkaṟi services in Adelaide.

The ngangkaṟi clinic would function as an Aboriginal traditional healing centre and a place to accommodate Aboriginal traditional healers during their stay in Adelaide. The combination of an Aboriginal traditional health centre and accommodation facility would facilitate the coordination of ngangkaṟi services and the development of a consistent and systematic process to access Aboriginal traditional healers.

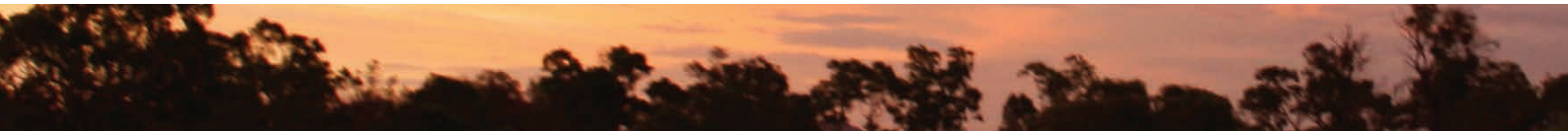
The ngangkaṟi clinic should be structured according to criteria set by the ngangkaṟi themselves. The facility should respond to their needs in relation to ngangkaṟi treatments. Consultations with some ngangkaṟi have provided key insights and defined some preliminary criteria. The ngangkaṟi clinic should include: a treatment area for men and one for women; an open space for treatment purposes; office room; toilet; accommodation for visiting ngangkaṟi; garden space for bush medicine.

In the short term, existing facilities, such as Step Down units, could be used to accommodate ngangkaṟi during their visits in the Adelaide metropolitan area.

Recommendation 14:

It is recommended that a ngangkaṟi clinic be established in Adelaide. The ngangkaṟi clinic should be structured in accordance with culturally appropriate criteria established by Aboriginal traditional healers.

In the short term, existing facilities, such as Step Down Units, could be used to accommodate ngangkaṟi during their visits in the Adelaide metropolitan area



Section 3

NGANGKARI AND THE CRIMINAL JUSTICE SYSTEM

3.1 Introduction *by Rosanne McInnes*

In 1988, the old stone building must have smelled strange, as Ruby stepped hesitantly inside a wooden cage inside a room, present yet not there. She stood, staring at a floor, uncomprehending, a prison officer beside her, in a white dress with red roses. Outside the wooden cage people with white faces, black gowns, and head dresses made of grey horsehair talked to each other as if she was not there. For more than an hour they spoke of her dead husband, and of her.

When a man at the apex of a triangle inside the room of black garbed people said she would be released on a suspended sentence for manslaughter to her it meant nothing. She only understood a touch on her arm meant that it was time to leave the room. A prison officer led her out. As she turned, people in black saw a great circle of red blood spreading in a great circle on her dress.

"We packed her in sanitary napkins six deep," said the prison officer, after Ruby had blinked in the February sunlight of the street, released without money, far from where she had lived. "She's been bleeding like that for weeks. After she killed her husband they pointed the bone at her."

Twenty years on, no one admitted knowing anything of Ruby, or what had happened to her after she disappeared from the street and merged into a mushroom circle of people sitting under the trees of a Port Augusta square. The old stone building had been consigned to history on a back street. Mangroves and a landscaped spinifex garden separated a new building from the sea. When all was quiet, on a weekend, an electric blue and yellow kingfisher rested near its entry doors. Inside, there were still wooden cages, now blonde, and topped with glass instead of air.

In the same place as Ruby had stood, in a newer courtroom, a young man stared at the floor. A prison escort officer stood beside him. Ruby's charge had been much more serious. In this room no one wore a wig of grey horsehair. Ruby's hands were always free. Metal bands constrained the black hands of the young man. Asked a question through the glass, he began to cry. His tears had nothing to do with what had been said. His story tumbled out in sobs. "My guts is bleeding. My woman is from up north". They had separated, and not happily.

The expertise this called for was not legal. An Aboriginal Legal Rights Movement field officer spoke to the young man privately in the cells.

In court after the visit the field officer said the young man had been bleeding from the bowel for some weeks. Doctors at the gaol had been unable to find anything wrong with him. The young man believed it was because "old fellas up north" were angry with him. He needed to see a ngangkari. If he was bailed the field officer would take him to see an "old ngangkari" who was "down from up north". The ngangkari was staying at a house in the Aboriginal community on the edge of the city.

Bailed he was. When he appeared again, for sentencing, a few days later the young man looked healthier, and settled, so unlikely to reoffend. In submissions no mention was made of the visit to the Aboriginal traditional healer. After court, the field officer said the ngangkari had taken stones doing damage from the young man's body. "He was right then."

The two episodes, 20 years apart, illustrated the actual workings of the system. In each case, the issue was known to people at the prison, but everyone involved in the case, including the defendant's solicitor treated it as "their business, nothing to do with us".

People in close contact with Aboriginal defendants, unable to avoid dealing with the issues, were dealing with the physical manifestations but also believed sometimes only a ngangkari could manage problems with mental and physical manifestations. Contact with a ngangkari would be arranged only if it could be done within the limits of the system, at no cost.

People in close contact with Aboriginal prisoners are not people who have budgets or discretions, any more than the field officer had any budget he could use. The field officer did not even have the right of audience inside the courtroom that a lay police prosecutor has.

It was the converse of the hospital without patients. Here were the patients, but to all official

intents and purposes - there was no hospital. At the epicentre of the "truth machine" that is a criminal court room, admiring the Emperor's new clothes was both normal and the accepted way of doing things.

To someone who knew a reasonable amount about courts, but not about Aboriginal people appearing in them, and who was reliant on surrounding experienced people around them for their training, education and professional development, it all seemed quite odd.

3.2 Role of ngangkaṟi: circuit courts in the APY Lands

In South Australia the term 'criminal justice system' is used in a broad sense. It describes the agencies dealing with everything that can happen after police suspect a person has committed a criminal offence. If police take action, in most cases two more government agencies will be involved. First, the police will put the person before a court. If the person is found guilty, the court will impose a criminal penalty. The correctional system will then carry out sentence administration. The simplicity with which the system can be described disguises its complexity. Each segment has complex processes for dealing with an infinite variety of people and events.

In this complex system, evidence from interview data indicates ngangkaṟi play a significant role in two particular areas, that is in the circuit court in the APY Lands and within the correctional system. In the circuit court, the role of ngangkaṟi is described as follows:

> In the APY Lands there had been fly-in/fly-out magistrates and fly-in/fly-out court staff and relationships were very bad. We went the second day I was there, there were people gathering with iron bars. That was something that was clear because people thought they had no voice. So then we went talking with people and the senior law-man came into court completely unexpectedly just sitting there and participating; and then it happened in other areas. The man who has been the mainstay of all this in one of the communities has been in court helping us for three years now and I have just been able to get a volunteer payment for him: he is a ngangkaṟi. The impact he has on people in court is profound in the sense that they listen and they respond to what is said. What has become clear working closely with him in court is that he is a healer as well, in that he is addressing the spiritual healing and the psychological healing, as well as giving advice.
>
> This is something that has been developed and put in by them and it has very much got that healing power involved in it, especially with young men coming into court that have got into trouble for whatever reason. There is more being addressed than just the court case and the clumsy tools that we have to work with *(Interview Magistrate 1)*

The involvement of senior ngangkaṟi, who can also be lawmen, provides an invaluable support for the circuit court. Their involvement operates on two levels: they provide psychological and spiritual support to Aboriginal defendants; and in turn, the psychological and spiritual support Aboriginal defendants can access with the ngangkaṟi can contribute to facilitating the processes and proceedings in the courtroom. It is indicated that a more consistent involvement of ngangkaṟi is possible.

> If magistrates are prepared to work with them, to accept that this is how this community is and this is how it operates then we can work with ngangkaṟi *(Interview Magistrate 1)*

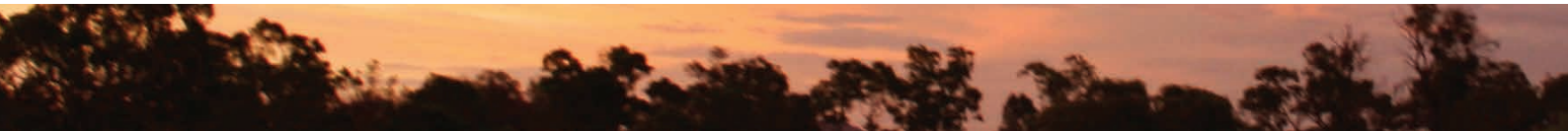
3.3 Role of ngangkaṟi: correctional system

The Department of Correctional Services facilitates the provision of ngangkaṟi interventions within South Australia's correctional services. This section investigates the role of ngangkaṟi within the SA's correctional system and identifies the key challenges that need to be tackled.

3.3.1 Demand for ngangkaṟi

There is a significant demand of ngangkaṟi from inmates. Most of the requests come from Aboriginal inmates. The request can be very specific, that is inmates ask to be visited by a specific ngangkaṟi; other times inmates request to see any ngangkaṟi, or they are open to see a ngangkaṟi, should a ngangkaṟi be visiting the facility.

> Yes, there is quite a significant demand by inmates, and the use of ngangkaṟi does make a difference. It's relevant because it contributes to calm inmates' behaviours *(Interview Aboriginal Liaison Officer 2)*



> In terms of request, generally we wait for a request from prisoners themselves. Some will identify that they want to see ngangkaṟi, others will say "look, I'm not sure about it, but if they are coming over I wouldn't mind seeing them" *(Interview Director NAO2)*
>
> Also non-Aboriginal inmates would like to be fixed, some ask for ngangkaṟi. But also there are some Aboriginal inmates that don't believe it *(Interview Aboriginal Liaison Officer 3)*
>
> Sometimes the prisoners will name the ngangkaṟi... *(Interview Aboriginal Liaison Officer 2)*
>
> Yes, they name one that they know *(Interview Director NAO2)*

The demand for ngangkaṟi in the South Australia' correctional system is higher in three correctional services: Port Augusta Prison, Yatala Labour Prison and Adelaide Remand Centre.

> Not all of them [request ngangkaṟi], usually it's more in the secure areas, because it's usually people who are not traveling well or they have behaviour issues because of their illness and they usually are transported to Yatala or Port Augusta and the ARC. There are three. So people coming in, usually people who had a pretty bad episode outside, will come in and they will request a ngangkaṟi...So Yatala, for example, it's a high security area, we've got people who are mentally disturbed, or feeling quite anxious for whatever reason; some will say "someone sung me, I need to talk to a ngangkaṟi", and then we work around that. The prison administration is usually pretty good getting people in *(Interview Director NAO2)*
>
> Most of requests come form Port Augusta *(Interview Director NAO2)*

The demand for ngangkaṟi can be difficult to be met sometimes. There are three main reasons: limited accessibility to ngangkaṟi; lack of a central body that can provide a systematic channel to access ngangkaṟi; lack of prison programs that include ngangkaṟi interventions.

> One patient called to see a ngangkaṟi but it's difficult to get in contact with ngangkaṟi *(Interview Aboriginal Liaison Officer 3)*
>
> The need for ngangkaṟi is always needed but because we don't have a centre where to ring and call for ngangkaṟi, it's difficult. We have 160 Aboriginal inmates out of 350, that's our capacity *(Interview Aboriginal Liaison Officer 3)*
>
> We never had a ngangkaṟi program. Prisons programs depend on interpreters. For example, for the 'anger management program' you will have mentors and interpreters *(Interview Aboriginal Liaison Officer 3)*

Sometimes the request to see a ngangkaṟi can be met only because a ngangkaṟi inmate can provide healing within the correctional facility.

> The Port Augusta Prison uses very much ngangkaṟi. There is a ngangkaṟi inmate who provides healing to the other inmates. He assists with a range of different issues: family business, mental health. Inmates feel more comfortable to see a ngangkaṟi, most inmates are from the Lands *(Interview Aboriginal Liaison Officer 3)*
>
> We need ngangkaṟi. If we didn't have him as our inmate we would keep requesting him because of the high demand and the good results and impact he has on the inmates *(Interview Aboriginal Liaison Officer 3)*

3.3.2 Access to ngangkaṟi

The Department of Correctional Services accesses ngangkaṟi through an informal channel. The Aboriginal liaison officers at Port Augusta Prison provide the key channel to access ngangkaṟi through personal contacts and interactions with the ngangkaṟi from the APY Lands.

> We use the Aboriginal Liaison Officer in Port Augusta. They'll make contact with the ngangkaṟi. ALOs from Port Augusta area, from the area they are linked in closely, so they know who the ngangkaṟi are in the area, who's there, who's available; so we use them to make the initial contact...So, because it's probably emails from me saying we need someone to come down, usually they'll get in touch with me and say "look, we've got these three ngangkaṟi'. They'll come down from the north, that's where they come from, generally from the APY *(Interview Director NAO2)*
>
> Sometimes if we're lucky, there might be someone that's fairly close here [Adelaide], that's here for business already that we can tap into. Prisons, specifically Port Augusta, are really supportive so we've had ngangkaṟi from Port Augusta. We would keep a lot of traditional fellas anyway close to home for

visits and so forth. So ngangkaṟi, that process is better there. We have brought them down to Yatala, where it's a little bit harder... It's in town, sort of north to the metropolitan area. It's a high security area. So we've got people who are mentally disturbed, or feeling quite anxious for whatever reason, someone say "someone sung me, I need to talk to a ngangkaṟi", and then we work around that. The prison administration is usually pretty good getting people in *(Interview Director NAO2)*

The degree of accessibility to ngangkaṟi can be hampered by three elements: the reliability on a single informal channel to access ngangkaṟi; the extent to which requests to see ngangkaṟi are concomitant; and the availability of financial resources to meet the costs involved.

We need ngangkaṟi...but it's difficult to get in contact with ngangkaṟi... *(Interview Aboriginal Liaison Officer 3)*

If one person does request a ngangkaṟi, we'll look around and see if there are any others that request for that ngangkaṟi to see everyone at the same time *(Interview Aboriginal Liaison Officer 2)*

I don't finance it unless I get three or four people that need to be seen at the same time *(Interview Director NAO2)*

There could have been other visits but it is very expensive, sometimes cost is an obstacle *(Interview Director NAO2)*

3.3.3 Funding and rates

Funding to provide ngangkaṟi care to inmates in South Australia's correctional services is drawn from a budget specifically designed to support a range of initiatives for Aboriginal inmates:

We have a budget, I have developed a couple of different initiatives and one of them is Aboriginal Initiatives, which is a budget. For that line, I'll do things like special days, for example NAIDOC day; if prisoners want to play a game of football I can fund it through that; funeral day, and also ngangkaṟi. So that's how I fund ngangkaṟi to come in. And it's just a matter of balance, to keep a fair bit of money in there *(Interview Director NAO2)*

The financing of ngangkaṟi interventions is linked to the availability of financial resources within this specific budget.

We handle it within our budget. For our budget line, it's just a matter of when it runs out, it runs out. And it hasn't run out yet, and ngangkaṟi are something that sort of comes up, and then it disappears for a while, and then suddenly it comes up again. It's not something that is constant. It comes in cycles *(Interview Director NAO2)*

There could have been other visits but it is very expensive, sometimes cost is an obstacle *(Interview Director NAO2)*

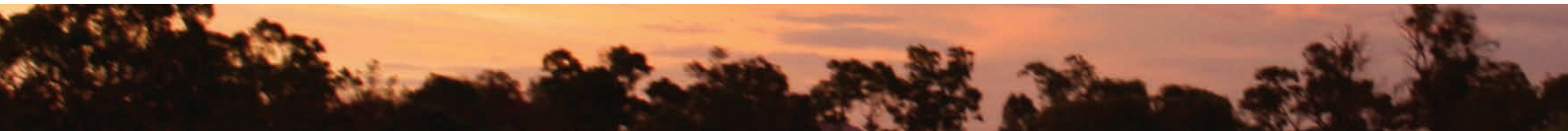
In terms of rates, payment for ngangkaṟi services is negotiated on an *ad hoc* fee-for-service basis. The payment includes the negotiated fee for the ngangkaṟi service, accommodation and travel expenses. The *ad hoc* nature of the arrangements inevitably produces rate variations that can influence the capability to meet the demand for ngangkaṟi from different correctional services.

It can get expensive...It depends. Ideally, I'd like a pay structure but we don't necessarily have one for ngangkaṟi. It's a negotiation before they come, that's how we do it. Usually it's a cost for accommodation, money for them, and also fuel is paid to get them here...And for the fees we have to be careful because at the end of the day, we have a finite budget and we can't spend it all on one particular service. We try to negotiate beforehand to try and get the figure reasonable, a reasonable figure *(Interview Director NAO2)*

3.3.4 Data collection

The Department of Correctional Services does not have a systematic recording system of ngangkaṟi interventions within SA's correctional services. However, ngangkaṟi interventions are recorded in the personal case notes of inmates who are visited by ngangkaṟi. The lack of a systematic data collection system is due to the *ad hoc* nature of the service, and the annual low expenditure of ngangkaṟi services relative to the cost of other programs for Aboriginal inmates,

On the case notes, you'd find that for each of those individual prisoners, the ALO will record that a ngangkaṟi see them. But in terms of recording... If it was something regular and I need to sort of get a handle of it, I would need to get a cost. I think overall, every year, about $1,000? $1,500? Not enough to report on. Funeral days, we do monitor them



because that works out to about $20,000 every year *(Interview Director NAO2)*

3.3.5 Health outcomes

Findings reveal how ngangkaṟi interventions have a profound positive impact on the health of Aboriginal inmates. First, ngangkaṟi play an important role in helping Aboriginal inmates to overcome critical stages of the so called 'Aboriginal Cultural Cycle':

> The Aboriginal Cultural Cycle represents what happens to Aboriginal inmates when they come to prison. There are different stages: Offending behaviour: silence; Cultural interruption/disconnection/neglect: responsibility of caring and sharing is disrupted. Cultural responsibility is affected: men are initiated in the APY Lands. If they are taken away there is a great suffering in the community because numbers drop. Ngangkaṟi play an important role when an inmate is neglected. Ngangkaṟi would help the person in these states. If they have access to ngangkaṟi, there would be no interruption, they would not be neglected, they would not feel a disconnection from their culture *(Interview Aboriginal Liaison Officer 3)*

Second, ngangkaṟi can provide a medical response to what are termed 'Aboriginal illnesses'. Aboriginal illnesses are characterised by a culturally defined illness causation process. Generally, there is not a western medical explanation and medical response to these Aboriginal illnesses – western medical treatments are not effective to relieve the symptomatic manifestations of these illnesses, neither their causes. Ngangkaṟi are the only health practitioners who can attend to 'Aboriginal illnesses'. Their interventions have two critical implications: improve inmates' health outcomes by providing adequate diagnosis and effective treatment; allow Aboriginal inmates to complete their rehabilitation programs so as to be eligible for a reduction of the imprisonment timeframe.

> Ngangkaṟi is very important when it comes to 'Aboriginal illness'. Mental and psychological illnesses can be caused by Aboriginal sickness that prevents inmates to participate in the rehabilitation programs. If someone has a headache, just take pills and back to the program. Whereas if Aboriginal inmates are not fixed from Aboriginal causes they can't go back to rehabilitation programs. Illness creates a barrier for Aboriginal inmates, a huge barrier! For example, you have a 18 years sentence but the inmate could get 12 years before they go on parole as long as they abide to certain conditions. But if someone cannot participate in these programs because of Aboriginal illness, that person instead of 12 years has to be in prison for 18 years. The Aboriginal inmate could have been released after 12 years if completed the courses *(Interview Aboriginal Liaison Officer 3)*

> Faith in ngangkaṟi of inmates is far more recognised and needed than white medication. Because fever, cough go away with medications but the illness caused by Aboriginal sickness doesn't *(Interview Aboriginal Liaison Officer 3)*

In terms of health outcomes, ngangkaṟi interventions achieve positive results particularly on psychological, spiritual and behavioural disturbances. The degree of accessibility to ngangkaṟi can significantly impact on inmates' health status.

> They settle prisoners... Anxiety, they are really good with that. I've been around for about seven years in Corrections and within the prisons, and that's the way I have experience with ngangkaṟi work... Once you see a ngangkaṟi, it's instant. It eases their souls. It really does *(Interview Aboriginal Liaison Officer 2)*

> We had a psychologist who saw a lot of progress with some inmates treated by ngangkaṟi. I remember there was an inmate who was released. The health report from a lot of agencies deemed him unfit to plead. He didn't want to be released, he was agitated and nobody could get through him, nobody. A ngangkaṟi talked to him and after that he just jumped in the van *(Interview Aboriginal Liaison Officer 3)*

> The impact of seeing a ngangkaṟi is immediate. People settle right down. It does make a difference, they relax inmates... *(Interview Director NAO2)*

> There are also issues related to death spirits that affect their [inmates'] health; ngangkaṟi will pick up on those things. They can pick up a lot of things... *(Interview Aboriginal Liaison Officer 3)*

> In the last six months maybe the ngangkaṟi saw about four inmates, but there are others

suffering. He fixed one officer, he had lost his spirit and put the spirit back in place. You can fix heart, lung, blood infected by poison *(Interview Aboriginal Liaison Officer 3)*

They [inmates] are really upset, some of them are weak. Our prisoners have been released and arrested the same day...yeah, come in, go and back in, and ngangkari can help them *(Interview Aboriginal Liaison Officer 2)*

We see them come in, usually they are really downtrodden and skinny, withdrawing, psychosis coming down generally, and when we see them leave, it's like a different person *(Interview Director NAO2)*

The officers, our general officers and admin are supportive because they know that difficult prisoners who have been seen by ngangkari become easier to work with. And the effect it's almost immediate. So the sooner we get the ngangkari in, the better it is *(Interview Director NAO2)*

Inmates feel more comfortable to see a ngangkari, most inmates are from the Lands *(Interview Aboriginal Liaison Officer 3)*

I had one come into Port Augusta one day; he was very jittery and he broke down and said he was bleeding from the bowel and bleeding constantly and he believed it was because of something he had done to his wife up on the Lands. So there was a ngangkari from that area down at the time, so we bailed him and they took him there and the ngangkari managed to stop the bleeding *(Interview Magistrate 1)*

There was an inmate who developed mental sicknesses for petrol sniffing from a young age. He was also punished for some things during ceremonies. He was boned. His uncle is a ngangkari and figure out that he was boned...but then the inmate went to Disability SA and the inmate has never been cured *(Interview Aboriginal Liaison Officer 3)*

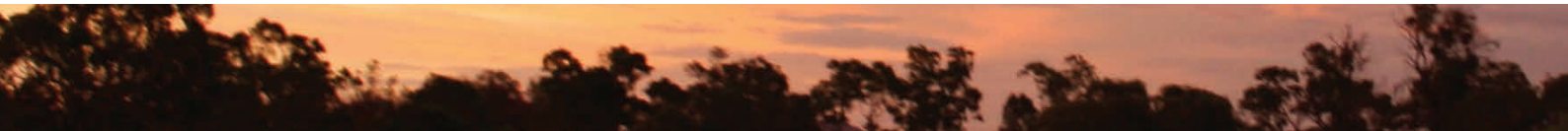
3.3.6 Recommendations

Findings from the interview data suggest the following recommendations to improve the provision of ngangkari within the correctional system in South Australia: a process of accreditation for qualified ngangkari; a register of accredited ngangkari and a payment schedule.

I think there are a couple of things that need to occur. First of all, there needs to be some sort of process for assessing people whether you're a ngangkari or not, but maybe it happens in the APY where they assess who can and cannot in terms of their qualifications. That's something they can only really determine themselves. Pay scale needs to be sorted, there needs to be one pay scale so we don't have someone getting $1,000 and someone's getting paid $200 because that is not fair. We also need a list of names we can use, and they can be aware that they can't just charge whatever, they'll be charged a certain level *(Interview Director NAO2)*

We need a central list because in the last few years, there are a lot more, lot of those Aboriginal people that are coming down to Adelaide and they are getting arrested and ending up in prison; from APY Lands, a lot of Alice Springs people and over the border, NT and around the borderlines that are coming into the prison system here in SA. And they'll probably have their own ngangkari up in their areas so they probably want one from their area if they ever requested one *(Interview Aboriginal Liaison Officer 2)*

I would love to have the possibility to call a number or jump on the internet and call a ngangkari *(Interview Aboriginal Liaison Officer 3)*



Section 4

ISSUES AND CHALLENGES IN SOUTH AUSTRALIA

This section discusses the key common issues and challenges identified by interviewees in mainstream and Aboriginal community controlled health services, other agencies and organizations accessing ngangkari across South Australia.

4.1 Recognition of ngangkari as legitimate health practitioners

The recognition of ngangkari as legitimate health practitioners raises a range of issues that require careful consideration.

First of all, it is important to outline that the issue of recognition lies at the interface between ngangkari interventions and mainstream health care settings. The need for a process of recognition to identify the 'accredited', 'qualified' or 'real' ngangkari surges from outside Aboriginal communities' contexts at the intersection between ngangkari and mainstream institutions. The identity, role and significance of ngangkari within their own communities are uncontested.

The issue of recognition poses challenging questions. Most of the health practitioners interviewed acknowledge the need for a process of recognition without concealing uncertainty in relation to appropriate pathways to follow.

> I don't really know. I think that their importance amongst the community is already there; so maybe it's getting outside people to recognise them and pay appropriately. I don't know how you do that. Funding is really difficult for anything and we struggle with getting funding, so it's always hard and then you got a lot of problems in administrating that which can create huge difficulties, and who does that and how it's done. I am not really sure; I think people would be the best to say what they think... *(Interview Registered Nurse 3)*

> Look, I am not sure. Is there any case anywhere else in the world? I am not sure, I don't know... I mean, is Aboriginal traditional medicine as valid as aromatherapy? Do I think ... I don't know... I am not sure... I truly cannot answer this question *(Interview Medical Practitioner 1)*

> Oh yes, it's so important! It's always falling off the shelf. We don't know where to put it and it really is a field that needs to be specialised and needs to have recognition and accreditation, same as doctors. We are wrestling with that at the moment. We had a meeting about that yesterday morning talking about ngangkari. It's been *ad hoc* in the past and still remains *ad hoc (Interview Counsellor 1-AHS6)*

> I'm not sure, I'm just concerned though that we are actually turning a very traditional way into a very westernized way...it's turning it into like a business with ABN numbers and I don't know, I think we need to keep things... They certainly need to be paid for what they do, and they need to be recognised *(Interview Psychologist 2)*

> That's a longer term commitment in trying to get the current ngangkari recognized, and also who is coming up and what are those processes? So that's not about knowledge and culture and teaching, it's certainly not going to a local university to get that *(Interview CEO AHS10)*

> It's something that may have to be discussed with the bureaucrats and the AMA, 'cause they would be the ones, they don't recognize anybody who is not a GP or a specialist, even naturopaths have that problem here, they tend not to recognize them, they are the only medical practitioners. Sometimes the doctors come from overseas and they have to go through these vocational exams to get registered in Australia because they don't recognize their qualifications. And these Aboriginal healers they will be seen as uneducated, and they're just doing something that doesn't fit with western medicine. It would be very difficult. I don't know how it could be done. It might be a Government thing, Government would recognize these people and set up an award for them *(Interview Financial Manager AHS6)*

> There are ngangkari and they should be properly recognised, as it's the case in other countries and this is where the work needs to be done, but it's a much more complex process. I am happy to support that *(Interview Psychiatrist 3)*

Recognition of ngangkari is considered critical in two respects: first, in relation to the value of ngangkari as health practitioners; second,

in relation to the need to improve current arrangements for the provision of ngangkari services.

> I know some ngangkari feel they are undervalued, that their work is not valued properly *(Interview General Practitioner 2)*
>
> ...from the state government's perspective, it's not 100 per cent "we've got to do it." It's more if a person requests it, they'll respond to it. But ngangkari should have a role to play in all the hospitals and all the medical clinics, whether they're Aboriginal medical clinics or mainstream medical clinics *(Interview CEO 2-AHS6)*
>
> I don't think people get really well rewarded either *(Interview Registered Nurse 3)*
>
> I think better conditions are really essential but I think it will be difficult to coordinate. Because they are all people who are here one day and the next day you have no idea, they are always moving around. And that is a bit of conflict when you have got them working on staff as well; if their role is in one clinic and then it is difficult if they've been employed in a clinic and they've got other things they are doing takes them away from clinic and there is a conflict with their work, you know staff and pay and all this sort of thing *(Interview Registered Nurse 3)*
>
> More funding and more recognition for them...I don't know if doctors grasp what ngangkari are capable of... Doctors from India or other countries are open to it. I guess they have their own traditional healers in their countries, and they might believe it...*(Interview Aboriginal Support Worker 2 AHS1)*

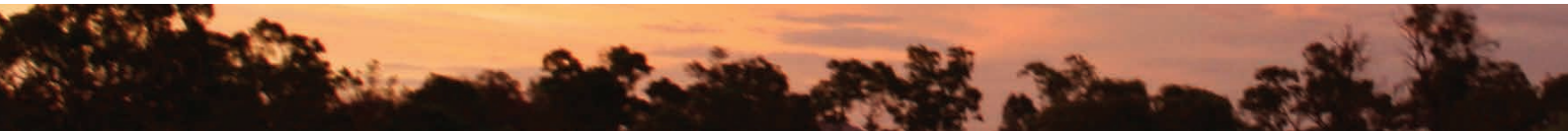
Recognition of ngangkari as legitimate health practitioners entails the development of appropriate standards and accreditation processes. Over the years, mainstream and Aboriginal health services have engaged in several discussions in an attempt to establish appropriate accreditation criteria and processes.

The interview findings identify three core interconnected questions lying at the centre of these discussions: where does the authority to establish ngangkari accreditation criteria lie? Who is endowed with the legitimate authority to set culturally appropriate standards for the recognition of ngangkari? Which is the most appropriate body to take the lead in ngangkari accreditation standards setting?

Findings show that even though Aboriginal community controlled health services have developed their own relationship with some ngangkari grounded on community-based recognition processes, no Aboriginal or mainstream health care service has taken on the critical responsibility of establishing a process of recognition and standards setting outside Aboriginal community contexts.

The danger of 'westernization' of a profoundly traditional process is repeatedly emphasised as intrinsically embedded into mainstream attempts to legitimise ngangkari within the western health care system.

> There was a discussion paper submitted to the Aboriginal Health Council but presented some major concerns around the fact the ngangkari have been expected to fill non-Aboriginal health professional requirements. Well, it's a kind of a catch 22. If you want to come into my world, well then there are going to be expectations of coming to the mainstream world in the same way I have got to respect when I go there, and particularly when someone comes into my world, it's got to be sighted from not only my point of view but the organization's point of view. The board has found disrespectful - as ngangkari have been in Aboriginal communities for generations - asking ngangkari to explain and describe to others how they work. This is a big taboo, working around this would be a challenge. Not particularly helpful, but I can understand where they come from and I think it's probably a very reasonable position. This was a while ago and that's my interpretation of the feedback. What was actually said or not said is another thing but you can see the dilemma that we are in. So from my point of view, where to go to next? *(Interview Psychiatrist 1)*
>
> There needs to be a simplified way. For example, if you look at Fregon, ngangkari work together with the doctors in the clinic there. Patients will come in and they will either see the ngangkari or they will see the GP. So if we could have some sort of system where it's recorded, if a ngangkari has seen a patient, whether it has been a long or short consult, and keep it really simple, and they get paid for that, I think that's great. But I think introducing ABN numbers and bank statements is turning something which is very



traditional and very beautiful into something very westernized. I think there's got to be a better way of doing it. To have provider numbers, that's basically just saying you're recognised as ngangkari, isn't it? And I think there does need to be the recognition of the ngangkari but I'm just wondering if there's a better way of doing it *(Interview Psychiatrist 2)*

I think you need to be very careful about efforts to incorporate ngangkari into the western medical system because I think it could be dangerous. It is a system that is functioning and if you start interfering with it and try and massage it so that it fits within a western medical system with the bureaucracy and salaries and so on, then it could change the ngangkari system adversely. It may be better to leave it within their own system functioning well, being paid a fee-for-service, without us interfering, without the western system interfering. I became aware very quickly that unless it is done very sensitively there is a danger. If we are going to create any structure you need to make sure it is as flexible as possible and is not one which has to fit into boxes. In fact it would be dangerous because it could dilute and weaken that whole community system that is still alive and strong *(Interview Medical Practitioner 2)*

I guess it's westernizing and bureaucratising what is a non-westernised system... Should a traditional Aboriginal ngangkari work according to our system? We're trying to bureaucratise it to suit our needs, our need to be able to do this, you know. And we have to do that as a state-based mainstream health service. It's difficult. But we're not the first people to advise that *(Interview Hospital Manager 1-H7)*

The challenge is finding that happy meeting where you don't go so far that you become so standardised in everyday that it loses its actual magic that makes it the ngangkari. Where's that fine line? *(Interview Hospital Manager 2-H7)*

I went to some of the Ananora Associated Health Alliance meetings in the early days and one of the things that they talked about was the fact that they needed to have a standardised system to make sure the ngangkari were recognised and that there was a standard payment. There was concern that people were ringing up, say Yalata, and saying "I am a ngangkari, I will come out and you pay me..." They had a register of people who were recognised as being legitimate ngangkari and there was a standard fee. So the health service would pay for somebody to come for two days and be recognised that the person was legitimate. That was developed back then within the health services... *(Interview Medical Practitioner 2)*

So it must be something that can be more formalised. On the other hand, then you lose that traditional, I don't know if it's a good thing or not. It brings sort of more bureaucratic structure *(Interview Mental Health Worker 1-AHS9)*

...when the Coroner recommended the use of traditional healers, we thought "how do we actually get a proper use of ngangkari in mainstream health services? What is the basis of this sort of arrangements?" We asked the Aboriginal Health Council "What are your recommendations to us with respect to how to use them in the context of no formal college, no registration board?" Although Nganampa now got their list – no association, no Medicare provider number, no ABN, medical-legal issues, payments, all of this sort of things. A paper on ngangkari in mental health went into the Aboriginal Health Council for ratification. My understanding is that the Aboriginal Health Council had difficulty doing that...they were unable to ratify it because of the cultural and other aspects; they didn't want the AHC to take responsibility to doing this. They thought that was the responsibility of the mainstream services. So it is a bit of a catch 22 too. Mainstream services go to AHC to get advice because we don't want to set something up which is not culturally sensitive and then... *(Interview Psychiatrist 1)*

The recognition of ngangkari involves the development of three interrelated elements: a process of accreditation; ngangkari accreditation standards; and a Register of accredited ngangkari.

4.1.1 Process of accreditation and accreditation standards

A fundamental question stands at the core of the provision of ngangkari services: who are the 'real' ngangkari? The identification of the 'qualified', 'recognised' or 'real' ngangkari

constitutes one of the greatest challenges the mainstream health care system, government departments and general public face. From a mainstream perspective there is not a statewide legitimate ngangkari accreditation process, ngangkari accreditation standards, or a consistent process to access the accredited ngangkari.

Access to the 'accredited' or 'recognised' ngangkari occurs via two main channels: personal contacts with communities members; enquiries to Nganampa Health, NPY Women's Council or AHCSA. Evidence shows that these channels have been successful, but only to a certain extent. Personal contacts with people or family members in the communities do contribute to accessing accredited or recognised ngangkari, especially those employed by NPY Women's Council and Nganampa Health. However, it does not provide a statewide systematic and consistent system to guarantee access and use of ngangkari services on an ongoing and long-term basis.

> We find out about ngangkari by whom that community retain as being a ngangkari and who does that community trust as a ngangkari. And that's how we would go about getting someone. We know that the ngangkari we deal with are actually recognised *(Interview Psychiatrist 2)*

> I rang the Aboriginal Health Council first because I thought they had a list of who were registered as ngangkari. People told me that this list existed but it didn't as far as I could see. So instead I thought was better to come back to my contact with the community, so I went back to Nganampa Health and when I could speak with Pitjantjatjara people on the phone they kept saying "yes yes, he is a ngangkari". I said "well, actually I know he is a ngangkari but in order for me to be able to get his services, we need some kind of letter or certification process". So that was important for me. That took a long time but eventually I did get a letter from Nganampa Health to verify that he was a ngangkari. It was a simple letter but that was for me much better because it makes it easier for us. Later on I wanted to get a female ngangkari and I thought she was a ngangkari because her father I know had been a really big ngangkari so in my mind I was fairly sure. But again, I needed something in writing but I never managed to get a letter for that person, yeah, I never could get anything in writing. In a way I know in my mind because I have seen so many people go to her as a ngangkari and if the people here are going to her as a ngangkari that for me is a kind of validation. But to have a process would be really really helpful, and there is other people who offered services that I don't know whether they are really seen as a ngangkari or not *(Interview Senior Project Officer 1-NAO3)*

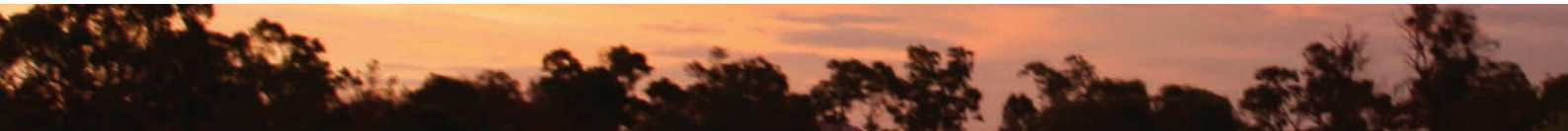
The danger of exploitation is a widespread concern. Interview findings reveal instances of fraudulent activities whereby individuals claim to be ngangkari and offer fee-for-service treatments. It is feared that the lack of an accreditation process and accreditation standards would enhance the potential misuse and exploitation of a system that recognises ngangkari as legitimate health practitioners and legitimises the provision of their services,

> ...and you got be careful because some of them will say they are ngangkari and some of them are not. They just do it for the money. That's why I'm really careful about ngangkari. So I'll ask the people in the community, and if they're recognised by them, then I'll use them *(Interview Aboriginal Liaison Manager H1)*

> We had a couple of kids and we had one lady coming and she said she was Pitjantjatjara and a ngangkari and we used her...then I was talking to some people from the APY Lands and they said that "*wiya wiya*, ngangkari *wiya*". But she got paid. So there's got to be a proper register of who is the accepted ngangkari by the communities as a whole. Otherwise, sometime it can be abused *(Interview Aboriginal Liaison Manager H1)*

> ...there have to be some guidelines around how the program worked because people coming in saying they are ngangkari when they were not supported by their community in that aspect...asking for all these outrageous fees that are just not practical and if supported, then the bucket of money would be gone in a very short period of time *(Interview Hospital Manager 3-H8)*

> I'm concerned and I don't know. I think there are different levels of ngangkari. I've seen cases where persons presented themselves as ngangkari but no one in the community knew they were a ngangkari. And that's the thing, we find out about ngangkari by who does that community retain as being



a ngangkaṟi and who does that community trust as a ngangkaṟi? And that's how we would go about getting someone. We know the ngangkaṟi we deal with are actually recognised. For example, when a senior ngangkaṟi endorses other ngangkaṟi, we know that it is fine *(Interview Psychologist 2)*

You got to be careful if you open the door with providers, all these people come out of the woodwork: "I'm a ngangkaṟi, I'm a ngangkaṟi". It's very special. You don't learn it. You get it handed down to you. From one of the elders, will say "right-o, I'll give it to my great grandson" and he could be two or three, or when he's older...*(Interview Aboriginal Mental Health Worker 1-NAO4)*

The thing I have a problem with is when people pay a lot of money for it.... And people get robbed by it *(Interview General Practitioner 3)*

We don't call other ngangkaṟi from other parts because at the present time the feeling is no one is too sure who are qualified and who aren't. Those who are claiming to be ngangkaṟi are not necessarily a ngangkaṟi; there is a bit of fraudulence activity out there and the dilemma is – and we are discussing it at the moment - what are we doing? We are trying to sort of list of qualified or the ones who are considered to be authentic ngangkaṟi...*(Interview CEO AHS11)*

I think that the ngangkaṟi system is more abused now than it used to be because it is become legitimized and therefore people are getting paid for it. I know at least two or three very young people who supposedly cluster as ngangkaṟi who claim full time work for the week and you just never see them; and because it's classed as a system that works outside, supposedly they are supposed to be working harder in the community; but I know at least one of these people who just doesn't do anything and says that he does and gets the money for it. And that's to say anyway, in any society you always get some people who get advantage of the system, so I am not saying that the system doesn't work because there is some people who take advantage of it. That happens also with doctors as well. Doctors who could also take advantage of the system, so I am not saying anything peculiar to Aboriginal society but I don't have a lot of faith in alternative medicine anyway *(Interview Registered Nurse 2)*

The need of an accreditation process is considered to be necessary and indispensable for three main reasons: to ensure the identification of those ngangkaṟi who have been trained according to traditional practices and who are recognised as ngangkaṟi in their communities; to ensure the provision of a quality ngangkaṟi service to patients in mainstream and Aboriginal health care settings; to avoid fraudulent appropriation of ngangkaṟi traditional knowledge and attempts of exploitation.

> ...I think to have a process would be better for the ngangkaṟi here because otherwise ngangkaṟi have been paid, and some get paid well at times; it is very attractive to people for exploitation. I think there is a great chance of that happening to tell the truth. And there is a real risk and that does a disservice to the people who are genuine ngangkaṟi as well as does a disservice to patients who are not actually getting what they thought they meant to get. I think in that way they'd be getting a lesser service *(Interview Senior Project Officer 1-NAO3)*
>
> I'm concerned, and I don't know. I think there are different levels of ngangkaṟi. There are different levels of ngangkaṟi and I think, I've seen one case where one person presented himself as a ngangkaṟi but no one in the community knew he was a ngangkaṟi *(Interview Psychiatrist 2)*
>
> And the other difficulty around is the credentialing. We are non-Aboriginal, we don't know whether some ngangkaṟi are respected or if they are random people. There is no credentialing process *(Interview Hospital Manager 1-H7)*
>
> I mean how do you actually go about it [credentialing]? Do you need in terms of your Aboriginality to be recognised by the group? Will the group be able to sort out the charlatans from the rest? *(Interview Psychiatrist 1)*
>
> In actual fact, I think that to actually ask for that sort of credential, is that being disrespectful to traditional healers? *(Interview Psychiatrist 1)*

The lack of an accreditation process is particularly important in relation to potential risk, safety and liability issues, particularly related to potential adverse events within mainstream health care settings.

It raises a range of issues for mainstream

services, we struggle with credentialing... for example with acupuncture, if someone in the ward wants acupuncture and something goes haywire and it is in our service, everyone has got to be credentialed to actually work within that service. What do you do about that? Do we credential traditional healers for our mainstream mental health services so that they are covered from a medical and legal perspective if something goes wrong? And that was never an issue for traditional healers within their kinship networks but if you are working within the whole context in terms of traditional healers being a specialist healer for a kinship network which has actually clearly defined itself and has a hierarchy in terms of a set of rules, initiated men versus not, all that as opposed to what we've got now. I think it is a really interesting area... *(Interview Psychiatrist 1)*

I think that credentialing hasn't been thrown in because of the hierarchy of the western medical system, people feel threatened by that, so I think it's only just lately that you can even have acupuncture, aromatherapy and things like that going on. Even when I was working in Adelaide and we wanted the ngangkari to come into the Women's and Children's Hospital, it's all about: you've got to have a police check, there's all these things to prevent them, you've got to have those things about risk and liability and so on...*(Aboriginal Mental Health Coordinator 1-NAO4)*

So what happens is that ngangkari come down at the health service and one of the dilemmas that we found not that easy is that the family believed that one traditional healer from one area had caused the psychosis. He got admitted into our services and we believed that person has psychotic illness, couldn't discount that there were also very strong traditional components to the presentation but didn't want the original traditional healer to be involved, wanted someone else so: who do we get? And if we get that person and something again goes wrong, who would then be potentially accountable for that intervention, particularly if there was harm to the person? Is it the mainstream service that brought the traditional healer? *(Interview Psychiatrist 1)*

The core question at the basis of the recognition of ngangkari remains the development of a legitimate accreditation process that provides appropriate accreditation criteria to identify and recognise ngangkari as legitimate health practitioners.

Findings from the interviews suggest two options: to identify and endow an existing body with the authority to indicate who are the accredited ngangkari; to allow ngangkari to set up a culturally appropriate accreditation process.

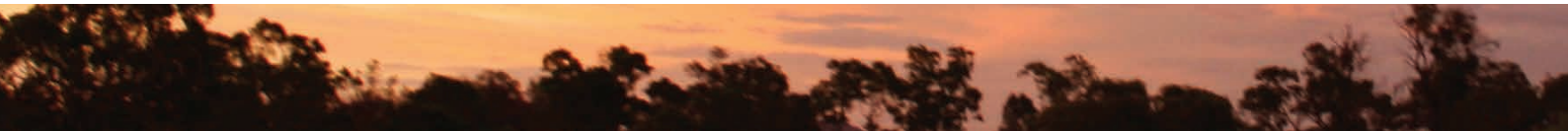
How do you credential? Because you get someone would say "I am a traditional healer" and well, does the community know? *(Interview Psychiatrist 3)*

How are they credentialed? There needs to be some central way of credentialing ngangkari so that we know that this person is a proper ngangkari and is accepted as such. But if they're not, then there needs to be some entity or body that can let us know that they are a charlatan or whatever it may be *(Interview Hospital Manager 1-H7)*

I think it is a good idea because ngangkari need to set up that process, whether it's like a council, a senior council of senior ngangkari... *(Interview Aboriginal Mental Health Coordinator 1-NAO4)*

Recommendation 15:
It is recommended that a process of accreditation be established in order to ensure the identification of qualified ngangkari who have acquired their knowledge and skills through the Aboriginal traditional educational and training system

Recommendation 16:
It is recommended that ngangkari determine the process of qualification, accreditation and registration. The qualification, accreditation and registration standards should be in accordance with ngangkariku Tjukurpa - ngangkari Law - and its traditional education and training system



4.1.2 Register of accredited ngangkaṟi

Interview findings reveal a widespread agreement on the need to set up a Register of accredited ngangkaṟi. Ngangkaṟi who comply with the accreditation standards and accreditation process can be included in the Register of accredited ngangkaṟi. The Register will list the accredited ngangkaṟi who are recognised as Aboriginal traditional healers from their communities and legitimate health practitioners from the mainstream health care system.

The Register of accredited ngangkaṟi should include all relevant information so as to allow patients, clients and agencies to make informed choices about available ngangkaṟi. Findings from the interviews reveal that information related to ngangkaṟi's language groups and areas of origin are relevant to Aboriginal people who want to access ngangkaṟi. Cultural issues and kinship relations can determine who is the appropriate ngangkaṟi.

