Central Australian Aboriginal Congress submission:

Inquiry into the accessibility and quality of mental health services in rural and remote Australia

Context for this submission

Central Australian Aboriginal Congress (Congress) is the largest Aboriginal community-controlled health service (ACCHS) in the Northern Territory, providing a comprehensive, holistic and culturally-appropriate primary health care service to more than 13 000 Aboriginal people[1] living in Alice Springs each year as well as the remote communities of Ltyentye Apurte (Santa Teresa), Ntaria (Hermannsburg) and Wallace Rockhole, Utju (Areyonga), Mutitjulu and Amoonguna.

Congress operates within a comprehensive primary health care (CPHC) framework, providing a range of services in remote areas of Central Australia. Alongside general practice, services and programs on issues such as alcohol, tobacco and other drugs; early childhood development and family support; aged and disability; and mental health and social and emotional well-being are also provided.

As Aboriginal people have significantly more complex health needs, ACCHSs provide a comprehensive model of care that goes beyond the treatment of individual clients for discrete medical conditions to include:

- a focus on cultural security
- assistance with access to health care
- population health programs including health promotion and prevention
- public health advocacy and intersectoral collaboration
- participation in local, regional and system-wide health planning processes
- structures for community engagement and control
- significant employment of Aboriginal people. [1]

Why it is important to specifically consider Aboriginal people in this inquiry

The highest proportion of Aboriginal and Torres Strait Islander people in Australia live in the Northern Territory (25.5 per cent of the NT population), which is predominately a remote area.[2] Furthermore,

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[1] In this document, we use the term 'Aboriginal' to refer to 'Aboriginal and Torres Strait Islander' and/or 'Indigenous' as the preferred term in Central Australia

most Aboriginal people (80 per cent) living in the NT live in rural and remote communities. [3] This means that to be effective rural and remote mental health services must consider the specific needs of Aboriginal people. This is further detailed in the response to the Terms of Reference, below.

As an ACCHS, Congress is an exemplar in health service delivery to Aboriginal people in both town and remote areas. Congress has also pioneered a 'three streams' approach to mental health services, which integrates social and cultural matters, physical health, and mental health, including attention to alcohol and other drug issues and suicide prevention. This service is provided in both Alice Springs and in remote communities as an outreach service.

The effectiveness of our services is contingent on the political and policy environment in which we work. Key challenges include competitive tendering which leads to fragmented, complex service delivery environments with multiple providers of health services. On the other hand, the announcement by the NT government to reduce alcohol supply, including by introducing a minimum floor price, is integral to a reduction in alcohol-related harms including suicide. This is alongside the paradigm shift that is currently occurring in youth justice in NT, which includes shifting from a punitive approach to a therapeutic, population health approach to improve long term and intergenerational outcomes.

Summary of key points

Key points raised in this submission are:

- The specific needs of Aboriginal people must be recognised by providers so that services are effective and accessible to Aboriginal people.
- That Aboriginal Community Controlled Health Services (ACCHS) are the most effective providers of culturally safe, integrated, mental health services to Aboriginal people.
- The key challenges to the ACCHS service model include competitive tendering and short term funding cycles, which have a significant impact on integrated, holistic, accessible service delivery in remote and rural areas.
- There is a need to integrate mental health, AOD and primary health care services to overcome the problem of "Dual diagnosis" and lack of access to integrated care based on the 3 streams of care approach – medical (pharmacotherpies), psychological and social and cultural support with intensive case management when needed.
- Suicide in Aboriginal communities is linked to disempowerment, disadvantage and the social determinants of health. Addressing the social determinants of health is imperative to reducing the high suicide rates in Aboriginal communities. This specifically includes:
    - Providing evidenced-informed early childhood learning and parenting programs
    - Reducing young people's contact with the justice system
    - Reducing the number of Aboriginal children in out-of-home
    - Reducing alcohol related harms.

- There is an ongoing need for a high-quality, culturally-competent mental health workforce, including an Aboriginal workforce, alongside the capacity to train clinicians outside of major centres.
- Governments should work with ACCHSs in the development of culturally safe technological solutions for mental health service delivery.

Recommendations

That governments:

1) ***Improve accessibility of mental health services to Aboriginal people by recognising intergenerational trauma. This means:***
    a) ***ensuring that all agencies delivering mental health and social and emotional wellbeing services to Aboriginal people use approaches that are trauma-informed and that validate and support Aboriginal culture and ways of being***
    b) ***supporting healing approaches run by the Aboriginal community***
    c) ***eliminating systemic and institutionalised racism.***

2) ***Recognise the need to combine medical care, psychological therapies and social and cultural support with intensive case management as the best practice model for integrated mental health services to Aboriginal people.***

3) ***Recognise and address the link between the social determinants of health, inequity and risk for suicide.***

4) ***Continue to invest in evidence- informed early childhood development and parenting programs for families at risk of having developmentally vulnerable children to support healthy brain development, resilience and self-control.***

5) ***Recognise the link between contact with the criminal justice system and risk of youth suicide and endorse preventive and diversion measures to reduce the numbers of Aboriginal young people being incarcerated, as well as therapeutic approaches for those where detention is necessary.***