> There is need to be some sort of register for the ngangkaṟi: who they are, what their language group is, what's their traditional group, what's their area so that when we have people come at the hospital, then we know that this is the appropriate ngangkaṟi for that area, this is the appropriate ngangkaṟi for those people about language group... *(Interview Aboriginal Regional Manager H4)*

> With the register I think they have to have a process where the community is consulted. It cannot be someone up there deciding on this name, or that name. It must be a process and it would be nice if that list was checked from time to time in term of the health of the people who are registered on that list, so you don't just become one and you stay as such in that register. I mean that is hard for me to know but I would imagine there are circumstances where they think that this person no longer should be working in that capacity if you like...I don't know if the community consider that a ngangkaṟi is sick and not well enough to work on people, they would put on hold until the next time with the list. If they had that as a basis we don't know where we could go from there; they could actually say "look this person can provide help with this, this or this...", I don't know how ngangkaṟi think. Always when I am accessing a service I go over it, I describe the problem first and say "is it something you can help with?" and leave it to them and sometimes they have said no, which is good. I think if I went to someone who wasn't a genuine ngangkaṟi they would say yes to everybody, I suspect so! *(Interview Senior Project Officer 1-NAO3)*

> There is a registry set up by NPY Women's Council: who is recognised by the community got registered. At the moment there are four to five people including two women. But I have heard there are other ngangkaṟi in the APY Lands... *(Interview Senior Officer AO4)*

> That would be excellent to have the registry and an accreditation process. That is going to save a lot of work *(Interview CEO AHS11)*

> A register would be very helpful to clear up who is the recognised ngangkaṟi. There is that level of trust in the community; if you go to a doctor you assume that is a qualified doctor, I mean it happened in a few instances in which they haven't been qualified with some disastrous results. For mainstream health to know who is registered, or whatever word you wanna call it, who are the recognised traditional healers would be good *(Interview CEO 3-AHS6)*

> I don't know, they are registering Aboriginal health workers at the moment and I see that as a disadvantage in some way because the level of numeracy and literacy they are required is quite high; sometimes that stuff is good for the profession but not necessarily good for individuals and not necessarily good for specific areas; so I don't think ngangkaṟi should be going down that road of registration or anything like that. It's a nightmare and I don't even know how you do that because it's not an area...it's very outside the western model, it is a cultural model. So I think it's more making people aware within organizations working here or coming here about who these people are. I don't even know...maybe you have a Register on the Lands somewhere of the ngangkaṟi, but again it's not going to be generally the whitefella that they are going to looking for that, or recommending a ngangkaṟi. Family is going to know anyway, they know who they want to see and who is the appropriate person to see in those contexts *(Interview Registered Nurse 3)*

A Register of accredited ngangkaṟi is strongly recommended in light of ongoing fraudulent attempts by individuals to be contracted as ngangkaṟi in different mainstream health care services. The danger of exploitation, as it has been outlined, is a widespread concern especially across mainstream health service providers.

> Avoid false ngangkaṟi. There is a need for a register and acknowledgment by local communities *(Interview CEO AHS1)*

> ...and also who are appropriate and respected and accepted ngangkaṟi. I mean, there's people that purport to be ngangkaṟi who really aren't, who don't have the confidence of the community *(Interview Hospital Manager 1-H7)*

> There are here in Adelaide some ngangkaṟi, well, they call themselves ngangkaṟi, I don't use them because I don't believe them, 'cause traditionally ngangkaṟi are identified by other ngangkaṟi. The ngangkaṟi line is usually passed down from bloodline to bloodline *(Interview Aboriginal Regional Manager H4)*

> They need to get it up there too. Up in the Lands, where those fellas come from 'cause there is some that come down and say they are ngangkaṟi but not really, they aren't trained properly. They claim to be, yeah... there are a couple in town that say they are and I've never seen them in this community *(Interview CEO 1-AHS6)*

> I think they need to be registered, there are only a couple registered though...the real ngangkaṟi need to be registered so you know who they are, otherwise you see people saying "oh that's good money and go and do that". They have to be registered and they have to be genuine...yeah, there are lots out there who are not registered therefore they are not recognised, and you have to have a register where they are registered, so you know when you're getting one *(Interview Aboriginal Liaison Manager H3)*

The setting up of a Register poses the same core question raised in regard to the development of accreditation standards and accreditation process: who or which organization should be responsible to set up and administer the Register of accredited ngangkaṟi?

Interview findings indicate Nganampa Health Council and AHCSA as potential bodies that could take on such responsibility.

> We asked the Aboriginal Health Council to set up a register and their response was: "This is not an area that the Council has expertise due to sensitive issues including cultural issues and clinical practice issues and we won't offer that service. We will support the right for Aboriginal people to have access to ngangkaṟi service and advocate for it" *(Interview Psychiatrist 1)*

> There should be a sort of register... Nganampa should take a lead role in it. That's where a lot of ngangkaṟi come from, from that area in the APY Lands. Notify the health services. So if they were to take a lead role, to take a photograph to identify them, so when they come down this way, people know this is a genuine ngangkaṟi *(Interview CEO 1-AHS6)*

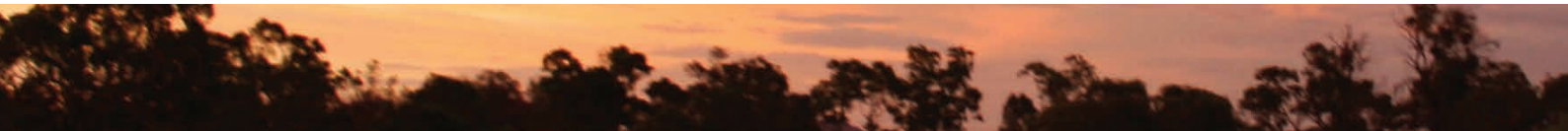
> ...and whether it be something like the Aboriginal Health Council have a list of ngangkaṟi from different communities that they know have been endorsed... *(Interview Psychiatrist 2)*

In some areas across South Australia, Aboriginal and mainstream health services have developed their own list of ngangkaṟi with whom a relationship of trust has been developed over time. Nganampa Health Council, for example, has a list of eight to ten ngangkaṟi who provide healing services in the clinics across the APY Lands.

> Yes, we do. We've got a number of people who we pay as ngangkaṟi, and sometimes there's argument about whether somebody else should be on that or whether somebody who's on it shouldn't be on it. Usually the board and the director decide *(Interview Medical Practitioner 3)*

> We also have a list of ngangkaṟi available within town and people make their choice selection. There are also visiting healers who are coming into town from the APY Lands *(Interview Director AHS1)*

The development of a Register of accredited ngangkaṟi will provide an invaluable resource to develop and implement a consistent statewide policy framework and health care model for the provision of Aboriginal traditional healers' services across South Australia.



Recommendation 17:
It is recommended that a Register of accredited ngangkari be established. The Register should include the ngangkari who are accredited as legitimate health practitioners according to the qualification, accreditation and registration standards in accordance with ngangkari Tjukurpa and its educational and training system.
The Register of ngangkari should include all relevant information about the accredited ngangkari as to allow individuals and organizations to make an informed choice about the most appropriate Aboriginal traditional healer to request

Recommendation 18:
Ngangkari should hold the responsibility to develop and administer the Register of accredited ngangkari

4.2 Rates, payment schedule and payment process

The remuneration of ngangkari services within the South Australian health care system presents three problematic issues: rates variation; lack of a consistent payment schedule; and lack of a standard payment process. These issues are distinct, yet strongly interrelated.

The variation of rates and the lack of a consistent payment schedule are considered a thorny issue. Rates for ngangkari services are established by each health service or agency independently. Sometimes, rates are negotiated with the ngangkari on an *ad hoc* basis, other times reference to rates used by other services, hospitals or organizations, provide an indication of the amount to be paid for different ngangkari services. On average, rates for ngangkari services are higher in metropolitan Adelaide than in remote and rural areas both within and outside the health care system. This factor skews not only the demand-offer fluctuations but also the availability and the accessibility of ngangkari in different areas across the state.

4.2.1 Rates and payment schedule

The financial remuneration for ngangkari services in health care settings can be traced back to the 1970s when ngangkari were treating patients within health care services in remote areas,

> In general there was a fee-for-service, so ngangkari were generally being paid for episodes of care back in the 1970s: generally $50 for an episode of care. It was recognised that when ngangkari were working with the health care service a payment would be made to them *(Interview Medical Practitioner 2)*

The fee-for-service model continues to be applied for the remuneration of episodes of care provided by ngangkari within the ACCHSs and mainstream health care services. Each health care unit sets rates independently; at times health services refer to other health services' rates to set their own fees to pay the ngangkari.

> Yes, we try to set a rate in conjunction with the hospital, that is $55 per hour according to the policy where they pay $55 per client. I guess many people assume it will take about 1 hour a client, but the ngangkari say can take up to 2 hours, 2.5 hours per client. So we'd like to go back and revisit that *(Interview Financial Manager AHS6)*

> The rate is $45 per individual. We tried to work roughly at the same level with other services *(Interview CEO 3-AHS6)*

> What we started doing was, because we didn't have a separate rate for them, looking through the salary manual. The rate for a visiting specialist was $55 for every client they see. So let's classify them as a visiting specialist and pay them at that rate. That's what we've been doing *(Interview CEO 1-AHS6)*

> We got five buildings so we put $200 aside for each building to pay the ngangkari. The $5,000 doesn't go very far because we have to cover the cleansing of the building and patients which is $45 *(Aboriginal Support Worker 2-AHS1)*

They can do clearance of a building. So they might do a Step down unit, and then various parts of the hospital. So we would pay $45 per consult and then would pay, depending on the size of the building, a negotiated price for the clearance for the building. And then paying for an interpreter if it is required *(Interview Hospital Manager 1-H7)*

The lack of a set payment schedule creates uncertainty and frustration especially for those responsible to establish the rates in line with funding allocations. The rate variation also creates disparity among ngangkaṛi working in different health care services both in terms of expectations and actual remuneration,

...I get frustrated every time I have to pay someone. What is the correct rate? We're just running on a draft. It's just a one-page policy...(*Interview Programs Manager AHS6*)

...ngangkaṛi aren't like GPs or other people that are covered by an award or organizations so that there is a set rate; so nobody knows how to value the ngangkaṛi services in terms of money and we have a real problem as some ngangkaṛi are asking $300 for doing a thing, others $55, and some would say that other worked in that community and he get paid more than me and this sort of thing. We've tried to get policies going on between the hospitals and us so we have a consistent policy, but no one is sure of what to put down as a monetary value on things. It is very difficult *(Interview Financial Manger AHS6)*

I don't know what they charge. That should be a reasonable amount to cover their time each day. At the health service, the health service would say "look, if you are here for *x* days, we will you pay *x* amount". But not over the top because there is also the other on-cost of accommodation, food, transport and the health service *(Interview Registered Nurse 6)*

I don't know what they are paying in this service; I think even amongst here people don't always pay, sometimes they pay, sometimes they don't and I have never seen a ngangkaṛi accused not to see somebody because they couldn't pay or something. In certain way, when I have used them myself, I didn't know what to pay. It's been quite difficult; I have done in terms of goods and things, I have provided with something *(Interview Registered Nurse 3)*

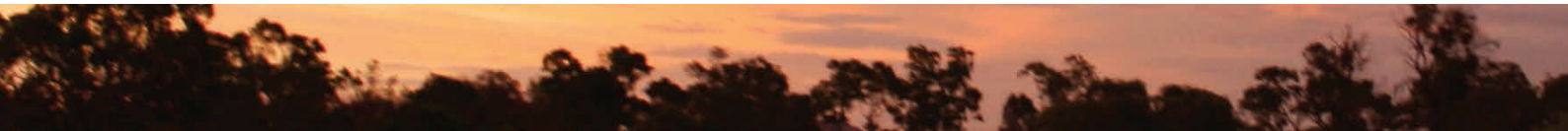
It varies because it depends on the type of work that they do for the clients; sometimes a person's health can be very demanding where they have to do a certain job, setting a consult for that person to clear that person. So it's very hard, it's something that we have been trying to sort out as well, but it hasn't been easy. It varies, you know. It could be around $150 for that person and they might come back at another time and get them cleansed again...*(Interview CEO AHS7)*

For us, a couple a day, day and a half, two days would be around $500 depending on the symptoms, how many ngangkaṛi are needed, everything. Obviously everything varies but it's quite affordable in our local community. It's only when we got to start sending them away. But we find when a lot of people, especially our elders are unwell, they want to come home anyway. Their disconnection from their land, from their community and their family doesn't help at all. So we try as a service to facilitate their return to country as quickly as possible. So they can get their tests done, get them back here, whether it's temporary at the hospital here and then we can transfer them from respite. But that's really just about our client group. When looking at the whole community, we have in the past facilitated ngangkaṛi work for younger people, but that was also complicated by alcohol or substance misuse and a bit of a misdiagnosis from Allied Health service providers, labelling them with mental health when it's been more a spiritual, cultural. *(Interview CEO AHS8)*

Overall, there is a high level of uncertainty regarding the determination of appropriate rates for different ngangkaṛi services. The lack of a set payment schedule is identified as a recurring issue that impinges upon the demand of ngangkaṛi and the capability of health services to offer their services.

One of the problems is that other organizations in town put the rates too high. There is no payment schedule. There has been an idea to propose the State a centralised system to manage money in AHCSA. Also when they consult privately the issue of payment is problematic. If they are paid in cash and if they don't declare it, it's a risk for taxation purposes *(Interview Senior Officer AO4)*

Rates vary; I think the ngangkaṛi rates are



either $60 or $90 an hour. I got a feeling it's $90 an hour for a treatment. But I am not really sure, AHCSA would have that information, I think...not sure, I did have a pay scale and rates somewhere *(Interview Aboriginal Regional Manager H4)*

We work with the ngangkaṟi on how much they wish to charge either on a person-to-person rate or a daily rate depending on how many people want to see them. We don't do it on the health system; we do it on our own. We also do another rate for cleansing the office, and we also do another rate for people who want to have their house cleansed. Work is quite generous about how they do it and they want to encourage the ngangkaṟi to do the work. We work a negotiable price. It is up to the ngangkaṟi if we want their services: that is how we pay. So we ask the ngangkaṟi how much do you think according to how many staff and how many days. I might say we will pay you $80 per person. Say if we had 20 staff I won't let them work any more than 8 staff per day because it is quite draining. So I will say between 8 or 10 depending on how the ngangkaṟi is feeling. We might do $800 to $1,000 per day and it is between eight to ten people. If we are doing a house it is $100. The office cleansing depends on how much they find – spiritual issues – or it could be based on the actual size of the building. It could be probably $1200 for our floor which is quite big – sometimes it has ranged from 10-40 spiritual issues. It depends on how draining it is for the ngangkaṟi. We provide him an office to work in and make sure everyone is comfortable and I also work with the ngangkaṟi and an interpreter so people can ask questions. In the community when we are doing a consultation outside the office, the ngangkaṟi might charge $80 per person or if there are two ngangkaṟi they might charge $100. So we leave it up to the ngangkaṟi and the interpreter how much they share between themselves – they are working on their own business so I leave it up to them. *(Interview Senior Officer AO1)*

I know ... charges $100 an hour and ... about $60 an hour. And also there are such irregular scales of people...so there's deception in that there will be $5,000 or $1,000? It's crazy (*Senior Project Coordinator 1-NAO5)*

To be honest I don't think we have worked it out properly yet because it's kind of worked out as half day this much or full day that much. For example, half day is $350 and it could include two or three consultations, probably not more than that because of the energy it takes out of them...I am saying it's not a very good way; we are trying to work it out ourselves how to do it. I actually think that is better to pay them on a service base schedule because a ngangkaṟi won't work if they are at someone's place from 9.00 to 12.00 and you can say it is half a day, but they don't see a patient every 15 minutes like a GP does, because the healing powers comes out of their body or through their bodies. I am not really sure how it works, but it is time for them and they may have their own health issues as well. Sometimes I discuss with them and say some cases can be particularly difficult and it may take two ngangkaṟi, they will decide themselves, we have to take two ngangkaṟi, because this is a bigger problem they might meet the patients once and then the next time decide they need two ngangkaṟi. We don't really know, there is not really a model to follow in trying to find a fair price for the ngangkaṟi... *(Interview Director NAO1)*

Nganampa Health in the APY Lands employs ngangkaṟi on a part-time basis. There are about eight to ten ngangkaṟi who are listed and have a well-established long term trust relationship. There are also some ngangkaṟi who are employed as Aboriginal health workers or managers, so that they attend to patients in their dual capacity of health workers and ngangkaṟi.

We have an allocation of money, and they get paid part-time salary for that activity *(Interview Medical Practitioner 3)*

The ones that Nganampa employs they are usually on pension so that they can't earn much because of their pension or they are actually working as staff which is incidental to their ngangkaṟi role and they use their ngangkaṟi powers or knowledge within their role as health worker or as a health manager. Sometimes the health worker is a ngangkaṟi as well and the managers, that is the manager of the clinic. They might do ngangkaṟi work during work hours but it's not as a specific role as ngangkaṟi, they've been paid as health worker. Nganampa has ngangkaṟi employees

but it's a part time and I think it's one per clinic *(Interview Registered Nurse 3)*

Overall, there seems to be discontent in relation to the current range of remuneration for ngangkaṟi even when they are employed on a full time basis in other organizations.

I don't think people get really well rewarded either... *(Interview Registered Nurse 3)*

...they employ ngangkaṟi and from what I've heard the amount of money that they provide is peanuts, it is peanuts, it's like $30.000 a year...This is less than a cleaner! That's peanuts to me! They are specialists because they are specialists in their own way and their culture has been for many years. To me that's degrading, we are very much appreciative the cost that we give them and I think that it should be given to them for the work that they do and if you know the culture in the way it happened, it does take a lot of energy out of you. The last trip that these guys came down and just did the hospital at that time and they were buggered, drained and there were singing for Panadol afterwards... it's something pretty strong within the culture *(Interview CEO AHS7)*

When you have someone telling "oh, we employ ngangkaṟi!" But it's a rate less than a cleaner, I don't think you really got any industrial benchmark set for *(Interview Registered Nurse 4)*

I think traditional healing in old days there was quite a lot of recompense for their work either food or reciprocal things, but I don't know that happened so much with money and stuff now... I think there is a couple who get paid from Women's Council but the others don't get probably anything from organizations or if they do it's a little bit; but they also don't get much from other Aṉangu, maybe it's become an expectation that they provide that service but there is not much of an exchange...I mean probably there is to a certain degree but not as much as they used to be I would say. Because a lot of that *nyapatji nyapatji* is disappearing too, some people manipulate the system to get what they want. I find generally that ngangkaṟi are very giving people anyway, they've got that people aspect so they are very generous with everything not just with their skills, but with their time, they are very generous and giving persons; probably they don't say no very often *(Interview Registered Nurse 3)*

4.2.2 Payment process

There is not a consistent payment process for ngangkaṟi services across the South Australian health care system. The payment process is a problematic issue, especially within the health care system. Difficulties relate to health services' compliance with financial and accounting requirements when contracting ngangkaṟi to provide healing treatments to their clients. Initially, some health services and organizations have used cash reimbursements, whereas cash cheques are currently the most common payment method. However, this method of payment still raises some difficulties to process payment of ngangkaṟi services through the current system. Difficulties relate predominantly to the uncertainty about the recognition and identification of ngangkaṟi as health practitioners, lack of key identifiers such as the Australian Business Number (ABN) or bank account numbers.

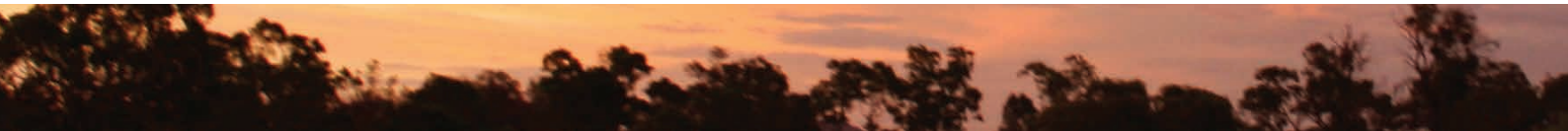
Because we are part of a hospital system and all that, I can't just take someone here to work as a ngangkaṟi unless they have been validated in some way *(Interview Senior Project Officer 1-NAO3)*

We previously used to have problems with paying the ngangkaṟi because there was that uncertainty about how much to pay, uncertainty about how you're going to justify getting cash and putting it in an envelope and giving it to them because our finance people want banks numbers *(Interview Psychiatrist 2)*

...the ngangkaṟi come straight off the lands, they've no ID or bank cards, no ABN numbers *(Aboriginal mental health worker 1-NAO4)*

There is always discussion about how payment should happen and I think it is an ongoing issue. I think you need to be very careful about efforts to incorporate ngangkaṟi into the western medical system because I think it could be dangerous *(Interview Medical Practitioner 2)*

We come to an agreed amount and then we just pay them by a cash cheque, and they go off to cash the cheque. We have a form the tax office has produced where they make a declaration that they're not in business, they're only doing this as a hobby, so we don't take



tax out and they get all the money *(Interview Financial Manger AHS6)*

...in that meeting this was one of the issues: having a common payment schedule so you didn't have ngangkaṟi getting paid different amounts at different sites and recognising and paying them appropriately and having an arrangement that met all the financial requirements like ABN or whatever. 'Cause now, we're under a centralised accounts payable function. They have to produce an invoice and things and for a traditional Aboriginal person ngangkaṟi that was problematic. They don't have an ABN, they can't produce an invoice, so they tend to come here and want to be paid in cash. And that's what we've done in the past. But now that we've gone to a centralised accounting system where all our accounts are paid by an entity that's from Adelaide, it's very difficult *(Interview Hospital Manager 1-H7)*

We haven't got the capacity to do that anymore. So it has to be like a business arrangement where if I don't have an invoice and an ABN number and possibly a Medicare number, is that where we want it to go? *(Interview Hospital Manager 2-H7)*

Well, a lot of traditional Aboriginal people like ngangkaṟi don't have ABN or tax file numbers often or any of that so they don't have an accounting software program that will receipt and provide us with an invoice and GST and all that stuff is sometimes problematic. So whether there needs to be, I think we need to link them to an organisation that can do that for them on their behalf. Well, it's just one option. Not the best. The best would be that they have an ABN and they operate as their own private entity. That's still the best option. Yes, the same as we engage with medical practitioners. They come and provide services as a contractor and they provide us with an invoice and we pay them. *(Interview Hospital Manager 1-H7)*

We pay a ngangkaṟi through the shared services payment scheme. We don't have that cash at the office here. So when I code it, I'll code it as a visiting consulting specialist. That's how we'll make the payment. It falls into some sort of a machine. Someone will sit down there and go, "what the hell is this and what are we paying?" At the end we need to be looking at the payment schedules and how to recognise them *(Interview Hospital Manager 2-H7)*

Payment at Aboriginal services has been done at times through a 'Statement by supply'. They sign a form in which they say that is a hobby: they don't pay tax on it. *(Interview Program Manager 1-AHS7)*

Maybe a decade ago, maybe 15 years ago, gradually people started wanting to be paid for that activity. There's no mechanism for people to be paid for that unless the health service pays for them, so they started to lobby the health service board and director and so we allocated some money for part-time employment of ngangkaṟi, and I think it's fair to say that there's a continued lobbying and debate about how much people should be paid, whether they should get vehicles, and all that sort of stuff. It just goes on. But again, most ngangkaṟi activity goes on outside the clinic, not inside the clinic. People get paid on a basis that they say they're doing activity in. Some other people say they don't. Like most things, there's often argument about that, so some people would claim to be doing a lot of ngangkaṟi activity, and other people say, "no, they're not doing anything", and they shouldn't get paid, so that sort of argument goes on *(Interview Medical practitioner 3)*

There is no charge to people presenting to see a ngangkaṟi. There is no charge. We pay for it. *(Interview Hospital Manager 2-H7)*

In Adelaide, the difficulties related to the process of payment for ngangkaṟi services have been mitigated to a certain extent. In the last couple of years, the Art Centre 'Better World Arts' in partnership with Ngura Wiṟu Winkiku Indigenous Corporation – a non-profit Aṉangu community organization established to support and assist Aṉangu in Adelaide - have facilitated access to ngangkaṟi through the arrangement and payment of ngangkaṟi services. Better World Arts and Ngura Wiṟu are located in Port Adelaide and provide an important place for urban Aboriginal population, particularly Aṉangu relocated in Adelaide. They provide employment options, assistance and service programs to urban Aboriginal people who 'constitutes a disadvantaged community that suffers lack of services and assistance' *(Interview Director NAO1)*

Probably it's in the last two years that we have been working with the ngangkaṟi service. It's really been in direct response to requests from other people; the approach has been mainly reactive to demands to see ngangkaṟi [rather] than proactive. There has not been any advertisement or publicity for ngangkaṟi, we don't do marketing or promotion of that service because we don't have staff and facilities. If we were to put a notice, we wouldn't be able to meet the demand...but if there is an opportunity for people to do that work, we facilitate it for them *(Interview Director NAO1)*

The work here involves taking phone calls from organisations or individuals who want to book a ngangkaṟi and coordinating that process, whether the people can come here and have the consult or whether the ngangkaṟi needs to go to those people *(Interview Senior Project Officer AO2)*

...Ngura Wiṟu is managing employment opportunities for Aṉangu, so they do all that booking and invoicing and they will keep a percentage of the fee that the ngangkaṟi charges and then pay the ngangkaṟi on Friday, every Friday is pay day; so whatever work has been done by any of the Aṉangu, they get payed on Friday, whether it's painting, inma, cultural exchange or ngangkaṟi services *(Interview Director NAO1)*

...what worked well for us is that Ngura Wiṟu actually pay them so at least someone gets paid on the usual day and they raise an invoice and I send it off to the university and get it paid *(Interview Senior Project Officer 1-NAO3)*

Ngura Wiṟu's client basis for ngangkaṟi services comprises hospitals, health care units, various organizations and the general public. The health care units and organizations include: GP Plus Super Clinic Noarlunga; Kanggawodli, Department for Families and Communities; Relationship Australia SA; South Australian Housing Trust; Statewide Gambling Therapy Service; Rural and Remote Mental Health Service; Wallaroo Community Mental Health Service; Aboriginal Liaison Unit, Royal Adelaide Hospital; Public Trustee (*Interview Senior Project Officer AO2*).

4.2.3 Current payment process and rates: an inconsistent system

There is not a consistent system of payment for ngangkaṟi services either in terms of fees nor in terms of payment process. Fees for ngangkaṟi services are paid either on an individual consultation basis, daily basis, or on a specific service basis. Individual consultation fees are paid per visit or by session time. Tables 2a and 2b illustrate the variation of rates for individual consultations in urban, rural and remote areas of South Australia. Table 3 shows the variation of rates per day in urban, rural and remote areas. Table 4 shows the rates paid for specific services, such as cleansing of buildings and private dwellings.

The lack of a consistent payment schedule, the variation of fees across urban, rural and remote areas and the lack of a consistent payment process have two main implications: a significant impact on the fluctuation of demand for ngangkaṟi services, and impact on the cost-effectiveness of current arrangements.

> The current service model is not cost-effective. Not really, because we've had a situation for example where we might try to engage a ngangkaṟi and we find we are paying for their fuel to come down as well as someone else and they double dip *(Interview Hospital Manager 1-H7)*
>
> There's a bit of a loosely agreed financial reimbursement arrangement. There's no hard and fast contractual arrangements or agreed approach or a binding one. But there needs to be some sort of agreement. What happens inevitably, and what we've seen in the last 12 months, we've had less and less ngangkaṟi coming here because other services based in the metropolitan area have started to engage ngangkaṟi and they are giving them more money. And when they come back to us, the ngangkaṟi have said they want more money... well this is the scheduled rate we use. And they say "no, we want more because they are getting paid more now." And so they go to town, because we say we can only pay what the scheduled amount. So other government agencies have paid exorbitant amounts because they wanted ngangkaṟi to provide them with services. *(Interview Hospital Manager 1-H7)*

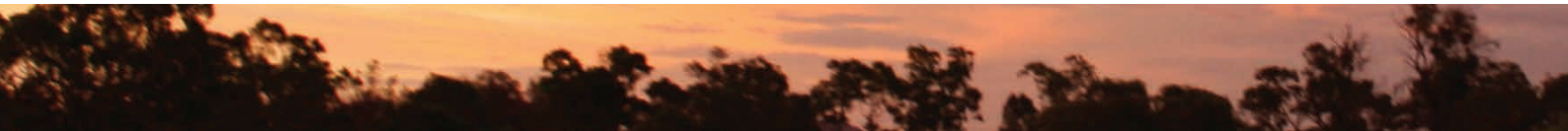


Table 2a: Individual consultation fees

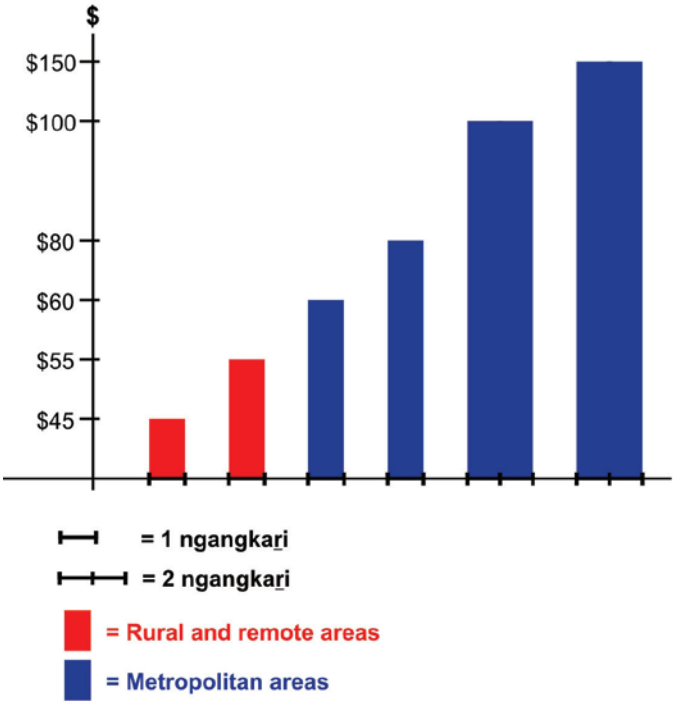


Table 2b: Individual consultation fees by session time

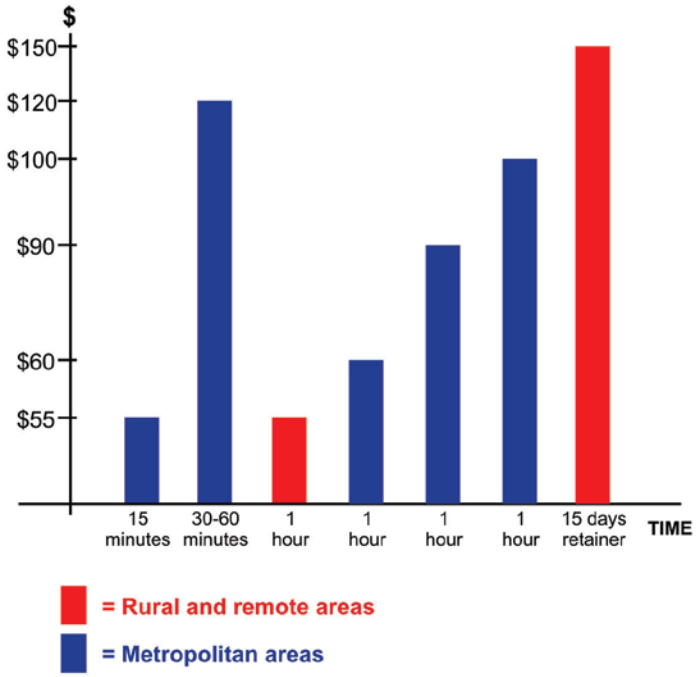


Table 3: Ngangkari service fees per day

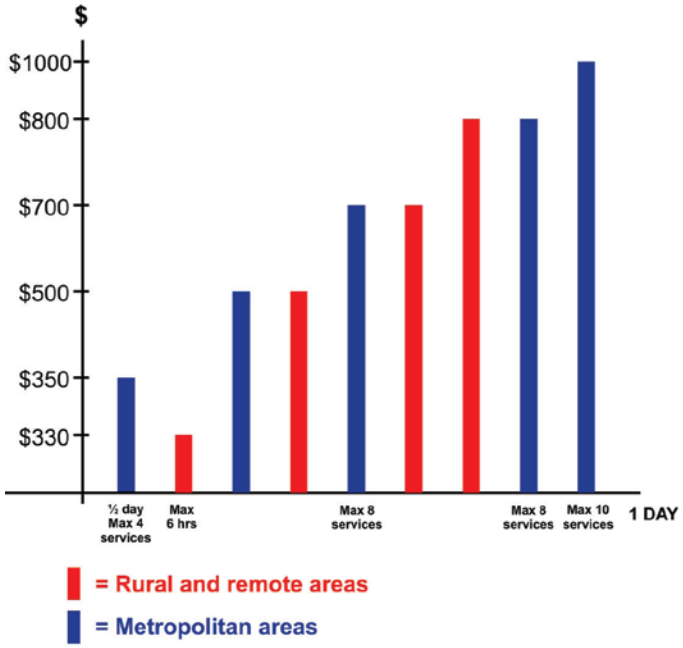
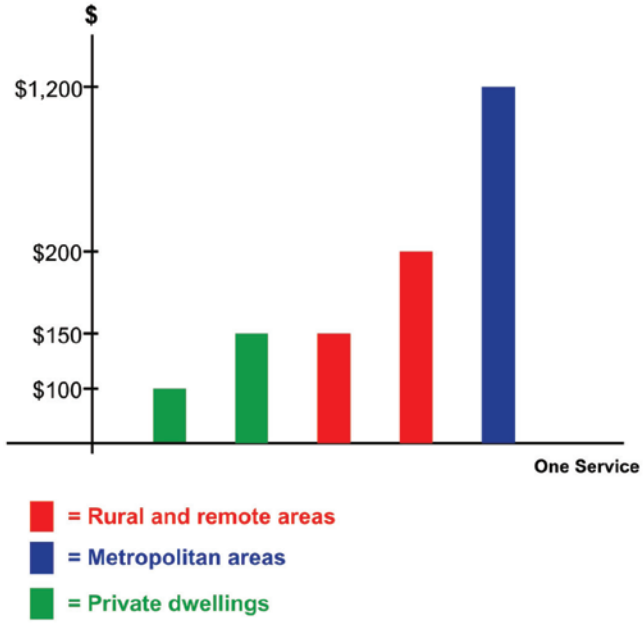


Table 4: Fees for cleansing of buildings and private dwellings



There seems to be an increase in rates. Like Mr..., we haven't seen him in about two years. Because he was offered exorbitant amounts of money to go to Adelaide and when we said we wanted to arrange for him to come here, he wanted $800 a day and ridiculous amounts of money and we said "no, we can't afford". We've only had $5,000. So we would have done that in one visit. Then they wanted us to pay $400 a day for the interpreter as well as the accommodation and travel to and from the APY Lands. *(Interview Hospital Manager 1-H7)*

Often the interpreters or other family members are making arrangements that are encouraging that because they are getting more money. But what it's meant is that for us, and for our community, the service has dwindled because they are pricing themselves out of the market, if you like... that's because there is no agreed fee...*(Interview Hospital Manager 1-H7)*

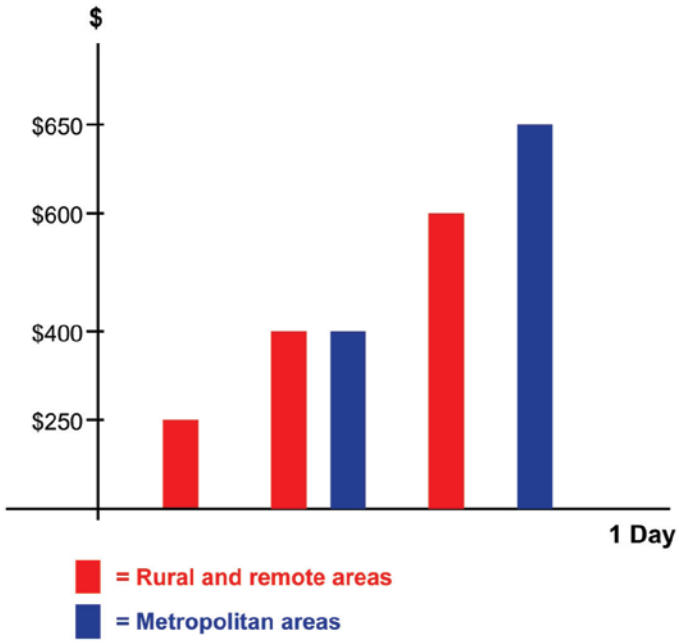
Until such time as we really bite the bullet and decide this is it and set rates, it's going to be *ad hoc* because there is no a formal system. Ceduna uses ngangkari, we use ngangkari, Nganampa uses ngangkari, what rate do you set? There isn't anything laid down *(Interview Registered Nurse 4)*

Further, additional costs related to travel, accommodation, meals, support workers and/or interpreters need to be added in cases where ngangkari have to travel to metropolitan, rural or remote areas to provide their treatments.

If we have to bring someone from Coober Pedy or the APY Lands, well the cost factor involved in that and we haven't got a budget to be able to do that. And you know, you've got to, you have to pay for their meal, their accommodation, their transport costs," which is maybe about 65 cents a kilometre. Then in addition to that, you got to pay them their normal rate. I think what we pay is about $55 for individual visits. That's the sort of rate we pay. So if you did a calculation, you're talking about maybe over $1,000 a day I suppose? *(Interview CEO 2-AHS6)*

Table 5 illustrates the variation of fees paid to support workers and interpreters. Fees for support workers and interpreters have been mostly paid on a daily basis. Sometimes the same person can be a support worker and interpreter. Expenses related to travel and accommodation costs vary significantly depending on distance and location.

Table 5: Fees for interpreters or support workers



4.2.4 Request for a consistent payment schedule and payment process

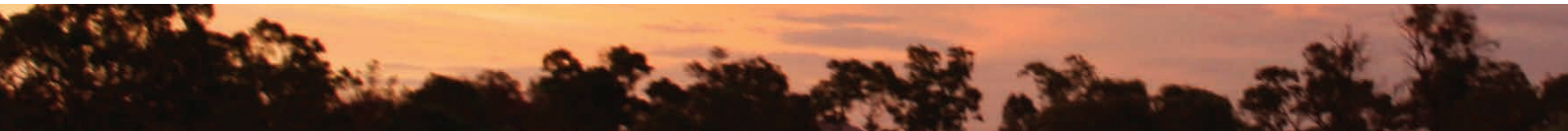
The need for a consistent payment schedule applicable within the South Australian health care system has been a recurring issue. In the past there have been discussions and attempts to set up a fee schedule, but they have been unsuccessful.

There needs to be very clear guidelines about how to pay someone without offending them... so there needs to be clear guidelines *(Interview Psychiatrist 2)*

It is something that must be done, because there isn't any price here. Some come in here and do their job or traditional healing and now expect this amount of money, and another one will come in and, whatever you can pay, and it's really unfair, it's not equal (*Interview Programs Manager AHS6*)

We have tried to get all ngangkari together and sit down and agree on some terms. Currently, it's every man for themselves instead of engaging ngangkari and it' s driving the price *(Interview Hospital Manager 1-H7)*

Through the Aboriginal Health Advisory Council we talked about fees and that's going to help, especially from Ceduna hospital because



they have a lot more contact than we do. We're trying to write some things up so we can introduce the service to our hospital here *(Interview CEO AHS4)*

There should be a state award for traditional healers, a set pay structure for them right across the state, mental health and everyone. They'd know what to expect from each. Otherwise everyone pays a different rate *(Interview CEO 1-AHS6)*

Need for a register and payment schedule: for example $120 per patient or something like that...*(Interview Aboriginal Liaison Manager H9)*

We also need a payment schedule *(Interview CEO AHS1)*

We're quite aware of valuing their services and government might recognize that, set up some sort of award *(Interview Financial Manger AHS6)*

It's difficult because for them it's a spiritual thing, private, personal and spiritual, and it's *ad hoc* on demand, so not really a business in that sense. But to set them and give them value, to get paid if they need to get paid, to help them to be recognized, then there has to be a system set up where a value will be recognized and they have to be conferred a professional status, so being in business, getting an ABN number is a bit tricky *(Interview Financial Manger AHS6)*

I think the Health Department will follow up with that. And they will come with the schedule there. We are all aware of the need of a schedule of payments and that's sort of the one that's been agreed with the women of Central Australia in terms of what they think was a good fee for service...*(Interview CEO AHS4)*

The issue of payment for ngangkari services and the need for a consistent payment schedule is strongly related to the recognition of ngangkari as legitimate health practitioners.

Payment is a big issue because they are professionals like any other person but they don't have a certificate; but the certificate that they have is something that is being handed down from generations to generations. So no Aboriginal person is going to provide you with a certificate but the skills that they bring is very overpowering too and they need to be recognised for the work that they do and what they provide...I think and I know that it should be recognised a lot more for the work they do in the community *(Interview CEO AHS7)*

The establishment of a ngangkari payment schedule and payment process may follow a statewide or nationwide model. A state-based model would entail the establishment of a ngangkari payment schedule and payment process applicable within the South Australian health care system; a nationwide model would entail the introduction of a payment schedule and payment process through the Medicare system:

There are different ways you can do it. You can have a more local model where they put fee-for-service payment schedule. So the same way we pay for doctors, the state government has a common agreement for payment for doctors by hospital by treatment. It's called SA Medical Officers Engagement Schedule (SAMOES). It has an agreed fee for hospital-based work that a doctor does and each doctor signs and they pay a fee for service for hospital work. So the two main ways we pay doctors is through that SAMOES or the Medicare one. It would be easier to look at the state-based one. I think it would be a lot more political, more politically difficult to go with the MBS schedules, to get a nationwide approach. It would be more difficult. Part of the issue with MBS and PBS is that until you've got a nationwide approach to it and acceptance and use of ngangkari, it's going to be very difficult for one state, SA for instance, for MBS arrangements for ngangkari. But in the short term, SA Health or NSW Health or Vic Health would need to look at their own arrangements and schedules for paying ngangkari with a view to looking at them being Commonwealth-funded. I think that would be easier *(Interview Hospital Manager 1-H7)*

The traditional healers will travel a fair bit, we get some from Northern Territory down here. And so we're crossing the state borders, we should have a Commonwealth consistent way, wherever they go they're treated the same *(Interview Financial Manager AHS6)*

I suppose if ngangkari are employees then it's negotiated, even doctors have an industrial award that sets their rights. It's not that a doctor goes along and say "I want this much"; it's laid down, it's got their schedule of rates that they pay. The doctors that are salaried have awards that determine their rates

of pay. If you decide to employ ngangkari those industrial rates would have to be set, but hopefully they negotiate it fairly, and somewhere at the level that does give them recognition for the skills that they have got. Someone's really got to bite the bullet. Until you test the waters, this is still an unknown area *(Interview Registered Nurse 4)*

A Medicare model for ngangkari? Definitely. We base our payments to ngangkari on a Medicare schedule base. So we pay them the same as Medicare would reimburse specialists for seeing a patient. So we base our payments to ngangkari on the Medicare schedules even though they weren't entitled to be paid through that. But I would have thought that the MBS would be useful for it if ngangkari can provide treatment and claim against MBS. I mean, it's Commonwealth money anyway. We're getting Commonwealth money to pay the ngangkari. It might as well go through the MBS *(Interview Hospital Manager H1)*

I don't see why not to include ngangkari in the Medicare system. Well, you see MBS and private funds pay people to see therapists. You can have Indigenous therapists. You would call them something... (*Interview Mental Health Worker 1-AHS9)*

There are certain areas like the Aboriginal health checks that are on PBS, that have a medical rebate attached to it for the doctors. The Aboriginal health check, there is PBS/MBS line for those now. That wasn't happening before, but they are getting specific lines to be covering specifically around the health checks. It's part of the COAG money around primary health, it's about giving health checks to all Aboriginal people, a full over general health check. It's something big that takes an hour and half. Doctors that do this get a rebate as well, they get a Medicare rebate. Because it wasn't always on that, they couldn't claim it but now it's one of the tests. Ngangkari treatments could be included in a similar way... *(Interview Aboriginal Regional Manager H4)*

The inclusion of Aboriginal traditional treatments in private health funds is considered another option. This option, however, would not have a significant impact on the degree of accessibility to ngangkari for Aboriginal people.

Sure, same as MBS. But the uptake of private health insurance within the Aboriginal community is low in my understanding. I don't know if you would have a lot of Aboriginal people (who would tend to be the predominant users of ngangkari) accessing their private health insurance because they don't have it. If MBS had ngangkari as rebatable service, patients could have a rebate. But at the moment it's not *(Interview Hospital Manager H1)*

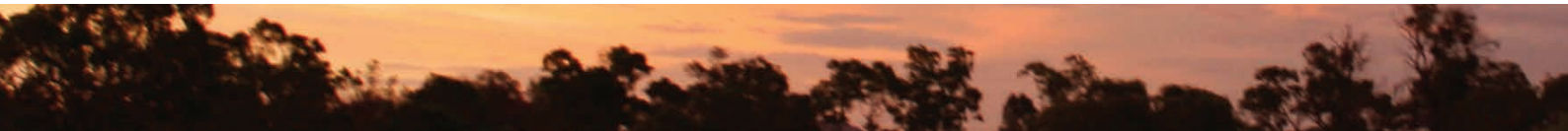
Recommendation 19:
Ngangkari employment scheme

It is recommended that a ngangkari employment scheme be established within the South Australian health care system. The ngangkari employment scheme should guarantee a fair remuneration for ngangkari as legitimate traditional health care practitioners.

The ngangkari employment scheme should be anchored to a three-fold structure:

1. *Contract employees: remuneration based on a fee-for-service payment schedule;*
2. *Full-time employees: remuneration based on an employment standards scheme;*
3. *Part-time employees: remuneration based on a fractional employment standards scheme.*

The ngangkari employment scheme should be negotiated in partnership with the ngangkari, relevant government departments, mainstream and Aboriginal community controlled health services



Recommendation 20:
Payment process

It is recommended that a consistent payment process be established to remunerate ngangkari for the provision of their healing services. The payment process should be developed in line with the ngangkari employment scheme and the financial requirements of the health care system.

The payment process should be negotiated in partnership with the ngangkari, relevant government departments, mainstream and Aboriginal community controlled health services

Recommendation 21:
Ngangkari employment scheme and payment process models

The establishment of a ngangkari employment scheme and payment process can be based on two models: a state-based model and a federal-based model.

State-based model: *Introduction of a ngangkari employment scheme and payment process negotiated and agreed by ngangkari, relevant federal and state departments, mainstream and Aboriginal community controlled health services. The state-based model could include the introduction of a 'ngangkari provider number' for accredited ngangkari to facilitate the application of a consistent and systematic statewide payment process.*

Federal-based model: *Introduction of a ngangkari employment scheme and payment process within the national Medicare system. The Medicare model could entail the introduction of an 'Aboriginal traditional healer provider number' for accredited Aboriginal traditional healers and the development of a payment process in line with the Medicare system.*

The state-based model could be introduced in South Australia in the short term and provide a pioneering model for the development of a federal-based model in the long term

Recommendation 22:

It is recommended that the introduction of a state-based or federal model should respect and align with a community-driven approach to the provision of ngangkari services

4.3 Data collection on ngangkaṟi services

There is not a consistent data collection system on ngangkaṟi services across mainstream and Aboriginal community controlled health services. Only a few health services have collected data in relation to the number of ngangkaṟi visits for reporting purposes.

> No, we haven't recorded it... it's unwritten. That's something that we need to develop *(Interview Aboriginal Liaison Manager H9)*
>
> We had four or five visits roughly, but we never kept records *(Interview Aboriginal Liaison Manager 1)*
>
> We've never collected it because it's not our funding as such... We would be able to collate that data though... *(Interview CEO AHS8)*
>
> We've got the visits they've done and we tick that. They're very general, there's no detail, just ngangkaṟi services *(Interview Aboriginal Mental Health Coordinator 1-NAO4)*
>
> If there is a patient that has had a ngangkaṟi service, we have that for our own records but I just do it all manually *(Interview Aboriginal Mental Health Worker 1-NAO4)*
>
> We put it in our notes, but not in a formal way. You always see a note saying 'visited by a ngangkaṟi', and it's good for us because sometimes they are cured and we don't have to worry about it. This happens especially with kids, they often go see ngangkaṟi after the clinic or they come to the clinic after they have seen a ngangkaṟi *(Interview General Practitioner 2)*

Most health services consider it important to create a database to record ngangkaṟi interventions. In cases where basic information has been collected, more specific data could be added, including sex, age group, symptoms, complaints, outcomes and any other information health professionals may consider relevant.

> What you'd be able to get is male/female, age group, psychotic disorder or mood disorder, something like that. Probably not much more than that, though, because of confidentiality *(Interview Psychiatrist 2)*

Questions arise around policies concerning the recording of consultations with patients.

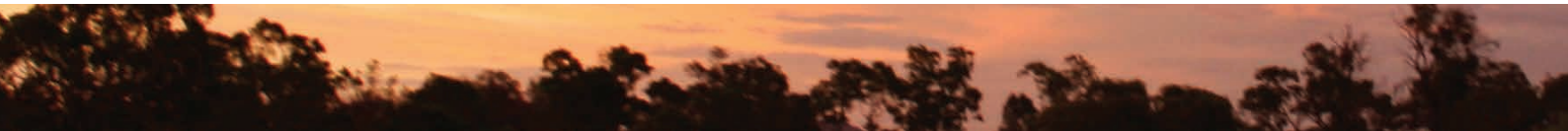
> Another question is that in medicine we do a lot of writing of what we've done. How do ngangkaṟi feel about things being written down about what they've done? *(Interview General Practitioner 3)*
>
> I think it is something that ngangkaṟi shouldn't even do because that's their culture, it's not like a doctor ... You would document it as a ngangkaṟi consultation *(Interview CEO AHS7)*

The development of a consistent database within mainstream and Aboriginal health care services across South Australia would be beneficial in different ways. First, it would contribute to developing a systematic evidence basis on the role of ngangkaṟi in the health care system; it would provide a consistent dataset on ngangkaṟi's episodes of care; and it would contribute to develop a more comprehensive patient history.

Recommendation 23:
It is recommended that a consistent database on ngangkaṟi interventions be developed within mainstream and Aboriginal health care services across South Australia. The database would contribute to creating an evidence-based dataset on ngangkaṟi episodes of care; provide relevant information in relation to the role of ngangkaṟi in the health care system; develop a more comprehensive patient history according to a two-way culturally appropriate health care model

4.4 Health professional training and development

Findings from interview data show that the degree of acceptance of ngangkaṟi by western health practitioners varies. Reluctance to accept ngangkaṟi is more prevalent in public hospitals in metropolitan areas than in mainstream and Aboriginal community controlled health services in rural and remote areas. Health professionals' attitude towards ngangkaṟi in health care settings is mostly determined by their own personal experience and extent of contact they have had with ngangkaṟi.



We've been having trouble with this hospital here trying to accept going into [the] hospital. They still frown on it and accept it reluctantly *(Interview CEO 1-AHS6)*

We don't have a lot of doctors and the doctors don't have a lot of time. So I know that when I've worked in the clinics and we've had someone who is critically unwell, I'd ask ngangkari to come in before we've flown people out as part of trying to stabilise them, because people generally recover or retain their system better if they're more comfortable. So I've worked with ngangkari in that way. We've had people who have been very sick, who we were not sure were going to live, we brought ngangkari in. They come in any time day or night, generally. People come in, once they get to know the clinic staff better, people will bring rocks or objects that have been removed from people by ngangkari. In general we put them in there so that people have got them there. *(Interview Programs Manager 2-AHS9)*

On the APY Lands the doctors rolled with the ngangkari, although there are some that are not quite convinced yet; their body language says that: when a ngangkari does something spectacular and the doctor says "oh *wirunya*, you are very good" but his body language is "what is all this about?"; you can pick when you say something and your body doesn't match up. Anangu on the Lands can have a psychology degree! They can pick you, if there is an incongruity they can pick it up within seconds.

But the fact is, when doctors generally work together with the ngangkari, it works well. But again remember the difficulty chiropractic had to get accepted. To doctors the chiropractors weren't legitimate medicine; that was a long fight by chiropractists to get recognised. The ngangkari is more – just have a longer fight – but at least for those of us who can do something that's putting a positive influence to make it happen quicker rather than later, before it's all lost *(Interview Registered Nurse 4)*

It is reported that a significant number of health practitioners are open to explore avenues of collaboration with the ngangkari and they are eager to learn and share their medical knowledge and practice. Education and awareness about ngangkari practices is considered a crucial element to enhance western health practitioners' understanding of ngangkari interventions and strengthen their collaboration.

The doctors who come here are very open to work with our ngangkari and I know that the first visit when they came up, it was just unfortunate that our female doctor was on a short trip. She was on site but what she was saying is that she would love to work alongside the ngangkari, it will also teach her on their work and also they learn from what she does. She is not here now, we got a male doctor now here. We have three doctors that rotate every six weeks. They are very, very keen to work with the ngangkari *(Interview CEO AHS7)*

It's a mixed model. Unfortunately, especially over the last four years, we've had a high turnover of doctors at the hospital. We have one doctor in town who has been here for over 20 years...So depending on where doctors come from and their background; we've had some doctors for example who were from India who were very active in traditional medicine and very supportive. And then you might have had a doctor from Australia who just goes "what?", who has never been exposed to such traditional processes. So it really is quite a mixed model. And unfortunately, we haven't had any consistency in doctors to see an ongoing pattern. But they are very respectful. I will always approach the doctor and the nursing staff and say "look, before the doctor goes in we want to go in first and do ngangkari", and they will let us go, shut the door and the doctor waits and goes in after. Sometimes the person might already be in hospital and we need to do ngangkari but by the time the ngangkari gets there, the doctors and nurses have already done their checks, "Please leave the room and don't come in until we ask you to". We're fortunate that we have rooms with side exits so the ngangkari can exist outside if they need to come back in without any interruption from the hospital. So they are very respectful. They're very curious too: "What are they doing? What is this kind of work?" So you can see that hunger for information possibly... *(Interview CEO AHS8)*

The need for educational programs for western health practitioners is considered an essential ingredient to foster a thorough understanding of ngangkari healing practices, strengthen their

collaboration with the ngangkaṟi, and promote a two-way health care model.

> Health professionals' understanding and awareness is absolutely important, for sure. I mean, I say to some people "ngangkaṟi", and they go "what's that?" And then they say "ah really, do you know one?" It's just a mixture of who knows what and where and how and a lot of Aboriginal people know about them, of course. It's just getting that to flow through. So it's sort of making them understand sometimes, that could be the preferred choice *(Interview CEO AHS8)*

> And I think for me going through this sort of pathway of learning the culture through working with them, I've been that person too. Ten years ago, I would have gone "oh yea ngangkaṟi, whatever..." I probably would have been scared of it, wouldn't want to believe it. It's the Panadol that works. But if you ask me today, I'd go to a ngangkaṟi before a doctor. It takes time...over time I've obviously learnt bits and pieces, it's almost like a big jigsaw puzzle. I remember when I first started, I was having a lot of headaches. A ngangkaṟi offered me assistance and I said 'yea, ok". I was taking Panadol and it worked, just didn't have enough understanding. But over the years, and after seeing it work, pretty amazing stuff. I still wonder how much people have documented all this... *(Interview CEO AHS8)*

> A lot of non-Aṉangu really don't have the in-depth knowledge about culture and it's very difficult to differentiate between what is traditional belief and what it is in fact a mental health issue. Lots of people do believe in their day-to-day life that they see certain spirits and it's not a sign that they're mentally unstable...that's quite confusing for people because it's hard to know whether someone is actually hallucinating or someone is actually going through a period of real spiritual traditional development or whatever.... We've had problems with that sort of picking up on it when people have assumed that what people were seeing was not normal. Because it's normal out here. And what is normal? So ngangkaṟi are very important from that point of view. I think if you have a good relationship with the ngangkaṟi, it helps the clinic nurses to understand why people behave the way they do. There's not a good understanding of most of the new staff *(Interview Programs Manager 2-AHS9)*

> So we do awareness of western staff formally and also informally. And informally is by having our Aboriginal mental health workers on the ward every day. Often doctors and nurses will pull them aside and say "can you just explain why this or why that?", because they've got that relationship now, they're not afraid to ask. So there's that informal education that happens on a daily basis which I think is probably more important than the formal. Seeing the ngangkaṟi and having that education session afterwards, no doubt those ngangkaṟi are approached and asked to clarify things. So you've got the formal and informal education, which are really important *(Interview Psychiatrist 2)*

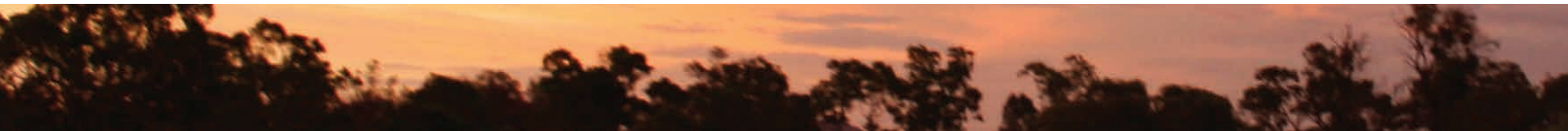
Recommendation 24:
It is recommended that educational programs on the role of ngangkaṟi in health care be introduced into health professional training and development statewide. Training modules for health professionals can contribute to bridge the 'knowledge gap' between western medical practitioners and Aboriginal traditional practitioners. An enhanced reciprocal understanding is fundamental for the delivery of an effective two-way health care model

4.5 Adverse events, safety and risk issues

Interview findings show that no adverse event due to ngangkaṟi interventions has ever occurred both in mainstream and Aboriginal community controlled health care services. The employment of Aboriginal traditional healers who are recognised and respected in their communities is identified as the main reason for the lack of adverse events.

> No, there hasn't been any adverse event *(Interview Hospital Manager 1-H7)*

> We never came across big concerns or adverse events *(Interview CEO AHS7)*



None adverse events from Nganampa's point of view because we've been here for 25 years and we've got people who know who is going to be appropriate and who is not going to be appropriate. I should imagine that if you put an ad in a paper for ngangkaṟi, that a number of people might apply for the position and they may not necessarily have the respect of the community or the skills to do what you're hoping they would do *(Interview Programs Manager 2-AHS9)*

In terms of liability, the use of ngangkaṟi interventions within mainstream and Aboriginal community controlled health services has not posed any issue of liability. The low-risk nature of ngangkaṟi interventions is indicated as being the key rationale:

> They don't carry their own public liability insurance as a general rule. So in theory we are using our own public liability insurance even though they are a contractor. So if something were to go wrong I guess there'd be an issue there. But they're not undertaking medical procedures so they're not undertaking surgical work; so the consults and the work they are doing tends to be low-risk. So they're not manipulating joints or providing medication or offering drugs. It's really from our point of view, legally medical low risk stuff *(Interview Hospital Manager 1-H7)*

Liability and risk issues are however identified as potential occurrences that should be taken into account. Suggestions of ways to deal with them are indicated in three forms: public liability insurance carried by a central body; extension of the insurance of the health service provider to the ngangkaṟi; use of patients' consent forms,

...but it is an issue, there would be an issue if someone felt they were injured by ngangkaṟi, there would be a liability issue. We would be responsible for having engaged them, I would imagine. Or the ngangkaṟi would also be equally as liable, as an individual, public liability. Certainly from our point of view there is a need for us to protect and reduce our liability and risk. I don't know how we'd go about that through the ngangkaṟi, again that's bureaucratising their system. That is something you need to get advice from the Aboriginal Health Council or a group of ngangkaṟi. That's an issue they would need to address. We've just sort of ignored it in some ways because otherwise the service wouldn't be able to occur. I mean there's a wiser way to get around things. A central entity surely could carry some sort of public liability insurance that they make available to ngangkaṟi when they are providing services. So there would have to be a way around, to find a simple solution. I don't think we should make the bureaucratisation of it all such an obstacle that this service can't exist *(Interview Hospital Manager 1-H7)*

The chance of litigation associated with the provision of ngangkaṟi treatments is very unlikely to occur with Aboriginal patients, but more likely with non-Aboriginal patients.

One of the things with the ngangkaṟi and Aṉangu is that our litigation is a self-fulfilling prophecy: we are scared as we might get sued and we act in a defensive behaviour. I found out that in America they teach nurses how to get patients to like them, because even if the nurse does it a little bit wrong, patients actually find very hard to sue someone who they actually liked. But the same thing is if you have a look at the regard that a ngangkaṟi has, it's not a litigation society and I don't think you find it as a problem in their own culture; I think it would be very bad if a Aṉangu wakes up in the morning and say the ngangkaṟi did something wrong and I am going to sue him *(Interview Registered Nurse 4)*

A non-Aboriginal person would probably sign a disclaimer. The other thing that comes out of litigation is that if you employ a ngangkaṟi would be the same, as every employee is protected as long as they follow the policies of the organization. The ngangkaṟi would have to work within the policy of the organization. I don't think that would be a litigation issue for any Aṉangu but if a white person wants to access it, white people now access naturopaths, homeopaths and other ones, they are all alternative medicines *(Interview Registered Nurse 4)*

... the ngangkaṟi would be covered by our insurance as any other employee in our service *(Interview CEO AHS-7)*

It is an increasing tension there when we have an alternative; let's say it was a reiki therapist coming to an aged care facility and then the family believes that the reiki

therapist had caused significant problems. The lawyers are now suing us for the care of the patient within our facility because of the employment of the therapist. How do we go around that? Is it an initial consent? Is it that if the person actually requests a traditional healer, nominates a traditional healer in a sense that signs a consent form, is it a way forward? The choice of the traditional healer goes back to the family, and the family agrees so that the healing takes place with the western medicine input but also there is acknowledgment and consent for using that ngangkari with some sort of disclaimer or whatever. It is then reasonable for mainstream services, so if there is an adverse event, if there can be an adverse event, then we are not responsible *(Interview Psychiatrist 1)*

Risk issues can arise in cases of self-harm or danger of harm to others. It is indicated that the management of these situations has been handled through a good collaboration between medical practitioners and ngangkari.

> The only other area of difficulty is where there may be some risk issues, like self-harm, harm to others, paranoid symptoms but I am pretty comfortable as I worked with Mr ... and we had discussions about patients that had some risk issues. In my experience ngangkari are very sensible so, from that point of view I am very comfortable *(Interview Psychiatrist 3)*

> We've not had any problems at all. The ngangkari we've employed here have all, you know, they've all been wonderful in the sense that they've done their work *(Interview Psychiatrist 2)*

> Yea, I haven't heard anything negative about it. There's no comment or good comment... *(Interview CEO 1-AHS6)*

4.6 Advantages of ngangkari services

There exists strong evidence about a range of benefits stemming from the provision of ngangkari services. These include building community trust; fostering Aboriginal patients' access to mainstream health service providers; increasing cost-effectiveness in the provision of health care; providing a holistic two-way health care model whereby the Aboriginal traditional medical knowledge system is included and respected as part of the health care system; delivering a culturally appropriate health care model; reducing the incidence of misdiagnosis and broadening treatment options.

4.6.1 Building community trust

Mainstream health services highlight how the provision of ngangkari services contributes to build Aboriginal communities' trust in mainstream health services and increase Aboriginal patients' accessibility to mainstream services.

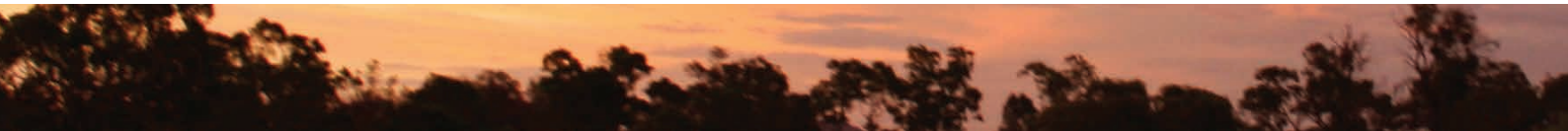
> The advantages are around building community trust, so having the Aboriginal community see that we, as a mainstream health service, are serious about improving Aboriginal health and respectful of traditional Aboriginal cultures. By building the trust in the Aboriginal community and by providing culturally appropriate and respectful services like ngangkari services means Aboriginal people are going to access our health service more and get more opportunity to provide services to Aboriginal people. Their health status is poor. So we see huge benefits in just that component, in building that trust. Sixty per cent of our consumers are Aboriginal, so some people would say that we are an Aboriginal health service rather than a mainstream health service because we provide more services to Aboriginal than non-Aboriginal *(Interview Hospital Manager 1-H7)*

> ...what it does is get rid of bad memories out of areas. It means that Aboriginal patients using our service can feel more comfortable and can access those facilities *(Interview Hospital Manager 1-H7)*

4.6.2 Increasing cost-effectiveness

The provision of ngangkari services can increase the cost-effectiveness of the provision of health care.

> The other advantage is the potential cost saving we have seen. There was a woman who couldn't walk and had a temperature. We thought it was some sort of neurological disease, virus or disorder. And we sent her to Adelaide on an RTS; it cost her $2,000. She was admitted to hospital there, Royal Adelaide, she had a CAT scan, and MRI, tests, and cost probably $15,000-20,000 of State health resources and treatments. And it turned out she had been basically cursed or sung or whatever the process was, but it was a traditional process that created this



disability that she had. We then brought her back here and after three sessions with the ngangkaṟi she was cured. So whether it was a psychosomatic disorder or what it was, but effectively western medicine couldn't fix this woman's illness and spent a fortune on her and for the cost of, I think it cost about $500 to get a ngangkaṟi down to treat her. And it was treated effectively: it was a much more cost-effective way of providing health services to that lady *(Interview Hospital Manager 1-H7)*

This case exemplifies the potential saving the inclusion of ngangkaṟi services could have on the health expenditure. The cost saving could enhance the cost-efficiency of the delivery of health care services.

4.6.3 Providing a holistic two-way health care model

The provision of ngangkaṟi services entails the endorsement of a holistic two-way health care model whereby the Aboriginal traditional medical knowledge system is included and respected as part of the health care system. The delivery of a consistent two-way health care model would contribute to overcoming the divide between the epistemological foundations of western and Aboriginal traditional medicine worldviews.

It's very outside the western model, it is a cultural model. So I think it's more making people aware within organizations working here or coming here about who these people are *(Interview Registered Nurse 3)*

Well, given the worldview of white society Aboriginal society is totally different, the cosmology is totally different. So what we've got at the moment it's a mainstream system trying to box the cosmology of Aboriginal people without any thought for the spiritual aspect where Aboriginal people come from *(Interview Mental Health Clinician 1-AHS6)*

The ways we work with Aboriginal people is a little different to what you would do with non-Aboriginal people, in the sense that really it's a holistic approach which is far more powerful: the family structure and extended family is so important... and also they are very spiritual people. Everything that happens in their lives has a spiritual background whether would be a headache or be a car accident it does relate to this area at the core. So I think that ngangkaṟi understand that spiritual dimension *(Interview Program Managers 1-AHS7)*

...because the western way of thinking – and we have been schooled in this way – it's empiricism that we are trained in, we are surrounded by it. So we can only understand something if it can be deconstructed or measured. And that makes sense too to a point in medicine, so if it's about a spleen or your epiglottis or something that's ok, but it's not holistic healing *(Interview Psychologist 1-AHS6)*

As far as ngangkaṟi go there isn't any room in the western model to address the spirit and the heart. All language is around that box mentality; what your head is doing, not what your heart is doing, not what your spirit is doing. People come to us with a broken heart, with a broken spirit and they are given a label, and we can treat easy and then you can disassociate from the humanity and the spirit of that person because you box them and label them *(Interview Mental Health Clinician 1-AHS6)*

There is a couple of situations: first of all people would go to a ngangkaṟi first and if they are not feeling better they'll come to us; other people will come to us first and then if they think things are not working they then will go to a ngangkaṟi. And then if things do work then quite often they will say "it's a ngangkaṟi" whereas my view would be that it just took longer for the antibiotics to work *(Interview Registered Nurse 2)*

There is not a lot of talk about ngangkaṟi in the mainstream. There is still not an understanding of ngangkaṟi practice *(Interview Clinician 1)*

For me Aboriginal communities and nations on this continent, and I would be really confident in saying on every continent where certainly there has been colonization, are washed with intergenerational trauma, absolutely prevailed by it. Most people we meet are trying to respond to that whatever way they can which revolves around using substances and all sort of things. For me it feels like we are at the front of a tsunami that has been rolling for 200 years, and we are only beginning, I think, the dominant culture begins to recognise some of that. I am hopeful of some of the younger people coming through that are

much more open to this, much more aware, perhaps some of them, of their privileges *(Interview Psychologist 1-AHS6)*

What Anangu value western medicine for is we are good at the symptomatic relief, we can stop the pain and fix the symptoms but the acknowledgment of fixing the illness is still the ngangkari. So we don't get too big a head about it, we are really just a Panadol dispenser. The acknowledgment of healing is still the ngangkari and I think that's important. The fact is that we are good at – we fix the symptoms, we don't fix the illness... *(Interview Registered Nurse 4)*

4.6.4 Reducing cases of misdiagnosis and enhancing quality health care

The provision of ngangkari services enhances the quality of health care for Aboriginal people. Evidence shows that the inclusion of Aboriginal traditional medicine contributes significantly to the delivery of a culturally appropriate health care model in line with Aboriginal cosmology and culture. On the other hand, the neglect of Aboriginal traditional medicine can have negative impacts on patients' health and well-being. Cases of misdiagnosis are reported as the result of the inability of the western medical system to provide a medical response to what are usually termed 'Aboriginal sicknesses'.

Everybody talks about cultural appropriateness but they continue to discard the very cement of their society and culture *(Interview Registered Nurse 4)*

We would be happy to strengthen the ngangkari program because access to ngangkari fits well within our culture as well. It is a very important service to us. It's important because of people's connection to culture, people's identity and belief system. It's valued and honoured within the health care service we provide; and also we should work from our community cultural model rather than just a medical model of service delivery. Aboriginal community controlled services provide for that opportunity *(Interview Director AHS1)*

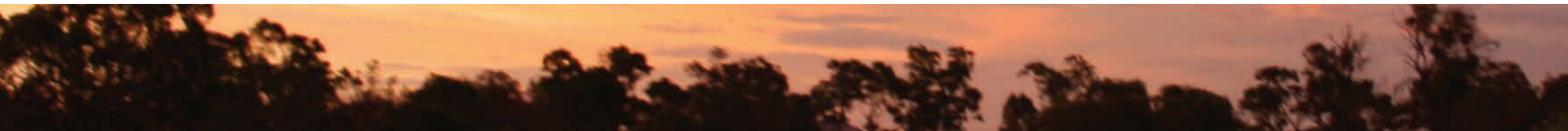
Obviously I've got a duty of care government-wise because we are government funded. I've got to ensure that patients have access to doctors and they've been diagnosed and treated. But you've got the flipside, it could be a cultural reason: a ngangkari is more required than a doctor. So to safeguard the service, because the organisation is managed by an Aboriginal Board and Aboriginal members, and to make sure people are looked after properly we have to do it both ways. It's managing two worlds in one and making sure they get access to the appropriate cultural service as well. And it has worked *(Interview CEO AHS8)*

We find a lot of people are misdiagnosed when they are hearing supposedly auditory hallucinations. An Aboriginal person who has recently lost a family member, it's perfectly normal for them to hear the voice of the person who has passed away, but it can be distressing with a lot of other things that are going on. So they present to a mainstream doctor "I am hearing the voice of my cousin." Bang – they are on Risperdal Consta before they are out of the door, without any thought of what the cosmology is, of what is normal for that society. We impose our mainstream view and it's not right. *(Interview Mental Health Clinician 1-AHS6)*

I have actually seen people labelled as mentally ill and sent away to mental institutions or withdrawn from their native tobacco and labelled as schizophrenic. Ngangkari would have taken a lot of time if they stayed in their communities, though, they probably would have got better had their family, resources and support mechanisms around them. But we, the hospital, the mainstream services tend to send them out of town. Which is more, damage, I feel, it's more damaging and I've seen it with a number of my clients. The minute you get them back here, they're changed *(Interview CEO AHS8)*

It gets to the point where mothers and grandparents come here quite desperate saying "can someone help my daughter, she is going to the doctor, she hears voices and not dealing with it at all." And when a ngangkari comes in and heals her, it doesn't really make sense with a doctor's diagnosis of schizophrenia or mental health. Sometimes young people are turning to alcohol or drugs because they are hearing and being told things in their head and it might just be another person doing the wrong thing and ngangkari can fix it. *(Interview CEO AHS8)*

Once they're caught in the system then



dragged along with that, and in our own small way we made small inroads into that. We have one of our clients, hopefully by Xmas will be off medications, that's taken five years, and three of our recent clients we haven't reapplied for their community like that which doesn't happen in mainstream. Once you are in there, you are in there for life! *(Interview Mental Health Clinician 1-AHS6)*

I think we pathologize people and we marginalise them ...they always say "oh you got a depression" which we understand the neurobiology of depression and why it may happen, but it's like seeing someone as being out in the paddock and getting sunburned and thinking that it's leprosy and trying to treat it as a skin disease and not looking at all the factors that are impacting on them, that are causing their suffering. That's where we miss the mark, I think *(Interview Psychologist 1-AHS6)*

4.6.5 Calming effects on patients

The provision of a two-way health care service has several benefits for Aboriginal patients, including a calming effect which facilitates the overall health care intervention.

It's both ways. In times of crisis when someone is very sick, we will bring in ngangkaṟi if we need, if the patient wants them or we'll ask them if they want them in, and the ngangkaṟi will come to the clinic if the patient is critically ill or needs some sort of reassurance before they are evacuated or we get them out of the communities. So the clinics are actually encouraged to use the ngangkaṟi and I found them to be extremely helpful. I worked for a number of years here *(Interview Programs Manager 2-AHS9)*

I think when people are frightened need lots and lots of reassurance. I think having the ngangkaṟi there, particularly if they are ngangkaṟi that have a good relationship with the community, are reassuring and they can reassure that spiritual aspect of people's concern as far as their illnesses go. I think it's very hard for non Aṉangu to do that if someone is really unwell and the nurses are trying desperately to stabilise them and ensure that they don't die. So having ngangkaṟi around is really important in that sort of situation. I've always found the ngangkaṟi invaluable in those situations and particularly with mental health patients; they can quite often settle people down more easily than we can *(Interview Registered Nurse 3)*

4.7 Disadvantages of ngangkaṟi services

No disadvantages have been reported by the interviewees in relation to the provision of ngangkaṟi services in health care settings. Difficulties and challenges, more than disadvantages, have been indicated to arise in the delivery of Aboriginal traditional healing within western health care settings. These issues and challenges have already been discussed in the previous section. Additional issues related to the provision of ngangkaṟi healing in clinical settings will be discussed in Chapter 5.

I'm not sure there is any disadvantage...The *ad hoc* nature of it, it is very difficult. The disadvantages are like fitting our bureaucracy around how ngangkaṟi work, like insurance and the payment schedule. That's problematic, not so much a disadvantage. I'm not sure there is any disadvantage *(Interview Hospital Manager 1-H7)*

I wouldn't say there aren't any disadvantages at all *(Interview Hospital Manager 2-H7)*

Not really, from our point of view we haven't had any disadvantages... at times it's difficult but disadvantages? Not really... *(Interview Registered Nurse 3)*

4.8 Lack of a statewide policy framework

The lack of a statewide policy framework for the provision of ngangkaṟi services in South Australia is a central issue. Mainstream and Aboriginal community controlled health services operate independently in relation to the way in which they engage with the ngangkaṟi. The lack of a statewide policy framework does impact on the delivery of a consistent and systematic delivery model for ngangkaṟi services. Statewide policies and guidelines are required in relation to a broad range of issues, including fees, payment schedule and process, accreditation standards, access to accredited ngangkaṟi, among others.

No, we don't have any policy directive from state or government that you have to follow to spend this money *(Interview CEO 1-AHS6)*

There needs to be very clear guidelines about

how to pay someone without offending them and all that sort of stuff. So there needs to be clear guidelines. But we still haven't got the basics right and the basics are education and employing Aboriginal people *(Interview Psychologist 2)*

No, there isn't any policy or directive we follow... *(Interview Aboriginal Liaison Manager H9)*

No, I don't think there is any policy *(Interview Medical Practitioner 3)*

We've got one draft policy that our previous Chief Executive Officer had. He negotiated with people at the hospital. This is where the rate came from. That's all, there's nothing, it was never actually adopted as a proper policy *(Interview Financial Manager AHS6)*

We had to look at policies for our service, how you fit ngangkari within, I think it has been a headache all along for years. Certainly the board tried to get their head around ngangkari. I originally contacted Dr ... from AHCSA who has spent a lot of time in remote areas and worked in that system; I contacted him if there was any consistent approach and really didn't go too far with that. So I contacted the other community controlled services. I knew they were using ngangkari and put it together to have a bit of a picture, which is pretty fragmented. I couldn't put it together because of the inconsistency *(Interview CEO AHS 3-AHS6)*

Everyone does it independently. There are no standard guidelines *(Interview CEO AHS1)*

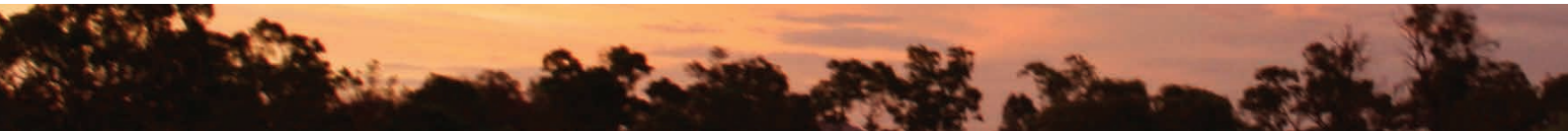
Ngangkari interventions with mental health patients may be recorded. I am not sure whether they have recorded much at that time. When I was there I asked "what's your policy?" And they said "you can't see this being described into a policy, you know". So if you don't have a policy you are working in a grey area... clearly it's a grey area that's ill-defined in terms of acceptance of traditional healing practices in western medical settings; so, those are the sort of barriers...*(Interview Psychiatrist 3)*

...in relation to policy, how to implement the policy and how it is actually operational within the ward level? *(Interview Psychiatrist 1)*

There have been numerous attempts to develop statewide policies to respond to the need for a consistent and systematic approach to the provision of ngangkari services within the South Australian health care system. Interviews data reveal that these attempts have been unsuccessful.

> No, there isn't any policy or procedure around ngangkari. There is none. And that's what those meetings were trying to develop, they tried to develop a statewide policy or country health policy, but they never went anywhere. It's all been too hard because they can't answer the questions about insurance and those sorts of things *(Interview Hospital Manager 1-H7)*
>
> Someone needs to take charge and do it, because at the moment no one is taking charge to set up fees, some policy guidelines or do anything. And that would need someone to drive it and also find out who the ngangkari are, and talk to them, see what their ideas are *(Interview Programs Manager AHS6)*
>
> It's disgusting that these things take so long, for anybody else it would have happened more quickly *(Interview CEO AHS10)*
>
> Everybody knows that they have this issue on their hands and no consistency and they would be happy if there was some consistency, to find somehow to make it fit with our system because there isn't a consistent approach *(Interview CEO AHS 3-AHS6)*
>
> No, there isn't any policy or directive we follow. It must be a systematic approach in order to work *(Interview Aboriginal Liaison Manager H9)*

The need to develop a statewide policy framework to ensure a consistent and systematic approach to the delivery of ngangkari services remains urgent. At the same time, the urge for a state-based policy should not discard the value of the current community-driven approach in relation to the provision of ngangkari services for Aboriginal and Torres Strait Islander people in their communities.



4.9 Conclusion

The multilayered analysis of this chapter provides the foundations for the development of a statewide policy framework which establishes a two-way health care model to guarantee the systematic provision of Aboriginal traditional medicine hand-in-hand with western medicine. The new statewide policy framework needs to include the following core components:

A central body endowed with the responsibility to coordinate, organize and manage the delivery of ngangkaṟi services across South Australia;

A ngangkaṟi accreditation process with qualification, accreditation and registration standards for the recognition of ngangkaṟi as legitimate health practitioners;

A Register of accredited ngangkaṟi;

A ngangkaṟi employment scheme and payment process applicable across South Australia;

A consistent database on ngangkaṟi interventions that documents ngangkaṟi episodes of care and develops a statewide two-way health care model.

Health professional training and development programs on the role of ngangkaṟi in health care. The reciprocal understanding between western medical practitioners and Aboriginal traditional practitioners is fundamental for the delivery of an effective two-way health care model.

The need to develop a statewide policy framework to ensure a consistent and systematic approach to the delivery of ngangkaṟi services remains urgent

CHAPTER 5

Western Medical Practitioners and Ngangkaṟi in Clinical Settings

Doctor.... you and me, we are a bit the same I am the number one ngangkaṟi on the APY Lands, number one ngangkaṟi on all APY Lands and you are number one doctor! You always go around putting things in, I always go around taking things out. Yeeh, you are number one doctor and I am number one ngangkaṟi!

(Interview Medical Practitioner 1)

5.1 Introduction

This chapter provides an in-depth and multilayered analysis of the relationship between western medical practitioners and ngangkaṟi in clinical settings within the South Australian health care system. It has a threefold aim: to provide a thorough examination of western medical practitioners' perspectives on the role of ngangkaṟi in Aboriginal health care; to identify the dynamics and issues arising at the interface between ngangkaṟi and medical practitioners' interactions; to draw on medical practitioners' insights and suggestions to improve current arrangements and develop a more integrated two-way health care model.

This analysis draws on interviews with medical practitioners, including physicians, general practitioners and psychiatrists. The analysis also includes insights from other health professionals, such as psychologists, nurses, health workers and other clinicians to provide a comprehensive analysis of the interplay between western health practitioners and Aboriginal traditional healers in South Australia's health care settings.

The chapter is structured in three main sections: the doctor-ngangkaṟi[19] relationship, the ngangkaṟi-patient relationship, and the patient-doctor relationship. This tri-party relationship stands at the core of the encounter between western medicine and Aboriginal traditional medicine.

5.2 Doctor-ngangkaṟi relationship

This section provides western medical practitioners' perspectives on the role of ngangkaṟi in Aboriginal health care within clinical settings. Interviews with medical practitioners are examined to identify what are the key issues arising from the doctor-ngangkaṟi relationship; to collect evidence on the benefits and limitations of ngangkaṟi services in clinical settings; and to draw on health practitioners' valuable inputs to develop a more inclusive two-way health care service delivery model.

5.2.1 Degree of interaction

The degree of interaction between medical practitioners and ngangkaṟi within the South Australian health care system has a significant impact on western practitioners' familiarity with the role of ngangkaṟi and their healing practices.

The degree of interaction varies according to two main factors: geographical location of health services and length of time medical practitioners have worked in health services where ngangkaṟi provide their treatments.

> I can't say I have a good overview of ngangkaṟi, I am a recent person here myself. I have been here five years...I mainly stay for a couple of months and we go back a couple of weeks most of the times *(Interview General Practitioner 2)*

> I have been working in Aboriginal health for 34 years. I was the first doctor to live and work up on the APY Lands. I went out there in the 1970s when we started the Pitjantjatjara Homelands Health Service...There were a lot of active ngangkaṟi in that area, so quite quickly I found that I was working alongside ngangkaṟi quite a lot *(Interview Medical Practitioner 2)*

> I worked with ngangkaṟi very occasionally... you don't see them around in urban areas very often, you know... (*Interview Medical Practitioner 4)*

19 In this chapter the term 'doctor' is used to indicate all medical practitioners interviewed, including general practitioners, physicians and psychiatrists.

In South Australia, the interaction between western medical practitioners and ngangkaṟi in clinical settings is greater in the Aṉangu Pitjantjatjara Yankunytjatjara lands (APY) located in the far north west of South Australia. It is in the APY Lands where most of the ngangkaṟi come from and live.

The first encounter between western health practitioners and ngangkaṟi in the APY Lands can be traced back to the mission days. At that time the relationship between ngangkaṟi and western health staff was informal. Ngangkaṟi would go in the clinic if someone was sick, usually the family called them in. There was an understanding from the clinical staff that the ngangkaṟi would do their things and then doctors or nurses would do their bits.

In the late 1970s a more formal recognition of ngangkaṟi was accorded by the South Australia Department of Health.

> In 1976/1977 the SA Health Department decided that they should recognise that there is another medical system out there and that they should be incorporating the traditional medical system into their clinics. So it became the policy that each clinic would employ a ngangkaṟi in the 1970s...The ngangkaṟi became employees of the South Australian Health Department... *(Interview Medical Practitioner 2)*

The employment of ngangkaṟi in the clinics was unsuccessful in the long term,

> ...but it was a failure because the nurses had to go out and find and employ a ngangkaṟi. They were now employed by the South Australian health bureaucracy, so they were expected to turn up at 9.00 and stay until 5.00pm, and if there was nothing important to do the nurse would give them a broom and say "go and sweep the path". They were employed on a salary. Because they weren't working all the time, the nurse would give them menial tasks. Very quickly they stopped turning up to work and so they got sacked and that was the end of that program... *(Interview Medical Practitioner 2)*

In 1983 Nganampa Health Council was formed and took over the provision of health services from the South Australian Health Commission and the Pitjantjatjara Homelands Health Service. Since then, Nganampa Health's clinics located across the APY Lands are the clinical settings where the encounter between western medicine and Aboriginal traditional medicine occurs. It is within Nganampa Health's clinics the the interplay between ngangkaṟi and medical practitioners mostly takes place.

In some remote and rural areas of South Australia the degree of interaction and collaboration between medical practitioners and ngangkaṟi is either limited or non-existent.

> We don't know any ngangkaṟi, we don't know how to get a ngangkaṟi, we don't know where they are, we don't know who would be appropriate, we don't have any association with any. Sometimes I hear that a ngangkaṟi comes for a funeral and nobody comes to the health service that day, but when the ngangkaṟi is gone after the sorry business everybody comes back. And people have talked a little bit about what happens, but not very much, they don't say very much *(Interview Medical practitioner 5)*

> ...one of the elder men just happened to mention he was a ngangkaṟi and that he helped two old men walk, which he had, because they were walking and they hadn't been able to walk before and we didn't know why they were suddenly walking. So that was interesting and it's just one of the men we all knew. And I said to the nurses "did you know he was a ngangkaṟi?" And they said "no" *(Interview Medical Practitioner 5)*

> I know of them, I've met some of them, but beyond that I haven't had much to do. As a doctor I have very little experience with them here, I don't know how many doctors here if they would have much experience with that, apart from what I came across, but beyond that, not a lot *(Interview Medical practitioner 3)*

The least degree of interaction between ngangkaṟi and medical practitioners is in urban centres. In urban or metropolitan areas the contact of ngangkaṟi with the mainstream health system is sporadic, although in some areas has at times been more frequent than in others.

5.2.2 Complementary role of ngangkaṟi

Western medical practitioners acknowledge the complementary role of ngangkaṟi in the provision of health care and the complementary nature of ngangkaṟi interventions. Medical practitioners who have been working in direct contact with ngangkaṟi indicate the complementary nature of

ngangkaṟi's role in the provision of quality health care to Aboriginal patients as follows:

> ...in general we would be there together. Sometimes there would be more than one ngangkaṟi. I have had an example where there was a ngangkaṟi massaging to pull out an object, a woman dancing around the person and another Aboriginal man was reading the Bible as well as me doing my work. My feeling is that we were certainly always very appreciated that we were working together; there was no question that people wanted that and saw that as being good. I think that people appreciated what western medicine had to offer. There was a feeling that western medicine is more a symptomatic treatment. For significant conditions there is often some underlying spiritual issue and that is where the ngangkaṟi came in. So the ngangkaṟi was dealing with the underlying spiritual problem that was causing the disease and I was treating the disease, treating the symptoms created by the spiritual disturbance. So it was complementary. We weren't clashing. I was doing part of what people wanted and he was doing the other part *(Interview Medical Practitioner 2)*

> ...and I also rapidly realized that what I knew to do was only a little fraction of what was required to be delivered and that there were a lot of people in the community, the ngangkaṟi who had a lot of respect, a lot of trust in both what they see and what they could do. In a way when I started working with the ngangkaṟi I realized that my contribution to people's medical care was only a small fraction of what those people expected, really. So from the start, I always found that the ngangkaṟi were inclusive in what I did, they included me in their work and I tried to include them... (*Interview Medical Practitioner 1)*

> ...we are using medications so we're treating from a medication point of view but having the ngangkaṟi come in, it's almost treating it from a psychological point of view and that's how I see it and the two go hand in hand *(Interview Psychiatrist 2)*

> I think it is smart to have it a bit each way; it is smart to have it each way and it is likely to be helpful *(Interview Medical Practitioner 1)*

> I had found and I still find that people in Aboriginal communities they usually come to people like me after they tried lots of other things anyway, and part of that would be trying and trying and trying what works. Ngangkaṟi generally is just as part of a daily activity. And not in the same way, but in a similar way that people in cities see general practitioners, they actually try a lot of other things... (*Interview Medical Practitioner 1*)

> Ngangkaṟi are part of this community, they are coming and help...It is good for us because if we've got a patient in the clinic, often it may be 10.00 at night, so the patient is in the clinic and everybody is upset, then ngangkaṟi can come in and give them a treatment and make feel them better: it helps us a lot. If there is a problem at the clinic, then obviously because there are several ngangkaṟi in each community, somebody will be available and sometimes the family say "oh no, that's not the right person for this or something", but generally there is someone available (*Interview General Practitioner 2*)

> I remember a problem that happened very early on when I was there in the days that it was quite hard to get people to hospital and we tried quite often not to send people to hospital truly. There was a little boy who came from another community – I think I had been in the community only three weeks then – he was staying with relatives in Fregon, he was 10 months old, it was a Friday afternoon, it was raining. The family brought this little boy to me because he was hot, he was one year old, and so he had a fever and he looked pretty unwell and he had quite a large abcess at the base of his neck, at the back. It was already late in the day and in those days we didn't have a night airstrip and it was very hard to get people out of Fregon. I was pretty clear about what was wrong with him: he had an abscess on the back of his neck, he needed intravenous antibiotics, he needed to have the abcess drained. He needed to go to hospital but I thought I could probably just keep him until the next day and not try to treat him overnight. I was trying to explain this to the family what we were going to do and they took the boy away for quite a while and brought him back and they brought one of the ngangkaṟi with him. Subsequently I got to know him very well and I never met this man before. He looked absolutely clear about the boy when I looked at him. He said "this boy has to go to hospital now! Not tomorrow, not later, this boy has to go hospital now!"

> And as every doctor who is pretty sure about what they are doing, I started having an argument about this. But it was very clear that I was on the back foot here and there were a lot of good reasons for this child going that night.
>
> It wasn't that the ngangkaṟi tried to cure this child, it wasn't that the ngangkaṟi thought he could fix the child. It was actually that the ngangkaṟi had a place himself in a social situation: he was well and truly across the anxiety that this family who was looking after this child for someone else was feeling. He was absolutely across of the idea that this was something that couldn't be fixed in Fregon and he was absolutely across of the idea that it may be dangerous to keep the child overnight. It was really... really something that stuck with me. We came to an equitable agreement and we actually managed to get that child out that afternoon. It was just an illustration of how foreign I was and how incompetent I was, and how this person who really had no medical training, but he had a lot of social and psychological skills and decided that this was inappropriate management *(Interview Medical Practitioner 1)*

Medical practitioners reveal how ngangkaṟi can play a fundamental role in the treatment of medical cases in which western medicine has difficulties to deal with.

> There are other things where we don't have very good answers to the problem and sometimes they take over, the family will take them to a ngangkaṟi or bring ngangkaṟi to take over because there is something that we haven't really helped, like they've got a headache or something and we can't see a medical response that fix their problems, so they go to a ngangkaṟi instead (*Interview General Practitioner 2*)
>
> We had some business recently where it was outside the range of the health professionals; it would have been really good to have a ngangkaṟi there because it was family business problems and it wasn't something we could deal with, we didn't have the skills to deal with these kind of business problems, that was making this person sick. So the person whose problem was, she drew what the problem was on a piece of paper and said "this is what it is", which was a whole lot of circles and lines. And she said: "this is my problem". And I said "I'm sorry, I don't understand what this means". And she said "a ngangkaṟi would understand this". And I said "sorry, I'm a whitefella and I don't understand, we need to find you a ngangkaṟi". She said "well..."; that was the end of the conversation. I said to people "we got any ngangkaṟi?" She went away and she came back, I haven't seen her since she came back. So maybe she went and found one. At that time...I didn't know how to find one and nobody knew how to find one. I didn't realize we had money, which would have been different 'cause if you can get one from the APY Lands that would be different *(Interview Medical Practitioner 5)*

Health professionals working with medical practitioners in clinical settings where ngangkaṟi can be accessed reinforce the complementarity between western medical care and ngangkaṟi interventions.

> I always ask if someone tells me they are sick, I often say to them "Have you seen a ngangkaṟi?" I think people turn to each, they will go to the clinic and ngangkaṟi (*Interview Registered Nurse 3*)
>
> They allow us to do all our essential work first and then we just respectfully step back and allow them to do their bit. We got an understanding of western medicine and I don't understand what ngangkaṟi do, but I have a great deal of respect for what is important in their culture, so I just step back and let them do whatever it is (*Interview Registered Nurse 1*)
>
> I think a lot of our people tend to have faith in both camps; they rely on the ngangkaṟi as well as western medicine (*Interview Registered Nurse 2*)
>
> Apart from my personal view, I am always happy to get a ngangkaṟi if someone asks to see a ngangkaṟi. I think if people want ngangkaṟi we should provide them to our patients and I've been always keen to get ngangkaṟi in for our patients. If this is what they want, I have no problems whatsoever to facilitate the provision of ngangkaṟi to patients (*Interview Registered Nurse 2*)
>
> Often they work outside of the clinic but occasionally they come in the clinic and as a health service we always check with people if they want to see the ngangkaṟi or if they had seen a ngangkaṟi when they came in. Quite often it was very helpful; I found that people

usually see both, they see both the ngangkari and the clinic (*Interview Registered Nurse 3*)

It's two ways. There are two-way medicine pathways *(Interview Mental Health Worker 1)*

Medical practitioners and health professionals who have not had a lot of exposure to ngangkari, express interest and willingness to explore ways of collaborating with them within the health care system.

Yes, I'd love to work side by side. Oh yeah, I don't mind doing that. One of the things that we talked about... that instead of me staying here consulting, I'd go out into the bush and consult. And that'd be an opportunity then to work with ngangkari; I reckon there is no reason why it couldn't happen here as well is there? But the other thing I guess it's time, I don't know how long it takes for bush medicine people to be involved (*Interview General Practitioner 3*)

I have worked with ngangkari very occasionally. Put it this way: I certainly encourage it if there's one around (*Interview Medical Practitioner 4*)

They are different systems but I don't see why you cannot work together *(Interview General Practitioner 3)*

We got to work with them, yes working with them, not this is what we do and this is what you do and this stuck up business of mine is better than yours type of thing. Working together, yes definitely! If you could get them working together, it would marry the two systems together beautifully... *(Interview Registered Nurse 5)*

Medical practitioners underline how ngangkari acknowledge the significance of western medicine and the complementary nature of western and Aboriginal medical practices.

He was always taking things out of people that were making them feel bad, and I might be putting something back that may cure something. I think he was pretty sure that what he was doing was important. He would always go around and say "You always go around putting things in, I always go around taking things out!" They know that there are certainly many aspects to that person's illness that they can't deal with, but there are certainly some aspects of their illness that they can deal with. Thinking about the case of that boy with a boil on his neck, that's an example where ngangkari could pretend that he could fix that, but in the end what this person needed was some medicine and an operation. He could deal with making that little boy feel better, and he could deal with making the family feel better, but in the end what the kid needed was an operation and some antibiotics (*Interview Medical Practitioner 1*)

I can't think of any experience where a ngangkari says "you should ignore the doctor's advice, you should do this". I can't think of that ever happening. It's never happened to me. Usually, they don't give that sort of advice *(Interview Medical Practitioner 3)*

They usually cooperate to help the person go on with medical treatment...they've got usually a quite good relationship with the clinic and the clinic staff. They don't act in competition, but in a more cooperative way (*Interview Medical Practitioner 1*)

When we think it is mental illness ngangkari sometimes help but not usually take over. They don't seem to me that they like to take over in mental illness; they think often that that should be more like medical, you know, a clinic medication problem. If somebody's acting, behaviour is very abnormal, they would help sometimes but often they say "it's clinic problem" *(Interview General Practitioner 2)*

They are really quick to know when there was something they couldn't deal with; they recognize that. For example that guy who hit his head and we weren't sure whether he had injured his neck or he had infection in his brain, that was a kid. He was very quick to say that there was nothing he could do, that he thought it was the brain and that he needed to go to Alice Springs. So he was very quick to realize that it was something that he couldn't fix *(Interview Registered Nurse 3)*

That's why in my experience, if something got obvious medical implications like a broken bone or something like that, ngangkari might help the person to generally give support, but they don't try to treat specific problems that they think's got the need for a specific medical journey *(Interview General Practitioner 2)*

Ngangkari are not claiming to fix everything... they work together with the clinics and doctors... *(Interview Psychologist 1)*

In mental health, psychiatrists and mental health care clinicians indicate how ngangkari play a vital complementary role in the provision of mental health care to Aboriginal patients. Medical practitioners highlight a working relationship based on mutual respect and collaboration.

> We are using medications so we're treating from a medication point of view but having the ngangkari come in, it's almost treating it from a psychological point of view and that's how I see it and the two go hand in hand *(Interview Psychiatrist 2)*

> You might have lots of people that are unwell and at the basis of their illness is the belief that there might be guilt associated belief that they've done something culturally inappropriate, or that they're being cursed, something put on them because they've done something wrong. And having the ngangkari come in and treat that, that's lifted. So that feeling of guilt, that feeling that they've done something wrong is no longer there. And it's then their psychological attitude has changed and it then allows our medications to work a lot better. You can just imagine if someone for example got a depression or got a psychosis and they're stressed and it might be for a number of different reasons, but it could be because they believe they've done something wrong, that's going to impact their illness; so if you can relieve that, it's going to make it a lot easier to treat them from our point of view. And it's also really a psychological sort of therapy. That's how I see it. So we are using medications so we're treating from a medication point of view but having the ngangkari come in it's almost treating it from a psychological point of view and that's how I see it and the two go hand in hand *(Interview Psychiatrist 2)*

> A psychiatrist who works in the APY Lands, talks a lot about the ngangkari up there and about how useful the ngangkari are if they're doing guardianship orders, or have difficulty settling someone who is psychotic; having a ngangkari on the side has been really helpful 'cause of their manners, especially if they're really quite psychotic, they listen to the ngangkari, they do what they say *(Interview Medical Practitioner 5)*

> We use ngangkari now quite regularly... all the ngangkari had done their work and have always reinforced the importance of working together, having white man way plus Aboriginal way together, and they've also indicated they're very keen for us to be able to do lots of things together and work together. So we've had a lot of success with the ngangkari *(Interview Psychiatrist 2)*

> So they've been fantastic because we've been constantly telling people not to smoke marijuana because of the problems associated with it and the ngangkari really enforce that from their own perspective and point of view. And they've always said we work together, white man way and Aboriginal way together, it's going to be so much better for you. As I've said, the ngangkari have been really keen for us to work together *(Interview Psychiatrist 1)*

> I think ngangkari are important. I think probably the mental health people may find them very good in that area *(Interview Registered Nurse 3)*

5.2.3 A collaborative team-based approach to Aboriginal health

The doctor-ngangkari relationship exemplifies a collaborative team-based approach to Aboriginal health care. Medical practitioners indicate how collaboration with ngangkari and respect for their healing practices promotes a team-based approach to the delivery of a holistic and quality health care model.

> I think collaboration, yes collaboration truly. I think it is a collaborative approach where I think they help me do what I need to do and I don't know if I – I don't think they need any help from me – but they are certainly helpful in progressing what I think needs to be happening *(Interview Medical Practitioner 1)*

> And they've always said "we work together, white man way and Aboriginal way together, it's going to be so much better for you"...As I've said, the ngangkari have been really keen for us to work together *(Interview Psychiatrist 2)*

> They often come to the clinic, they've got usually a quite good relationship with the clinic and the clinic staff. They don't act in competition, but in a more cooperative way *(Interview General Practitioner 2)*

> Ngangkari are not claiming to fix everything... they work together with the clinics and doctors... *(Interview Psychologist 1)*

> So the ngangkari would work with the patient's spirit. Sometimes we're invited to

observe and sometimes we do and sometimes we don't, depending on the context...We had one particular ngangkari called Helicopter, he was amazing. He would send clients to be seen at the clinic. And then he would come back afterwards and say "what was wrong with them?" "We think it was tummy pains or whatever". Even now the other ngangkari, they'll send people to the clinic because they feel that they need the clinic medicine as well. People do it themselves as well, they'll say to you "oh, I feel better now. I've been to see a ngangkari. Or someone will say "a ngangkari saw me, that was good". And they will, so they will feel stronger to come and get follow-through with the clinic *(Interview Mental Health Worker 1)*

I am happy to work together with the ngangkari... *(Interview Psychiatrist 3)*

This collaborative team-based approach generates significant benefits in three key areas of the patient's health care journey: consultation, diagnosis and treatment.

5.2.3.a Consultation

A two-way consultation approach is considered to be beneficial for a more comprehensive assessment and management of patients' health conditions and treatment options. The practice of a two-way consultation mode presents two interesting features. Firstly, the timing in which the doctor and ngangkari consultations occur can vary: they can occur at the same time, the ngangkari consultation can happen before the doctor consultation or the opposite. Secondly, the privacy that characterizes the concept and practice of consultation in the western health care system differs from the way in which ngangkari consultation is perceived and practiced. These features, however, do not prevent the practice of a parallel two-way consultation approach whereby medical practitioners' consultations and ngangkari's consultations are equally taken into account.

I have always found that asking what a ngangkari saw, asking what a ngangkari said, asking what a ngangkari recommended was an important part of any significant consultation... Sometimes watching how ngangkari worked with people, what they were finding and what kind of recommendations they had was an important part for me deciding how I would approach the problem (*Interview Medical Practitioner 1*)

I remember probably in the first year when a lady whom I have never seen before came from one of the communities in Western Australia and she was an older lady who was staying with relatives in Fregon, and was brought into the clinic one evening pretty sick, she looked pretty sick, she was febrile and had abdominal pain. We were struggling again because we couldn't talk very well with her, couldn't talk very well with the people who were with her, everybody was really frightened because she really looked like she was going to die. Fortunately one of the ngangkari came in to see her and I have learnt by that time that whenever I thought things were really bad, it was always really important to let them do what they had to do. I learnt that no matter how anxious you were about a patient, no matter how close to death you thought they were and how quickly your intervention was needed, it is always better to stand back and let a ngangkari see the patient if it is all possible; because you can actually learn from this particular care and I subsequently did it on numerous occasions. You can actually watch what the ngangkari did. The ngangkari would immediately, almost immediately settle the patient down. So the fact that there was someone there that the patient trusted was really important. Ngangkari could settle the relatives down so a lot of their anxiety would go and it did in this case, and then you could watch how the ngangkari operated... (*Interview Medical Practitioner 1)*

The fact is with ngangkari it is a very public kind of thing, whereas it is quite a contrast to the kind of practice that I need to service with confidentiality and so on, there needs to be no one else around. For ngangkari it is very public and sometimes I wouldn't know what happened at the same time and I might need to pull them apart later and clarify something that I didn't want to talk about in front of other people. But in general we would be there together... *(Interview Medical Practitioner 2)*

It is also a bit of a social thing. It is not just someone saying I am sick so I need a doctor. It is other people saying this person is sick I think you need to get a ngangkari around. And people would all crowd around while the ngangkari was working. I think to some

extent it is legitimizing the fact they have an illness and everybody is concerned and we are all gathering around... *(Interview Medical Practitioner 2)*

I understand that a ngangkaṟi could sum up his or her consultation, and he is always willing to discuss that consultation with me. He would often give an idea and argue for what they saw I should be doing; and they would often give me a realistic impression of that person; if he was just a little be sick and he would get better with the kind of things of what they have done, otherwise taking that on board of what I do too (*Interview Medical practitioner 1*)

Ngangkaṟi generally weren't used in that way, something like "I have an appointment with my ngangkaṟi to check up my condition." It would be when somebody is sick, word would get around, the ngangkaṟi would come over and treat acute episodes to help that episode resolve *(Interview Medical Practitioner 2)*

5.2.3.b Diagnosis

Medical and health practitioners acknowledge the value of ngangkaṟi's diagnostic abilities.

They do actually focus quite well on what the person perceives as their pathology. They don't sort of mumbo jumbo behind the curtain, they actually examine the patient. If you watch how they examine the patient, you can often find where the focus of the problem really is *(Interview Medical Practitioner 1)*

You always get a considered kind of approach: "how bad do you think this problem is?" and the ngangkaṟi would say "I think it is a really bad problem. You know, I think this is a bad problem". And from my point of view, that becomes quite helpful because the ngangkaṟi said "I fix this problem, this problem is fixed, what you need to do is to have the doctor to do something too, she needs to do something too" *(Interview Medical Practitioner 1)*

I think ngangkaṟi are mainly important when someone is unwell from pain and we haven't got a particular diagnosis *(Interview General Practitioner 2)*

I would do my diagnosis, do what I needed to do, prescribe medication and whatever and the ngangkaṟi would do what he needed to do *(Interview Medical Practitioner 2)*

Ngangkaṟi is very quick to work out when it is something that needed to go to the clinic and refer them on to the clinic. There was a couple of times we had very sick patients, or patients we weren't sure what was wrong with them and they've asked if they could see a ngangkaṟi and we were happy to encourage the ngangkaṟi to come in and see them. On one of those occasions where we weren't sure if somebody had an infection in the brain or they actually hit their head, they were very quick to say after they examined the person that they needed to go to Alice Springs and there was an infection in the brain and there was nothing they could do; which did turn out to be right, after they've gone to Alice Springs and had had tests, it turned out to be right. They also hit the head but the problem wasn't that, so that was quite interesting. We would have sent them anyway but it was good to have a confirmed diagnosis where everybody agreed *(Interview Registered Nurse 3)*

If you have a conversation with them after they visit the patient you can find out. So, you know, I asked: "where do you think this problem is?" And the ngangkaṟi said: "I think this problem is here'. And I watched them examining the patient and I thought that's where the problem was too *(Interview Medical Practitioner 1)*

So something that I have always done, no matter how anxious I am, I generally just stand back if there is a ngangkaṟi there that the patient trusts and wait to see what they find... It makes a difference, it makes a huge difference because you've got someone who is confident about what he has found, he is confident about what he has done, you are confident and you can go ahead with the cooperation of the patient *(Interview Medical Practitioner 1)*

This person kept presenting with a particular complaint, I don't remember what it was. Apparently they had gone to the ngangkaṟi after seeing us at the clinic and the ngangkaṟi had said that it was something to do with the lung, but at this stage we couldn't say definitely that's where the problem was. Surely enough after a few days of this person presenting these symptoms developed into a

type of pneumonia. So I stepped back and thought, well the ngangkaṟi said it straight off and at the time of the presentation was not that clear that that was the diagnosis in the end *(Interview Registered Nurse 1)*

In those days on the Lands we didn't have a telephone; we had a big lightening storm and for four months we had no phones at all there, and I had someone who was having a myocardial infarction. Anyway, I stabilized it because there was no doctor and no way to contact the doctors, so I had to stabilize it... Anyway, I stabilized this lady and treated her almost like intensive care and the lady asked for a ngangkaṟi, and I said "they are coming". When the ngangkaṟi arrived I asked "what do you think the problem is?" And he talked to sort of no one in particular, he looked at her and said "Oh, no blood to the heart". Now, what is a myocardial infarction? It is no blood to the heart *(Interview Registered Nurse 4)*

One day I treated someone for three bouts of pneumonia on the Lands in a winter. It was a 24 year old lady and the only X-ray facility we had was at Ernabella, which is 160 Km away. I happened to be going to Ernabella and I said to this lady, because it happened three times, "let's get an X-ray". She said "I talk to dad" and her dad said "I come along too". Anyway, I took them to Ernabella, had an X-ray, it was the old machine that took a while to develop, it wasn't the instant thing. So I had the X-ray done and the father said "can I take my daughter to the ngangkaṟi?" He saw the ngangkaṟi and he came back even before the picture was actually developed and had something that they had drawn out. I asked "where was the sickness?" and he pointed to a lobe in the lung, I think it was the right lower lobe. Anyway, the X-ray then was developed and the doctor called me and said "come and have a look at that! He has to be sort of good to recognize that". And, because I had given her already procaine penicillin, he said "you have to look closely: there it's the consolidation and there still some consolidation although it's responding well to the procaine penicillin. It is exactly the same lobe that the ngangkaṟi had pointed out" *(Interview Registered Nurse 4)*

5.2.3.c Ailments

Medical practitioners provide evidence of a range of ailments ngangkaṟi attend to, including physical and mental health issues. Physical complaints include headaches, body pain such as limb pain, tummy pain, chest pain, stomach-ache; other complaints include breathing problems, vomiting, diarrhoea, high temperature, wounds, cancer related sicknesses. On the one hand, doctors and health practitioners indicate how ngangkaṟi interventions involve care of acute illness, chronic pain problems, and when the cause of pain is undiagnosed. The latter occurs when symptoms persist where no medical reason is found and no medical response can be provided. On the other hand, they explain how ngangkaṟi interventions cannot tackle a range of ailments and illnesses.

I don't think they just work on things that are quite clearly of a mental health nature. They work on true physical complaints, like headaches, limb pains, vomiting, diarrhea, all kind of common garden western medical complaints... I really haven't seen any illness that ngangkaṟi don't attend to *(Interview Medical Practitioner 1)*

Often people see ngangkaṟi about chronic pain problems. That's quite common. I think they often see them about mental health problems, when usually they're taken by their family. Sometimes children are taken to ngangkaṟi, but I don't think that's as common. I think, especially nowadays, children would mostly come to the clinics first *(Interview Medical Practitioner 3)*

...they usually fall into what we think is a quite often an undiagnosed pain or something like tummy pain, chest pain, or breathing, or when we can't find a major medical reason to be worried, but the person still has the problem, they still have the symptoms, sometimes we might think it's a self-limiting thing that is going to go away or something that we don't think it needs medical response; but ngangkaṟi will help them with that and maybe give them some cure for the treatment often by removing stone or something like that from there *(Interview General Practitioner 2)*

When we think it's mental illness ngangkaṟi sometimes help but not usually take over, they don't seem to me they like to take over in mental illness they think often that that should be more like medical, you know clinic medication problem. If somebody's acting – behaviour is very abnormal, they would

help sometimes but often they say "it's clinic problem" because that person is not thinking properly...*(Interview General Practitioner 2)*

Generally they are acute conditions. These days out in health services a lot of what we deal with are chronic conditions – people with diabetes, hypertension, kidney disease, things that go on and on and you have to make sure the health system is providing ongoing continuous care for them. It is important to have in our health system GPs to manage your arthritis and diabetes over years and years *(Interview Medical Practitioner 2)*

...the ngangkari would come over and treat acute episodes to help that episode resolve. Acute episodes of illness rather than chronic illness and acute episodes often have pain *(Interview Medical Practitioner 2)*

I have seen them with people vomiting, stomach upset and things like that. They work on their stomach and settle the stomach down. I've seen them with a young kid who had severe fever that we couldn't get down with Panadol. They came and they put it down. I've seen lots of different things really *(Interview Registered Nurse 3)*

My sister in law...was getting headaches and tummy pain...They sent her to a screen and all that sort of stuff, couldn't find anything, so when she went back there, they took her to Fregon and Indulkana and they pull these two things out of her head, like little pieces of wood in the head and apparently gave them that things and put in the jar and showed the doctor. On the scan there was nothing. I haven't physically seen that, but ...yeah, she was having a lot of problems in her head and tummy, they found one in her tummy and two in her head *(Interview Aboriginal Health Worker 2)*

Cancer? Yes because when the person has cancer, they feel sick and it is the feeling sick that is being treated *(Interview Medical Practitioner 2)*

Ngangkari attend to a variety of things, but they can't cure if someone has got a heart attack or something like that or alcohol related addictions. There are a lot of things they cannot do but they didn't exist before we came *(Interview Registered Nurse 3)*

In the area of mental health, ngangkari are considered to play a significant role. Mental health practitioners identify a range of mental health issues ngangkari can assist patients with. It is also indicated how cases of co-morbidities are very hard to treat either through a western or traditional medical approach.

There are mainstream mental health problems recognized or mental illnesses from the World Health Organization; some of these disorders are universal, how they actually present, how they are actually managed is quite different and so the opportunity to get the best from both worlds is probably what you contribute; if people choose to see traditional healers in those contexts my expectation is that they have often done that first *(Interview Psychiatrist 1)*

They talk about somebody is not right in the head because something happened, a *mamu* has got in the soul, what they class as the soul, I guess, has moved; so they would look for that and find that and putting it back in *(Interview Registered Nurse 3)*

It's really difficult with the co-morbidities where there is alcohol and introduced problems like petrol, drugs and marijuana. Whereas the psychosomatic, what we call psychosomatic, where there is mind and brain, emotional, and what we would also call neurotic, there is clearly a role, and particularly you hold a worldview about how that can be managed or not managed *(Interview Psychiatrist 1)*

Ngangkari take a very strong view against the use of marijuana, and that's regardless of what we say. They personally have a very strong view against marijuana. They are so anti-marijuana because marijuana weakens the spirit and by weakening the spirit, it allows all the evil spirits to come in and take over. If someone smokes marijuana, even ngangkari cannot help you anymore. So they've been fantastic because we've been constantly telling people not to smoke marijuana because of the problems associated with it and the ngangkari really reinforce that from their own perspective and point of view *(Interview Psychiatrist 2)*

I've seen them working a lot with people who had been mentally disturbed, usually if someone is very upset about something and going off about it. I remember once a lady who wasn't from our community; she came on and she was really out of control

and talking rubbish and just off her head, really. The ngangkaṟi took her into a room and quitened her down; she left completely normal, she went off completely normal and I said to the ngangkaṟi "oh it's amazing, you fixed her" ... *(Interview Registered Nurse 3)*

In addition, ngangkaṟi can be specialized in the treatment of specific ailments or particular body areas; also, ngangkaṟi present different levels of specialization.

I only have been in the APY Lands and I don't know in other communities, but there are a number of people who act as ngangkaṟi... You know, it's just like in our system, some of those ngangkaṟi specializing in particular ailments, particular body areas. They get a reputation for curing particular kinds of things. But then you got a lot of other people who might do a bit of ngangkaṟi work, but don't really have much of a name for doing good work, I guess...ngangkaṟi are obviously of very varying quality (*Interview Medical Practitioner 1)*

I think they certainly recognize someone is better than others or some are better at specific things than others. They can specialize in specific areas *(Interview Registered Nurse 3)*

5.2.3.d Treatments

Ngangkaṟi interventions and treatment processes epitomize a concept of health and healing which differs from the western medical system.

It is also a bit of a social thing... people would all crowd around while the ngangkaṟi was working. I think to some extent it is legitimizing the fact they have an illness and everybody is concerned and we are all gathering around. I think that is part of the treatment having everyone around. The two main modes of treatment are massaging and pulling out an object, or sucking and spitting. The ngangkaṟi would do one or the other. Whether it was pulling an object out or spitting out the blood into a tobacco tin, it was passed around and everyone would comment. So it was very much a communal kind of thing. I think that was very much part of the whole healing process, getting this person recognition that they are sick and that we, as the community, are concerned *(Interview Medical Practitioner 2)*

Medical practitioners appreciate ngangkaṟi's treatments as potential alternative treatments to improve people's health. Limits of western treatments are discussed and a place for Aboriginal alternative responses to illnesses is acknowledged.

Whatever gets people better, as far as I am concerned it is a good thing. I have no problem with that, when it doesn't make them worse. Which happens of course, but I mean, we make people worse as well. You know...we often give people things that make them worse. Old people, for instance, I mean I see with people who are on lots of different medications as they get older, you stop the medications, and hey presto they get better! It's common in old people. One of the biggest causes of admissions to hospital in people as they get older is their medications: too many, or inappropriate, or wrong combination; get rid of that polypharmacy! Polypharmacy it's called. What happens is they end up with lots of different medications. If you get five or more medications in someone, after five I think there is a pretty good chance there is a significant interaction between them, which has an adverse effect... there is no doubt we do it as doctors.

So often I've seen old people that might be dizzy or something, they stop some medication and they start to get better. You know dizziness and falls, if they break their hips it's a pretty disastrous for an old person. So you know we do things that are not necessarily beneficial for people. Sometimes you do have to try, clinical trial is not the word but a trial, a therapeutic trial, 'cause there's not much alternative you know. We try and give someone an antibiotic but really it's a therapeutic trial, you hope you pick the right antibiotic for that particular organism. And sometimes people might get vomiting with the antibiotic you give them, that sort of stuff you know...*(Interview General Practitioner 3)*

Medical practitioners provide evidence of the existence of a team-based approach in managing patients' treatments in clinical settings. Ngangkaṟi's treatments are often provided in parallel with western medical treatments; other times they are propaedeutic to western medical care and treatments. In other cases, ngangkaṟi treatments can resolve physical or mental complaints either partially or completely.

If we are treating somebody, giving medical treatment, then often ngangkaṟi get involved

giving additional treatments at the same time. They are coming and we often let them give treatment and go out or just wait around and then continue after. So if someone is having a drip or antibiotics or something, ngangkari often come in and give treatment at the same time (*Interview General Practitioner 2)*

You might have lots of people that are unwell and at the basis of their illness is the belief that they might be guilt associated, the belief that they've done something culturally inappropriate. Or that they're being cursed, something put on them because they've done something wrong. And having the ngangkari come in and treat that that's lifted. So that feeling of guilt, that feeling that they've done something wrong is no longer there. And then their psychological attitude has changed and it then allows our medications to work a lot better. You can just imagine if someone for example got a depression or got a psychosis and they're stressed, and it might be for a number of different reasons, but it could be because they believe they've done something wrong, that's going to impact their illness. So if you can relieve that, it's going to make it a lot easier to treat them from our point of view. And it's also really a psychological sort of therapy. That's how I see it. So we are using medications so we're treating from a medication point of view but having the ngangkari come in it's almost treating it from a psychological point of view and that's how I see it and the two go hand in hand *(Interview Psychiatrist 2)*

It's taken that guilt out and then it's just that illness to take care of... *(Interview Aboriginal Mental Health Worker 1)*

They usually cooperate to help the person go on with medical treatment *(Interview General Practitioner 2)*

I have got one client at the moment who has nightmares, had nightmares for a long time and said there is someone in the house. He ended up going to Glenside and he was put on Risperdal Consta, it's a medication, it is injectable anti-psychotic medication. Anyway, he was seen by a ngangkari in the hospital so briefly his nightmares went away. He came back to Port Augusta, nightmares came back. We got the ngangkari to come so they took the stones away from him but it wasn't only just the person, when the ngangkari was there said "no, there is something in this house". They came back and spent the night in the grounds of the house and waited and cleared the house from anything that was there disturbing him. Well, he doesn't have any nightmares since. Now, we have to negotiate around this anti-psychotic injection. One they are in the system, gee it's hard to get them out *(Interview Mental Health Clinician 1)*

Spiritually it's a big thing. Once they get the spirit back and strengthened they're all aligned as well *(Interview Psychiatrist 2)*

5.2.4 Positive health outcomes for patients

Medical practitioners and health professionals provide evidence of a range of positive health outcomes for patients treated by ngangkari. The following extracts are only a small sample of cases reported during the interviews:

Last time I was there one of the elder men just happened to mention he was a ngangkari and that he helped two old men walk, which he had because they were walking and they hadn't been able to walk before and we didn't know why they were suddenly walking. They're both in their 80s these people – which is pretty rare – and one of them has got chronic lung disease and the other one's got really bad arthritis in his hips. They're not sort of walking around the community like everybody else can, but they're able to get up and walk around. One of them never actually wore any trousers because he was always sitting on the ground and he got down to sort of moving around on the ground. And he's taken to wearing trousers, which is very nice, I'm pleased about that! *(Interview Medical Practitioner 5)*

There are countless stories that I can give you, and the funny thing is that even kids who have no understanding of it, you have them with bad croup or asthma and the ngangkari saw them, the kids were relaxed and calmer; and it wasn't like an adult who might have been inculcated and say "oh the ngangkari can fix you", and you have the full psychosomatic effect coming. Even with kids that were too young to understand, the ngangkari did their bit and they were OK *(Interview Registered Nurse 4)*

It is amazing we had another Aboriginal

woman whose son was very, very sick. There were to fly the boy from here but she turned around and made the decision to take that boy to the Lands and get him seen by a ngangkaṟi. He was fixed just like that, and he was very sick, very sick. But she was panicking because she thought she was going to lose him. But she made that choice to take him to the homeland *(Interview CEO AHS8)*

I saw the positive effects of it and the fact is that in their traditional medicine they can set bones and had a root that's plaster; and there is spider nest that you have to take carefully there and wet that and put it on, burns are healed with no scar. So it's not just a psychosomatic element that we put importance on now, in their bush medicine they have answers for a lot of problems... *(Interview Registered Nurse 4)*

We had a non-Indigenous staff member working for us a few years ago and she had a bite wound on her foot and she's being using creams and so forth, but it just would not heal. I have been here previously for two years and her foot would flare up all the time constantly. When we had a ngangkaṟi down, they did some stuff to her foot and she never had any problem since...This made me think more about the ngangkaṟi practices, it's just amazing and after that first trip they went over to the hospital and they did the cleansing of the hospital, even the acting CEO she even mentioned, because I said "how did it go?" and she said "I can't believe it, it just feels really good. You feel a really good feeling in the hospital" *(Interview CEO AHS8)*

In mental health, evidence of positive health outcomes for patients treated by ngangkaṟi demonstrates the significant role ngangkaṟi play in providing a holistic and culturally appropriate health care to Aboriginal patients. Medical practitioners validate the complementary nature of ngangkaṟi's treatments and the viability of an effective two-way health care model,

...the two people we've got the ngangkaṟi to see got better. They improved markedly, the ngangkaṟi was in fact able to see somebody who I think would have exceeded dozens of hours of psychotherapy because of the particular family dynamics and issues; and he was able to resolve, it made a significant difference *(Interview Psychiatrist 1)*

...and we've had a lot of good outcomes...

There was one boy who had a psychotic depression: he'd stop eating and drinking. And they just didn't know what to do, they were giving him ECT,[20] they were giving him treatment but he just refused to eat and drink because he thought he'd basically been sung. So they got the ngangkaṟi in and they just said it was amazing the transformation. The next day he got up and started eating and drinking and he was fine (*Interview Psychiatrist 2*)

...I think most of the people we had here who they've either requested a ngangkaṟi or in the cases that we felt perhaps it was appropriate and we've suggested it, we've actually always been met by really positive response and they really wanted a ngangkaṟi *(Interview Psychiatrist 2)*

One person really strikes me in terms of just the difference in care. There was a middle-aged man who had schizophrenia...he was on a depo medication and injections to help with schizophrenia. The report from the health workers was that he was becoming more disturbed within the community and I guess the approach that the flying doctors took, which seemed pretty reasonable, was to increase the dose of his injection. We went back there later on and on my attachment and he was clearly markedly better. The conclusion that we drew from our western perspective was that obviously the increasing dose of the injection actually had done a good work. I got to know one of the health workers and the health worker had a clearly different explanation, including the input of a traditional healer, a ngangkaṟi during our absence. In actual fact another way of understanding this was that there had been interventions within the spirit world, and the community had recognized this. I think it may have been a transgression around traditional business and I don't know that for certain but there was obviously something happened that the traditional healer had become involved and the community's explanation wasn't that it was the increasing medication, it was that the traditional healer had become involved *(Interview Psychiatrist 1)*

You might have lots of people that are unwell and at the basis of their illness is the belief that they might be guilt associated, belief that they've done something culturally

20 ECT stands for Electro-Convulsive Therapy.

inappropriate. Or that they're being cursed, something put on them because they've done something wrong. And having the ngangkaṟi come in and treat that that's lifted. So that feeling of guilt, that feeling that they've done something wrong is no longer there. And then their psychological attitude has changed and it then allows our medications to work a lot better. You can just imagine if someone's for example got a depression or got a psychosis and they're stressed and it might be for a number of a different reasons, but it could be because they believe they've done something wrong, that's going to impact their illness so if you can relieve that, it's going to make it a lot easier to treat them from our point of view... So we are using medications so we're treating from a medication point of view but having the ngangkaṟi come in it's almost treating it from a psychological point of view and that's how I see it and the two go hand in hand. And the good outcomes that we've had, the guy that we had in 2007, he'd had a number of hospital admissions and ever since then he's never come back to hospital *(Interview Psychiatrist 2)*

I can tell you some of the outcomes of the patients I saw. There was a young man with psychosis with schizophrenia; I had seen him and he was on injections. They are often on community treatment orders where they are ordered to have injections for an illness. It seems to me that at least in the communities I have worked, the family decided that this person was unwell and they accepted the injections because it's needed. When I was asked to see this young man he couldn't sit on the chair. He was up and down; was he nervous about seeing me? But what he actually had was like akathisia, which is extreme restlessness which is a side effect of the medications, that's what I thought. He was on 400 milligrams, which is a relatively high dose. The problem being, the dilemma that I was given was that the community felt that he was becoming unwell again which I thought he had a side effect of the medication; the tendency would be that if he is becoming a little bit unwell the increaser of the medication would increase the side effect, so it is a bit of a dilemma: how do you actually manage this without actually compromising more the situation? So that's the discussion we had through the interpreter with the ngangkaṟi and we asked "would he be happy to see a ngangkaṟi? I was really unsure about what to do really, but anyway we had this chat and I had decided I will go back and have a look at this man's notes because he had this illness for over 10 years, I didn't have access to that and I thought I'd go back and see what worked or not worked. There was a month between visits, so I was going to see him in a month's time and do this work and go back to his GP because he does the prescribing; so I didn't want to make a decision on the day because I thought if I increase the dosage he's going to get worse, more side effects. He wasn't dangerous. The family could manage him but they wanted a way forward. So what I thought rather than jump in and do something, I'd get the background I needed and get back to the GP before his next injection is due in terms of what to do. So I looked at all the notes and what became clear is that he tended to get unwell around the same time of the year, which is not unusual, but it was just something that struck me and a lot of his admissions had been – and he had a lot of admissions – down to Adelaide around the same time of the year, which in retrospect becomes important not because of the illness but because of one of the causes of his distress. And again when I saw him a month later without changing anything, he could sit still. He still had some akathisia, that you still describe as restlessness but he wasn't that agitated that he couldn't sit still. He had seen a ngangkaṟi in between and you could see the outcome if he hadn't seen the traditional healer, because we may have increased the medications, and this may have caused the change, but we didn't – but he was sitting still. I didn't get to speak to the ngangkaṟi but what was really clear and what that young man was able to talk about was the fact that – and he didn't want to talk to me because I wasn't Aboriginal – he was still seen as a child within the community because he had never been initiated; he became unwell at the time that he was about to do the initiation, so he developed an illness, I think he had schizophrenia but he developed an illness at that time. He had actually gone out bush with the group and I don't know what happened, but clearly something happened, and so in addition to his illness every time

business was talked about in the community he would get increasingly anxious and we were interpreting that as an exacerbation of his illness as opposed to alternative explanations. My understanding was that he saw the ngangkari a couple of times and we didn't have to change his medications. And very interestingly the next time business came on, it didn't increase his agitation. So clearly what importantly happened was that he had contact with someone who actually knew what to do, that respected that level. So again it was very powerful. In that situation you have to argue that without access to traditional healers then the outcome for that person would have been markedly worse in the long term. This wasn't going away without being dealt with *(Interview Psychiatrist 1)*

...and there are a few others that come quickly to my mind, one of the older men who had a significant alcohol problem and really that was the main reason for him to see me; they were worried that the alcohol had affected his cognitive thinking and he looked a little bit depressed. He was very elderly, in taking his history he was clear that he was involved in a wrong marriage: he married someone from another group and this is a long time ago and clearly I couldn't fix that. I think it contributed to his use of alcohol and because of his health and his family, I said "why don't you try having a yarn to a traditional healer? Have you done that?" He hadn't and he did that and although couldn't stop his alcohol problem, he was markedly more settled *(Interview Psychiatrist 1)*

I know that when we had a client down at Glenside the psychiatrist acknowledged that this person was unwell but he wasn't psychotic. So he actually arranged for the ngangkari to go there. They got a ngangkari from the Lands to go down there and the ngangkari spent a couple of days there. Well, within a week that person was back to the community. So people are really respectful of ngangkari, especially the mob at Glenside. If there is any way that they can help the client by getting a ngangkari they'll do it; they are really really good down there *(Interview Aboriginal Health Worker 2)*

It was really interesting because I had low pain in my back, I had a lump and the ngangkari picked that up. He said "there is a lot of pain and it should get small"; it was really big, it lasted a while and over the last three to four years it got smaller. But they often do that as well, so I am not associating... but he focused on that. That was a personal thing *(Interview Psychiatrist 1)*

We see things change dramatically for the clients sometimes when they have seen a ngangkari. Somebody with grief and loss issues, for example, appearing very, very depressed. The sort of interacting with the western model of psychiatry that we provide and ngangkari is really good. In that case when I mentioned "oh, do you want to see a ngangkari?" There was no response, but once we got interaction with the family and the issue was brought up, just seeing the ngangkari made a big difference. Their intervention affects the change dramatically *(Interview Mental Health Worker 1)*

5.2.5 Significant contribution of ngangkari irrespective of personal belief systems and lack of explanatory models

Medical practitioners and health professionals recognise the important role of ngangkari irrespective of their personal belief system. They firmly assert their adherence to the scientific-based system of allopathic medicine and its grounding on rationality and evidence-based practice. They acknowledge the conceptual and practical divide between western allopathic medicine and Aboriginal traditional medicine, particularly in relation to medical responses to illnesses and treatment methods. The recognition of such a divide and the lack of an explanatory model to understand ngangkari's healing practices, however, do not dilute the unique role of ngangkari and their contribution to the provision of a holistic and quality health care.

I have a mechanistic approach to medicine. I come from an academic background and I have a very firm grounding in western medicine and a very firm grounding in science. I don't actually believe in healing of organic traditions by other than what I can read and learn in books. I am very mechanistic but I have to say that...I have actually found that collaboration with traditional healers and respecting the kind of

what they deliver is an incredibly important part of delivering the kind of medicine that I think needs to be delivered (*Interview Medical Practitioner 1*)

Quite frankly I don't believe in sticks and stones, but it doesn't actually matter because by the time the ngangkari has finished, if the patient thinks and is convinced that there has been something helpful done – and I know that the left kidney is where the money is – I can more easily provide medical care to the patient... My way of thinking about it is that illness, irrespective of what I think of the 'causation', has a psychological or psychosomatic element that unless the person is convinced that has been dealt with it is unlikely to resolve anyway (*Interview Medical Practitioner 1*)

I know there are a couple of healers in town at the moment, and so they're going to smoke some houses I think. I respect that, that's fine; I don't know how it works (*Interview Medical Practitioner 3*)

I think they fulfill a very important role and I certainly know from my own personal experience. I don't understand it but there is certainly value to it. It does work, and why it works I don't know *(Interview Registered Nurse 3)*

I can see that there's in Chinese medicine the benefits of various things like acupuncture which I think it's got a logical way of working by working on the nerves and things like that, so I can see that as a logical way of working. I would never sort of say, I would never ever go to a ngangkari to make myself better, never. Because I don't believe that it's a logical system. I have seen people coming and a ngangkari comes in and then pulls sticks or bones out of them which said has caused that. I don't believe that actually happens. I think he's got the stick in his hand and he just says he has pulled it out. And again I think there is a lot of things even in medicine that in the past have been based on sort of pure perceptions of how things work. So I don't have a lot of faith in most alternative medicine but I can see the advantages...mmm...well, for example I wouldn't even call them alternative if they worked; so for example I can see the obvious advantages of yoga, chiropractics and all this sort of thing. I don't see a lot of logic in the ngangkari system, that's just my view. Having said that, if people think that it works then it does work. If people ask me to see a ngangkari in the clinic, I will get them a ngangkari. Yes, I'm always happy to facilitate that...*(Interview Registered Nurse 2)*

I find it quite a fascinating area and often I find fascinating when they are often considered good at working even when they are quite young as they're still learning. Ngangkari recognize straight away they are ngangkari from very early even sometimes when they are first born, they see something special, and often there will be seven year old kids who are already treating people. I have seen it a couple of times and I know some of them are really good...I don't understand that *(Interview Registered Nurse 3)*

We've got an understanding of western medicine and I don't understand what ngangkari do but I have a great deal of respect for what is important in their culture so I just step back and let them do whatever it is *(Interview Registered Nurse 1)*

I sort of see ngangkari as pretty much the same as the alternative care system in our society, which I think has got its place but I am not too sure...definitely, I am sure it's got its place because basically if people believe something has made them better, I don't care how that happens as long as they're better. If they don't believe that it's our medicine, but they believe it's ngangkari medicine, well fine, as long as they are better it's fine *(Interview Registered Nurse 2)*

They are different systems but I don't see why you cannot work together (*Interview General Practitioner 3*)

The lack of an explanatory model regarding ngangkari's healing practices lies at the core of the divide between western medicine and Aboriginal traditional medicine. Medical and health practitioners cannot refer to any western science-based explanatory model to grasp the conceptual underpinnings and methods used by ngangkari in their consultation, diagnosis and treatment processes.

I am not quite sure, I don't really have the word to describe it. I think in a way it's validating an illness or a feeling that the patient has in a context that it is appropriate for the patient and it is dealing with it in

a mechanistic and spiritual way, which the patient believes in. I think that it is important (*Interview Medical Practitioner 1*)

I don't really think there is a full comprehensive understanding of the circulative system, for example. I mean, I think of these things that are removed as symbols and I certainly know, obviously I have seen those things being removed, I have seen them stored and some ngangkari carry around with them. So I don't know if individuals know that or whether they really believe that the thing that appears out really comes from inside or whether they know that they are symbolic...I don't know. We often do get requests from patients to have X-rays. That's something that has only really been the case only maybe in the last 10 years where patients would be, I think there would be an unusual illness, which I think can be a psychosomatic or mental illness of some kind which the root of, the person believes, has been caused by another person, that somebody has put something inside and that's causing the illness this way. We often receive requests of X-ray to see whether there is a stick or a stone inside that is causing the problem but again I don't know, I don't know how firmly people believe that or it is a bit of a guess, or an attempt to figure out what's wrong with you... I am not sure (*Interview Medical Practitioner 1*)

I think of them as things that symbolize illness, I don't think of them as the mechanistic cause of illness. Now, I am not sure but I think that individuals actually believe them as the mechanistic cause...I think they are symbols of illness or bad spirits that are being removed. This is what I think (*Interview Medical Practitioner 1*)

Whether it's just symbolism or firm belief that stone in the liver was causing the trouble, I've never worked out. But I've seen them do it (*Interview Medical Practitioner 4*)

...one of the elder men just happened to mention he was a ngangkari and that he helped two old men walk, which he had because they were walking and they hadn't been able to walk before and we didn't know why they were suddenly walking *(Interview Medical Practitioner 5)*

Sometimes I've heard people say that they leave the window open, so they [ngangkari] come back in spiritual form and fix them, but you know I haven't really, I don't know...I only know what I have seen *(Interview Registered Nurse 3)*

I try to make it look not too obvious that I am watching what they are doing but it seems like it is just a bit of *hocus pocus* over the body. They mutter some words or perhaps it's like they are saying a prayer of some sort. In our community they tend to have a Christian background as well, it might be combined with some spiritual healing as well. So that is my understanding... *(Interview Registered Nurse 1)*

Blockages are things that people talk about, I don't know whether that's just the way to explain it to people who don't know the language but the idea of blood being blocked and not getting to where it's supposed to be, it's something that the ngangkari do talk about but I don't know if it is just a way of explaining something to me (*Interview Medical Practitioner 1*)

5.2.6 Issues in doctor-ngangkari relationship: disagreements, tensions and adverse events

Medical practitioners do not indicate any insurmountable problem in their relationship with ngangkari both in primary and mental health care settings. Tensions or disagreements may arise in cases where medical practitioners' diagnosis or medical response conflicts with the ngangkari's assessment. However, no instances are reported whereby differing perspectives have compromised or adversely affected their relationship. Importantly, medical practitioners indicate that no adverse events have ever occurred as a result of ngangkari interventions.

Sometimes I had people I disagreed with, but no, I have never encountered problems *(Interview Medical Practitioner 1)*

There may be conflicts at times, but you work that out, there's always, most of the time, there is a position you can come to... *(Interview General Practitioner 3)*

It's not common to be an adverse event. The sort of adverse events that occur are, someone says: "I'm not going to let my kid go to town with pneumonia because, I think, I don't want to go", or "I can't go into town, because I don't think they're sick enough", and they might ask to see a ngangkari, but

it's not usually the ngangkari that slows the process...I can't think of any experience where a ngangkari says: "you should ignore the doctor's advice, you should do this". I can't think of that ever happening. It's never happened to me. Usually, they don't give that sort of advice. So, if there's an adverse outcome, it's usually the patient or the parent, rather than the ngangkari that cause that. That's what I think anyway *(Interview Medical Practitioner 3)*

I don't think, no...I've been working with ngangkari since 1995 when I was working in Western Australia, and since then I've never had any problem in the clinics or with patients...*(Interview Mental Health Worker 1)*

We rarely had trouble. Sometimes something might happen when we think there is a big medical response, a big medical problem that needs to be managed. Just sometimes ngangkari may have a different opinion and that can be very difficult because I think the person will generally want to have the ngangkari support to take their advice and if that is conflicting, then that can be a problem. But we only had one major conflict and was quite civilized anyway. There was a young girl with a big mass. We were saying that big lump was dangerous, it was an aneurysm, the blood vessel was coming up and going to burst. Ngangkari felt that was snake's eggs that would be treated, that was put there by a powerful person, he would treat it and would go away. We couldn't see that that was going to be the right answer for that person we talked to him and said "look, if you are going to tell her that she is going to stay here and get better, we think it's a big problem. You should tell her that she should go to the hospital, and they do a big operation. And he said: "all right, ok". And he went back and told her that she should go to the hospital *(Interview General Practitioner 2)*

We use ngangkari now quite regularly and we have never had any problems apart from one time when a family indicated that they had their own ngangkari they wanted to bring in and this ngangkari basically was very anti our medications. So we just sat down with this person beforehand, the ngangkari, and we explained what was happening and the fact that we really wanted to work together but the person did need to take medications and so we just said you're free to do what you want to do but we would ask that you not advise them not to take their medications because if we work together, the person is going to be getting the benefits of not only white man medicine but also the benefits of Aboriginal way and spiritual healing and it's going to be a much more powerful treatment. And that person was incredibly reasonable once they knew what we were getting at and the fact that we certainly did not want to tell them what to do but if we work together, it's actually going to be a much better outcome. We were worried that we were going to be met by hostility but they were incredibly reasonable and that turned out to be positive as well. That was the only time we had any possible problems. Ever since then though all the ngangkari had done their work and have always reinforced, they actually reinforce the importance of working together, having white man way plus Aboriginal way together, and they've also indicated they're very keen for us to be able to do lots of things together and work together. So we've had a lot of success with the ngangkari (*Interview Psychiatrist 2)*

In terms of tensions arising from interactions between doctors and ngangkari in clinical settings, interview data report very few cases. Tensions with clinical staff usually arise in three instances. Tensions can relate to the intervention of ngangkari within a mainstream health care service and the potential liability issues in case of adverse events. Instances of tensions with clinical staff may also occur when the clinical staff are not aware of the role of ngangkari within mainstream health settings. This can happen when new staff are introduced in the workplace with no cultural awareness training or with a limited exposure to ngangkari interventions within clinical settings. At times, tensions arise between clinical staff and patients of their families when a ngangkari from a different community or area is requested to deal with specific complaints or difficult cases. The inability to provide the requested ngangkari can at times create some tensions with medical staff,

...the first time we got a ngangkari in there was a lot of concerns from a lot of people, from a number of the medical staff because they were worried about medical/legal problems and what if there was a negative

outcome and where would we stand in the Coroner's court if something bad happened (*Interview Psychiatrist 2)*

I never had any problem in the clinic. There might be a problem if people don't know who they are. If the staff is unaware of who they are and what they are doing there, they might create some difficulty, just because they don't know that they are there and what they are doing or may not believe in it. It may then be difficult for them to do that, but generally as I said most of the time if it's not happening in the clinic, it's happening out in the community. They either see the ngangkari before they come to the clinic or after being to the clinic. I haven't seen any problems. But when you have changes of staff and you have new staff they are not always aware of who people are and how they fit in and what they do. There might be some misunderstanding occur because of that. The only negative thing I've found for ngangkari is that they are so tired, as they work so hard. I have them often say to me "I am so tired, I have been working so hard" *(Interview Registered Nurse 3)*

We got to work with them, yes working with them, not this is what we do and this is what you do and this stuck up business of mine is better than yours type of thing. If you could get western practitioners and ngangkari working together then it would marry the two medicines together beautifully. ... *(Interview Registered Nurse 5)*

The other problem we have is sometimes they will get sick, they get something. Maybe we think it's a medical problem; sometimes they say "oh, there is one ngangkari very powerful, but he is in WA, we've got to go there and get him, you've got to give us petrol, car to go and get him, 300 miles away. And we say "the ngangkari is here ..." Often they – that's a bit of an exaggeration – often they want to get somebody they can see for a specific problem. They say "there is a person, but it is somebody a long way away, we got to go and get him". That's a problem sometimes but mostly for ordinary problems, it's ngangkari in the community *(Interview General Practitioner 2)*

5.3 Ngangkari-patient relationship

The ngangkari-patient relationship stands at the core of the tri-party doctor-ngangkari-patient interface. Ngangkari are highly respected and trusted in Aboriginal communities and people consult them on a regular basis before, during or after medical practitioners' interventions.

> I had found and I still find that people in Aboriginal communities, they usually come to people like me after they tried lots of other things anyway and part of that would be trying and trying and trying what works. Ngangkari generally is just as part of a daily activity...certainly in Aboriginal communities, they always see ngangkari... (*Interview Medical Practitioner 1*)
>
> They have to be very traditional to be respected as ngangkari and so they have to be still doing culture and that sort of stuff (*Interview Medical Practitioner 4*)
>
> Ngangkari are people who are well respected and who people consult very often *(Interview Medical Practitioner 1*)
>
> ...people do see ngangkari a lot. They will go and see them themselves *(Mental Health Worker 1)*

The ngangkari-patient relationship provides a critical bridge between Aboriginal patients and mainstream medical practitioners. Ngangkari function as an important link between Aboriginal patients and western health practitioners in three interrelated ways: they embody the explanatory model of illness causation and treatment response engrained in the Aboriginal health belief system; they facilitate Aboriginal patients' understanding of their health conditions and the need to access western medicine when necessary; they contribute to fostering Aboriginal patients' trust in western medicine and their compliance with medical treatments.

5.3.1 Aboriginal health belief system

Aboriginal traditional healers are at the core of the health belief system that underlines Aboriginal traditional medicine. Ngangkari interventions in mainstream clinical settings satisfy Aboriginal patients' health belief systems and complement the science-based bio-medical model.

> People would consult a ngangkari first as part of a mechanistic idea in Aboriginal health that many things happen to people because, for example, the headache may have occurred

because a person put some kind of spell on them. Get the ngangkaṟi to deal with that mechanistic intervention *(Interview Medical Practitioner 1)*

How does a ngangkaṟi heal? Well, they can name the problem, they hold the same worldview, they are talking the same language. They then have a way of actually dealing with it, which is understood by the person that you are interacting with, which then come to a plan or whatever intervention that the person understands because it is within a context...*(Interview Psychiatrist 1)*

Often there's some sort of an interpretation of that. Might be some transgression of some cultural law or someone inflicting this on them from outside *(Interview Medical Practitioner 3)*

To me it helps the patient. If we are truly practicing holistic medicine we have to take into consideration their spiritual beliefs. So to be a good practitioner you need a good understanding of your own medicine and practice and an understanding that for particular clients they need to have this spiritual aspect to be respected *(Interview Registered Nurse 1)*

You might have lots of people that are unwell and at the basis of their illness is the belief that they might be guilt associated, the belief that they've done something culturally inappropriate. Or that they're being cursed, something put on them because they've done something wrong. And having the ngangkaṟi come in and treat that that's lifted. So that feeling of guilt, that feeling that they've done something wrong is no longer there. And then their psychological attitude has changed and it then allows our medications to work a lot better *(Interview Psychiatrist 2)*

They're very holistic. So for example, their belief systems about frogs and sticks and that sort of thing being stuck inside and all that sort of stuff and also just to do with other family members, what they are doing, when someone becomes sick, an uncle might be misbehaving in Ceduna and that's why the daughter gets sick in Yalata. It's holistic. I don't pretend to understand it in detail, just what I've picked up. And certainly there's some symbolism, like they might sort of knead in the belly like that and have a bit of kangaroo liver or a stone and produce it as evidence that was in theirs. The other side of it is that, like social work in a way, they will spend time firstly understanding the family anyway, usually they know who's related to whom and that sort of stuff. And secondly, they will talk in detail about what's happening in the family. So there's that sort of bond and so forth. There is some sort of uplifting... *(Interview Medical Practitioner 4)*

... it explains their understanding of their illness. So there's a lot of literature on people describing their spirit being weak or losing their spirit...*(Interview Mental Health Worker 1)*

What Aṉangu value western medicine for is we are good at the symptomatic relief, we can stop the pain and fix the symptoms but the acknowledgment of fixing the illness is still the ngangkaṟi... The acknowledgment of healing is still the ngangkaṟi and I think that's important. The fact is that we are good at fixing the symptoms, we don't fix the illness... *(Interview Registered Nurse 4)*

5.3.2 Trust in western medicine and compliance with medical treatments

Ngangkaṟi interventions can significantly enhance Aboriginal patients' trust in western medicine and western practitioners' medical care. The ngangkaṟi-patient relationship and the fulfilment of Aboriginal patients' health belief systems constitute an important aspect of a holistic two-way health care model. Ngangkaṟi interventions not only provide a culturally embedded response to Aboriginal patients' complaints and illnesses, but they can pave the way to western medical practitioners' delivery of health care with the full cooperation of patients and their families. Ngangkaṟi constitute an indispensable bridge between Aboriginal patients and western health practitioners. They act as mediators between western health professionals and patients so that their interventions enhance Aboriginal patients' trust in western medical care and their compliance with western medical advice and treatment.

Form my point of view, ngangkaṟi interventions become quite helpful because the ngangkaṟi said "I fix this problem and now the doctor can do something too, the doctor needs to do something too". It makes a difference, it makes a huge difference because you've got someone who is confident about what he has found, he is confident about what he has done, you are confident

and you can go on with the cooperation of the patient *(Interview Medical Practitioner 1)*

It is just an acceptance that the ngangkaṟi is there and said that it is ok to go given their permission and it is just like a bridging. I guess. It just validates our need to take the person into a further level of care. And for the client having the ngangkaṟi doing their bit and then they feel they can trust us to take them further. It is a bridging of cultures and respect. And I think the ngangkaṟi respect us to allow us to do our thing first. So if we show that mutual respect I think it's a good relationship *(Interview Registered Nurse 1)*

When you get that trust back, you know, sometimes especially on the Lands and remote areas they've lost that trust in the system. [We're] slowly getting it back. If we respect the culture of the clients and the ngangkaṟi when they come in, the whole process of health care is improved...*(Interview Psychiatrist 2)*

...having a ngangkaṟi on the side has been really helpful 'cause of their manners, especially if they're really quite psychotic, they listen to the ngangkaṟi, they do what they say *(Interview Medical Practitioners 5)*

So just to say, we've got a 23-bed unit and historically 14% inpatients were Aboriginal. Whereas if you have a look now, our percentage of patients that would be Aboriginal would be 25% or 26% now. It's really increased. They're a lot more willing: we also do telemeds and in 2009 we did six, and now we're doing well over a hundred. People are just more willing to engage with us because they know we have Aboriginal staff, which certainly speaks a lot, they know if they come here they've got access to Aboriginal staff, but also the fact that they know that if they say "we want a ngangkaṟi", we're not going to say "sorry what's that?" Do you know what I mean? We have an understanding, we embrace it and if needed we facilitate it as well *(Interview Psychiatrist 2)*

5.3.3 Calming effects on patients

Medical and health practitioners underline the significant role ngangkaṟi play in settling patients down, especially in critical and difficult situations. Their interventions can be decisive to create or maintain a calm environment within the clinical setting so as to allow western medical practitioners to progress in the delivery of health care.

They have a very calming kind of effect on patients; they settle them in their anxiety and I guess because they feel so competent in what they are doing, often they are often happy to talk to people like me who are just observing *(Interview Medical Practitioner 1)*

Ngangkaṟi are very useful when having difficulty settling someone who is psychotic; having a ngangkaṟi on the side has been really helpful, especially if they're really quite psychotic, they listen to the ngangkaṟi, they do what they say *(Interview Medical practitioner 5)*

I remember...an older lady...was brought into the clinic one evening pretty sick, she looked pretty sick, she was febrile and had abdominal pain. We were struggling again because we couldn't talk very well with her, couldn't talk very well with the people who were with her, and everybody was really frightened because she really looked like she was going to die. Fortunately one of the ngangkaṟi came in to see her and I have learnt by that time that whenever I thought things were really bad, it was always really important to let them do what they had to do. I learnt that no matter how anxious you were about a patient, no matter how close to death you thought they were and how quickly your intervention was needed, it is always better to stand back and let a ngangkaṟi see the patient if it is all possible; because you can actually learn from this particular care and I subsequently done it on numerous occasions. You can actually watch what the ngangkaṟi did. The ngangkaṟi would immediately, almost immediately settle the patient down. So the fact that there was someone there that the patient trusted was really important. Ngangkaṟi could settle the relatives down so a lot of their anxiety would go and it did in this case, and then you could watch how the ngangkaṟi operated... It makes a difference, it makes a huge difference... your examination might be quite useless because the person is so anxious *(Interview Medical Practitioner 1)*

The ability of ngangkaṟi to not just deal with physical illness but to try give people a sense of mental ease, I think that is probably the most important thing that some of the ngangkaṟi do really...I think that giving assurance and the calming effects that ngangkaṟi can have on people even

with things that I classify as being absolutely of physical nature can be quite important because the patient's mind is generally in a frame where you can deal with that. It is really important I think. So...no matter how anxious I am, I generally just stand back if there is a ngangkari there that the patient trusts and wait to see what they find (*Interview Medical Practitioner 1*)

Other times I was privileged to be able to stay in a room while they were working on somebody and in certain ways it seemed to give the patient a lot of relief and very happy with what they are doing *(Interview Registered Nurse 3)*

It's a very...most people find it very soothing and calming. So, you do see some really interesting results from that *(Interview Mental Health Worker 1)*

It gives that peace of mind to that particular sick person too *(Interview Registered Nurse 2)*

It can also help in the fact that it helps to settle and calm and helps them spiritually and culturally *(Interview Aboriginal Mental Health Coordinator 1)*

5.3.4 Psychosomatic effects

Medical practitioners consider very important the psychosomatic effects that ngangkari interventions can have on patients,

...Illness, irrespective of what I think of the causation, has a psychological or psychosomatic element that unless the person is convinced that has been dealt with, it is unlikely to resolve anyway *(Interview Medical Practitioner 1)*

I come from a mental health perspective and clearly some of the areas of medicine that traditional healers (probably they've got some of the greatest inputs) would be what we call psychosomatic, where people present physical issues which have got a non physical cause; and in these cases a range of interventions potentially will be helpful, particularly when it's consistent with someone's beliefs about causations of symptoms or distress. And if that's a traditional healer, well there is a significant role for them potentially (*Interview Psychiatrist 1*)

I can see as logical with ngangkari that if you believe they're helping to get better, they may well do...if people think it works, then fine it does work; if you think it works then it does work. It's not even that maybe works, it does work because if people think that something is helping making them better, that makes them feel better and therefore their body reacts better to whatever illness they've got. You always react to get better in a stronger way if you are actually thinking that you're going to get better. If something makes you think that you are going to get better, then it does work *(Interview Registered Nurse 2)*

...if the patient thinks and is convinced that there has been something helpful done – and I know that the left kidney is where the money is – I can more easily provide medical care to the patient... (*Interview Medical Practitioner 1*)

My perspective on the power of the mind is that if someone believes that they're going to be better, they will *(Interview Registered Nurse 1)*

5.3.5 Duty of care

Health practitioners indicate how duty of care is the primary focus of ngangkari interventions. Ngangkari's diagnosis and treatment options are carefully pondered to provide patients with the most appropriate medical advice. This can include traditional healing treatments, referral to western medical practitioners, or a combination of traditional and western treatments.

Ngangkari intervention is always for the best of the patient... yes, it's absolutely duty of care, what's best for the patient because the patient believes that it's going to help, and it does *(Interview Medical Practitioner 1)*

They know that there are certainly many aspects to that person's illness that they can't deal with, but there are certainly some aspects of their illness that they can deal with. Thinking about the case of that boy with a boil on his neck, that's an example where ngangkari could pretend that he could fix that, but in the end you think what this person needed was some medicine and an operation. He could deal with making that little boy feel better, and he could deal with making the family feel better, but in the end what the kid needed was an operation and some antibiotics *(Interview Medical Practitioner 1)*

Most of the better ngangkari are quite pragmatic about what contribution they think

you can provide to actually care for the patients. It is very rare where you have a ngangkaṟi who would in a critical situation say "I don't think you should help this patient". I don't think that ever happened. They are a bit like me, you know, in the way I am talking to you now *(Interview Medical Practitioner 1)*

I think the thing about good ngangkaṟi is that they are smart, and they actually don't want people to die *(Interview Medical Practitioner 1)*

5.4 Doctor-patient relationship

The doctor-patient relationship is central in the functioning of any health care system. The understanding of this relationship and its dynamics is particularly important in the context of Aboriginal health. This section discusses what are some of the problematic issues characterising the western doctor-Aboriginal patient relationship and how the inclusion of ngangkaṟi in the delivery of two-way health care contributes to improve the relationship between mainstream health practitioners and Aboriginal patients.

5.4.1 Communication and language barriers

The doctor-patient relationship can be problematic due to language barriers and difficulties in communicating health-related information, particularly to traditional and elderly Aboriginal patients.

Whitefella medicine is not easily understood by traditional Aboriginal people, especially amongst old people. I remember I had this lady with TB in one of the communities and to treat tuberculosis is six months of often toxic antibiotics. And to sort of comply with that in the bush is very difficult, and this lady was old. Anyway, she completed the medication regime for six months. And then I said to her, "You know, I found another patient with TB in the community", and she said "black and white or color?" She thought I meant TV. It still hadn't sunk in. So it's not easy. I mean, old people... It doesn't matter what color you are. Old people develop their ways and get set in their ways *(Interview Medical Practitioners 4)*

Ngangkaṟi's interpretation is different to ours. If he sees something in someone's stomach or back he explains it like a blood clot: it is

a big black thing, the blood goes round and round but is not getting through the area, so it builds up and causes a clot and a lot of health problems. So that is what he is getting rid of *(Senior Project Officer 1-NAO3)*

5.4.2 Clash of worldviews

A clash of worldviews in terms of health belief systems is often at the basis of poor communication and understanding between western health practitioners and Aboriginal patients. The reciprocal lack of understanding can have significant impacts on patients' response and acceptance to western medical advice and treatment, which can ultimately impact on Aboriginal patients' short and long term health outcomes.

We find a lot of people are misdiagnosed when they are hearing supposedly auditory hallucinations. An Aboriginal person who has recently lost a family member, it's perfectly normal for them to hear the voice of the person who has passed away, but it can be distressing with a lot of other things that are going on. So they present to a mainstream doctor, "I am hearing the voice of my cousin." Bang they are on Risperdal Consta before they are out of the door, without any thought of what the cosmology is, of what is normal for that society. We impose our mainstream view and it's not right (*Interview Mental Health Clinician 1)*

At the Women's and Children's hospital, a young burns patient was in there from a traditional Aboriginal community. And the parents had wanted a ngangkari to come in; the young person was stressed, there were other things happening in that child's life and the family wanted a ngangkari there but the doctor said no because when he inquired as to what the ngangkari might do, the mother and father said the ngangkari, a traditional healer, will be doing some rubbing, rub down, and the doctor said "no way, he's a burns victim. There's no way I'm letting you touch him". "But we're the parents" they said and the doctor [said] "Not as long as you're in my hospital, you won't be having ngangkari touch someone who is a burns victim". So that was a clash of two different medicines and I think maybe the ngangkari would have seen and said I can't touch you, but I can do work up here. That was an example of where there was no dialogue, the doctor just said no, there was no room for discussion and this whole aspect of credentialing, our western doctors, they wouldn't even consider giving credentials to our ngangkari (*Interview Senior Administrator 3*)

So I guess as a young medical student there was a totally different explanation for someone getting well, so it made me think about it and I guess in that context also we had a way of classifying illness and clearly the local health workers had a quite markedly different explanation for illnesses including natural causes and also that sort of external attribution for disease which would then be in the spirit realm and sorcery, pay back, all those sort of things, which I think were probably much more relevant 30 years ago when I am talking about than perhaps are now. But clearly they are still important, they are obviously embedded within their culture, within the frameworks and within relationships in terms of how the kinship networks and so forth work. So it was very important I guess in my early career to actually see that there were different explanations and different ways of thinking about things, including the use of traditional healers *(Interview Psychiatrist 1)*

Well, given the worldview of white society Aboriginal society is totally different, the cosmology is totally different. So what we've got at the moment it's a mainstream system trying to box the cosmology of Aboriginal people without any thought for the spiritual aspect where Aboriginal people come from *(Interview Mental Health Clinician 1)*

5.4.3 Health professional training and development

Medical and health practitioners underline the significance for western health professionals to gain a thorough understanding of the role of ngangkari, how they work, what contribution they can make and how they can relate to western health practitioners in health care settings.

I think that there needs to be at the level of all training programs in health like in medical school, for people learning allied health professions, for nursing; there needs to be a regular component dedicated to, not Aboriginal history *per se*, but Aboriginal culture and working with Aboriginal people.

I think it's an absolute joke that people can do a two-day cultural awareness course and tick a box and say "yup, they've done everything they need to do". I think it's actually offensive, yeah, I find that very offensive. Even in medical school, there should be a component there *(Interview Psychiatrist 2)*

We'll need some educators. The health professionals, the whitefella health professionals need educating about what ngangkaṟi do, what sort of situations we would ask for a ngangkaṟi, how we would approach one, what to say, how you address one, their last name... All of those things, what is a culturally respectful way of doing this. But also what situations they would be useful in, and to start thinking about what sort of things we can help the people to get better with *(Interview Medical Practitioner 5)*

What they've got to do is get rid of their prejudices, and willing to learn. I mean I would give my eye teeth to be able to go for six months with these people and learn their stuff because they can not only fix their own people they can fix white people as well *(Interview Registered Nurse 5)*

I have been told to be very careful around ngangkaṟi, not to go into a room unannounced, always check with them if I could go in because it was very easy to pick up sicknesses from them if you sort of took them unaware, so you have to be very careful about that. I think it's important that new staff are oriented towards that and Nganampa does have an orientation program so we certainly make all our staff aware that there are traditional healers. Nganampa's policy is to allow people to see traditional healers in the clinic and we make them available. So we include it in our orientation and I guess it's important to know about them. A lot of organizations on the Lands don't have an orientation program for this stuff so maybe making sure that new staff are oriented to the Lands and how things work on the Lands. I think it's very important and making people aware of ngangkaṟi *(Interview Registered Nurse 3)*

The more you learn, in my case – I'm not Aboriginal – but the more I learn the more I realize that I don't know. That's what happens. So I think education is the key. Once people are educated as well, and you know, people are aware of what options are available and they can then say "ok, well this could be a cultural issue". And I think as well, the importance of employing Aboriginal staff in health services: that is vital, I mean, we couldn't function here without them. Really, there's not way we could function without them *(Interview Psychiatrist 2)*

Education and training programs on the role of ngangkaṟi are also recommended for Aboriginal health professionals. The idea that all Aboriginal health professionals have an understanding and first hand experience in working alongside ngangkaṟi is a biased assumption.

I think a lot of people assume that because you are Aboriginal you know who a ngangkaṟi is but not everyone knows, not everyone has been exposed to that type of life. You might struggle a bit here, it could benefit people who've gone to Court but not all I believe, not all people understand *(Interview Aboriginal Health Worker 2)*

I remember meeting an Aboriginal worker at Royal Adelaide who really had very little idea about how Aboriginal people in the Lands or the central part of Australia lived; and had very little attachment to cultural issues and little understanding, because you've grown up in a westernized sort of way. It's a false belief to think that a lot of Aboriginal workers have automatically that knowledge *(Interview Psychiatrist 2)*

...you never ever stop learning. You can always be learning about Aboriginal culture. We still haven't got the basics right and the basics are education and employing Aboriginal people. Even clients in all the other wards around on the campus will say "oh, I wish we had workers like you guys!" I'm learning all the time as well. Even though I'm Aboriginal, I'm still learning. You never stop learning. You always be learning 'til the day we pass away *(Interview Aboriginal Health Worker 1)*

It should be a mix of white man education and their education. They need to be taught their own culture because it is really beautiful culture that they have got *(Interview Registered Nurse 5)*

Training modules for non-Aboriginal and Aboriginal health professionals are highly recommended as a way to bridge the knowledge gap between two different medical

knowledge systems, that is western medicine and Aboriginal traditional medicine. A better understanding of Aboriginal traditional medicine can contribute to close the 'communication gap' between doctors and patients, and ultimately have positive impacts on Aboriginal patients' health journey.

5.4.4 Community participation and respect for Aboriginal culture

The doctor-patient relationship can benefit from the inclusion of ngangkari in the provision of health care to Aboriginal patients in mainstream health care settings. The collaborative team-based approach that characterises the doctor-ngangkari relationship contributes to enhance community participation in mainstream health service providers. Findings indicate that the provision of a two-way health care model does demonstrate respect for Aboriginal culture and worldview. In turn, more culturally sensitive health care settings can have positive impacts on the relationship between western health professionals and Aboriginal patients.

> I think as well having our working with ngangkari, it shows a lot to Aboriginal people and Aboriginal communities we are actually embracing Aboriginal culture. As a result of that, a lot of people are willing now to engage with our services *(Interview Psychiatrist 2)*

> My feeling is that we were certainly always very appreciated, that we were working together, there was no question that people wanted that and saw that as being good. I think that people appreciated what western medicine had to offer...I was doing part of what people wanted and he [the ngangkari] was doing the other part *(Interview Medical Practitioner 2)*

> I was pretty keen for any help I could get really, and in the kind of setting that I worked I was much part of the community not somebody coming in from outside to the service, but I actually lived there. So, there was certainly an expectation from the members of the community that people who were living and working there fitted with the community, you couldn't really not fit in (*Interview Medical Practitioner 1*)

> ... you can say that if ngangkari go to the clinic, there's some sort of engagement of the health service with the community. I used to believe in that a lot more than I do now; anyway, maybe that's an advantage... (*Interview Medical Practitioner 3*)

> It's the matter of keeping the culture strong. If you talk about physical health, it's not going to happen unless you've got mental and societal health or community health; that's very much a part of being healthy as an individual, so you need them *(Interview Registered Nurse 4)*

5.5 Conclusion: a two-way health care model

The analysis of the doctor-ngangkari-patient tri-party relationship provides evidence of an embryonic two-way health care model whereby Aboriginal traditional medicine is provided in parallel with western allopathic medicine. Despite the lack of a formal recognition of Aboriginal traditional medicine and Aboriginal traditional healers in the South Australian health care system there exists a de facto recognition of the significant role of Aboriginal traditional medicine and Aboriginal traditional healers in the delivery of health care to Aboriginal people.

> We're working in parallel and it's not formalised in this way...clearly from my point of view we need to work together *(Interview Psychiatrist 3)*

> The two go hand in hand *(Interview Psychiatrist 2)*

> Ngangkari have always reinforced, they actually reinforce the importance of working together, having white man way plus Aboriginal way together, and they've also indicated they're very keen for us to be able to do lots of things together and work together. So we've had a lot of success with the ngangkari *(Interview Psychiatrist 2)*

> They are the sort of specialist healers, they are the healers with special skills, with the supernatural or other phenomenon *(Interview Psychiatrist 1)*

> We see things change dramatically for the clients sometimes when they have seen a ngangkari *(Interview Mental Health Worker 1)*

> We've seen that happen a lot [ngangkari bringing the patients' spirit back]. And they get the person stronger, changing the medications and that. So I think from a psychological perspective, it's a great benefit. You know, healing people that are scared and

We see things change dramatically for the clients sometimes when they have seen a ngangkaṟi

helping them to access whatever services they need *(Interview Mental Health Worker 1)*

I think we could go a hell of a way to get these people better managed healthwise and I think personally there is a huge place for them [ngangkaṟi] *(Interview Registered Nurse 5)*

They are practitioners in their own right *(Interview Registered Nurse 6)*

Ngangkaṟi are proven work for thousands of years and I have seen amazing stuff for 20 years I have been in the Lands *(Interview Registered Nurse 4)*

I think most of the people we had here who've either requested a ngangkaṟi or in the cases that we felt, perhaps, it was appropriate and we've suggested it, we've actually always been met by really positive response and they've really wanted a ngangkaṟi...and we use ngangkaṟi now quite regularly *(Interview Psychiatrist 2)*

I know some ngangkaṟi feel they are undervalued, their work is not valued properly *(Interview General Practitioner 3)*

I certainly encourage it if there's one around because you're matching a belief system and a lot of traditional people find it really strange being in hospital *(Interview Medical Practitioner 4)*

Ngangkaṟi are part of this community, they are coming and helping. It is good for us because if we've got a patient in the clinic, often it may be 10 o'clock at night, so the patient in the clinic and everybody is upset, ngangkaṟi can come in and give one a treatment and feel better: it helps us a lot *(Interview Medical Practitioner 2)*

I think ngangkaṟi it's one of the positive strengths of the community the way they function now... *(Interview General Practitioner 2)*

They usually cooperate to help the person go on with medical treatment...they've got usually a quite good relationship with the clinic and the clinic staff. They don't act in competition, but in a more cooperative way (*Interview Medical Practitioner 1*)

Some people go both ways (*Interview Medical Practitioner 4*)

I think it is smart to have it a bit each way; it is smart to have it each way and it is likely to be helpful (*Interview Medical Practitioner 1*)

Interview data demonstrate how the delivery of western allopathic medicine is pivotal to ensure the provision of quality health care in Aboriginal communities. Yet, allopathic medicine seems to be limited, to a certain extent, in responding to the complexity of issues involved in overcoming the health disadvantage of Aboriginal people.

CHAPTER 6

Stories of Healing

6.1 Introduction

This chapter provides a collection of stories of healing as told by Aboriginal and non-Aboriginal patients, community members, health professionals, and staff from different organizations. These stories complement the ngangkari's episodes of care discussed in chapters 4 and 5, which exemplified specific cases of ngangkari interventions. The stories of healing have been reported in their full account as told by the interviewees. These stories include cases of reproductive and maternal health, child health, palliative care, grieving, physical pain, cancer, mental health, spiritual disorders and other episodes of care.

6.2 Reproductive and maternal health

My name is Sonia Waters. I am an Aboriginal woman from Adelaide. My family ties are to Ooldea on the Far West Coast of South Australia. Back in 2001, I fell pregnant with my first child and like most women very excited about all that experience. It was new and I guess I was pretty ignorant around being pregnant and what to expect. I sort of thought like everyone in my family it was just falling pregnant, gone in, had their baby and came home. And I thought that mine would be like that as well, but my experience was quite different. I had a lot of complications.

At about 12 weeks into my pregnancy I was bleeding, I went to the hospital and they couldn't work out what was wrong at that stage. At about 17 weeks the bleeding was getting heavier and heavier and I had been back to the hospital a number of times. So this time they decided that they would do an ultrasound and see if they could find anything that may be happening. So I had an ultrasound and then I went downstairs waiting for the results. We got called up and we thought that everything was going to be good, that they might be telling us that we could have twins because there is a history of twins in both our families. But the information that they told us was not positive. They said that our baby showed significant markings, some soft markings of complications; they thought she had Down Syndrome and they also thought that she had some complications around her heart, because I have lost family to heart conditions, I really became quite anxious about that. So the only offer of further assessment that was put to me was to have an amniocentesis and, like I said I worked in health for a long time but I didn't know all the sorts of these procedures and so forth. It was given to me as the only option and I was scared; when they talked about the risk factors of having that they changed the percentages around; so when they said something like "oh it's only 1 in 200 chances that something could go wrong with your pregnancy, they said that's 0.5 per cent", so it doesn't seem as bad when they say figures like that. Anyway, I had to make a decision over the weekend whether I would have that because on the Monday I would click over the 18 weeks. I was indecisive but I booked in to have it done. I went along and I had the amniocentesis done; when I got home that night I've lost a lot of fluid and had blood, so it looked worse than it probably was; so I got really scared and I rushed to the hospital and they decided to keep me overnight and check the pooling in the morning. When they came in the morning they actually had the preliminary results of the amniocentesis ready; they do what they call a 'fish test' and they were able to determine from that 'fish test' that my daughter did not have Down Syndrome and there wasn't anything significant in relation to the heart but they were still doing more tests, but these were just preliminary results. The preliminary results also revealed that my daughter had a condition called Trisomy 18 which they said, coupled with the lack of fluid now, that she would be significantly disfigured and that she would, if she survived at all, live probably for about four hours. No mother or parent, family want to hear this sort of news. They went on to say that my membrane had been ruptured, which didn't mean anything to me, but basically meant that my womb

was punctured and so I would continuously lose this fluid; so they said I would most likely miscarry as a result and if I didn't there were other risks such as bacterial infections. They discharged me from the hospital and said that they would be in touch in relation to the other results; I was petrified leaving the hospital because I didn't know how to take care of myself and I thought 'how can I try to find information, it's hard enough to find information when you are inside the hospital, let alone being outside the hospital'. I was so distressed so I went to see an Aboriginal counsellor hoping that she might be able to help me and then I called back to the hospital to see a social worker as well because I was very distressed. The social worker basically said to me that there wasn't much that she could do to offer any support because my baby hadn't died yet and she could support me in that but the chances of my baby surviving were about 5% and she didn't know how to support me in that.

Then a couple of weeks later I got a phone call from a highly respected Aboriginal woman here in Adelaide and one I had high regard for. She said to me that she had heard about my complications and she encouraged me to see a ngangkari. I was quite frightened because I grew up in the city and I trusted the western system and I was really frightened about it: this was unfamiliar to me and I just didn't know what to expect. My partner is Aboriginal as well and he said to me that it would be a really good idea. The western system had done so much damage already and it wasn't just the physical damage that they may or may not be able to heal but my emotional and spiritual damage that they [ngangkari] would be able to provide some support there. So I went along, we went to a motel room where the women were staying and when I walked into the room I felt very safe and supported: the women understood what was going on and I guess my medical condition at that point was that I was losing fluid, the amniotic fluid around the baby constantly, every day I could feel it, reminded every day of the chances of my baby surviving if I continued losing this fluid. She needed it for breathing, for her lungs to develop, and without that her lungs wouldn't develop. The ngangkari sat behind me and my partner was allowed to stay in the room, which was great because it was our pregnancy, our baby and it was a joint thing; whereas in the hospital they really focused their attention on me and not on the father which made me feel uncomfortable as well, that he wasn't really part of it, it was like you are treated like you are the body that's carrying this baby and so all the attention was focused on me.

But the ngangkari women made that experience very different. They came behind me and they were touching my stomach and what I had known from the ultrasound that I had at the hospital was that there was little fluid around my baby, without that she was going to die, she could be even more disfigured because she can't move as there is no fluid; and she had the umbilical cord all wrapped around her really tangled. When I met with the ngangkari and they touched my stomach they immediately said "oh your baby, she is palya, she is palya", which means good, and I didn't know that was a 'she' at that stage either, so that was great. But she also said "oh, the baby she is tangled, you know, all tangled, tangled, tangled", and I knew that and so immediately I believed, they knew what they were doing and I felt safe. And she also said that she could smell the fluid, the fluid had a very sweet smell to it and she said that she could smell what was happening and she said "If you are going to have infection and you are going into labour, baby needs to be engaged, you know, head down". She also said she needed to untangle the baby as well and what the baby's head would do was hopefully to create like a plug against that hole in my womb so I wouldn't lose amniotic fluid and the fluid would keep filling up and because the baby will be able to breathe, her lungs will get developed. She also said "you will keep loosing the fluid as the fluid builds up 'cause baby will move naturally because she is not ready to be birth yet, and 'cause you will keep losing the fluid, at that point you need to come back to us again and we'll position her again". So with that she started turning and turning; I was still a bit apprehensive because I didn't know how they could tell; with ultrasound you can see which way to turn unwrapping the cord but with this they couldn't tell, but obviously they could. Anyway, she did all that and she engaged baby and then she went and shed

herself of that negative stuff that was going on. And I felt very good.

A few days later I went for another check up at the hospital, they did another ultrasound and the ultrasound showed enormous pockets of fluid around my baby and particularly around her mouth. So they were saying that it was a really good sign, that she was able to breathe this fluid and they couldn't understand how this baby had untangled herself and how these pockets of fluid and how she had moved to be able to be engaged. They were really shocked they couldn't medically describe it. The doctor was just like "oh my god, there is so much fluid, your baby is engaged and she is untangled, how could that happened?" And I said "I've seen a ngangkaṟi". The doctor went off at me and said "We will not be held responsible if anything happens to your baby because you've seen this alternative medicine". I thought to take the risk because I now see medically on an ultrasound that this works, this works. So because my stomach would fill up with fluid and naturally baby would move, and then fluid would come and gush on me so I went back and saw the women again and they repositioned the baby again and of course the fluid would fill up, I could feel it, and I could feel baby move and all the fluid will lose again.

I just, I just wish that I could have kept seeing the ngangkaṟi because it worked but the medical system, my health insurance it didn't recognise them as practitioners. But the western system wasn't doing anything for me, they weren't doing anything to try to position my baby like these ngangkaṟi women were doing, it was clearly, clearly working. I have physically seen on the scan the fluid was building up around my baby, was right near her mouth, she was creating that plug so everything they were doing was working.

But when I got to about 27 weeks I had to stop seeing the women because I couldn't afford and they went back to Coober Pedy and I couldn't afford to travel up there every other day and they couldn't afford to be down here. Like I said no health system recognised it, not my health insurance, not the hospitals. So, I did get a bacterial infection, I went into labour, I had to have an emergency caesarean and my baby came out and her lungs were severely underdeveloped, so she didn't stand a very good chance of surviving. She lived for 19 hours, which was good in some respects, some parents don't get that opportunity at all.

What I know for all that experience and what I am ever thankful for is, if I didn't have that sort of treatment from the ngangkaṟi, I am absolutely convinced that my baby, her lung wouldn't have developed to the extent that they had, and I don't think I would have been able to hold a live baby if it wasn't for them; at least I got to hold my baby and she was alive and 19 hours isn't a long life, but when you know that the chances of this baby surviving, 19 hours of spending time with her was a long time. I feel forever grateful that I got the opportunity to do that; but I also know that if I have had regular access to the ngangkaṟi my baby would be alive today because what they were doing I saw it medically on the screen, they created these pockets of fluid and she was able to breath and have her lungs developed. I truly believe that if I could have seen that ngangkaṟi for another three weeks my baby would be still alive. But I didn't have access and couldn't afford it.

When I was in the hospital I was made to feel alien, I was alienated, I was placed in a room down the corridor right down the back where I wouldn't hear other babies crying or other mums attending to their babies. And the day I was discharged no special arrangements were made for me. It was really hard to leave the hospital with empty arms; leaving at the same time as other mums are leaving loading their babies into the cars with flowers and everything. I got showered with flowers the day my baby was born for celebration and I got showered with flowers for death. I left all of that behind, I also left my baby at the hospital deceased and I felt like no social work, no counselling. Emotionally I was a wreck; they were attending to my medical needs and no attending to my emotional and spiritual needs.

That day when I got home we pulled into our street and I saw a white van in the driveway and I kind of hoped that it would be who I needed to see; and I just couldn't believe it that the ngangkaṟi were in my house, waiting for me to get home because they knew what

had happened. There was nothing they could do for me medically, but the emotional and spiritual support that they provided to me was not offered by anybody else. They stayed for about an hour and we did an inma for healing, for letting go spiritually of my baby, and I really felt from that moment I could then move on with my life, knowing that my baby's spirit had moved on as well.

Yes, that was my journey with ngangkaṟi. I absolutely trust in their knowledge, their skills, their abilities and I just hope that they are engaged in the health system not as an alternative provider but as another provider because for a lot of our people it's the first choice of medicine. For me it wasn't, it was offered to me as culturally this is the first choice, but I've never been exposed to it – I heard about it – and when I was I've benefited enormously. But as I said I just wish I could have more access.

I would like to add something else. In 2002 I was working in the health system and internationally it was revealed that hospitals in some part of the world were retaining organs and tissue samples after autopsy. I was leading a body of work in the health system which was about repatriating these samples to the right place because we hadn't done very well in terms of our communication strategies. In 2007 I received a phone call to say if I did check with the hotline at all about my own daughter, because she was born and she took a breath so she was subjected to an autopsy. I hadn't, so I made a few calls. I found out that they had kept around 75% of organs and tissues samples of her without my consent. My trust in the western health system was fully broken.

I tried to rebuild that trust after I lost my first baby. I went on and had two successful pregnancies; part of the success I attribute to staying away from the system. I basically went, find out I was pregnant and my obstetrician was a lovely old man and he said "would that be any reason whatsoever that you would think about not keeping this baby?" And I said "no". " I see you at birth then". So it was his relationship with me that rebuilt some of that trust, but still had Aboriginal women and ngangkaṟi beside me during my pregnancies. But when this happened in 2007, when I found out that without my knowledge they kept samples of her, I was just devastated and I just did not know how to tell my partner because he is a very cultural man and when her body was picked up from the hospital and taken to the funeral he accompanied her, he carried her over, he buried her in a very culturally respectful way. To then find out that parts and pieces of her were retained without our consent was just horrific. This is something we are still healing from because that level of trust is broken, it's very hard to fix especially when you haven't had any control over that.

Thank you. I wanted to share this with you. I do strongly support ngangkaṟi.

I have had some instances where some women have had problems getting pregnant. We had three or four people who consulted with Mr Rupert and end up pregnant... things move around when he touches them... *(Interview Senior Officer AO1)*

6.3 Child health

Ngangkaṟi look after our *tjitji* and everyone. You go and say "I am sick, can you fix me?" or *tjitji* in the middle of the night crying, and you know, you go and look for ngangkaṟi. Yeeh... ngangkaṟi are very, very important for us *(Interview Community Member 2)*

...even little kids with health problems. The ngangkaṟi will see them and the parents can't believe when they have taken them back to their western doctor. Because we tell people who are on western medications don't go off it, continue with it until your GP says it is ok; and the doctors in the western world can't believe this child has come back with nothing wrong with it *(Interview Senior Officer AO1)*

I have got a grandson who was bitten by a red spider. Another ngangkaṟi helped him. My grandson had a trauma. He was only three or four years old and the doctor up in the hospital was really, really concerned that he was bitten by a red spider and thought that there would be symptoms like sickness, and there was a real danger because of his age. But when I came back from Adelaide one day and I received this phone call from my doctor at the hospital saying "you better bring back your grandson to the hospital because he's been bitten by a red spider and it's very dangerous because of his age". But I looked at my grandson and he was jumping around

as normal, he didn't look like he'd been bitten. But it's because this old ngangkaṟi had done something to my grandson. I wasn't there when the ngangkaṟi saw him. I just came back from Adelaide and really I didn't know what the doctor was talking about and I looked at the grandson and he looked fine to me. But I took him back to the hospital at the doctor and I said "Are you sure he's been bitten?" He doesn't look like he's been bitten, but he was really bitten because in the shed his father was there and he saw the spider and saw a little bit of blood in the front of his hand. Yeah, the father was there on the scene at that time... *(Interview Patient 5)*

The program I was in we would do outreach; it was a family program so we worked in pairs: a caseworker alongside an Aboriginal worker. We had visited the town camp on that particular day and a child who was about 18 months had ongoing scabies; medically the reports being: 'child neglect, child not treated, not compliant". These are the sort of the ongoing child protection type level and the program I was in was to divert children from child protection, so we were the last resort strategy. We had been out in the camp and the grandmother had him, and he was all covered, he was just black from his toes up his belly, he was just black. His legs were bubbled with scabies and visually this blackness and I thought "oh my god, poor kid, we've got to get him to the hospital!" And because I was working with the Aboriginal worker as well, the other two girls started laughing... And I could see that part of their back land, they had just burnt it, and it was that particular plant or ash that they actually had rubbed over his skin, and that was their way of treating the scabies. So medically it appeared that they were not compliant and if I had been on my own without that Aboriginal worker with me, I wouldn't have had the knowledge or the expertise to go and say "No, actually they are caring for this child, they were treating him". I would have made an assumption, a westernised assumption – "this child needs to go to hospital". And actually the treatment worked. Also the persistency of it, and I am not sure of the ins and outs of it, but the burning, the plant was something that was cheap, it was accessible, they believed in it for once and they valued it and they've seen it work, whereas creams that they can't store, they don't know how to use, they don't necessarily read or understand it; and even a doctor explaining it they don't necessarily understand. I mean I do get confused when I'm listening to a doctor. And for a lot of them, English, it's their fourth language. So this is one of the examples and the program I was in, and the value of it was that you worked alongside an Aboriginal person who had all that cultural knowledge that as a white person you don't have. Also, some of the communities or outstations don't necessarily have their clinic that they can walk to and they are reliant on the ngangkaṟi: their own healing and traditional medicine are something that is more accessible consistently *(Interview Senior Project Coordinator 2-NAO5)*

My name is Kathy and I live in Nyirripi community. I am gonna talk about ngangkaṟi and how Aboriginal people use it. Maybe a person was sick and was very ill, they would go and get that person who have the ngangkaṟi to make him better, so sometimes they can feel it from long distance who is sick and who is not.

One time a little kid from Alice Springs got sick, he was in hospital for a long time, the doctors didn't know what to do, so one man he went to the doctor then he said to them, he did something to him, he put his hands on him and did these things and a couple of minutes later the kid woke up. And the doctors they were shocked. People use ngangkaṟi all over, mostly up in NT, WA, right down there and SA.

I think most of ngangkaṟi are good for us, but some of them they don't really believe in it but some people do it. There is a lot of different kind of ngangkaṟi they use. Some people they use for certain things, they can make a person better...*(Interview Patient 6)*

You asked me about experiences I had with ngangkaṟi of healing people or *malpan,* it's what we call it up in the Kimberly. My experiences come from a very early part of my life when I was a kid...stories that have been passed from my mum and others. There have been occasions in the past in my early childhood where I had things done to me by *malpan* people, because these are practices that our people living in the Kimberly still practice as very close to our

traditions; so hospitals were not much part of my early experiences in the 1950s. There was a woman called Betty Johnson who was a healer and she was someone who I remember; even I can still recall in my primary school years in the late '50–early'60 who was around and doing things at that time around healing people. Because as a kid at that age you don't think very much about this sort of things, except yes it's there and it's happening, you know, and you go off and play as any kid at 7, 8 or 9 years old would do. Much later you get to appreciate these things.

There are still people now that continue these practices. My view is that if something in practice that contributes to human beings being better or being healed, it has to be a good thing. One of the things about a *malpan* business is that it's done in secret, and this is one of the difficulties, how to balance how this practice is carried out in secrecy with the need to have recognised the good value from it and promoted it. If something contributes to make conditions better for people, then it's a good thing. I certainly support it, you need to be quite conscious, you tend to trust people from your own country than elsewhere to develop a relationship with people, but by and large the basic idea of having Aboriginal traditional healers is a good thing and I guess my first preference would be to look for healers from my own country, up in the East Kimberly. But it doesn't mean that I can't allow myself to be treated by a ngangkaṟi from other country. That will be fine. It's something that we are all working through, yeh...*(Interview Patient 8)*

6.4 Palliative care and grieving

Sometimes we get people calling in from the hospital. Say a family member who is in ICU and only has a couple of days to live. And they are an Indigenous family and they will ask the ngangkaṟi to come in. It's not that he will get physically fit, but at least his spirit will be with the family and that will give comfort to the family for their grieving and knowing that that member will be with the family even though his physical body has passed over *(Interview Senior Officer AO1)*

I think the most recent one was someone who actually wasn't from the Lands. The came from Top End and because someone close in their family died, there was absolutely no way they could get to the area for the funeral, which caused a lot of distress, so they came here in crisis, really. It was at that time of the year where a lot of services are shut down. We were not able to access any special funds, help them access funds, to maybe travel for the funeral. And what was decided, what they decided to do was to see a ngangkaṟi even from a different area on the day of the funeral and they let their family know that they were seeing the person on the same day, and they said that that was helpful afterwards *(Interview Senior Project Officer 1-NAO3)*

6.5 Physical pain

I had an experience when I was travelling with health workers and one of them was a ngangkaṟi whom I didn't know was a ngangkaṟi, I just knew she was a health worker. We were travelling and we were in WA and we've gone to a welcoming dinner from a health organization. Everybody was having a bit of day, some giggles and carrying on. Anyway, I turned around and grabbed this girl and when I did that it's like everything slowed down and I just knew I've done something wrong but I didn't know what. She was just facing somebody and I grabbed her by the arm, but she got a shock and she turned around, but everybody sort of looked at me, all the health workers I was traveling with just gave me this funny look and I knew I've done something wrong I didn't know what. Anyway we went to bed that night and when I woke up in the morning I just had this incredible headache, my head felt like it was going to explode and I was actually convinced that I was going to die. I could get out of bed, I sort of fell out of bed and I crawled to where the other health workers were and I said "You got to ring an ambulance, I got to go to hospital, I am really really sick." They just looked at me and they looked at me very strange and I said "What?" And they said "She [the health worker ngangkaṟi] did that!" And I asked, "What do you mean? How she did that?' And they said "When you grabbed her you got some sicknesses and stuff out of her that she was keeping inside." And I said "Can she

take it back?" So they went and got her and she worked on me, she manipulated my face, I felt like she was pulling my all face off; but she sort of massaged and pushed it and pushed everything up into my forehead and the she sucked on my forehead and she started spitting all this blood out. She spit all this blood out on the floor and then – it went on for about 10 or 15 minutes – then she told me to go to sleep. And when she was sucking blood there was no cut done in my forehead, and it was a lot of blood, it was about a half a cup of blood, it was a lot because I had to clean it up afterwards. She put her hands on my eyes, held them over there and I went to sleep; I woke up about 10-15 minutes later and the headache was completely gone. They then told me that when someone is a ngangkaṟi you should never grab them like I did, because when they take sicknesses out of people they take them into themselves and that doesn't make them sick, but if they lose concentration, escapes sometimes, so that's what they told me. Anyway, I was better and I didn't have to go to hospital and have my head opened up! I don't understand how it works, I don't have any explanation for it but I know it did work. I definitely felt like if I hadn't got her, I really really thought I was gonna die, I thought I was burning in my brain, I never had a headache like that, it was such intense pain and it wasn't like a migraine headache, it was different *(Interview Registered Nurse 3)*

Some people came with aches in legs and backs and rang back two or three days later saying the pain has gone *(Interview Senior Officer AO1)*

I am Gwen Crombie and I live in Aparawilinitja homeland 30 km from Fregon community in South Australia with my husband, Jack Crombie a traditional owner of this land. I have been working with Aboriginal communities for the past 20 years in different capacities.

I have had quite a bit of experience with ngangkaṟi over the years. When I was working at Muṯitjuḻu and Uluru there was an old man working as a ngangkaṟi; he was paid $100 a week as long as he was in the community and could be on call. I was managing the healthcare facilities at the time and when people asked to see a ngangkaṟi when they were unwell Jack would come and pick him up and bring him over and he would come whenever we needed him. I saw much improvement in many people that he worked with.

A personal experience that I had in 1996, I had an unexplainable pain in my shoulder, back in my right shoulder for three months. I was going to Brisbane on holiday so the doctor gave me a referral to a specialist. I went to Brisbane and I had an ultrasound, CT, physio and medication with no effect. I could not sleep at night. The only relief was a hot shower and then I might have an hours sleep and then be back under the hot shower. After I came back from Brisbane one morning that I was feeling particularly miserable the ngangkaṟi that was Jack's nephew rang me and asked "are you alright Aunty Gwen?" and I said "No, I am in a lot of pain".

Some people came with aches in legs and backs and rang back two or three days later saying the pain has gone

He came over and he came to my office and did hands on treatment for two days in a row and I went back home that night to go to sleep. That night I slept feeling something moving in my shoulder like the movement of a baby in my shoulder. I slept soundly which I had not done for three months and I woke up without pain and I have not had any pain since.

Originally I came from Victoria as a nurse. I was a nurse in South Australia and Northern Territory. I changed my career to be doing Indigenous age care management until 2003 and during that time of my working career I have seen the ngangkari working many times and I have seen great results and feel that is invaluable for Aboriginal people to be able to access that service. I was often called to try to facilitate that happening for them.

I'd highly recommend that ngangkari receive support so that they can be accessed by the general community and other organisations. It is an area that can have a good place within any and certainly in Aboriginal cultures, to help improve the health of Aboriginal people. It is highly important *(Interview Patient 11)*

I am Beverly and I work as a manager at the art centre. This is Iwana, she is probably one of the longest standing artists here. She is a ngangkari, I had a really, really sore lower back pelvic area, I could hardly walk, in fact I had to go home one day and lie down. Anyway, Iwana rubbed my back for me and eased it really a lot and then she made up and gave me some rubbing medicine – *irmangka-irmangka,* traditional leaf – and rubbed that on and I kept rubbing it on me as well. Relief from that really quickly and I know Iwana does a lot of ngangkari work for community people. So I recovered, never knew what it was but it was quiet debilitating *(Interview Patient 10)*

Sometimes I get a sore neck, using the computer too much, not sitting properly, constant headaches. There is a lady and she'll spend 20 minutes touching me and doing what she does on my neck and my body and rubbing some *irmangka* on me and I'm fine, it'll go away. If I go to a doctor I'd probably get some anti-inflammatory and some Panadol and some pain relief, it takes longer. I guess because there is no medicine involved, it just feels more appropriate...I don't know, I can't really explain it. But you go to your doctor here and nine times out of ten you've never seen him before, he doesn't know who you are. So I just find using the ngangkari is much easier, but I've got them, they are here all the time or most of the time. And it's far more effective *(Interview CEO AHS8)*

The following story is told by both the patient and the ngangkari who provided the treatment:

I don't know about how this all works other than he [ngangkari] is someone recognised to be quite good in this field of work and he helped a lot of people in the past...I asked if he could come around just to have a look. I had trapped nerves in the neck, especially in the right side. It was very painful as any nerve damage is, and I went to see the doctor. The x-rays showed four damaged nerves. I got prescriptions, painkillers, valium and some of those medications dosage were quite strong. It is worse than the symptom of the injury because make you quite ill in the stomach and all that sort of stuff. So I was struggling along with that and then he came around and had a look and had a chat with me. Then he did some sort of massage and some work on the neck. Then basically told me to throw the neck brace off and throw the medications away and I was sort of...you know too good to be true, you know? It also helps as a person that's been treated that you believe in what it's going on and what he's done and I did believe; so that all helps and he just gave me some good advice on how to manage the injury, things like long distance driving is gonna obviously aggravate, regular exercise with the neck just to keep it. Yeah, basically from that day on, after he gave me that massage, I was back to normal and I haven't worn the neck brace since. I am glad I went off medications. The doctors said if the medication doesn't fix it, then the next step would be an operation, some sort of procedure in the neck, and they also said that I may be paralysed...I don't know how it works but it didn't sound good to me. I think most people don't like to have an operation... Maybe I would be unable to walk around or turn my neck...I don't know these procedures, what they involve but I was quite happy to not do that. Like I said since then I am happy to jump in a car and be comfortable and I can go up to the APY Lands and drive on

these bumpy roads and get back to what I love doing the most, sitting in the community and talking to the people.

I am happy to help and I think ngangkaṟi is a specialised skill and there is a lot that they do. And your work going around interviewing people and talking to people about them and raising awareness of ngangkaṟi, I think it's fantastic, it's great! It's really, really good, I know that Pika Wiya uses ngangkaṟi, they see the value in them and when we talk about the oldest culture, this is part of it. It's fantastic because ngangkaṟi and their healing are very important. It does need to be acknowledged. You got my support *(Interview Patient 5)*

He had a CAT scan because the doctor told him that he was to have an operation, but he was fearful because of the outcomes because he could be paraplegic, not *palya*, you know. He thought that he would come and see me, he thought that would be another way around for doing that and not being operated. He turns up at the back. In his neck, the muscles in his neck were tied up and not right; but I straightened them by healing by hands and he was fine. I mean, in the back of his neck you got these blood vessels that run down through your spinal cord and those were tense and like in a knot. So what I did with that, I rub my hands along them and massage it and basically strengthened in a way that his neck could be more mobilised. In other terms, because he was stiff and he couldn't move, so I told him to take the neck brace off and rub some bush medicine as I was massaging at the same time. Then he said he had no pain. There was like a little fracture, just the bone it just moved a bit, what I did with my hands I just strengthened up a bit, that way it would be back in its place *(Interview ngangkaṟi 5)*

I am a non-Aboriginal older woman and I've had good health all my life, since six years of age. Recently I had very bad health with my lungs, and it just kept recurring, recurring, recurring. I was going to mainstream doctors with very little success, but I was continually on antibiotics and so forth. My daughter who was working with Aṉangu women told them that I was unwell and they sent a ngangkaṟi lady over to give me some treatment. I was quite open to it because I figured that anything that works towards good health has to be beneficial, and I'm certainly supportive of my western antibiotics, but I also believe that it was important to try something else, so I was quite open to it. And it was the most interesting experience for me because when the lady came to my house she asked me about some things that I had been involved in, like she said to me that somebody had put a bad thing on me, I don't know what you'd call it, like a spell I suppose. But she asked me if I had been in a certain place up in the Lands, and I had been, and she said that's when that had happened. And interestingly she said they were using the moon and the stars to make this happen to me. And you know I've got two small grandchildren living with me now, and for the last year I'd take them out every time there was a moon and I would show them the moon. So for the last year I had been taking them out to look at the moon and the stars. I couldn't believe that. It was quite extraordinary from that point of view. She gave me just the one treatment and it was an interesting experience, just really more hands on stuff, touching my body, finding bits where she felt there was something inside me that needed to be taken out. And she just spent I think about half an hour doing this with me, took me outside and said this thing had been gone from my body and now I would get better. I only had the one treatment, but as I said I was having western medicine as well. I did get better, but I have got a bit of a lung disease apparently... but I was quite open to it, and I think I did get better, who knows, I did get better, who knows why I got better...So that is my experience and I would certainly do it again, I am prepared to try anything.

Anyway, I wholeheartedly believe all these options should be available and subsidized, particularly if you have private medical health cover or anything like that. I think the ngangkaṟi are equally as valid as remedial massage, acupuncture and all of the other kinds, and indeed our western medicine, because how much of what we receive as treatment and we get better is because we have a belief in our mind to get better? If you don't believe in the treatment you are getting, regardless of what sort of medicine you're receiving, I don't think it would give

you the capacity to get well again. I think it should be the all of these options, and I think this is equally as valid as a remedial massage. Because in fact she massaged my tummy, she massaged parts of my stomach and areas where she thought there was something inside me *(Interview Patient 12)*

6.6 Cancer

There are some anecdotal accounts about cases of ngangkaṟi treatments on cancer patients.

One lady had cancer in her chest underneath her neck cavity. He consulted her. She of course went through radiotherapy and she is fine now. It could be a combination of both or it could be either. If you can use both at the same level it would be fantastic because it is a spiritual thing and also physical *(Interview Senior Officer AO1)*

A young fella went up to Fregon. He had cancer in the stomach and they took him up there and then brought him back and the doctors had a look and couldn't believe it, he's got none left. They combined the spiritual work with law *(Interview Community Member 1)*

6.7 Mental health

...he has a very florid kind of psychosis. So what I was noticing... we had dinner and the whole time he'd be up, down, up, down, restless, all over the place. So I asked the workers a bit more about what was happening for him, what were they observing, and if he did actually sleep. They said "he's up most of the night, during the day he only might go into his room for an hour, but some days not at all". So I came back to Management Assessment Services and said that the patient doesn't seem well to me, like there's got to be better quality of life for this man. He is in psychosis at the moment, it has totally taken over his life... so I went down to the psychiatrist who had dealt with it and I said "look, I'd really like to run a dual approach; yes, there is psychosis, there is no getting away from that, I'm not asking for a ngangkaṟi to come here and cure his psychosis; however I want to respond to his cultural needs and to value using the ngangkaṟi in running that dual approach with him". So we provided two ngangkaṟi to go and see him; they spent a lot of time around his head, and around his ears – he's got hearing impairment; they did that more in the first session, and then the second session sort of started with the head and moved down to the stomach and sort of neck-shoulder, and then they removed a stone that seemed to come from the side of the abdomen: it's called a *mammal stone*, it's a very dark stone and they had to keep it wet and I had to go and get a glass of water to put it in. And what we had to do later on was that I had to find a site that no people would walk past, but it had to be dark and put away with water, I had to use a lot of water in the hole and cover it up. So now he's more social, he still would have his voices stuck, however they don't seem as dominating - and some of that would be the impact of his medication - and he's actually getting a nice sleep. So his capacity to manage this sort of thoughts would have been more difficult, but the workers said he's far more interactive, he's willing to be involved in activities which previously he was very reluctant to. Definitely his quality of life has improved... *(Interview Senior Project Coordinator 1-NAO5)*

I believe if people are walking around talking to themselves on the street they can actually be talking to somebody in a spiritual sense. Working with Rupert I have seen a lot of people doing these types of things and him removing another person's spirit that shouldn't even be on that person. It is very interesting. You have a lot of people being sceptics. How come ngangkaṟi can't heal themselves? They have diabetes, health problems, alcoholism in the community or petrol sniffing and drug abuse. That is all western stuff that has been brought in. The ngangkaṟi can fix the spirit and some ngangkaṟi don't like trying to fix people who have alcoholism or drug addiction because there is no point if they are going to do it again. He has helped people with mental issues – anxiety – it is really quite intriguing *(Interview Senior Officer AO1)*

I have got one client at the moment who has nightmares, had nightmares for a long time and said there is someone in the house. He ended up going to Glenside and he is put on Risperdal Consta – it's a medication, it's an injectable anti-psychotic medication. Anyway, he was seen by a ngangkaṟi in the hospital so briefly his nightmares went away.

He came back to Port Augusta, nightmare came back. We got the ngangkaṟi to come and it wasn't only just the person, so they took the stones away from him but what the ngangkaṟi said there: "no, there is something in this house". They came back and spent the night in the grounds of the house and waited and cleared the house from anything that was there disturbing him: he doesn't have any since. Now, we have to negotiate around this injection anti-psychotic. Once they are in the system, gee... it's hard to get them out *(Interview Mental Health Clinician 1-AHS6)*

6.8 Spiritual disorders

Spiritual disorders refer to a range of ailments related to different spiritual issues, including spiritual disturbances and displacement of a patient's own spirit.

6.8.1 Displacement of a patient's own spirit

There was a baby in intensive care and was crying constantly. We walked in. This baby was crying and crying and crying, they didn't know what to do for her. They couldn't work out what was wrong. They had to put her on a drip because she wasn't eating. We walked in. Mr Rupert actually put the baby's spirit back where it should have been and the baby shut up just like that. It was amazing. I said "are you sure that is all it is?" and he said "the baby is right now, let's go". The spirit was in the wrong spot on its back and it should have been on its front under the ribs. Everyone turned around when the baby stopped crying and we just walked out. I had the mother on the phone later she was just over the moon. I talked to her and asked how the baby had gone and she said "she still has temperature but she is getting better" *(Interview Senior Officer AO1)*

Even just having stresses and anxieties and headaches and all those small issues that bother us from day to day can be just your spirit not being in the right place because it is sitting in the wrong place maybe through trauma or just through someone yelling at you sometimes it gets frightened and it can jump in a different spot. It's a combination of a lot of things *(Interview Senior Officer AO1)*

I know a little bit. Ngangkaṟi heal people when they are sick. If someone gets sick ask the ngangkaṟi. Ngangkaṟi go there and maybe your spirit, *kurunpa*, not there. Ngangkaṟi go there and the spirit going back and says "*palya*, no problem". People get better. *Kurunpa*, spirit, go away when somebody you maybe sleeping like a lady or man or little baby sleeping and somebody come and get up...Sick and weak and we take man or lady maybe spirit going back. Ngangkaṟi different way. Aṉangu we like ngangkaṟi. Ngangkaṟi make people better, happy.

Yes, ngangkaṟi work a lot in our community and clinic. We go to them, talk to ngangkaṟi and doctor. Yeah, we talk to ngangkaṟi and clinic, both ways, you know, yaeh...ngangkaṟi and white doctor medicine, both ways *(Interview Community Member 2)*

I think they are an important part of our culture, ngangkaṟi, because they are spiritual healers, for pains and everything. I got a healing experience when I was living near Oodnadatta and I was sick there, very sick. I was lethargic and weak, no movements.

They put me in hospital and they gave me antibiotics and stuff, I think because I remember having big needles, so it must have been antibiotics. And at the start I was spewing, spewing, spewing a lot, spewing phlegm from the chest. But I didn't get better. Mum took me home and I remember her giving me some sweet tea but then she took me to the healer. Yeah, I didn't get back in the hospital and my mum took me to the healer that was living at the edge of the community; she took me there and in two seconds I was up playing and he said that my spirit jumped out but my spirit followed me to his place and hang around. And he said "Oh, I have been waiting for you to bring your daughter because the spirit has been here for a couple of days". And as soon as he fixed me up, I was up and about and playing around, I was back to normal. The ngangkaṟi said to my mum that when I was playing – because I was hiding inside the toilet – he said that my spirit saw two snakes and jumped out, I got a fright from the two spirit snakes but I didn't see them, no I didn't see them with my eyes. But I felt sick at the toilet, that's where I felt sick, very sick, at the toilet. My mum had to piggyback me and showed the man how my legs were dragging...

So the hospital wasn't able to cure properly. 'Cause usually when your spirit jumps out of you and you are in the bush, if there is no healer they put you outside, they put you on the edge and everyone has to be quiet and the spirit will come back into you. But when you got houses and you are sleeping in the house the spirit can't come back into you. I don't know how to explain it, but in the open it's easier for them to go back in. But if you are in a house only a healer can grab them and put it back in. It would be good to have ngangkaṟi in the clinics. Being available for the clinics to ring them, you know, the Aboriginal clinics *(Interview Patient 14)*

Ngangkaṟi can fix pains, headaches, for little baby when somebody shuts the door and the spirit jumps out and only the ngangkaṟi can put it back. When I was sick my spirit jumped out and I was weak for like two or three weeks, sitting up in a corner, you know, no energy at all, lethargic, and you just want to sleep and feel weak. So they took me to Mintabi to see the ngangkaṟi there but nothing, he couldn't fix me. So they took me to Mimili, tried there, Fregon, Ernabella; so then they took me to Amata and I was very weak and my spirit was up on top of a tree crying out for help. And the ngangkaṟi seen it there, one of the ngangkaṟi from Amata, so they came to my mother's camp and say "your kid is sick", and my mother ask "can you fix her up?" And they came and I was weak, couldn't eat so the ngangkaṟi said "I put the *kurunpa* back inside" – my spirit – so they fixed me up that day. Same day I was up eating *(Interview Patient 13)*

I am from Amata, far north-west of South Australia in the APY Lands. In the Lands there is a lot of ngangkaṟi, but it's used to be more ngangkaṟi: men and women and young ladies and young men, and young girls and young boys. Ngangkaṟi is very important for our culture, ngangkaṟi is sort of magic doctor, fix up people when they are sick. There is a lot of ngangkaṟi but now these days few ngangkaṟi, a few ladies, maybe ten-seven ladies across the lands and there is maybe ten *wati* ngangkaṟi. They used to pass it on when they are younger, tell them how to do it, teach them how to do it. Some still have it but some not using it, they are keeping it to themselves...

If *tjitji kurunpa* – children's spirit – goes somewhere and they are asleep and someone wakes them up, the *kurunpa* moves and goes in the wrong place, and they start feeling sick. And their mum and father think something is wrong and they go to the clinic, and they say "you are not sick, *wiya*, you are fine". But the *kurunpa* is not right, they can't fix it, but ngangkaṟi they can fix the spirit. And they realise, "ah, something has moved, *palya"*.

One day someone came and knock on the door in the morning, that time I was really asleep. My *kurunpa* went around, wrong side. I went to Amata and I called my uncle and he came. And all day I was very hot and ill, I said to him "I'm very hot and I knew my spirit moved. And he found it down in the back, so it was hiding; he moved my *kurunpa* back to the centre, and I was fine. When the *kurunpa* is in the wrong side can cause fever, headache, vomiting, feeling very hot and you can't see properly; you can feel that something is coming, put everything in the body and you can't see it, it is not right; and sometimes your body is shaking, feeling really hot, and then cold and you want to feel warm. So if I go to the clinic they couldn't fix it, they'll say "you are all right". 'Cause they can't see. This happens a lot of times for Aṉangu in the clinic. A lot of times Aṉangu in Alice Springs in the hospital or clinics in the Lands, they are sick but they go and they say "no, you are all right". Because they can't see it, only ngangkaṟi can see, men and women.

Ngangkaṟi is really really important for our Land. It's very important. Ngangkaṟi doctors was before white doctor came, yeah ngangkaṟi was there I don't know how many years...since the beginning. Ngangkaṟi used their spirit like a bird, a eagle or *tjiltjitji*, it's a dream, they use it in the dreaming and it's very important for us. And they are still using it. How I see it, if the elders ngangkaṟi pass away, there is no more ngangkaṟi left in the Lands if they don't pass it on *(Interview Community Member 4)*

I am Pitjantjatjara and I born in Ernabella. I'm married and I got two children and they are growing and both got big ones. I am a grandmother and they have children. Today I'm talking about ngangkaṟi. There is a hospital in Ernabella and I was born there that time and I grow up. Sometimes I am sick,

and spirit may be a little bit sore. Someone may talk and spirit goes wrong place; sometimes I am sick and spirit maybe sore. Everybody is talking and the spirit can go wrong way. So the ngangkaṟi find our spirit and put it back in the right place. Sometimes we are shaking and ngangkaṟi come in and see sick people and touching and if there is no spirit the ngangkaṟi put it in the right place with their hands. We are sitting outside not sitting in our house inside, trees and hills in a good place a lot of trees and hills it's good. We are all right and sometimes *mamu* get inside and we get sick and the ngangkaṟi make us well *(Interview Community Member 5)*

6.8.2 Spiritual interferences

... my ex-partner committed suicide and I constantly had him in my head talking to me like I am talking to you now. That was my first encounter with Rupert where he assisted with the grieving of that spiritual person as well as the family as well. It is amazing stuff. Once I had consulted with him the talking in my head stopped immediately *(Interview Senior Officer AO1)*

He [ngangkaṟi] has helped a lot of people who have passed over that are still here in the spiritual form. The person who is in the physical form is having trouble letting go. He has the ability to see that person that has passed over – their actual face. He will ask for photos and he will say 'that person there" and sure enough that's the person *(Interview Senior Officer AO1)*

6.9 Other episodes of care

I was paralysed in a wheelchair. Doctors said I will not walk again. My grandfather worked on me. He said that the problem was in my testicles; the testicles were affected, there was fluid around them that could not make me walk. The fluids were pressing on the spine. He worked on me with his hands and that's it, I could walk again, yee I could walk again. That was my grandfather *(Interview Patient 7)*

We got ngangkaṟi in our community Fregon and one ngangkaṟi and another ngangkaṟi and we got *minyma* ngangkaṟi; in the bush we go there and the men get a *pika,* so they are taking him bush and make him better there. We sing and make him better, blowing and singing, *uwa* we sing and make him better. Secret songs, we singing and making him better. People from other community come and ngangkaṟi they are coming and visiting; we see the ngangkaṟi is busy, they working hard and getting tired and they making people better, *uwa*. One ngangkaṟi in Fregon work hard with people, *tjitji*, he works very hard and get very tired.

We had another man, a petrol sniffer. Ngangkaṟi talked about the glue, the inhaling of paint, and they said it is kind of poison to your system. They did a lot of work with him, a little bit around his head, but a lot of work around his stomach. And again, removed a mammal stone...*(Interview Senior Project Coordinator 1-NAO5)*

People with problems, feeling sick, vomiting, ngangkaṟi can make them better, when people get sick maybe vomiting, weak and they call the ngangkaṟi and we know him. And the men sick not eating, no sleep, no happy, something and taking to the bush, we ask and we taken to the bush and making him better, *uwa*. We got *minyma* and *wati ngangkaṟi pulka*. One man from Mimili tell us already he got a problem, ngangkaṟi try to go to Mimili and make him better. He asked to go there. Too cold to go to Mimili... *(Interview Community Member 3)*

My name is Jack Crombie and I'm a traditional owner of this land Yankunytjatjara and down from Fregon to Mimili all that area I've been walking when I was a kid. Ngangkaṟi was playa, really good ngangkaṟi... First in the history we had our own doctor, ngangkaṟi, we had ngangkaṟi before the doctor came with the medicine, tablets. We had ngangkaṟi and we weren't crook, anything like that. Ngangkaṟi was here before the clinic and doctors came out. I grew up in this country and I grew up with my family, kids wailing around, and ngangkaṟi looking after us, we always have ngangkaṟi. Ngangkaṟi is palya, really good because I believe in ngangkaṟi, the first doctor we had, we didn't have tablets, nothing. Ngangkaṟi used to feel us when we're kids, and we were good, palya wiru. Recently, one day I was crook here and the ngangkaṟi felt me so I wouldn't see that Alice Springs doctor. And he fixed me up and I was palya, I was good *(Interview Patient 15)*

My own experience with ngangkaṟi is when my dad was sick and he was in Brisbane.

They heard that my dad was sick, I only been here for six months and they actually came and knocked at my door in the evening and said 'we hear your dad is sick, we'd like to do some work on him'; and I said "Thank you, that's very nice but he is in Brisbane, a long way away." They said "Palya, it's all right, we can work on you and we go through you to your dad." So, they said they would like to do that and I said "Fine, I am happy for you to do it." I didn't know whether I believed it or not, but I thought it was very sweet and I was happy about it. The ngangkari asked me to sit outside. There was three of them and they had their hands on my head and on my back, and they were yelling in Pitjantjatjara which I didn't really understand at that stage, so I didn't really know what was going on. I felt incredibly faint, I was struggling to stay sitting up, I felt like I was going to faint and I could feel from where their hands were on my head down to my back I could feel like a column of heat come through my body and that lasted for about four or five hours even after they finished. After about, I don't know how long it was, they finished and they said "Palya, it's all finished and you can go to bed now," and they actually told me "Oh, if you're going to clinic, you may go back to church and think of your dad." So, I did that, I had to go the clinic for something and church was on the side at the back and thought I may go there. My father was in ICU, he had a major heart surgery and hadn't recovered very well. The next morning at about 6.00, they bang on my door and said "We fixed your dad, ring your mum, tell everything is ok." So I rang later and my mum said to me "Why are you ringing I talked to you yesterday, there is no change..." I told her the story, and said "Just see what happens, if dad has anything to say." So she went up to see him at the hospital that afternoon and he was completely disconnected from everything in the machinery; he was sitting up, bright and happy and he said "Oh, I feel fantastic but I had the weirdest dream last night." And I asked "What did you dream?" And he said "I dreamt that I was Aboriginal and I was travelling with another Aboriginal man and we were tracking this person through the country and eventually we came to this cliff and we got to the cliffs and I threw up.. then I woke up feeling better."

So I talked to somebody else about the story and asked how they interpreted this: what they were tracking was the sickness in your father and when they found it they made him throw up. So that was my story. I don't know how it worked when he was so far away but certainly my father had an experience he never had before. Then about eight months later my dad visited and I hadn't seen the ngangkari actually since then. When my father arrived he [the ngangkari] was on my doorstep knocking in the morning. One of them came in and had breakfast with us and then when he went my dad said "Who is that man? How do I know him? I recognise that man, did you show me a photo of him or something?" And I said "No, it's a ngangkari who worked on you." And after that he used to ring my dad and checking if he was OK every six months, yhe to check how he was." It was very sweet, it was lovely. That was my experience with my dad *(Interview Registered Nurse 3).*

6.10 Conclusion

The stories of healing reported in this chapter represent only a very small collection of countless cases of ngangkari's episodes of care occurring in Aboriginal communities, Aboriginal community controlled health services, mainstream health care services, correctional services, and other organizations across South Australia. This collection is not intended to be exhaustive, rather to give a glimpse of the significant contribution Aboriginal traditional healers make to the health and well-being of Aboriginal people and their communities.

CHAPTER 7

Ngangkaṟi

> We are everywhere. Ngangkaṟi are everywhere, and we are men, we are women, and we are children. We did not invent any of this yesterday, either. All this Tjukurpa comes from ancient days. Because it is so old, it will never die. Ngangkaṟi power will be around forever
>
> *(Andy Tjilaṟi, NPYWC 2003: 35)*
>
> We hold strong Tjukurpa and all ngangkaṟi have to look after this Law. We always want to have ngangkaṟi around. We always need to have ngangkaṟi. They are good for us. We never want to lose our ngangkaṟi. We want to have ngangkaṟi with us for all time. Always
>
> *(Arnie Frank, NPYWC 2003: 82)*

7.1 Introduction

This chapter provides an overview of *ngangkaṟiku Tjukurpa*, that is the law that governs the ngangkaṟi traditional medical knowledge system, its educational and training model, methods of healing and treatment, and the code of conduct by which ngangkaṟi abide. It illustrates the role of ngangkaṟi in health care, ngangkaṟi's perspectives on western medicine and western health practitioners, and what ngangkaṟi consider being the way forward for the actual implementation of a two-way health care model.

The chapter draws on stories as told by ngangkaṟi themselves in the interviews and in the book *Aṉangu Work – Aṉangu Way. Traditional Healers of Central Australia* (NPYWC: 2003). This book provides an exceptional collection of stories directly told by several ngangkaṟi from Central Australia. The idea of this book emerged during a ngangkaṟi meeting facilitated by NPY Women's Council in Muṯitjuḻu, NT. The book brings together ngangkaṟi's stories with the aim to provide non-Aboriginal people, particularly health practitioners, with a better understanding of ngangkaṟi's role and significance; and to promote greater collaboration within the western health care system. Most of ngangkaṟi interviewed referred to the stories told in the book to explain their role, treatments, methods of healing and practices.

7.2 Ngangkaṟi: role and significance

Who are the ngangkaṟi? What is their role and how significant is their work for the health and well-being of Aboriginal people and their communities? And "...why do Aṉangu keep asking for ngangkaṟi help when they can access good health clinics these days and they can easily get a quick needle or a tablet?" (NPYWC 2003: 14). Ngangkaṟi themselves explain who they are and the significant role they play in the health and well-being of Aṉangu and their communities.

Ngangkaṟi are doctors. We are the same as doctors that you would see today. We always were doctors. It doesn't matter that we were bare-bottomed and naked once. It doesn't take away our skill and our power. Just because we wear clothes today doesn't take away our power either. Ngangkaṟi are important! (*Sam Watson*, NPYWC 2003: 43)

In truth, we gravitate towards people who need our help, toward sick people. Sick people call for us. We go to those sick people and we *wiṟunymankupai*. *Wiṟunymankupai* means for a ngangkaṟi to give true spiritual and physical healing, and to declare the person to be well again. People ask for us to come. We see them, give them healing, and later we see them walking around well. That's because of the skill of the ngangkaṟi. We can heal people. All we have to do is see someone and we know straight away that they are ill, and what is wrong with them, and how to put them to rights. We go to them, ask them how they are, talk to them, and heal them successfully (*Arnie Frank,* NPYWC 2003: 86)

I give healing treatments to everybody: to men, women, children, old women, old men, young women and young men. They all come and ask me for help. I work on children and women primarily (*Mrs Curtis,* NPYWC 2003: 29)

Ngangkaṟi live on the earth but they travel to the skies. We ngangkaṟi, including myself, oversee Aṉangu life, from up above in the sky. Up there are many beautiful and wonderful things that have been taken there by our ancestors. It is a good place *(Arnie Frank, NPYWC 2003: 83).*

I am happy to tell you a little bit about my work. It is really good work. I love giving the healing touch to Aṉangu people, particularly little children. Sometimes little children are vomiting and their spirits are low. I always heal them... I love my work. When people ask me for help, I don't make them wait. I am willing to help them right away if they have headaches and so on. If they have more serious illnesses I always respond by applying immediate healing work (*Maṟingka Burton,* NPYWC 2003: 48)

We'd be very careful to look after all the extended family while dangers to our spiritual well-being were about. The ngangkaṟi's job is to make sure everyone is safe. That is the work of ngangkaṟi (*Dickie Minyintiri,* NPYWC 2003: 24)

We support families with our work. We prevent even more sadness from entering families' lives by preventing the death of a family member. Sometimes people can become so sick that their very lives are threatened. For instance, they can suffer great internal pain, as well as feel great sadness and distress. They are desperate for help. Ngangkaṟi can help. We ask the sick person to lie down or to sit down, and then we begin the healing process by touch. After we arrive we sometimes consult with the spirit ngangkaṟi in the heavenly skies for help. By doing so we are given even more strength to do our work. Only ngangkaṟi can do this. Families really value this level of communication, as it brings a special power to the ngangkaṟi and a special level of healing to their sick loved one (*Arnie Frank,* NPYWC 2003: 84-85)

7.3 Ngangkaṟiku Tjukurpa

Ngangkaṟi Tjukurpa or Ngangkaṟi Law encompasses the whole Aboriginal traditional medical knowledge system passed down from generation to generation since time immemorial. *Ngangkaṟi Tjukurpa* incorporates the health belief system on which ngangkaṟi's health care model and healing processes are grounded. It includes the conceptual foundations of illnesses, their causes, symptoms and effects; it incorporates the practical knowledge and skills associated with ngangkaṟi treatments and methods of healing; it dictates the rules of a rigorous ngangkaṟi educational and training model.

Aṉangu own a lot of information and Law from healing to gathering bush tucker and wild foods. We have always had this knowledge and it has been taught to others by example. We have spent our lives following in the footsteps of our elders and they taught us by example until we became proficient ourselves (*Arnie Frank*, NPYWC 2003: 84)

We live and work on our land and we have been given strong Tjukurpa from this land. We have been taught the stories of the land, which we now inherit. It is our duty to keep on working, so as to be able to pass down the Law that we know. We do not want to

die without properly passing it down to the right people. We are not much use to the living if we are dead...We need to be as strong as we can so that the culture we have can be held really strongly by living, healthy people (*Arnie Frank*, NPYWC 2003: 86)

A normal kind of ngangkaṟi treatment comes from the hands, where the main power is. Power! Power! Ngangkaṟi power enters the sick person, and the sickness is extracted in a physical form, so that the sufferer can see with his or her own eyes what was causing the pain. The healer can either throw the object away, or bury it somewhere...this is ngangkaṟi Tjukurpa (*Andy Tjilari,* NPYWC 2003: 35)

What a very special gift we have, don't you think, when we can get into touch with the spirit ngangkaṟi who reside in the skies? I don't know anyone else who has such an intimate relationship with the stars. What are stars? Lumps of stone? Not really! They are *kililpi* – stars – and they are made of special substances. They are very, very ancient. *Kililpi* have their own spirit. The spirit descends from the stars down to us on the earth just like a waterfall. They are also teachers. Our own fathers told us, "Never forget about the spirit of the stars. Watch them all the time. They can teach you." So we keep the Tjukurpa alive because it is so important. Ngangkaṟi can heal people because of all this power and old Law. Ngangkaṟi men are called *Wati Tjukurtjara* – men with ancient power. Men who can heal inside without cutting open their stomach (*Arnie Frank,* NPYWC 2003: 85)

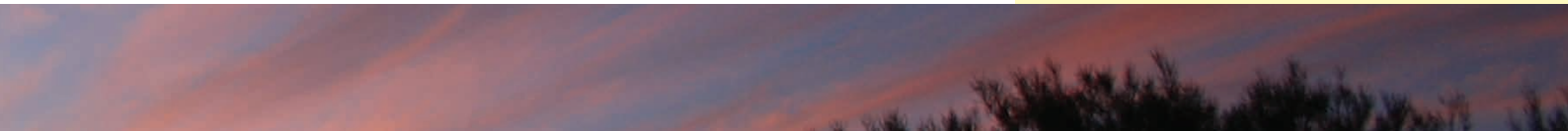
We hold strong Tjukurpa and all ngangkaṟi have to look after this Law. We always want to have ngangkaṟi around. We always need to have ngangkaṟi. They are good for us. We never want to lose our ngangkaṟi. We want to have ngangkaṟi with us for all time. Always (*Arnie Frank*, NPYWC 2003: 82)

7.4 Ngangkaṟi educational and training model

Ngangkaṟi's traditional medical system is based on a unique Aboriginal educational and training model. The educational and training model consists of a conceptual and practical learning process grounded on a trans-generational transfer of medical knowledge, skills and healing techniques. The learning process starts from an early age: child ngangkaṟi are taught from their ngangkaṟi elders, fathers, grandfathers, mothers, grandmothers, uncles and aunties. The training and nurturing of child ngangkaṟi is pivotal for the trans-generational transfer of medical knowledge and healing techniques on which the educational model is based.

Ngangkaṟi learn from other ngangkaṟi. They are taught from a long heritage of traditional healing. There are ngangkaṟi men, women and children. All ages can be a ngangkaṟi. Ngangkaṟi speak many different languages and dialects. Ngangkaṟi become ngangkaṟi because somebody else has given them the power. Ngangkaṟi teach by example. A person will inform a ngangkaṟi about a certain person's

Land is our university. Our university is different we don't learn from books, we learn from old people through the land, through the stories... The land is sacred, the land belongs to our ancestors and all things on land are sacred, we have to look after our land *(Cyril McKenzie)*



sickness and that ngangkaṟi will then go about healing the problem (*Arnie Frank*, NPYWC 2003: 84)

We have been working for many years as ngangkaṟi. We started working as ngangkaṟi when we were children, after we were given the powers from our grandfathers (*Kumanara Peters*, NPYWC 2003: 38)

I became a ngangkaṟi when I was only a child. At a young age I learnt how to travel to the sky in my spirit body. Ngangkaṟi always do this. It is one of our special skills. My father used to take me up and we would often travel around the skies together in our spirit bodies. My father was a very powerful ngangkaṟi (*Sam Watson*, NPYWC 2003: 40)

There are still a lot of new ngangkaṟi coming up...We need as many young ngangkaṟi as we can get in this life. We need to make sure that the new young ngangkaṟi get as much training in the old ways as they can. We need all the old powers and skills to be kept alive and not get lost. People need to have these ngangkaṟi around today. They'll need ngangkaṟi tomorrow and in the future too. Child ngangkaṟi make good ngangkaṟi. Their ngangkaṟi powers increase as they grow up and by the time they are adult men and women, they are very powerful, highly skilled and experienced (*Sam Watson*, NPYWC 2003: 42)

There are some very good young child ngangkaṟi around, which is great news for us. They are starting out at the same age as we did (*Andy Tjilari*, NPYWC 2003: 20)

I was taught by the old men, and I carry their old skills with me today. Most of those old men are now dead. My uncles are dead, my fathers are dead. But those old men taught many young ngangkaṟi of my generation and here we are still today (*Sam Watson*, NPYWC 2003: 43)

Grandfather was the man who gave me so much. He'd teach me and give me knowledge and power. He'd sometimes extract dangerous sicknesses from me. He'd then show me what he did with them and instruct me how to do it myself next time (*Dickie Minyintiri*, NPYWC 2003: 22)

I was just a little child when I became a ngangkaṟi. When I became a man I felt I was a fully-fledged ngangkaṟi. Ngangkaṟi learn all the basics of ngangkaṟi healing arts when they are children. We become more powerful ngangkaṟi when we become men (*Jimmy Baker*, NPYWC 2003: 76)

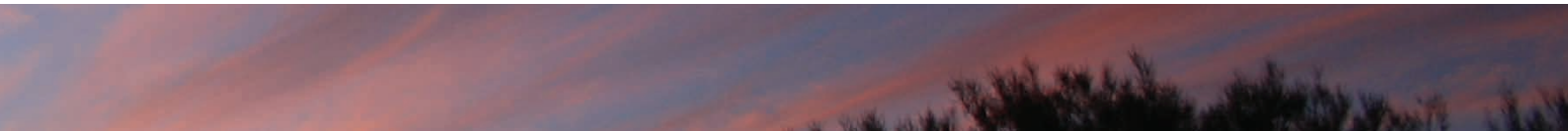
My mother helped me greatly to do my work when I was a junior ngangkaṟi. I started my life as a child ngangkaṟi, healing people, and now, as an old man, I am still healing people. So I have come full circle (*Whiskey Tjukaṉku*, NPYWC 2003: 61)

I said to my father, 'But how? How am I supposed to do that? I don't understand how ngangkaṟi work. How could I ever be able to do that?' He replied, 'Don't worry, we'll show you. It won't be hard once you know how. So I was shown, I was given the power of a ngangkaṟi by all my grandfathers, and I still have that power today. They taught me everything I know. They didn't tell me how to do it. They showed me. They also placed inside me the sacred objects I would need to be my tools for working as a ngangkaṟi. These are called mapaṉpa. Nobody else showed me or taught me. I didn't learn from any books or papers (*Andy Tjilari*, NPYWC 2003: 33)

I had two fathers. Both were powerful ngangkaṟi...Both these men gave me powers and training. They would take me with them on their travels. We travelled around in the middle of the night. I saw and learnt many skills. I was taught how to remove objects from sick people. Objects like chips of bone. My father would watch me pull out chips of bone from people. He would observe my way of working, making sure I was doing it right. He taught me a lot over the years, all through my childhood and young adulthood... By the time I was a young man, I was on the way to having great powers. By the time I became a man, I was as powerful as my father (*Sam Watson*, NPYWC 2003: 40)

When I was growing up I used to have three grandfathers who were ngangkaṟi. The first one was my mother's father. The second was my father's father and there was a third, who was another one of my father's fathers. So I lived with these three ngangkaṟi. Well, actually, there were four, because my father was a ngangkaṟi as well... (*Andy Tjilari*, NPYWC 2003: 32).

My grandfather asked me, 'Do you want us to give you ngangkaṟi power, so that you



can live your life as a ngangkaṟi? You'll have to help sick people and heal them, whether they are men, women or children'. I replied, 'But grandfather, I am not a ngangkaṟi. I don't know how to do it'. He replied 'Well, if you want to, I can give you some power right away, and you can make a start on your life as a new ngangkaṟi. What do you think? You tell me. Don't forget, if you do become a ngangkaṟi, the power will stay with you all your life and you'll never lose it or be able to throw it away. So if I make you a ngangkaṟi now, you will always be a ngangkaṟi' (*Andy Tjilari,* NPYWC 2003: 32-33)

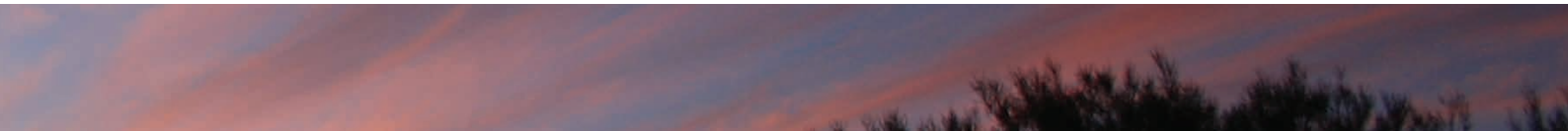
When I started as a ngangkaṟi I was only a small child...my grandfather was a ngangkaṟi. He was my mother's father. I was always watching him work on sick people. I used to run and fetch things for him, and do things for him. I was always nearby... As he was working I looked carefully at his hands. At one point I saw something come into his hands. I wondered, 'what is that he has there?' I was intrigued, I hung around really close, pestering him to show me what he had...Later on, I asked him, 'Grandfather, what was inside that person's muscle? What was that dark thing, that blackish thing?' My grandfather told me...that something had been lodged inside that knot of muscle. He'd looked and searched and he'd found what he was after. Then he took it out and cleared out all the space, widened the space, and then threw away the black object. He cleared out all of the things that were inside. He also went up and down the spine carefully looking for foreign objects that may have been lodged in there too. He took whatever it was from the sick person's body. He took it outside. He carried it away, all the time thinking about the state of the person's spiritual well-being and their spirit (*Kumanara Peters*, NPYWC 2003: 36)

I learnt all my ngangkaṟi skills from my grandfather and my older brother when I was a small child. They taught me how to touch in the healing way. They'd call me over when they were treating a sick person. The sick person would be saying, "I am really ill." I'd come running up and I'd watch and learn and listen carefully to what they were saying...They'd show me the sorts of objects I'd have to extract. "Here, take a look at this. This is what you've got to extract from the sick person." They'd wriggle the object out of the sick person's body. So I'd work too, very very carefully, with both hands. You have to be very careful because of the risk of actually spreading the sickness even more widely through the body. You must gently ease the sickness into a round bundle. I learnt how to do this when I was just a young child' (*Dickie Minyintiri*, NPYWC 2003: 22)

'Father, how do you get your powers and how do you keep them?' He replied like this 'It happened like this. Our minds are opened and our two hands are opened, and we then become ngangkaṟi'. I then told him, 'Father, one day I want you to give me some of your powers. I want to inherit your powers of healing and to follow in your footsteps. One day I want to be able to pass it on down the line to your grandchildren. I want to be able to heal all my nephews and nieces when they need it, and one day in the future, help my own grandchildren too'...He gave some of his powers to me. He gave me some *mapaṉpa* – ngangkaṟi sacred tools – I still have the *mapaṉpa*. The mapaṉpa he gave me were absorbed into my body. They help me to enter into people's spirits and heal them from within...He gave me the power to look at people's spirits and to reposition them if they are out of place. I can see their spirits clearly, when I enter into the bodies of the women and children who come to see me for healing (*Maṟingka Burton*, NPYWC 2003: 47)

These testimonies illustrate the ngangkaṟi educational and training model. This unique educational and training model is governed by specific rules, training techniques and processes for the development of the necessary skills to become, and practice as a fully-fledged ngangkaṟi. This educational and training model stands at the core of the Aboriginal traditional medical knowledge system in the same way the western educational, training and professional development model stands at the core of western allopathic medicine.

Ngangkaṟi work the same as doctors. We are equal in our work. The only difference is that doctors and nurses learn their jobs at university. This is the way white people get most of their learning, regardless of what they do... (*Andy Tjilari and Kumanara Peters*, NPYWC 2003: 20)



7.5 Ailments

Ngangkaṟi attend to a broad range of ailments, including specific women's, men's and children's health; physical pains such as back, head, tummy, or stomach ache; mental health issues, eye problems; teeth and mouth problems; cold, fever and flu. Some ngangkaṟi attend to any ailment occurring in men, women and children; some ngangkaṟi specialize in treating specific sicknesses or specific part of the body whereas others specialize in women' health, children's ailments or men's health issues.

> ...I have lived all my life working hard, healing hundreds of people, and banishing their illnesses in the ngangkaṟi way. I heal sick people: children, children with upset stomach, sick women and sick men. I specialise in problems with the head. If a woman with a bad head problem needs help, I can heal her. It is one of my specialties. I heal them in the health clinic too...' (*Nakul Dawson*, NPYWC 2003: 55)
>
> Everybody has their own specialties. The men certainly have strong power and special abilities. They are generally at the top, they are number one, the men. They have a special power (*Josephine Mick,* NPYWC 2003: 57)

The next sections provide a sample of ngangkaṟi interventions in specific health areas as told by the ngangkaṟi themselves.

7.5.1 Mental health

The significant contribution of ngangkaṟi in the area of mental health has been nationally and internationally acknowledged. In particular, the ngangkaṟi service provided through the NPY Women's Council Ngangkaṟi Project has received national and international recognition with the following awards:

· 2011 International Sigmund Freud Prize delivered at the Sixth World Congress for Psychotherapy held in Sydney, 26 August 2011;

· 2009 Mark Sheldon Prize awarded by the Royal Australian and New Zealand College of Psychiatry (RANZCP);

· 2009 Dr Margaret Tobin Award for excellence in the provision of mental health services to those most in need;

· 2004 'Gold Medallist', National Services for Australian Rural and Remote Allied Health.

In South Australia, ngangkaṟi across the APY Lands continue to provide assistance and healing in the mental health area in remote, rural and urban area.

> Aṉangu call people who have mental health problems 'ramaṟama' people. They can be ramaṟama for a number of reasons and we can usually help them (*Jimmy Baker*, NPYWC 2003: 76)
>
> We specialize in treating people with mental health problems. We go around and see people after they contact us (*Andy Tjilaṟi and Kumanara Peters,* NPYWC 2003: 18)
>
> I...also treat people who are ramaṟama. Ramaṟama means that they are suffering emotional or mental problems...I look into their ears and at their cheeks. I take negative energy out of their cheeks. For very sad people and for people who cannot seem to get out of their depression, I always give ngangkaṟi treatments. It always makes them better...' (*Mrs Curtis,* NPYWC 2003: 30)
>
> Ngangkaṟi help with emotional issues and stress in a much more gentle and clean way. They use various methods (*Elsie Wanatjura*, NPYWC 2003: 15)

7.5.2 Child health

Ngangkaṟi attend to a range of children's ailments, including diarrhea, gastroenteritis, stomach sickness, temperature, cold and flu. Ngangkaṟi women mostly specialize in treating newborn babies' ailments and children's health issues.

> I work hard as a ngangkaṟi. I work all hours of the day and night: at the health clinic in the day, and at home in the middle of the night...I often have to help sick babies in the middle of the night...By taking care of sick little children straight away, especially at night, we can avoid an emergency evacuation by plane the next morning. We Aṉangu don't like to see little children getting evacuated by plane. Sometimes if they have terrible diarrhoea and gastroenteritis they have to be evacuated. But by stopping the problem before it becomes serious we can avoid emergency evacuations. When children with bad diarrhoea are brought to us, the treatment is usually a healing breath. We will

work on them and give them the ngangkaṟi healing breath. That special breath stops diarrhoea and stomach sickness...Once they are treated, they get better and they are taken back home. They don't need to go to Alice Springs. It is really good and important work...I enter their spirits to heal them and they are soon up and laughing *(Maṟingka Burton, NPYWC 2003: 48-49)*

Children who get sick usually have really tight bellies that give them a lot of pain. I work on them and quickly make them well again...I travel a lot giving treatment, especially when there are infections going around and people have fevers and high temperatures...When someone has high temperature, a ngangkaṟi can easily bring down the temperature... Ngangkaṟi can sort out bad backs, no problem! Others can have trouble with their eyes... (*Mrs Curtis*, NPYWC 2003: 29)

When I am asked to give healing treatments, I am always willing to help, especially for little children, as they are so important. I often hear about little children who are evacuated to distant hospitals where they have to sleep among a great number of other sick children. In Adelaide Hospital there are lots of sick children, but this can be avoided to a certain extent if the children are brought first to a ngangkaṟi like me, who can give them the healing touch. I make children well and healthy before they get too sick. We ngangkaṟi can stop sickness escalating into something more serious. That is our work. We prevent children from having to go to hospital. We heal children at home. We are keen to heal children, as we love them all. When children get sent off to hospital, their mothers and fathers are so sad and worried. They worry about their children being in a hospital so far away from home. When children are brought to us for ngangkaṟi healing we make them better, and that makes their mothers and fathers very happy' (*Lily Baker*: NPYWC 2003: 68)

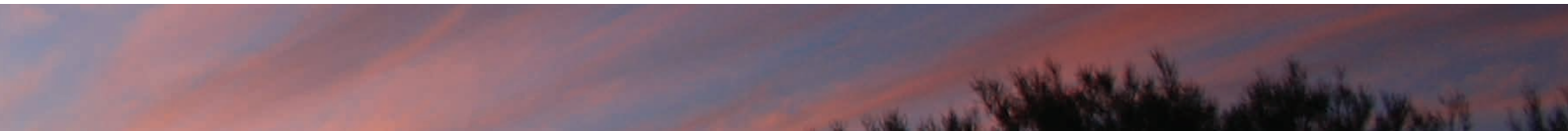
I worry about the little children. Even if little children are brought to me at night I don't mind. I always get up out of bed and give them the healing touch. Their mothers and fathers are always desperately worried about their children when they fall sick because they think they'll get sent off to Alice Springs Hospital or Adelaide Hospital. That's why they bring they children to me, so I can heal them quickly before they get worse. Us two ngangkaṟi here at Iwantja have been able to prevent a number of children from having to be evacuated to hospital, because of our healing touch. We might touch the child and say, 'This child has got a high temperature'. So we give them the ngangkaṟi healing, to make them well again. When a child has got bad gastroenteritis, I stop it by blowing on them. The healing breath and healing touch can stop diarrhoea (*Lily Baker*, NPYWC 2003: 70)

...I have looked after a lot of children and they have all been good...I do this kind of work often and I don't get paid for a lot of it. This is my work. I look after sick children. Men look after children too, but it is primarily the work of the women to look after children. We are the primary carers. This is our Aṉangu way, our tradition. We care for our sick children, and us ngangkaṟi also do that work (*Josephine Mick*, NPYWC 2003: 56)

Sometimes they bring sick children to me at night and I say... You've brought this little girl to me in the middle of the night'. But I still get up and I heal her that night. After the healing I say to the child, 'Tomorrow, you'll be better and you'll be playing again!' I use my power but I also say 'perhaps you could take her back to the clinic again tomorrow for the doctor to check and to get some other medicine. If the clinic can't do anything for you, bring her back to me and I'll work on her again' (*Naomi Kaṉtjuṟiny*, NPYWC 2003: 62)

...a woman came to me carrying her small son, who was sick with diarrhoea as well. She said, 'Hey, he has bad diarrhoea and I don't know what to do about it'. I said, 'You should let the nurse know'. She replied, 'No, I tried but I wasn't satisfied. She gave me only rehydration fluids' So I said, 'Oh all right then, hold him and I'll blow on him'. So I blew on the child. He got better again after he was home and held close and given loving attention. I went to see him later and he was completely better (*Naomi Kaṉtjuṟiny*, NPYWC 2003: 62)

One day a little boy was very sick vomiting, diarrhoea and they called the doctor flying on the airplane. I went and see the little boy and I touch here and here [the belly] with



my hands and the diarrhoea and vomiting stop. Yes, and the doctor arrived and he had to go back in the airplane, little boy was OK *(Interview Ngangkaṟi 9)*

7.5.3 Women's health

Ngangkaṟi, mostly *minyma* ngangkaṟi, can attend to specific women's health issues.

As a ngangkaṟi I help to heal women who have women's problems. Women come to see me and sometimes they get a big surprise to find the level of help they get from me. I understand women's problems and I can help them out with these women's sicknesses. That is one of my specialties. Not everyone likes working with women's problems, but I do (*Josephine Mick*, NPYWC 2003: 56)

...one night a woman came to see me. She called out, "I've come to see you Naomi! I'm sick!" I said, "What's wrong with you?" She said, "I'm in pain." I replied, "All right then, you'd better show me." So she showed me and I did some healing work all over her. When I was done I said, "Well, are you still in pain now?" She said, "No, I feel so much better. I am so much better...you really shifted that pain from me" (*Naomi Kantjuriny*, NPYWC 2003: 63)

There are some women's sicknesses, however, that can be attended only by ngangkaṟi men.

7.5.4 Physical pains

Ngangkaṟi play a significant role in the delivery of pain relief treatments.

I have come across many different ailments in my lifetime. I deal with the pain and the sickness... (*Jimmy Baker*, NPYWC 2003: 76)

There is the healing thing we call it *puntja*. One day in NT south-east of Alice Springs, *ngayulu*, that's my story. This man was very ill, he was playing football and they were looking for ngangkaṟi and they couldn't find a ngangkaṟi. They came around and said "Are you ngangkaṟi?" And I said "Why?" And they said "This is my son, is very sick, his ankle was really bad and hurt." And I said "What's wrong with him? There is something wrong with him?" "The ankle." And I said "Palya, come around, I will have a tea first." And they took me to their place and it was first time here. And this man *puntja*, we call it *puntja*, I don't know how you call it in English, *puntja* is like doing something, like doing. This man was really hurt and he was crying in pain and I went around with my cousin. And I started see his ankle and I did *puntji* his ankle and five minutes later he was fine and he was so happy next day. He was telling the world about it (*Interview Ngangkaṟi 8*)

Last night I saw a *kungka*, pain in the back. Another one she got pain here in the shoulder. I did the blowing, and she's better now. I am waiting for more coming over here to do ngangkaṟi (*Interview Ngangkaṟi 7*)

If your legs are not working, then things like that can be healed by a ngangkaṟi and some aches as well. Most things we can do the same as a GP but with our hands (*Interview Ngangkaṟi 6*)

I work day and night with people, people who are sick come and say "Hey I am sick here or here, I've pain here and here," and I do ngangkaṟi work with my hands, my hands get very warm and I do the healing with my hands (*Interview Ngangkaṟi 3*)

7.5.5 'New' sicknesses

Ngangkaṟi talk about 'new sicknesses' when referring to the range of illnesses emerged after the arrival of Europeans. These include alcohol and substance abuse, diabetes and petrol sniffing among others. Ngangkaṟi explain how they can not heal these 'new' sicknesses, especially those related to substance and alcohol misuse and petrol sniffing,

...people who expose their bodies to petrol fumes or alcohol, or any other dangerous and poisonous substances, are particularly at risk. We ngangkaṟi cannot help them when their bodies start breaking down and they cannot control their motor functions. We ngangkaṟi have never been very successful at treating substance misuse...When I give treatments to the petrol sniffers, I often use the blowing breath type of treatment... (*Mrs Curtis*, NPYWC 2003: 30)

If they have been touching too many wrong things, such as petrol inhalation and other substances like marijuana, they can ruin their brains. Ngangkaṟi can't help them. Too many people are like this today. They might go from one ngangkaṟi to another but it won't work. We can't help with petrol sniffing and drug damage, no matter what you try to pay us! (*Jimmy Baker*, NPYWC 2003: 76)

We never used to have cancer. We used to drink water, only water no soft drinks but when they introduced drinks, sugar coming in the sickness coming. Sugar big trouble, too much sugar. All white man sicknesses, diabetes, we didn't have it before...*(Interview Ngangkaṟi 1)*

7.6 Methods of healing and treatment

Ngangkaṟi methods of healing and treatment are part of ngangkaṟi *Tjukurpa*. The methods of healing and treatment are ingrained in the Aboriginal traditional knowledge system as fundamental components of a whole and coherent system which includes illness causation processes; physical, mental and spiritual manifestations of illness; restoration of physical, mental and spiritual health and well-being. Ngangkaṟi use a range of healing methods and treatments. These are primarily hands-on treatments.

A normal kind of ngangkaṟi treatment comes from the hands, where the main power is. Power! Power! Ngangkaṟi power enters the sick person, and the sickness is extracted in a physical form, so that the sufferer can see with his or her own eyes what was causing the pain. The healer can either throw the object away, or bury it somewhere... (*Andy Tjilari,* NPYWC 2003: 35)

We ngangkaṟi heal with our hands. We heal with *maṟa,* hands, to take out sickness from sick people, and we make them well and happy *(Interview Ngangkaṟi 7)*

My father...told me that the way I would have to heal people would be to pull the sickness out of their bodies in the form of pieces of wood, or sticks, or stones, things like that. This is so that people can actually see with their own eyes the sickness that is removed from their bodies. This is the commonly accepted way we ngangkaṟi do our work. It is so that people can see us taking their sickness away from their bodies, which gives them a sense of removal. My father told me I'd have to make sure I showed them what I took out, so they could see it, before I disposed of it (*Andy Tjilari*, NPYWC 2003: 33)

Ngangkaṟi use their special skills to pull sickness out of people (*Sam Watson*, NPYWC 2003: 40)

Ngangkaṟi's hands-on methods of healing include different typologies of treatments. In addition, there are other methods of healing including:

a. *Blowing breath method*
b. *Spiritual healing*
c. *Suction method*
d. *Massage and wound healing*
e. *Bone manipulation*

These methods of healing can be combined or performed independently depending on the typology of sickness. All these methods aim at removing a wide array of ailments and reinstate the physical, mental, emotional and spiritual health of patients.

7.6.1 Blowing breath method

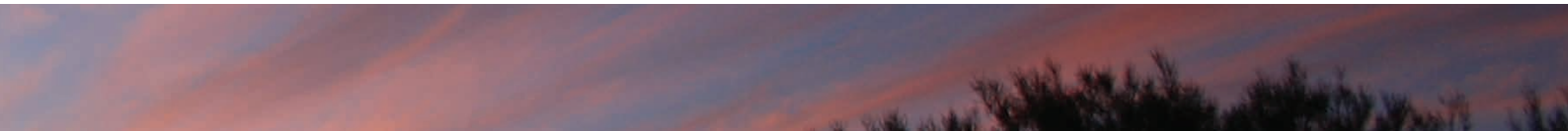
The blowing breath method – *puuṉi* – involves the use of ngangkaṟi healing breath to execute the healing. The ngangkaṟi blows on the sick person on a specific part of the body so that the healing breath is introduced in the patient's body to provide the required healing.

When children with bad diarrhoea are brought to us, the treatment is usually a healing breath. We will work on them and give them the ngangkaṟi healing breath. That special breath stops diarrhoea and stomach sickness. I often give that treatment to children with diarrhoea and to adults with headaches. It is really good and important work...I enter their spirits to heal them and they are soon up and laughing (*Maṟingka Burton*, NPYWC 2003: 49)

My husband was...skilled with the healing breath treatment (*Mrs Curtis*, NPYWC 2003: 28)

One time, they did bring a young girl back [after the clinic] to me and after I did some more healing work I said "She is all better now!" She was the same tiny child that had just been brought to me, really ill! Another time, a different child was brought to me with an upset stomach and diarrhoea. So I did some healing work to fix the diarrhoea. I also blew on the stomach area. From my healing breath on the stomach, that child became well and the diarrhoea was cured. After that blowing therapy she was well and playing again (*Naomi Kantjuriny*, NPYWC 2003: 62)

...a different child turned up with an upset stomach. He had diarrhoea. He turned up at my house. I worked and worked on him but his bowels continued to spasm and contract



again. His bowels were still loose when he came back to me, so I blew the breath on him and then I was able to say, "You are all right now...don't go off to Alice Springs. Stay here and get well" (*Naomi Kantjuriny*, NPYWC 2003: 63)

I can usually determine if a person has been sick for a long time or only a short time. I can tell if they have something rotten inside of them. I look at the object closely and I blow on it – this is called *puulpai*. I blow on it from above. This can sometimes neutralise the sickness. My spirit gets a strong feeling about what to do. Next, I usually have to grab it and throw it back to where it came from (*Nakul Dawson*, NPYWC 2003: 55)

7.6.2 Spiritual healing

Tablets can't heal the spirit. Ngangkaṟi can. Ngangkaṟi can see right into the spirit and the mind. Ngangkaṟi see right inside the *kurunpa* – the spirit – and get straight to the heart of the matter. What is *kurunpa*? There is *kurunpa* inside you and inside me. It lives inside our bodies giving us life...(*Elsie Waṉatjura*, NPYWC 2003: 14)

Ngangkaṟi spiritual healing focuses on patients' spiritual wellness. Spiritual healing is grounded in the existence of a spiritual realm that interacts with the three-dimensional biological forms of existence. Ngangkaṟi spiritual healing involves the interaction of three main spiritual entities: ngangkaṟi's own spirit, patients' own spirit, and different spiritual entities called *mamu.*

Ngangkaṟi's own spirit, patients' own spirit, and other spiritual entities take part in a complex web of interdependent relationships that impact on the health and well-being of individuals, families and communities. The spiritual realm, in its diversified forms, plays a significant role in the health and well-being of individuals, families, communities, land and the environment. As a result, patients' physical, mental and emotional ailments can be caused by or associated with spiritual disorders or disturbances occurring in the spiritual realm.

Ngangkaṟi identify spiritual disorders as either the main or concurring cause in the illness causation process of different ailments, such as fever, vomit, headache, physical weakness, lack of appetite, depression and emotional imbalances. In these cases ngangkaṟi utilise different methods of healing to treat such spiritual disorders. These methods of healing include:

1. Realignment of patient's own spirit
2. Use of ngangkaṟi spirit bodies
3. Intervention on terminal and deceased patient's own spirit
4. Removal of spiritual interferences

1. Realignment of patient's own spirit

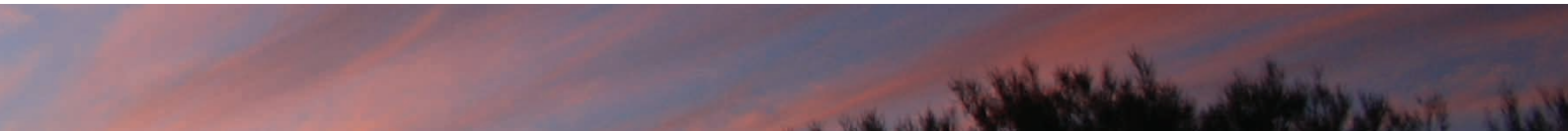
The realignment of patient's own spirit is a method of spiritual healing utilised when the ngangkaṟi diagnose the displacement of the patient's own spirit – *kurunpa* – from its proper position in the physical body. Displacement of one's own spirit from its original position can cause physical, emotional and psychological ailments, including fever, vomit, headache, physical weakness, lack of appetite, depression and emotional imbalances. In these cases ngangkaṟi can reposition the spirit of the sick person in the right place. This realignment provides immediate relief from the ailments caused by the displacement of the patient's own spirit. Realignment of a patient's own spirit is a method of spiritual healing that involves the following procedure: the ngangkaṟi examines the patient to locate where the patient's own spirit is misplaced; the ngangkaṟi identifies, captures and repositions the spirit in the right place with his/her hands.

I can touch the spirit of someone who is suffering from sadness, depression, or is feeling out of sorts or not quite themselves. They'll be feeling a displacement of spirit. I can find their spirit and relocate it to the correct spot. I can get them back on the right track (*Sam Watson*, NPYWC 2003: 42)

What works best for a ngangkaṟi is to look over the person both outside the body and inside, where the spirit dwells. Ngangkaṟi are particularly effective when working with children this way (*Kumanara Peters*, NPYWC 2003: 37)

When we see people's spirits, we see them as alive and moving. We see their blood, living and moving. Ngangkaṟi see the spirits of people. It is easy for us. We see their spirits with our eyes and with our mind's eye too (*Jimmy Baker*: NPYWC 2003: 77)

The realignment of patient's own spirit is a method of healing that allows ngangkaṟi to



treat ailments that often cannot find a medical response in the western biomedical system.

2. Use of ngangkaṟi spirit bodies

Ngangkaṟi use their spirit bodies as a method of spiritual healing. Ngangkaṟi spirit bodies – *marali* – can temporarily leave the ngangkaṟi physical body to visit sick people and provide them with spiritual healing. The use of ngangkaṟi spirit bodies is a method of spiritual healing which involves the diagnosis and treatment of patients in the spiritual realm. It is a method that requires special skills which are unique to ngangkaṟi. This method is explained in the following way:

> A ngangkaṟi can sometimes get a better diagnosis and a more effective healing treatment if he or she is able to see the person and treat them at night first from the *marali* – spirit body...the ngangkaṟi will go out in his *marali* spirit body and heal the sick person through his spirit body (*Kumanara Peters*, NPYWC 2003: 37)

> I gained more skills when I was travelling around in my spirit body because when ngangkaṟi do that, they get to see and hear sick people calling out for help. People, children and adults, ask for help in their dreams. Their spirit calls out for help, and our spirit bodies hear them and go to them (*Whiskey Tjukanku*, NPYWC 2003: 60)

> During the night, when they were asleep, the spirit bodies of the ngangkaṟi would start to rise up from their sleeping bodies and soar upwards. Now, you know how people fly around in aeroplanes and drive around in cars? Well, for Aṉangu ngangkaṟi, when they are asleep at night, their spirits move around in a similar kind of way. The ngangkaṟi could be men, women or children. Their spirit bodies begin to fly around and to visit the sleeping spirits of other people to make sure all is well *(Andy Tjilaṟi,* NPYWC 2003: 33)

> I work in the communities, I do a lot of ngangkaṟi work. Sometimes people knock at the door at night and I have to help. Sometimes it's very tiring, you know, our work is with our spirit *(Interview Ngangkaṟi 9)*

> We ngangkaṟi enter the skeleton by way of the spirit. We enter the body like that. We travel by spirit and enter the bones or the muscle. We heal from inside. We don't give injections and we don't spill blood. Blood doesn't come out from the skin by our method. Doctors give a person who is having an operation another person's blood by transfusion into the veins under the skin. This can bring the person back to life, but the blood is still somebody else's blood. Sometimes the blood comes from a person who is now dead. We ngangkaṟi can see it. Other people's blood inside a sick person is a problem for us ngangkaṟi. We also believe that putting someone else's blood into a person can kill them. We worry about that dead person's blood being in a living person's body. We can see it and we can feel it. It can be the cause of that person dying during the operation. This is what the ngangkaṟi believe (*Jimmy Baker,* NPYWC 2003: 74)

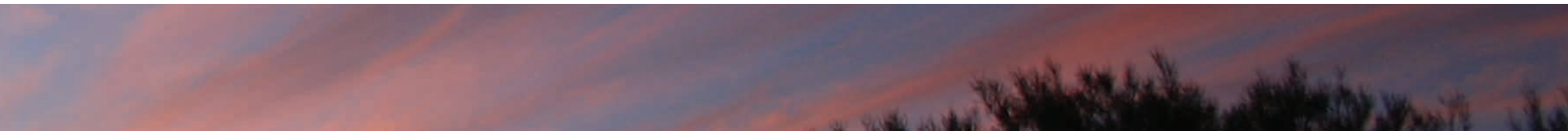
> Aṉangu doctors work with the spirit of the sick person, both when he or she is awake and when he or she is sleep. Ngangkaṟi work at night when all is quiet, gliding among people's sleeping spirits similar to the way an eagle soars... Ngangkaṟi travel in their spirit bodies at night, meeting up and conferring with each other (*Elsie Waṉatjura*, NPYWC 2003: 15)

3. Intervention on terminal and deceased patient's own spirit

The intervention on terminal and deceased patient's own spirit is a method of spiritual healing that focuses on assisting and supporting patient's own spirit in the last period of their life and after death. Ngangkaṟi provide spiritual healing to terminal patients by assisting their spirits to pass away in a safe way. Ngangkaṟi's spiritual healing provided to patients in palliative care provides invaluable spiritual and emotional support, not only to the dying patients, but also to their families. Ngangkaṟi provide unique emotional and psychological support in the grieving process of the patient's family and friends. Ngangkaṟi intervention on the spirit of a deceased person has profound benefits for the afterlife of the spirit and for the maintenance of balanced relationship within the family of the deceased person.

> Ngangkaṟi also help people who are dying. If a person who is dying is not clean in body and spirit, it can leave them open to preying on by *mamu*. So when a dying person is attended by a ngangkaṟi, their death and afterlife is safe and wholesome (*Sam Watson*, NPYWC 2003: 43)

> Sometimes when people die and their spirit



is lost, it goes around in the house. We pick it up and put it in the family because family has to look after the spirit (Interview, *Cyril McKenzie*)

4. Removal of spiritual interferences

The removal of spiritual interferences is a method of spiritual healing that re-establishes the physical, emotional and mental health of patients in cases where their health has been disrupted by some spiritual interferences. Spiritual interferences can be caused either by spiritual entities – *mamu* – or by the spirit of deceased people. These interferences can have serious negative consequences on people's physical, emotional and mental health as they cause a range of physical and psychological ailments, including hallucinations, headache, weakness, vomiting, body pain:

> I sometimes get asked about my methods. I have to tell people that my work is dangerous. Ngangkaṟi work with *mamu*. *Mamu* are dangerous. So you've got to be terribly careful. I don't want anybody saying bad things about the work that ngangkaṟi do, because you can't underestimate our work. It is dangerous because of *mamu*. People do get sick (*Dickie Minyintiri,* NPYWC 2003: 26)

> Many years ago, a very serious *mamu* – a negative dangerous force – attacked Aṉangu people... It is called Measles. It attacked from all direction...I worked myself to the bone giving people endless healing treatments for Mamu Measles. I would get very tired, I would just cry. It was terrible, people had terrible pain in their heads, chests and hearts... Fortunately, there were powerful ngangkaṟi around at the time, including my husband and me.... That time was very informative. I learnt a great deal and became so much more experienced (*Mrs Curtis*, NPYWC 2003: 30)

The removal of spiritual interferences through ngangkaṟi spiritual healing also includes the elimination of *mamu* from public buildings and private dwellings. The presence of *mamu* or spirits of deceased people can seriously affect people's health and contribute to the development of different kind of spiritual disorders and physical ailments.

7.6.3 Suction method

The suction method involves the use of the mouth to suck and pull out sicknesses. Ngangkaṟi use the suction method for different purposes. These include: to pull out sicknesses from the patient's body; to clean out the blood; to provide pain relief for different body pain, for example headache. The suction method can also be used in combination with other healing treatments.

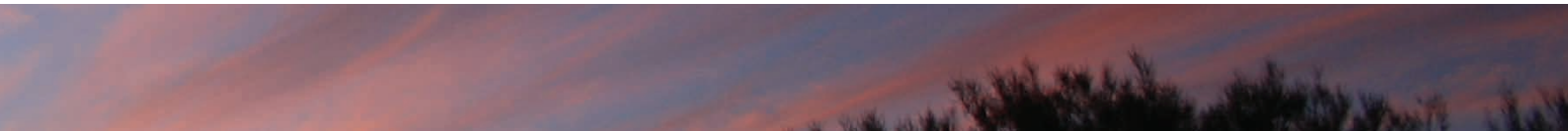
> Ngangkaṟi can capture negative energy inside the body and expel it, mostly by using the mouth – more often than using the hands. We can see clearly what is wrong with somebody (*Dickie Minyintiri*, NPYWC 2003: 24)

> If I extract [something] like a coal or an ember, I'll get it out of my mouth, then show it to them so that they can see it. Then I will get rid of it. I'll destroy it... People's spirits suffer if we don't do this. Once we've got rid of things out of people's bodies they'll quickly feel much better. My grandfather told me, "Be careful with the things you do. You've got to be careful because you can get sick yourself. Make sure you put it into your hand as soon as you extract it." So I'd always hold onto these objects as soon as I got them, making sure they didn't do even more damage. It is to make sure that women and men live healthy lives (*Dickie Minyintiri*, NPYWC 2003: 25)

> Ngangkaṟi clean blood effectively using the old methods. We take out the dirty blood by the mouth and spit it away, without damaging the body internally or externally. However, a blood transfusion sends old dead blood around the veins of a living person, and we are not happy about that. It is dangerous. When a ngangkaṟi uses the suction method to clean out blood, he would never swallow it. He would always spit it out. Unclean blood is dangerous. We all know that. Where there are no ngangkaṟi treatments available, I suppose a blood transfusion is the last resort and if it will save a life, it must be all right (*Kumanara Peters*, NPYWC 2003: 37)

> I use suction to draw out concentrated illness in the form of a mouthful of blood. I draw out items such as a sliver of wood or a chip of one from the muscles or flesh of the sick person (*Sam Watson*, NPYWC 2003: 42)

> We see disease as forming something solid and physical, such as a small piece of wood. The treatment means we have to remove the piece of wood from the sufferer's flesh or bone in which it has lodged. After removal



we use suction by the mouth, which removes the final parts of the rubbish. This rubbish collects wherever there is illness. We have to suck out the rubbish and then dispose of it by throwing it away into the wind (*Andy Tjilari and Kumanara Peters,* NPYWC 2003: 20)

7.6.4 Massage and wound healing

Ngangkaṟi healing includes wound healing and massage. Ngangkaṟi can heal wounds and sometimes their treatments are combined with the use of medicinal plants or bush medicine. The preparation of bush medicine is not a prerogative of ngangkaṟi, but any Aṉangu can make bush medicine by using different kinds of plants. Ngangkaṟi also use massage as a method of healing; massage is used for muscle and tendon manipulation, to relieve pain and to strengthen muscles around joints.

A ngangkaṟi healing treatment cleans wounds...The treatment is a clean and wholesome treatment, which supports the healing of the flesh (*Sam Watson*, NPYWC 2003: 43)

Sometimes we use bush medicine for wounds, we put bush medicine on the skin, sometimes after we heal with our hands. Everybody can prepare bush medicine. There are different plants, one of them is *irmangka irmangka* (*Interview Ngangkaṟi 7*)

They use various massage on various tendons, muscles and on tendons, muscles and 'strings' associated with the circulation of blood to the brain. They ease out the tension in all these parts. This results in the problems and stress disappear (*Elsie Waṉatjura*, NPYWC 2003: 15)

7.6.5 Bone manipulation

Ngangkaṟi use manipulation to realign bones in cases where they are misaligned or broken. This method requires a thorough knowledge of the skeletal structure and anatomy of the human body.

If they have problems with their bones being misaligned, I can manipulate them back into place and take the pain away at the same time...I can replace a lost spirit and replace misaligned bones, ribs, spines and all those sorts of bones. Ngangkaṟi know about the skeleton and individual bones and the whole anatomy of the body. So we can put things to rights easily (*Sam Watson*, NPYWC 2003: 43)

7.7 Mapaṉpa: ngangkaṟi sacred tools

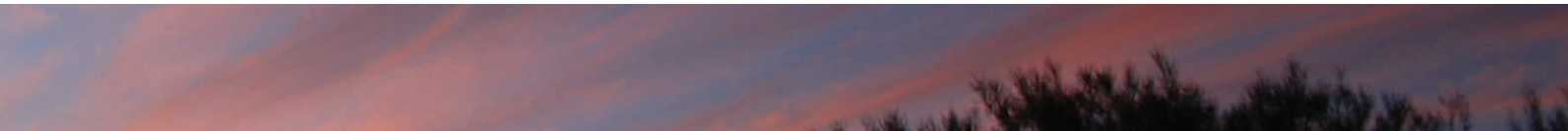
Mapaṉpa are ngangkaṟi sacred tools that are used in the healing process. Ngangkaṟi receive their mapaṉpa from powerful spirits called *karpaṟinypa*. Ngangkaṟi use these sacred tools in the diagnosis and treatment of sicknesses:

There are some very powerful spirit figures in our culture called *Karpaṟinypa. Karpaṟinypa* give ngangkaṟi gifts of mapaṉpa that help in the healing process such as *tarka mapaṉpa* – sacred ngangkaṟi tools made out of bone. Powerful healing forces from our *mapaṉpa* can bathe a sick person in healing energy. The forces seek out *mamu*, or the malignant forces that cause the sickness in the first place, and destroy them. You'll see nothing form the outside, but the healing is taking place on the inside. This is our usual healing method (*Andy Tjilari*, NPYWC 2003: 35)

I don't know how to take a person's temperature with a thermometer. I only know about *mapaṉpa* or special sacred tools. *Mapaṉpa* can look like small pieces of bone. They are kept in water or inside the hand. They are kept inside the hand and help to locate *puṉu* or little pieces of wood that get lodged in people's bodies. I find these pieces of *puṉu* in people's bodies, drifting in the blood, flowing along the inside of their veins. I feel them floating inside and I can grab them and extract them from the vein. Once I have got them out I take a good look at them, in order to identify them. I sometimes get a surprise with what comes out (*Nakul Dawson*, NPYWC 2003: 55)

Ngangkaṟi can easily detect if anyone's spirits are flagging or illness is setting in. If this is the case they send *mapaṉpa* to aid the sufferer. The *mapaṉpa* seeks out the sufferer and enters into their spirit. The *mapaṉpa* goes in and starts searching around inside the person's spirit for *mamu* – negative spirit forces – that should not be there. The presence of mamu is often the same as having an alien spirit displacing your own (*Elsie Waṉatjura*, NPYWC 2003: 15)

Land plays a significant role for the attainment of healing power and sacred tools that ngangkaṟi use in the healing process. Land is very important because spiritual powers come from the land and ngangkaṟi can access those healing powers and skills.



When we ngangkaṟi travel to places we put camps on the land, and we get power from the land; ngangkaṟi see spiritual beings which come into their body and give us power. Mining can damage our land because there are spiritual beings powers. Only ngangkaṟi know about what is inside the land. Underground there are special places and rocks. I saw a lump in the ground and I removed the dirt and there was a hole and a special rock sitting in the middle and this rock was going to come out. It's a special rock, we call it *kuti*: it's round and smooth and it can be any colours, black, white... When we touch it, it disappears and it comes inside our body; it gives us healing power, they shoot bad spirits. Thanks for the land, we can't damage it, we ngangkaṟi look after the land, it's important for Aṉangu *(Interview Ngangkaṟi 7)*

7.8 Ngangkaṟi and western health practitioners: a two-way health care model

Ngangkaṟi recognise the importance of western medicine. They acknowledge the remarkable differences between the western medical knowledge system and the Aboriginal traditional medical knowledge system. Despite these differences, Aboriginal traditional healers emphasise that mainstream health practitioners and ngangkaṟi work for the same purpose: restoring the health of sick people.

I realise this sounds very different to all you doctors and nurses who have studied so hard at school to get where you are today. You have studied so many books. But consider that we are still, nevertheless, working towards the same goal of healing sick people and making them feel better in themselves. In that way we are equal. We are the same (*Andy Tjilari*, NPYWC 2003: 34)

Ngangkaṟi work the same as doctors. We are equal in our work. The only difference is that doctors and nurses learn their jobs at university. This is the way white people get most of their learning, regardless of what they do. Doctors learn, for example, how to perform operations, give medicines, blood transfusions and saline drips (*Andy Tjilari and Kumanara Peters*, NPYWC 2003: 20)

Ngangkaṟi work differently from doctors who prescribe medicines (*Arnie Frank*, NPYWC 2003: 82)

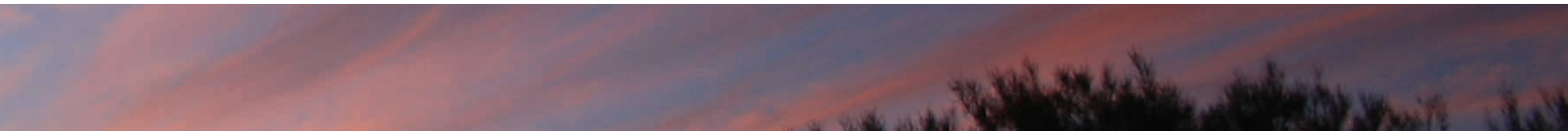
Aboriginal men and Aboriginal women give healing treatments in a similar yet different way. We see disease as forming something solid and physical, such as a small piece of wood. The treatment means we have to remove the piece of wood from the sufferer's flesh or bone in which it has lodged. After removal we use suction by the mouth, which removes the final parts of the rubbish. This rubbish collects wherever there is illness. We have to suck out the rubbish and then dispose of it by throwing it away into the wind (*Andy Tjilari and Kumanara Peters* NPYWC 2003: 20)

Ngangkaṟi continue to stress the significance for ngangkaṟi and western health practitioners to work hand-in-hand to ensure the provision of a holistic two-way health care. Ngangkaṟi support the strengthening of a team-based approach to health care and the promotion of a better understanding of their role and healing treatments among health professionals.

When an Aṉangu person is terribly ill with a life threatening illness, we understand that sometimes it takes a doctor to do a full operation to save their life. Yet that sick person's spirit may still harbour something that will continue to affect their recovery. So ngangkaṟi can help on another level that modern doctors cannot (*Andy Tjilari*, NPYWC 2003: 35)

If you are working for the health and well-being of Aṉangu in our region and you would like to work more closely with ngangkaṟi, then this is a way we suggest you could go about it. Ask Aṉangu to introduce you to the ngangkaṟi. Explain what sort of work you are doing and find out if ngangkaṟi are able to help you in your particular area...Develop ways you can work together. Think and talk about payment. Make friends. Go and ask for advice. Don't be frightened or shy. We want to work together to improve the health and well-being of Aṉangu (*Andy Tjilari and Kumanara Peters,* NPYWC 2003: 20-21)

...I work with the health service, working with little children and women... This is what I am doing today at Iwantja. It is good work. If someone becomes ill, the nurse will come to pick me up. I will see the nurse or an Aṉangu health worker arriving to get me, and we'll go together to the health clinic. We both work for the health service, and we'll work in



the clinic together. We work quietly together and we work well together... We enjoy our work, because we know it is good and important work (*Maṟingka Burton*, NPYWC 2003: 47)

I work continually at healing many people – women, men and little children. From my hands, many children are healthy. The health clinic nurse always says to them, 'Go and find Naomi!' So parents bring their little children to me. I heal them and when they take the child back to see the nurse again, she always says, 'Hey! This child is completely well again'. She says, 'You know, Naomi, you really are the number one!' They remember this and have learnt to always bring their children straight to me (*Naomi Kantjuriny*, NPYWC 2003: 62)

I started going to the clinics and working in them from time to time. I have been shown many things by white people and I, in my turn, have taught them many things. White clinic staff come up to me from time to time and asks me, 'Please come up and see someone in the clinic'. I go up there and I check someone out. All they want is to be healed and then declared to be well. So I give them a ngangkaṟi healing treatment. I have even given a healing treatment to *walypala* – white men, and to *walupara* – white women (*Nakul Dawson*, NPYWC 2003: 54)

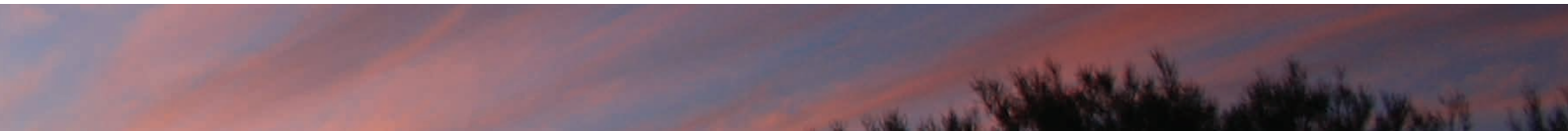
At the clinic they give sick people medicine, but I don't work with medicine. I work alongside doctors who use needles and medicine. There is often lots of blood. The types of white man's medicines that are available to us are tablets, rubbing ointment, eye drops, needles and bandages for open wounds. We are all familiar with these things. Ngangkaṟi don't use them, though. The ngangkaṟi healing therapy that I use cannot be seen, nor can it be written down. It happens invisibly and usually quietly off to the side. Clinics need to remember to treat us ngangkaṟi with respect, and to remember that we might have just come out of the bush. Our work is important (*Jimmy Baker*, NPYWC 2003: 73-4)

Health clinics have started up in this area because of sick people. They started up because of a need. But the old treatments have found it difficult to keep their proper place in the clinic environment. We have to deal with new sicknesses and modern medicines. We know we have the chance to utilise these new medicines. They are certainly very useful. But there are still many new techniques that we are not comfortable with. One in particular is the shedding of blood. As we will tell you later, ngangkaṟi are never comfortable with the way blood is shed in an operation (*Andy Tjilari and Kumanara Peters*, NPYWC 2003: 20)

I also go into the health clinic if people ask me. People will cry and cry if they are too sick. I don't really get paid money for any of this work. I am a bush ngangkaṟi. I'm *wati puṯitja* – a man of the bushland. I work in the bush and I throw my spirit objects around in the bush. When I work as a ngangkaṟi I get something from the people. I don't know anything about the health service. They don't call on me. They only employ nurses and doctors in the clinic. They work inside the clinic buildings inside private rooms, so I can't say what they do. Their work is hidden. I talk to other doctors about how ngangkaṟi work. I say, 'I work with my hands and my mouth. You work with a knife'. Doctors know I do this work. They know I help people to get better. Mostly though, they don't know I do it, because I work in the bush. They just know I do it, because I tell them. Most people don't understand this kind of work (*Dickie Minyintiri*, NPYWC 2003: 25)

Some people don't understand or know about my work. I have been a ngangkaṟi for many, many years and so it is familiar to me. But not everybody understands it (*Maṟingka Burton*, NPYWC 2003: 46)

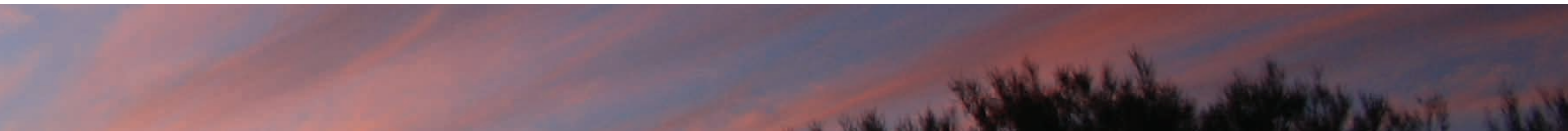
Our children and women are often taken away for very serious operations these days. Nobody likes having these operations, or having their bodies cut open. They would much rather see a ngangkaṟi first, who can check them out. Ngangkaṟi have something like x-ray vision and can look right through a body and right through a person's spirit. Ngangkaṟi can look inside people. They can see why people are sick, so say, for instance, someone is vomiting repeatedly, the ngangkaṟi can see what is causing it and make an immediate improvement. They can bring about an immediate sense of wellbeing and good health. This is my work. This is what I do (*Josephine Mick*, NPYWC 2003: 58)



7.9 The way forward: recognition, respect and fair remuneration

Ngangkaṟi voice their frustration and dissatisfaction with current arrangements for the delivery of their treatments in health care settings. Most ngangkaṟi denounce a lack of or limited recognition, understanding and respect of their role, their skills and the whole ancestral ngangkaṟi traditional knowledge system – *Ngangkaṟiku Tjukurpa*. Ngangkaṟi indicate the way forward to work hand-in-hand with western health practitioners and consolidate a real two-way health care system. The way forward requires: proper recognition and respect for ngangkaṟi's role, skills and medical knowledge; fair remuneration for their work as legitimate traditional health practitioners.

> We sometimes find ourselves bypassed and forgotten, which is a shame for the sick people who could benefit from seeing us. We find ourselves being treated suspiciously, as if we were charlatans. Treated suspiciously as if we were charlatans! As if we were absolute charlatans!
>
> So, what is it we want? Well, we want all the good things in life like everybody does and the means to look after our sons well. We wish to be more respected for our skills and to get better work conditions and pay. Some ngangkaṟi say that the work they do is very sacred and important. So they really need more support, such as an income to help them to continue their important work. So we are trying to make it plain and obvious, by speaking out truthfully and clearly, about who we are and what we do that you will believe us. We don't want to keep on talking about it, only to be forgotten. That wouldn't be fair.
>
> We ngangkaṟi are asking for proper recognition of our special skills. Better pay and a better working life isn't really asking for much, considering the job we do. We are all asking, I am advocating on behalf of all the other ngangkaṟi because it is a topic of conversation among us.
>
> Ngangkaṟi want recognition and understanding in return for talking clearly and revealing our names and our work... If this brings about a greater demand for our services, then we want an improvement in the way our services are used. So don't forget this. Don't forget that I've asked and don't forget that I am not the only one who is dissatisfied with the current arrangements for most ngangkaṟi. We need to make a living. Many of us go hungry a lot of the time. So if we have got a skill that is in demand and is respected as it should be, then we should like to start making enough income to improve our living conditions and to stop having to go hungry all the time (*Arnie Frank*, NPYWC 2003: 83, 88)
>
> ...it is the lack of recognition that is the hard part. As I said, I specialise in treating women and children. I work as a ngangkaṟi. I don't get paid for ngangkaṟi work as apparently there is no money to pay ngangkaṟi. This is big Tjukurpa, ngangkaṟi Tjukurpa. We are specialist doctors, just like other specialist doctors. That just about sums up what I want to say...We would like the government to try to understand us more and to give us better recognition (*Josephine Mick*, NPYWC 2003: 58-59)
>
> It is sad that sometimes the most highly skilled ngangkaṟi out here in the bush don't even have enough money to buy food (*Andy Tjilari and Kumanara Peters*, NPYWC 2003: 20)
>
> I am an old man now but I am still working away. Sometimes I get a bit embarrassed by my poverty. Most of us ngangkaṟi receive nothing for our work, and we are all very poor. It is a shame it is like this. White people don't have any understanding of our situation. They don't realise that there are spirit doctors working away out here who are all broke. Look at me. I am broke. No money. I have heard that the health service pays some money for ngangkaṟi work and I have been thinking of asking them if I can get involved. I was wondering if they could help me out a bit with some pay or perhaps something to get around in, like a car. But I am too embarrassed to ask. So I haven't, even though it means that I am totally broke the whole time. It must be our lot, these days (*Sam Watson*, NPYWC 2003: 43-44)
>
> There is a lot of demand on us ngangkaṟi to give healing treatments. People demand treatments from us at all hours of the day and night. We are happy to help, of course, but we are frustrated that though we are doing more than a full time job, we just cannot match it with the kind of income that



we are worth. Where do ngangkaṟi get their income from? The health clinic? No, from Yarnangu who receive the treatments. Not many of us ngangkaṟi have cars, so it is hard for us to see all the people that want us to give them treatments, particularly if they are a long way away in the bush. I would like to travel further afield (*Tjapalyi Giles*, NPYWC 2003: 50)

When I do ngangkaṟi work I don't get paid unless the health clinic calls me up and asks me to come in. I get paid for my clinic work. Just a little bit though...(*Jimmy Baker*, NPYWC 2003: 73)

When I do my healing work, I really appreciate it if someone buys me a kangaroo tail or some meat, or gives me enough money to get a tank of petrol. Don't forget what I said though, ngangkaṟi work is mostly a labour of love because everyone is our kin. But we've got to live on something. No point in going around hungry. It's a terrible thing if we are starving hungry and we have to refuse to help someone. Nobody can work on an empty stomach, can they? (*Arnie Frank*, NPYWC 2003: 86)

Ngangkaṟi clarify how the claim for a fair remuneration is a necessity of contemporary Aṉangu life. The practice of ngangkaṟi traditional medicine needs to be contextualised in today's economic and societal settings.

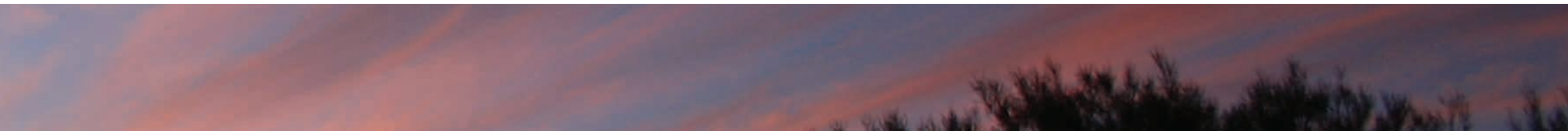
When I was a young man, I used to heal people all over the country. This was for no money. I've never received money for my work. But these days all us modern people have learnt about working for money. I have healed many people in my lifetime. I think that I would like to start getting paid regularly for my work, and put the money away until it has built up enough for me to buy a car. I am getting old and sick now, and I can't get around so much. A car would be good for me, poor old thing that I am. I can't move very fast at all and find it hard to see the people like I used to (*Jimmy Baker*, NPYWC 2003: 72-3)

We are specialist doctors and ngangkaṟi want to be recognised as specialist doctors. Because of that we would like to get the pay of a specialist doctor. We already get other kinds of specialists who come in from distant places from all over Australia, but don't forget us specialists who live here. The specialists come in and are able to diagnose particular illnesses and recommend particular treatments. We ngangkaṟi do exactly the same. We are specialists and have had a long training, too. Not everybody has the training and ability to be a ngangkaṟi. We have a certain power in our hands. We have the ability to capture sicknesses and heal people. The way a non-Aṉangu specialist works is to diagnose an illness, say, inside the body, and then recommend an operation. They'll perform the operation by cutting open the body and removing a part of the body. The skin will be cut and blood will be spilt. Spilt blood is wasted blood. Ngangkaṟi do not cut open the skin nor spill blood. They touch, massage and knead the skin and the body. They can extract sickness and bring about rapid healing and relief. This is all done in a pain-free way, which only a specialist doctor can perform. We are specialist doctors, there is no doubt about it (*Josephine Mick*, NPYWC 2003: 57)

I don't get paid for ngangkaṟi healing. No money, but some get paid, I don't.... I would like to be paid for my work but you know, no money...*(Interview Ngangkaṟi 8)*

I am *minyma* ngangkaṟi. I fix all kids, women, also that woman there. I work every time, all day, day and night but I don't get paid, money *wiya*, no money. I work in three places, Fregon, Coober Pedy, Port Augusta. I don't get paid in the clinic. I do the work but no money. Another doctor they give money but I never get money. I do ngangkaṟi to anybody, woman, kids but they don't give money. I work to Pika Wiya in Port Augusta and they give me money to do ngangkaṟi, but not in the community *(Interview Ngangkaṟi 9)*

At the health clinic I work under the title 'health worker'. We get paid as health workers from the clinic. Everyone who works for the health clinic has to fill out a timesheet, but when I do ngangkaṟi healing outside clinic hours, I do not fill our a timesheet. We ngangkaṟi fill out a timesheet when we work as health workers, but we don't record the ngangkaṟi work we do. I get paid for all my work with the clinic, but I don't get any additional pocket money for my ngangkaṟi work from anybody. But this doesn't worry me. I don't worry about money as much as some people. It is more important to me to keep up my skills as a ngangkaṟi and a



> traditional healer and to keep practising them. I worry more about helping sick people and using my ngangkaṟi powers (*Josephine Mick*, NPYWC 2003: 57)
>
> ...we see white male doctors who are specialists and earn a lot of money. Well, our wati ngangkaṟi are just the same. They, too, should receive equal pay. They do equal work. Government people, please listen to us, as this is such an important issue (*Josephine Mick*, NPYWC 2003: 58)
>
> We ngangkaṟi love our work and all we are asking for is a better deal. There are quite a few people who are having such a difficult time in life that they are starting to say that they won't be able to continue working as ngangkaṟi any more despite the special gift that they have. We are hoping that by telling people about our work that we will become able to be qualified to receive a proper amount of payment for our work. An amount that will give us enough to live on, like so many other people who are specialists. People like to see our work. It is a special thing... (*Arnie Frank*, NPYWC 2003: 86)

Recognition, respect and fair remuneration are the key components for a real two-way health care model whereby Aboriginal traditional healers and western health practitioners work hand-in-hand to provide holistic and quality health care. The new statewide policy framework proposed in the next chapter incorporates the two-way health care model based on these components as its foundational cornerstone.

CHAPTER 8

A New Statewide Policy Framework

You are number one doctor and you've got that motorcar,
I am number one ngangkaṟi and I have no motorcar. What about I get a motorcar?

(Interview Medical Practitioner 1)

8.1 Introduction

This chapter proposes a new statewide policy framework in the South Australian health care system. This policy framework establishes a two-way health care model to guarantee the systematic provision of Aboriginal traditional medicine hand-in-hand with western medicine. The statewide policy framework builds on the body of evidence of this enquiry and encapsulates a new Aboriginal corporation established by the Aboriginal traditional healers from the Aṉangu Pitjantjatjara Yankunytjatjara: the Aṉangu Ngangkaṟi Tjutaku Aboriginal Corporation (ANTAC). The Aṉangu Ngangkaṟi Tjutaku Aboriginal Corporation is founded on the principle of self-determination and plays a central role in the proposed policy framework and two-way health care system.

8.2 A new statewide policy framework

The new statewide policy framework provides a systematic response to the issues and challenges identified in the current arrangements for the provision of ngangkaṟi services across South Australia. It builds on the strengths of current arrangements and untangles the identified hindrances. The new statewide policy framework proposes six core constitutive components in line with the report's recommendations:

1. Central body (Rec. 9,13)
2. Ngangkaṟi accreditation process: qualification, accreditation and registration standards for the recognition of ngangkaṟi as legitimate health practitioners (Rec. 6,15,16)
3. Register of accredited ngangkaṟi (Rec. 11,17,18)
4. Ngangkaṟi employment scheme: a state-based model (Rec. 19,20,21,22)
5. Database on ngangkaṟi interventions (Rec. 23)
6. Health professional training and development modules on the role of ngangkaṟi in health care (Rec. 24)

8.3 Central body: the Aṉangu Ngangkaṟi Tjutaku Aboriginal Corporation

The Aṉangu Ngangkaṟi Tjutaku Aboriginal Corporation (ANTAC) is a registered Aboriginal corporation under the *Corporations (Aboriginal and Torres Strait Islander) Act 2006.* ANTAC is the first organisation of Aboriginal traditional healers in Australia founded on the principle of self-determination. In July 2011, the ngangkaṟi from the Aṉangu Pitjantjatjara Yankunytjatjara lands came together and initiated a process of consultation to self-determine the way in which they desired to provide their traditional healing within a two-way health care system. Since then numerous ngangkaṟi meetings have provided the forum for ngangkaṟi to discuss and approve the establishment of their own organization through an ongoing process of self-determination.

ANTAC is the central body of the proposed statewide policy framework. ANTAC integrates the fundamental ingredients for 'effective contemporary Indigenous governance' in the provision of Aboriginal traditional medicine. Effective contemporary Indigenous governance, defined as 'the more recent melding of our traditional governance with the requirement to effectively respond to the wider governance environment' (ATSISJC 2012: 89), is considered 'a key factor in the realization of human rights and sustainable development' (ATSISJC 2012: 84). It requires Aboriginal people to 'develop structures that incorporate both their cultural governance requirements as well as meeting the requirements of non-Indigenous governance models' (ATSISJC 2012: 54).

ANTAC incorporates two body of law: *Ngangkaṟiku Tjukurpa* and the rules of the *CATSI Act 2006*. *Ngangkaṟiku Tjukurpa* and the *CATSI Act 2006* provide the legal foundations under federal law and Aboriginal customary law that govern ANTAC's organisational structure, decision-making processes and mechanisms, internal and external accountability.

Ngangkaṟiku Tjukurpa encompasses the whole Aboriginal traditional knowledge system that defines and regulates the ngangkaṟi's traditional medical system, its methods of healing and treatment, code of conduct, educational and training system. *Ngangkaṟiku Tjukurpa* is the primary body of law held by the ngangkaṟi and passed down from generation to generation since time immemorial. It provides the foundational customary law on which the ngangkaṟi members of the Aṉangu Ngangkaṟi Tjutaku Aboriginal Corporation operate.

The *CATSI Act 2006* provides the federal legal framework on Indigenous corporate governance. ANTAC, as an Aboriginal corporation registered under the *CATSI* Act, complies with the rules of the Act in relation to its organisational governance system that includes its organisational structure, decision-making mechanisms and processes, internal and external accountability.

8.3.1 Organisational governance

The Aṉangu Ngangkaṟi Tjutaku Aboriginal Corporation has developed a unique system of organisational governance. This system is articulated in the Rulebook of the Aṉangu Ngangkaṟi Tjutaku Aboriginal Corporation. The Rulebook incorporates the norms on Aboriginal corporate governance in accordance with the *CATSI Act 2006* and ngangkaṟi's traditional customary norms in accordance with *Ngangkaṟiku Tjukurpa.*

a) The Rulebook

The Rulebook is the constitutional document of the Aṉangu Ngangkaṟi Tjutaku Aboriginal Corporation in compliance with the *CATSI Act 2006*. It establishes the organizational structure of the corporation: objectives, membership requirements, rights and duties of its members and directors, decision-making mechanisms, internal and external accountability processes.

The Rulebook also incorporates two constitutive components of the policy framework: the ngangkaṟi accreditation process with its qualification, accreditation and registration standards and the Register of ngangkaṟi. Qualification, accreditation and registration standards for the recognition of ngangkaṟi as legitimate health practitioners are established in accordance with *Ngangkaṟiku Tjukurpa* and embedded in the constitutional document of the corporation. The Register of accredited ngangkaṟi is part of the ngangkaṟi accreditation process. The ngangkaṟi members of ANTAC hold the Register of accredited ngangkaṟi who comply with the qualification, accreditation and registration standards.

The Rulebook establishes the corporation's objectives, membership and directors' requirements as follows:

b) Objectives

ANTAC aims to pursue the following objectives:

a) To promote the health and well-being of Aṉangu people and their communities in the Aṉangu Pitjantjatjara Yankunytjatjara (APY) Lands, across South Australia, and in the cross border areas of South Australia, Northern Territory and Western Australia;

b) To provide ngangkaṟi healing services to Aboriginal and non-Aboriginal people in:

a. our communities in the APY Lands;

b. hospitals and any health care service providers in remote, rural and urban areas;

c. police courts, prisons and correctional services to assist people in custody, people working with people in custody, and offenders released into the communities under supervision;

d. any organizations and institutions that request our ngangkaṟi healing services;

c) *To work with mainstream doctors and health professionals to provide patients with a two-way health care;*

d) To look after our land, animals and plants. Our ancestors gave us the land to look after it and all things on it, including plants, minerals and animals. Our land is sacred and we need to look after it through our ngangkaṟi work;

e) To work individually or together with other ngangkaṟi to ensure that patients receive the most appropriate healing treatments;

f) To develop and strengthen our ngangkaṟi

skills and practices through ceremonies and regular visits to our sacred sites;

g) To pass down on our ngangkaṟi children and future generations our ancient and unique ngangkaṟi knowledge;

h) To provide ngangkaṟi children with an ongoing training to ensure the learning, development and strengthening of their ngangkaṟi healing skills and practices.

i) To ensure that our ngangkaṟi children are nurtured to grow healthy and skillful to provide ngangkaṟi healing to people, communities, and the land (ANTAC Rulebook, rule 2)

c) Membership

The members of the Aṉangu Ngangkaṟi Tjutaku Aboriginal Corporation are exclusively ngangkaṟi. The ngangkaṟi have established three criteria to become a member of their corporation. The criteria include:

a. ngangkaṟi must be Aṉangu Pitjantjatjara Yankunytjatjara;

b. ngangkaṟi must be 15 years old;

c. ngangkaṟi must be recognised as ngangkaṟi by their community (ANTAC Rulebook, rule 3);

Membership to the corporation is subject to these three criteria and the ngangkaṟi accreditation process. The ngangkaṟi who participated at the pre-incorporation meeting have become members upon registration pursuant to the *CATSI Act 2006*;

d) Directors

The Board of Directors directs the Aṉangu Ngangkaṟi Tjutaku Aboriginal Corporation. The Board of Directors comprises five directors endowed with the responsibility to make decisions about the affairs of the corporation, and how the corporation is run and managed. The Directors must be ngangkaṟi members of the corporation and must include at least 2 ngangkaṟi women and 2 ngangkaṟi men (ANTAC Rulebook, rule 6).

8.4 Ngangkaṟi accreditation process: qualification, accreditation and registration standards

The ngangkaṟi accreditation process establishes a process of certification for qualified ngangkaṟi (ANTAC Rulebook, rule 3.4). The ngangkaṟi accreditation process aims to guarantee that only qualified ngangkaṟi become members of the Aṉangu Ngangkaṟi Tjutaku Aboriginal Corporation. The accreditation process is grounded on *Ngangkaṟiku Tjukurpa,* the ngangkaṟi Law which regulates the skills development and learning process of ngangkaṟi's educational and training model.

The ngangkaṟi accreditation process entails the following stages:

1. A ngangkaṟi apply to become member of the corporation by oral communication to the Directors of the corporation;
2. The applicant ngangkaṟi must fulfill the membership criteria stated in rule 3 of the Rulebook to be eligible to apply;
3. The Directors will call a general meeting;
4. All ngangkaṟi members of the corporation will gather at the general meeting to assess whether the applicant ngangkaṟi satisfies the qualification, accreditation and registration criteria in accordance with *Ngangkaṟiku Tjukurpa*;
5. All ngangkaṟi members of the corporation verify whether the applicant ngangkaṟi has acquired the appropriate skills and methods of healing in accordance with the ngangkaṟi educational and training model;
6. All ngangkaṟi members of the corporation verify whether the applicant ngangkaṟi can perform the healing in line with *Ngangkaṟiku Tjukurpa*;
7. All ngangkaṟi members of the corporation determine whether the applicant ngangkaṟi is a qualified ngangkaṟi by resolution at the general meeting;
8. The applicant ngangkaṟi is notified of the outcome of the resolution and its rationale;
9. The qualified ngangkaṟi becomes member of ANTAC and listed in the Register of accredited ngangkaṟi.

8.5 Register of accredited ngangkaṟi

The Register of accredited ngangkaṟi provides a legitimate source to identify and access qualified ngangkaṟi for the provision of ngangkaṟi services across South Australia. The Aṉangu Ngangkaṟi Tjutaku Aboriginal Corporation holds the Register of accredited ngangkaṟi. The Register is an essential component of the ngangkaṟi accreditation process established by the Aṉangu

Ngangkaṟi Tjutaku Aboriginal Corporation. The Register includes the list of qualified ngangkaṟi who have been accredited through the accreditation process established in rule 3.4 of the ANTAC Rulebook. The Register contains all relevant information regarding the accredited ngangkaṟi. Ngangkaṟi who stop being members of the corporation will be listed in the Register of former ngangkaṟi (ANTAC Rulebook, rules 4.1- 4.3).

ANTAC's ngangkaṟi accreditation process regulated by qualification, accreditation and registration standards, and the Register of accredited ngangkaṟi respond to the widespread evidence-based demand for a legitimate and systematic mechanism to access qualified ngangkaṟi not only in the South Australian health care system but also correctional services, other agencies and the general public.

8.6 Ngangkaṟi employment scheme: a state-based model

The enquiry shows that remuneration for ngangkaṟi is tainted by three problematic issues: rate variation, lack of a consistent payment schedule, lack of a standard payment process. These issues have significant implications on the fluctuation of demand for ngangkaṟi services, level of remuneration, and capability of health services to offer consistent ngangkaṟi services to their patients.

The statewide policy framework proposes the introduction of a state-based ngangkaṟi employment scheme to guarantee a fair remuneration for ngangkaṟi as legitimate traditional health care practitioners. The ngangkaṟi employment scheme should be anchored to a three-fold structure:

1. Contract employees: remuneration based on a fee-for-service payment schedule;
2. Full-time employees: remuneration based on an employment standards scheme;
3. Part-time employees: remuneration based on a fractional employment standards scheme.

This three-fold ngangkaṟi employment scheme requires the development of a consistent fee-for-service payment schedule to guarantee a fair and consistent remuneration for fee-for-service based contractual arrangements; and the development of an employment standards scheme to guarantee a fair and consistent remuneration for full-time and part-time employment arrangements. The Aṉangu Ngangkaṟi Tjutaku Aboriginal Corporation will develop the three-fold ngangkaṟi employment scheme in partnership with relevant government departments, mainstream and Aboriginal community controlled health services.

The ngangkaṟi employment scheme requires also a consistent payment process in line with broader financial requirements. The Aṉangu Ngangkaṟi Tjutaku Aboriginal Corporation will negotiate the payment process in partnership with relevant government departments, mainstream and Aboriginal community controlled health services and process payments to accredited ngangkaṟi for the traditional healing services provided. The state-based model could include the allocation of a 'ngangkaṟi provider number' for ANTAC's accredited ngangkaṟi to facilitate the application of a consistent and systematic statewide payment process.

8.7 Database on ngangkaṟi interventions

The Aṉangu Ngangkaṟi Tjutaku Aboriginal Corporation will develop a systematic database on ngangkaṟi interventions provided by accredited ngangkaṟi member of the corporation. The creation of a systematic database will be part of ANTAC's operational activities. The database will develop a systematic evidence-based dataset on ngangkaṟi episodes of care. The dataset will contribute to provide a systematic body of relevant information in relation to the role of ngangkaṟi in the health care system; and to develop a more comprehensive patient history according to a two-way health care model.

8.8 Educational programs for health professional training and development

The development and introduction of educational programs on the role of ngangkaṟi in health care is considered an important component of the proposed policy framework. The inclusion of training modules in health professional training and development can foster a reciprocal understanding between western medical practitioners and Aboriginal traditional practitioners on their reciprocal contribution to the health and well-being of patients. It can contribute to strengthen the collaboration between western medical practitioners and Aboriginal traditional practitioners, and operationalise a two-way health care model through the effective delivery of two-way health care services.

8.9 Benefits of the proposed statewide policy framework

The adoption of the proposed statewide policy framework to guarantee the systematic provision of Aboriginal traditional medicine hand-in-hand with western medicine in the South Australian health care system has the potential to further Australia's Indigenous health policy making and make a significant contribution to Closing the Gap in the health status of Aboriginal people.

Recommendation 25:
It is recommended that a new statewide policy framework be adopted to guarantee the systematic provision of ngangkaṟi services across South Australia. The policy framework establishes a two-way health care model based on six constitutive components:

1. *The Aṉangu Ngangkaṟi Tjutaku Aboriginal Corporation as the central body for the coordination, administration and delivery of ngangkaṟi services*
2. *A ngangkaṟi accreditation process with qualification, accreditation and registration standards for the recognition of ngangkaṟi as legitimate health practitioners*
3. *A Register of accredited ngangkaṟi*
4. *A ngangkaṟi employment scheme grounded on a state-based model*
5. *A systematic database on ngangkaṟi interventions*
6. *Introduction of health professional training and development modules on the role of ngangkaṟi in health care*

The benefits of the proposed policy framework are discussed in the following sections.

8.9.1 Compliance with international human rights standards

The application of the statewide policy framework and two-way health care model in South Australia provides a landmark model which aligns with international human rights standards. First, the inclusion of Aboriginal traditional medicine in the South Australian health care system fulfils the holistic conception of health as recognised under international human rights law. The Declaration of Alma-Ata acknowledges that '...health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right...'. Second, it brings together the international legal standards defining the right to health (ICESCR, art.12), the key principles of international human rights law and the Indigenous peoples' right to health as recognised in article 24 of the UN Declaration on the Rights of Indigenous Peoples. The key principles of international human rights law applicable to addressing the Indigenous health disadvantage are the 'non-discrimination principle' and the 'progressive realization principle'. The 'non-discrimination principle' set out in article 1.2 of the United Nations Convention on Economic, Social and Cultural Rights (UNCESCR) recognizes the right of all people to exercise their rights, including the right to health, without any discrimination; whereas the 'progressive realization principle' (UNCESCR, art.1.1) requires state parties to take any appropriate steps to ensure the progressive realization of the Conventions' rights. The adoption of these principles in Australia's Indigenous health policy agenda (ATSISJC 2006; AHRC and SCIHQ 2008; ATSISJC 2009; CGSC 2010; FaHCSIA 2009; Australian Government 2010) has a significant impact on the Australian government's obligation to rectify Indigenous Australians' health inequality. It sanctions the Australian government's legal responsibility to close the health inequality gap suffered by Aboriginal and Torres Strait Islander people and to take time-bound targeted 'special measures' to ensure achievable health outcomes. It also reaffirms the direct link between the Australian government's obligation to respect, protect and fulfil Indigenous Australians' right to health and the design, implementation and

evaluation of policy strategies, health services and programs (ATSISJC 2006: 48-66).

The statewide policy framework proposed in this report offers the opportunity to fulfil core international obligations and create a two-way health care system that would implement, within Australia's domestic jurisdiction, Indigenous peoples' right to health in its integral form:

> 1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.
>
> 2. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.

Third, the full and ongoing participation of Aboriginal traditional healers from the APY Lands in the development of the proposed two-way health care model realises the internationally recognised right to self-determination according to article 3 of the UN Declaration which states that

> Indigenous peoples have the right to self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development.

The formation of ANTAC by the ngangkari from the APY Land as the central body of the proposed statewide policy framework, is undoubtedly an act of self-determination.

8.9.2 Consistency with the international policy framework, strategies and standards on TCAM

The inclusion of Aboriginal traditional medicine in South Australia's health care system would initiate a process to align Australia's policy and regulatory framework on 'Complementary and Alternative Medicine' with the international policy framework, strategies and standards on 'Traditional, Complementary, Alternative Medicine'. The World Health Assembly has urged countries to include traditional medicine in their national health systems in accordance with national capacities, priorities and circumstances.[21]

The proposed statewide policy framework and two-way health care model is consistent with the international policy development on TCAM at different levels:

i. it advances and harmonises Australia's process of policy development on CAM with the international health policy agenda and standards setting on TCAM. The South Australian policy framework has the potential to bring Australia in line with the international and regional efforts to foster the development of national regulatory systems on TCAM (WHO 2000; 2001; 2002a; 2002b; WHO/WPRO 2000a; WHO/WPRO 2000b; WHO/WPRO: 2002; WHO/WPRO: 2007; WHO/WPRO: 2012);

ii. it aligns Australia with the *Regional Strategy for Traditional Medicine in the Western Pacific (2011-2020)* (WHO/WPRO: 2012). The *Regional Strategy* provides a landmark strategic and policy framework on 'how to maximise the health potential of traditional medicine, and advance the cause of primary health care and universal access to health services for the people of the Western Pacific Region' (WHO/WPRO 2012: v). The WHO-Western Pacific Region has taken a leading role in developing a regional strategic framework to promote the inclusion of traditional medicine in specific national traditional medicine programmes. The regional framework is grounded on five key Strategic Objectives for 2011-2020 (WHO/WPRO 2012: vii):

1. to include traditional medicine in the national health system;
2. to promote safe and effective use of traditional medicine;
3. to increase access to safe and effective traditional medicine;
4. to promote protection and sustainable use of traditional medicine resources; and
5. to strengthen cooperation in generating and sharing traditional medicine knowledge and skills.

South Australia's proposed policy framework and two-way health care model is consistent with the

21 World Health Assembly resolution, WHA 62.13.

current regional public health policy agenda on TM in the Western Pacific region. It also creates a precedent for Australia to cooperate and align with the other states members of the WHO-Western Pacific Region.

The consistency of the proposed statewide policy framework with international and regional policy framework and strategies on TM provides a keystone state-based case that can pave the way for the recognition of Aboriginal traditional medicine as a legitimate complementary system of medicine in Australia's national health care system and broaden the understanding and significance of Aboriginal traditional medicine in Australia. As the WHO-WPRO emphasises

> Traditional medicine is an important form of health care for many people in the Region. The use of safe and effective traditional medicine practices and products can make an important contribution to national and individual health care and the promotion of health equality (WHO/WPRO 2012: v)
>
> Traditional medicine has many contributions to make, especially in primary health care. The Declaration of Alma-Ata...called for the inclusion of traditional medicine in primary health systems, and the recognition of traditional medicine practitioners as health workers, particularly at the community level' (WHO/WPRO 2012: 3).

8.9.3 Advance the development of a holistic *National Aboriginal and Torres Strait Islander Health Plan*

The recognition and inclusion of Aboriginal traditional medicine and traditional healers in South Australia's health care system can make a significant contribution in relation to the current development of a *National Aboriginal and Torres Strait Islander Health Plan*. The recognition of Aboriginal traditional medicine and the inclusion of a two-way health care model are in line with the principles on which the development of a National Health Plan is anchored (DoHA 2012). These principles are drawn from the Declaration of Alma-Ata, the *National Aboriginal Health Strategy* (NAHSWP 1989) and the *National Strategic Framework for Aboriginal and Torres Strait Islander Health* (NATSIHC 2003a; 2003b). The principles on which the National Health Plan is grounded include:

i. a comprehensive and holistic conception of health which includes the physical, mental, spiritual health of individuals, the well-being of whole communities, healthy and interdependent relationships between families, communities, land, sea and spirit;

ii. the understanding of health as a fundamental human right;

iii. the significance of Aboriginal traditional medicine in primary health care. The principles of the National Health Plan refer to the Declaration of Alma-Ata which unequivocally acknowledges the important role of traditional healers in primary health care:

> primary health care relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community (*Declaration of Alma-Ata, vii.7*)

The forthcoming *National Aboriginal and Torres Strait Islander Health Plan* should seriously consider the statewide policy framework proposed in this report and the benefits that could stem from its implementation particularly in relation to primary health care. The *National Aboriginal and Torres Strait Islander Health Plan* cannot ignore the role and significance of traditional medicine in the international health care agenda:

> Traditional medicine is a health practice with strong historical and cultural roots. It is widely used, and is of increasing health and economic importance... It is an important primary care resource that can increase the availability and affordability of health care and contribute to improved health outcomes (WHO/WPRO 2012: 1)

8.9.4 Integrate the Closing the Gap policy framework and contribute to closing the gap in Indigenous health outcomes

The recognition of Aboriginal traditional medicine and the inclusion of Aboriginal traditional healers in a two-way health care system in South Australia advance the current Closing the Gap policy framework in the following ways:

a. it rectifies the partial integration of

article 24 of the UN Declaration in the Closing the Gap policy framework. The proposed state-based policy framework and two-way health care model complement article 24.2 - currently included in the Closing the Gap framework – with section 24.1 which recognises that 'Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals';

b. it initiates a process of decolonization of the epistemological foundations on which the prevalence of the western allopathic medical model rests within the Closing the Gap policy framework and health care system. It promotes the coexistence of western medicine and Aboriginal traditional medicine within a coherent and consistent two-way health care system;

c. It has the potential to contribute to closing the gap in Indigenous health outcomes. Evidence provided in this report demonstrates the positive outcomes of ngangkaṟi interventions. The inclusion of Aboriginal traditional healers in a consistent two-way health care model can contribute to achieve COAG's Closing the Gap objectives, targets and health outcomes. The systematic integration of Aboriginal traditional healers' interventions can have a significant impact on achieving the health outcomes in the five priority areas agreed in the *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* (COAG 2009a). These include:

   i. *Preventive health:* ngangkaṟi can play a major role in reducing some of the factors that contribute to chronic disease, such as mental health interventions;

   ii. *Primary health:* ngangkaṟi can play a significant role in expanding 'access to and coordination of comprehensive, culturally secure primary health care...';

   iii. *Hospital and hospital-related care*: ngangkaṟi can contribute 'to deliver better clinical outcomes through quality, culturally secure hospital and hospital-related services...';

   iv. *Patient experiences*: ngangkaṟi can play an important role 'to ensure access by Aboriginal and Torres Strait Islander people to comprehensive and co-ordinated health care, provided by a culturally competent health workforce within a broader health system that is accountable for Indigenous health needs, in genuine partnership with the people and communities they target; and to build service reach and influence to re-engage the most vulnerable Indigenous people into mainstream and targeted health services';

   v. *Sustainability*: the inclusion of ngangkaṟi will 'increase the number of Aboriginal and Torres Strait Islander people in the health workforce, reform and improve the supply of the health workforce...'. In addition, the Aṉangu Ngangkaṟi Tjutaku Aboriginal Corporation can play a significant role for 'the adoption of complementary workplace reforms, create sustainable program and funding models, measure performance and ensure that services are responsive both to national targets and local community needs' (COAG 2009a: 5-6).

These key areas have been embedded in the *National Indigenous Reform Agreement* (COAG 2011), which establishes seven 'Building Blocks' to integrate policy strategies and implementation

plans to close the gap against the six COAG targets. The 'Building Blocks' include early childhood; schooling; health; economic participation; healthy homes; safe communities; governance and leadership. The recognition and inclusion of Aboriginal traditional healers in a two-way health care model can make a significant contribution across the 'building blocks' of the *National Indigenous Reform Agreement*. This report provides evidence of significant contribution of ngangkari interventions in reproductive and maternal health, early childhood, child health, primary health care, mental health, social, emotional and spiritual well-being. The recognition of Aboriginal traditional healers as legitimate health practitioners and the establishment of a two-way health care model would provide the necessary systematic structure and process for Aboriginal traditional healers to make their contribution to closing the gap in Aboriginal and Torres Strait Islander' health disadvantage. This is in line with the WHO-Western Pacific Region's strategic objective 1, which states that '[t]raditional medicine, as a component of health care, has to be recognised and function effectively alongside other demands on the national health system, if it is to fulfil its potential in health care' (WHO/WPRO 2012: 14).

8.9.5 Economic development and economic participation

The statewide policy framework can bring significant benefits also in relation to economic development and participation. The policy framework proposed in this report is in line with the *Indigenous Economic Development Strategy 2011–18* (FaHCSIA 2011b). The *Indigenous Economic Development Strategy* is an important component of the Closing the Gap framework since '[e]conomic independence and security are necessary foundations for good health, functional families and successful communities' (FaHCSIA 2011b: 5); and it provides a blueprint for the Australian Government to create jobs and economic activity for Indigenous people to help close the employment gap (FaHCSIA 2011b: 14). The statewide policy framework and the two-way health care model can make a substantial contribution in achieving key policy objectives established within the *Strategy*'s priority areas which include: *'Strengthening foundation'*; '*Education'; 'Skills Development and Jobs'; 'Financial Security and Independence'* (FaHCSIA 2011b).

a) Strengthening foundations. Objective 1.3 Increase access to health services

The *Strategy* poses good health as a key foundation to create an environment to support economic development: poor health conditions can have a major impact on people's capacity to participate in economic development. The *Strategy*, in line with the Closing the Gap framework, establishes key strategies to increase Indigenous Australians' access to health services in order to overcome the Indigenous health disadvantage (FaHCSIA 2011b: 26). The adoption of the proposed policy framework with the recognition and inclusion of Aboriginal traditional healers in a two-way health care system can contribute to achieving these strategies at the state level in the following ways:

a) *Improve health infrastructure.* Investment for 15 new or expanded Indigenous health clinics is a strategy established to improve access to health services. Access to health services can also be improved by supporting the provision of Aboriginal traditional healing services within the health care system. The investment to improve health infrastructure can also include: 1. the expansion of existing infrastructures to facilitate the provision of ngangkari services; 2. the construction of a ngangkari clinic tailored to the coordination and delivery of ngangkari services (*see Rec.14*).

b) *Support an expanding Indigenous health workforce.* The recognition and inclusion of Aboriginal traditional healers as legitimate health practitioners can contribute to expanding the Indigenous health workforce across mainstream and Aboriginal community-controlled health services.

c) *Increase access to mental health services.* The recruitment of Aboriginal traditional healers can contribute to delivering and increasing access to culturally appropriate mental health services.

d) *Improve access to primary health care.* The recruitment of Aboriginal traditional healers in a two-way health care model can increase the capacity of the primary care workforce to deliver effective health care to Aboriginal people.

b) Education; Skills Development and Jobs; Financial Security and Independence

The *Strategy* recognises access to quality education, training, skills development and paid employment as fundamental elements to fostering economic development and increasing Aboriginal and Torres Strait Islander people's ability to participate in the economy (FaHCSIA 2011b: 33-50). Targeted strategies are established to improve access to quality education and training (FaHCSIA 2011b: 33-40); to support job readiness, improve employment service, assist more Indigenous Australians to secure and retain a job (FaHCSIA 2011b: 41-50). There is no doubt that 'jobs are the pathway to greater economic participation, financial security and independence' (FaHCSIA 2011b: 42). This range of strategies aims to increase the number of Aboriginal and Torres Strait Islanders 'fulfilling their potential by staying in school and moving into work, rather than onto welfare... Having a strong education, a job and an income helps people to improve their standard of living, allows for a stable home life and builds assets for long-term financial security' (FaHCSIA 2011b: 42).

These strategies, however, do not take into account the existence of a diverse Aboriginal traditional knowledge system taught through equally valuable educational systems, training models and skills development processes. A comprehensive Indigenous economic development strategy should include and support Indigenous traditional knowledge, skills and practises as valuable economic assets in line with the Australian government's position on the role of Indigenous cultural diversity for economic development:

> Indigenous Australians have unique and important assets and skills to bring to the broader economy. This includes strong social networks and community identity, and a rich traditional and cultural knowledge that can be valuable economic assets. Indigenous culture and its practice can support economic participation, development and financial independence (FaHCSIA 2011b: 14).

In the health sector, the Aboriginal traditional medical system constitutes a coherent knowledge system with a definite educational system, skills development and training model. In the current mainstream health care system, the lack of or limited recognition of Aboriginal traditional healers' roles, skills and practices as valuable economic assets creates substantial barriers for Aboriginal traditional healers to move into paid employment, gain financial stability, economic self-reliance and contribute to the economy. As a matter of fact, 'financial security and independence' is indicated as a key priority area in the *Strategy*:

> Financial security gives people choices and provides the stability individuals and their families need to plan for the future. With a steady and well-managed income, Indigenous Australians can build assets that can be used to generate greater wealth for their families and communities. Such assets can be passed on to future generations, creating economic self-reliance and helping to break the cycle of welfare dependency... (FaHCSIA 2011b: 60)

The recognition of Aboriginal traditional healers' role, skills and practice as valuable economic assets in the health sector; the recognition of qualified Aboriginal traditional healers as legitimate health practitioners eligible for recruitment as part of the health workforce in the context of a two-way health care system, are in line with the fundamental pillars of the *Indigenous Economic Development Strategy*. The adoption of the proposed statewide policy framework in South Australia offers a unique opportunity to the Australian government to implement its vision of an Indigenous economic development strategy inclusive of and grounded on Indigenous traditional knowledge and skills.

In the proposed policy framework, ANTAC plays a pivotal role: as a self-determined ngangkari corporation, ANTAC establishes and implements a thorough ngangkari accreditation process to ensure that only those ngangkari who have successfully gone through the traditional education and training system can qualify to become members of the corporation as accredited ngangkari. ANTAC includes all accredited ngangkari who are keen to provide their traditional healing services hand-in-hand with western health professionals. Investment to support ANTAC by the Australian and South Australian governments would be in line with the policy strategies and principles set in the *Indigenous Economic Development Strategy*. Financial support to make ANTAC operational would implement key principles of the *Indigenous Economic Development Strategy*

in the following ways: ANTAC would be able to provide a pathway to demonstrate that 'Indigenous Australians can make a unique contribution to our economy'; the governmental support would be in line with the principle of 'genuine partnership' and 'a relationship based on trust and mutual respect... with all levels of Governments'; it can demonstrates that 'lasting Indigenous economic wellbeing relies on Indigenous Australians having the opportunities and taking responsibility for their individual and family wellbeing, education and economic independence'; it would function as a vehicle to 'Indigenous economic self-reliance', 'Indigenous leadership in leading and shaping sustainable improvements in Indigenous economic well-being' (FaHCSIA 2011b: 18).

The Aṉangu Ngangkaṟi Tjutaku Aboriginal Corporation can make a significant contribution not only in closing the Indigenous health disadvantage but also in closing the employment gap. It provides an invaluable opportunity to the Australian and South Australian governments to broaden the spectrum of pathways to greater economic participation, financial security and independence for Aboriginal and Torres Strait Islander people.

8.9.6 Increase cost-effectiveness: potential reduction of health care expenditure

The integration of Aboriginal traditional healers in a two-way health care system has the potential to reduce health expenditure. The potential cost saving from a two-way team-based approach could increase the cost-effectiveness of the provision of quality health care in mainstream and Aboriginal community controlled health services. The systematic integration of Aboriginal traditional healers in the health care system has the potential to bring about significant cost saving in different ways. The following case exemplifies the potential cost saving to South Australia's health resources that a ngangkaṟi intervention would have made, had the ngangkaṟi been involved at an earlier stage, for example as part of the medical assessment and diagnosis:

> The other advantage is the potential cost saving we have seen. There was a woman who couldn't walk and had a temperature. We thought it was some sort of neurological disease, virus or disorder. And we sent her to Adelaide on an RTS; it cost her $2,000. She was admitted to hospital there, Royal Adelaide, she had a CAT scan, and MRI, tests, and cost probably $15,000-20,000 of State health resources and treatments. And it turned out she had been basically cursed or sung or whatever the process was, but it was a traditional process that created this disability that she had. We then brought her back here and after three sessions with the ngangkaṟi she was cured. So whether it was a psychosomatic disorder or what it was, but effectively western medicine couldn't fix this woman's illness and spent a fortune on her and for the cost of, I think it cost about $500 to get a ngangkaṟi down to treat her. And it was treated effectively: it was a much more cost-effective way of providing health services to that lady *(Interview Hospital Manager 1-H7)*

The intervention of Aboriginal traditional healers can contribute to reducing the number of referrals and admissions in the health care system through a range of different kind of ngangkaṟi interventions: ngangkaṟi intervention can avoid patients accessing or being admitted in the health care system when they are able to cure the patient; ngangkaṟi intervention can avoid repeated consultations or admissions in cases when western medicine cannot find an answer to patient ailments; they can reduce the number of avoidable referrals for country residents to health services based in urban centres and when western treatments are not sufficient or not totally effective:

> We put it [ngangkaṟi's episodes of care] in our notes, but not in a formal way. You always see 'visited by a ngangkaṟi' and it's good for us because sometimes they are cured and we don't have to worry about it *(Interview General Practitioner 2)*

> There are other things where we don't have very good answers to the problem and sometimes they take over, the family will take them to a ngangkaṟi or bring ngangkaṟi to take over because there is something that we haven't really helped, like they've got a headache or something and we can't see a medical response that fixes their problems, so they go to a ngangkaṟi instead (*Interview General Practitioner 2*)

> ...they usually fall into what we think is a

quite often an undiagnosed pain or something like tummy pain, chest pain, or breathing, or when we can't find a major medical reason to be worried, but the person still has the problem, still has the symptoms; sometimes we might think it's a self-limiting thing that is going to go away or something that we don't think needs medical response. But ngangkari will help them with that and maybe give them some cure for the treatment often by removing stone or something like that from there *(Interview General Practitioner 2)*

My sister in law...was getting headaches and tummy pain...They sent her to getting for screen and all that sort of stuff, couldn't find nothing. So when she went back there, they took her to Fregon and Indulkana and they pulled these two things out of her head, like little pieces of wood in the head and apparently gave them that things and put in the jar and showed the doctor. On the scan there was nothing. I haven't physically seen that, but ...yeah, she was having a lot of problems in her head and tummy, they found one in her tummy and two in her head *(Interview Aboriginal Health Worker 2)*

You might have lots of people that are unwell and at the basis of their illness is the belief that they might be guilt associated, the belief that they've done something culturally inappropriate, or that they're being cursed, something put on them because they've done something wrong. And having the ngangkari come in and treat that, that's lifted. So that feeling of guilt, that feeling that they've done something wrong is no longer there. And then their psychological attitude has changed and it then allows our medications to work a lot better... So we are using medications so we're treating from a medication point of view but having the ngangkari come in it's almost treating it from a psychological point of view and that's how I see it and the two go hand in hand *(Interview Psychiatrist 2)*

I have got one client at the moment who has nightmares, had nightmares for a long time and said there is someone in the house. He ended up going to Glenside and he was put on Risperdal Consta, it's a medication, it is injectable anti-psychotic medication. Anyway, he was seen by a ngangkari in the hospital so briefly his nightmares went away. He came back to Port Augusta, nightmares came back. We got the ngangkari to come so they took the stones away from him but it wasn't only just the person, when the ngangkari was there said "no, there is something in this house". They came back and spent the night in the grounds of the house and waited and cleared the house from anything that was there disturbing him. Well, he doesn't have any nightmares since. Now, we have to negotiate around this anti-psychotic injection. Once they are in the system, gee it's hard to get them out *(Interview Mental Health Clinician 1)*

...and we've had a lot of good outcomes... There was one boy who had a psychotic depression: he'd stop eating and drinking. And they just didn't know what to do, they were giving him ECT, they were giving him treatment but he just refused to eat and drink because he thought he'd basically been sung. So they got the ngangkari in and they just said it was amazing the transformation. The next day he got up and started eating and drinking and he was fine (*Interview Psychiatrist 2*)

...the two people we've got the ngangkari to see got better. They improved markedly, the ngangkari was in fact able to see somebody who I think would have exceeded dozens of hours of psychotherapy because of the particular family dynamics and issues; and he was able to resolve, it made a significant difference *(Interview Psychiatrist 1)*

What would be the cost saving if we multiply the economic implications of these few cases on the health expenditure statewide?

At this stage, the lack of a systematic integration of Aboriginal traditional healers in a two-way health care system and the lack of a systematic data collection process of their interventions does not allow the assessment of the full extent of their impact in terms of cost-effectiveness and cost saving in state and federal health resources. The evidence presented in this report, however, demonstrates the significant role of Aboriginal traditional healers in the health care sector and the viability of a two-way health care system grounded on a team-based collaboration between western medical practitioners and Aboriginal traditional practitioners.


The evidence presented in this
report paves the way for the
recognition and practice of
Aboriginal traditional medicine
hand-in-hand
with western medicine

Appendix 1

LIST OF INTERVIEWEES

South Australia Department of Health

April Lawrie-Smith, *Executive Director,* Aboriginal Health Division, SA Health

Kim Morey, *Assistant Director,* Aboriginal Health Division, SA Health

Robert Zadow, *Executive Director,* Country Health South Australia Local Health Network (2010)

Glenise Coulthard, *A/Executive Director Aboriginal Health,* Country Health South Australia

Azmiri Mian, *Senior Project Officer, Aboriginal Patient Pathway Journey,* Country Health South Australia Local Health Network

Dr Ken Fielke, *Psychiatrist, Clinical Director Country Mental Health,* Country Health South Australia Local Health Network

Dr Peyman Bakhtiarian, *Consultant Psychiatrist in Communities*, SA Health

Commonwealth Department of Health and Aging (DoHA)

Office for Aboriginal and Torres Strait Islander Health (OATSIH)

Bridget Booth, *Director,* OATSIH (DoHA)

Rachelle Wingard, *Assistant Director,* OATSIH (DoHA)

Rural and Population Health in South Australia

Vichy High, *Manager,* Rural and Population Health SA (DoHA)

Voola Varvounis, *Senior Project Officer,* Rural and Population Health SA (DoHA)

Department for Families and Communities

Suzanne Lacey, *Senior Service Coordinator, Homelessness Support Program, Exceptional Needs Unit,* Department for Families and Communities

Rachelle Bloomfield, *Targeted Families Support Service, Central Australian Aboriginal Congress*

Royal Australian and New Zealand College of Psychiatrists

Maria Tomasic, *President*

Department for Correctional Services

Richard King, *Director, Aboriginal Services*

Denise Agius, *Aboriginal Liaison Officer*

Owen Brady, *Aboriginal Liaison Officer, Aboriginal Liaison Unit, Port Augusta Prison*

Magistrates Court Far North Region

Rosanne McInnes, *Magistrate, Country Regional Managing Magistrate Far North Region*

Michael Amos, *Interpreter*

ADELAIDE

Aboriginal Health Council of South Australia

Dr David Scrimgeour AM, *Public Health Medical Officer*

Alwin Chong, *Senior Research and Ethics Officer, Aboriginal Health Research & Ethics Committee (AHREC)*

Shane Pilot, *Workforce Development Officer*

Rural and Remote Mental Health Service (RRMHS)

Dr Adriana Lattanzio, *Psychiatrist, Clinical Team Leader*

Peter Taylor, *Aboriginal Mental Health Liaison Worker*

Karen Bates, *Aboriginal Mental Health Liaison Coordinator*
John Bukskin, *Aboriginal Cultural Consultant and Liaison Officer*

Women's and Children's Hospital
Margaret Hampton, *Aboriginal Liaison Manager, Aboriginal Liaison Unit*
Bonita Sansbury, *Aboriginal Health Liaison Officer, Aboriginal Liaison Unit*

Royal Adelaide Hospital
Denise Karpany, *Aboriginal Liaison Manager, Aboriginal Liaison Unit*
Josie Owen, *Aboriginal Liaison Officer, Aboriginal Liaison Unit*
David Power, *Aboriginal Liaison Manager, Aboriginal Liaison Unit*

Queen Elizabeth Hospital
Natalie Williams, *Aboriginal Liaison Manager, Aboriginal Liaison Unit*

Flinders Medical Centre
Laney Mackean, *Regional Manager, Karpa Ngarrattendi Aboriginal Health Unit*

Lyell McEwin Hospital
Carol Cooper, *Aboriginal Patients Pathways Officer*

Noarlunga Health Centre
Theresa Francis, *Regional Manager of Aboriginal Health Services Southern Adelaide Local Health Network*
Sharon Miller, *Clinical Manager*

Flinders Human Behaviour and Health Research Unit - Flinders University
Sue Bertossa, *Indigenous and Multicultural Project Officer*

Nunkuwarrin Yunti of SA Inc.
Polly Sumner-Dodd, *Chief Executive Officer* (2009)

South Australian Native Title Services (SANTS)
Parry Agius, *Chief Executive Officer*
Lynette Ackland, *Senior Field Officer*

Ngura Wiṟu Winkiku Indigenous Corporation
Murray George, *Director*
Inawintji Williamson, *Board member*
Varity May, *Project officer*

Better World Arts
Carolyn Wilson, *Director*

CEDUNA

Ceduna District Health Services
Andrew Lane, *Campus Manager*
Rebecca Kavanagh, *Manager Community Health*

Ceduna-Koonibba Aboriginal Health Service
Leonard Miller, *Chairperson*
Tauto Sansbury, *Chief Executive Officer* (2009)
Johanne Pompey, *Aboriginal well-being support worker*

Community members
Patricia Gunter, *Bush medicine healer*
Joy Haynes, *Ceduna Arts and Culture Centre*

YALATA

Tullawon Health Service
Darrel Brock, *Chief Executive Officer*

OAK VALLEY

Oak Valley Aboriginal Health Service
Sue Twining, *Chief Executive Officer*

KAKARRARA WILURRARA HEALTH ALLIANCE (Yalata, Oak Valley, Tjuntjuntjara)
Dr Jill Benson, *Medical Director,* Kakarrara Wilurrara Health Alliance

PORT LINCOLN

Port Lincoln Aboriginal Health Service Inc. (PLAHS)
Harry Miller, *Chief Executive Officer*
Carolyn Miller, *Corporate Services Manager*
Angela Dufek, *Manager Health Programs*
Peter Moxey, *Clinical Coordinator*

WHYALLA

Nunyara Wellbeing Centre Inc.
Cindy Zbierski, *Chief Executive Officer,*
Leonard Miller, *Aboriginal Health Worker* (2009)

PORT AUGUSTA

Pika Wiya Aboriginal Health Corporation
Cephas Stanley, *Chief Executive Officer* (2009)
Charlie Jackson, *Chief Executive Officer* (2010)
Paul Ashe, *Interim Chief Executive Officer* (2011)
Marsha Warren, *Aboriginal Health Worker, Social and Emotional Well-being Team*
Diana Murphy, *Mental Health Shared Care Clinician, Social and Emotional Well-being Team*
Valma Ah-nge, *Bringing Them Home counsellor, Social and Emotional Well-being Team*
Chris Connelly, *Clinical Psychologist*
Henry Walker Morton, *Financial Manager*
Janet McKenzie, *Programs Manager*

Port Augusta Hospital
Glenise Coulthard, *Manager Aboriginal Liaison Unit* (2009-11)
Medical practitioner
Joanne Dingaman, *Cultural Consultant*

COOPER PEDY

Coober Pedy Hospital Health Services
Donna Ganey, *Manager Community Health Services*

Umoona Tjutagku Health Service
Priscilla Larkins, *Chief Executive Officer*
Dr Stewart Martin, *General Practitioner*
Roland Ruff, *Registered nurse, Healthy for Life Coordinator*
George Laslett, *Drug and Alcohol Program Planning Manager*
Peter Gregg, *Registered nurse*

Angela Scott, *Registered nurse*
Ian Crombie, *Aboriginal Health Worker*

Umoona Aged Care Aboriginal Corporation
Sonia Mazzone, *Chief Executive Officer*

The Flinders and Far North Division of General Practice
Clinician

AṈANGU PITJANTJATJARA YANKUNYTJATJARA LANDS (APY)

Nganampa Health Council
John Singer, *Director*
Dr Paul Torzillo, *Clinical Director*
Dr Kerrie Gell, *Consultant Medical Officer*
Dr Peter Bennet, *General Practitioner*
David Busuttil, *Health Service Manager*
Vivienne Humnond, *Clinical Service Manager*
Denise Smith, *Registered nurse and midwife*
Stewart Smith, *Registered nurse*
Cyndi Cole, *Registered nurse, Aboriginal Health Worker Training Program Co-ordinator*
Nazi Inrentulla, *Mental Health Worker, Mental Health Program*

AMATA
Brenda Stubbs, *Director, Tjurma Bush Products; Aboriginal Engagement Officer*, *Remote Service Delivery*
Tapaya Edwards, *community member*

MOUNT GAMBIER

Pangula Mannamurna Health Service Inc
Karen Glover, *Chief Executive Director*
Sarah Bates, *Programs Manager*

MURRAY BRIDGE

Kalparrin Community Inc.
James Mulvihill, *Director*

Ngangkaṟi

Ngangkaṟi members of ANTAC
Sam Watson, *Director*, Pipalyatjara
Gordon Ingkatji, *Director,* Pukatja-Ernabella
Arnie Frank, *Director,* Fregon
Iwana Antjakitja, *Director,* Fregon
Debbie Watson, *Director,* Fregon
Andy Tjilari, *member,* Pukatja-Ernabella
Roger Kayipipi, *member,* Fregon
Wongka Wongka, *member,* Fregon
Cyril McKenzie, *member,* Fregon
Rama Sampson, *member,* Pukatja-Ernabella
Witjiti George, *member,* Fregon
Taylor Cooper, *member,* Fregon

Max Watson, *member,* Pipalyatjara
Hector Mitakiki, *member,* Amata

Other ngangkaṯi

Kumanara Peters, *Fregon*
Toby Ginger, *Finke*
Robin Kankapakantja, *Fregon*
Anyupa Treacle, *Fregon*
Teddy Edwards, *Mimili*
Huie Tjami, *Mimili*
Mukayi Baker, *Ernabella*
Glen Minutjikuru, *Ernabella*
Kumanara Brown, *Mimili*
Max Hubert, *Ceduna*

Patients and community members

Sonia Waters, *Adelaide*
Kathleen Doolan, *Adelaide*
Ribgna Green, *Adelaide*
Bonita Sansbury, *Adelaide*
Patricia May, *Adelaide*
Rameth Thomas, *Coober Pedy*
Beverly Carroll, *Coober Pedy*
Pauline Lewis, *Coober Pedy*
Sandra Lewis, *Pukatja-Ernabella*
Beverly Peacock, *Fregon*
Kanytjupai Robin, *Fregon*
Gwen Crombie, *Fregon*
Jack Crombie, *Fregon*
Margaret Pumani, *Mimili*
Fery Stevens, *Fregon*
Kanginy George, *Fregon*
Margaret Richards, *Pipalyatjara*
Kanakiya Tjanyari, *Pipalyatjara*
Nyukana Norris, *Fregon*
Polyanne Smith, *Fregon*
Patient, *Fregon*
Tapaya Edwards, *Amata*
Paul Tanner, *Port Augusta*

Appendix 2

PITJANTJATJARA GLOSSARY

Mamu: negative spirit, illness

Ma̲ra: hands

Minyma: mature woman

Mapan̲pa: ngangka̲ri sacred tools

Marali: spirit body

Minyma ngangka̲ri: women ngangka̲ri

Ngangka̲ri: Aboriginal traditional healers – men and women – from the Pitjantjatjara, Yankunytjatjara, Ngaanyatjarra Aboriginal language groups in Central Australia

Ngangka̲riku Tjukurpa: ngangka̲ri Law

Pulka: strong, powerful

Puulpai: blowing

Puun̲i: blowing breath method

Pun̲u: wood, wooden object, tree, timber

Karpa̲rinypa: powerful spirit figure giving ngangka̲ri sacred tools

Kurunpa: spirit

Kililpi: star

Rama̲rama: person with mental health issues

Tarka mapan̲pa: sacred ngangka̲ri tools made out of bone

Tjitji: children

Tjukurpa: Law

Walypala: white men, and to

Walupara: white women

Wati: men

Wati put̲itja: man of the bushland

Wati Tjukurtjara: Ngangka̲ri men

Wi̲runymankupai: to give true spiritual and physical healing, and to declare the person to be well again

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About the author

Dr Francesca Panzironi is an independent researcher with a particular research interest in Indigenous traditional medicines and health care systems. Francesca has been investigating the harmonisation and integration of Indigenous traditional medicines in national health care systems around the world. The lack of any reference to Aboriginal traditional medicine in Australia within the international context triggered the urge to investigate the status of Aboriginal traditional medicine in Australia. In her latest work *Hand-in-Hand Report on Aboriginal Traditional Medicine*, Francesca provides a thorough analysis of the status of Aboriginal traditional medicine from a legal, social and policy perspective and proposes a new statewide policy framework for the systematic harmonisation of Aboriginal traditional medicine in the mainstream health care system. The proposed policy framework establishes the foundations for the recognition of Aboriginal traditional medicine in Australia and the development of a two-way health care model to guarantee the systematic provision of Aboriginal traditional medicine hand-in-hand with western medicine.

Francesca has extensive experience as a researcher and lecturer. She attained a PhD in Law from the Sydney Law School, University of Sydney. She has worked as lecturer at the University of Sydney (2003-2008) and the University of New South Wales (2009-2012) teaching a range of subjects, including development studies, social and community development, international human rights law, international law, international organisations, human rights-based project design, management, and evaluation. Her research has focused on the interface between Indigenous peoples' rights under international law and national public policies. In her PhD thesis *Indigenous Peoples' Right to Self-determination and Development Policy,* she investigated the implementation of the internationally recognised right to self-determination through public policies. In particular, she adopted the human development paradigm and 'capability approach' to broaden the scope of public policies to embed the overarching right of Indigenous peoples to self-determination. Her publications include *The "Capability Approach": a Theoretical Framework to Interpret Indigenous Peoples' Right to Self-determination'* (2009), *The Capability Approach in the Asia-Pacific Region: Development Practice and Public Policy in the Asia-Pacific Region* (2012), *Capabilities, rights and public policy: Indigenous Australian's right to health in South Australia* (2012), *Closing the Gap and Aboriginal Traditional Medicine: Foundations for a National Dialogue* (2011).

ISBN 978-0-9875311-0-0

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