6) ***Recognise the need to address the number of Aboriginal children in out-of-home care as part of a suicide prevention strategy.***

7) ***Undertake measures to reduce the supply of alcohol as the best way to reduce alcohol-related harm, including suicide. In particular this means introducing a minimum floor price and a volumetric tax, to reduce the availability of cheap alcohol and raise funds to address alcohol-related harm.***

8) ***develop strategies for a high-quality, culturally-competent mental health workforce, taking into account rural and remote distribution and Aboriginal health workforce development.***

9) ***reject open competitive tendering processes for the funding of mental health and social and emotional wellbeing services for Aboriginal communities as an ineffective approach that undermines integration and leads to fragmented and ineffective service systems.***

10) ***support and resource needs- informed planning through established collaborative structures that include significant representation from the ACCHS sector, to ensure the effective distribution of resources and appropriate service models to address Aboriginal mental health and social and emotional wellbeing.***

11) ***commit to long term block funding for comprehensive primary health care services including ACCHSs.***

12) ***continue to work with remote and rural service providers particularly ACCHSs in developing culturally safe technological solutions, and the delivery of psychological assessments via telehealth.***

Addressing the Terms of Reference

1. The nature and underlying causes of rural and remote Australians accessing mental health services at a much lower rate

To be accessible to Aboriginal people, services must be trauma- informed, culturally safe, and free of racism

Intergenerational trauma

For Aboriginal people living in rural and remote areas services must not only be available, they must also be accessible. This means they must be trauma- informed, culturally safe, and free of racism. The colonisation of Australia and its ongoing process and impacts must be acknowledged by mental health service providers to understand Aboriginal mental ill health and social and emotional wellbeing today.

Dispossession, exclusion, discrimination, marginalisation, the forcible removal of children from their families, and ongoing inequities has led to and continue to impact on poor physical and mental health outcomes for Aboriginal people.[4,5]

This historical and ongoing experience is now recognised as resulting in 'intergenerational trauma' whereby traumatic experiences of the first generation are passed on to the next generation and the next.[6] Intergenerational trauma can manifest in many symptoms of poor mental health and social and emotional wellbeing and adverse behaviours including panic attacks, anxiety, sleep disturbance, severe obesity; smoking, illicit drug use, alcoholism; and intercourse at an early age.[7]

There is growing evidence that unresolved intergenerational trauma underpins many of the social and emotional wellbeing issues and mental illnesses experienced in some Aboriginal communities. For example, a recent study examined the health and wellbeing of Aboriginal people who had either been removed from their families as children, or who had parents, grandparents/great-grandparents or siblings who had been removed. This group is 50 per cent more likely to have been charged by police, 15 per cent more likely to consume alcohol at risky levels and 10 per cent less likely to be employed than the wider Aboriginal and Torres Strait Islander community.[8]

Trauma informed services

There is growing recognition in Australia that policies and service providers must address and respond to traumatic life events appropriately to ensure better outcomes. [9] This includes providing services in a safe way and creating the opportunities for people affected by trauma to regain a sense of control and empowerment. [10] Moreover, a trauma informed service is cognisant of the effects on staff who are exposed to this trauma and, if Aboriginal, may have also had traumatic experiences in their own or their families background.

The service system must recognise the prevalence of intergenerational trauma not only on the wellbeing of individuals, but populations and communities as a whole.[11] All services accessed by Aboriginal people should therefore aim to be 'trauma-informed' such that they are able to recognise the different ways that the experience of unresolved trauma can manifest (for example, in mental health issues, or addiction, or violence) and address them in an informed way.[12]

Healing programs

Culture and spirituality is highly important in supporting resilience and positive social and emotional well-being and good mental health and living a life free of addiction to alcohol and drugs[13]. Cultural is a source of strength, identity, structure and continuity in the face of ongoing change, stress and adversity, and as a protection against suicide.[14]

The recognition of the positive nature of Aboriginal culture and knowledge, despite the impact of ongoing colonisation, racism and harmful policies that impact on the health of Aboriginal communities, supports healing.

There is an emerging body of evidence which demonstrates that in this context, healing programs are an effective way of addressing the effects of intergenerational trauma. In Canada for example, healing centres – spaces which supports healing work for Aboriginal people – are proven to be effective in preventing the negative health and wellbeing outcomes, including suicide, associated with intergenerational trauma experienced by Aboriginal communities. [15]

> *"Healing works best when solutions are culturally strong, developed and driven at the local level, and led by Aboriginal and Torres Strait Islander people."*[16]

Healing will often make use of both mainstream and traditional knowledge and practices, but valuing Aboriginal knowledge and leadership is a prerequisite for adaptive solutions to be developed.[17] Effective healing programs must be:

- Locally led and driven
- Evidence- informed
- Include a combination of Western methods and traditional healing
- informed about and understand the impact of colonisation and intergenerational trauma and grief
- build upon individual, family and community capacity.[18]

Support for living on country

Where appropriate and desired, living on traditional lands with strong connection to family, community, country, language and culture has physical, mental and emotional health benefits, including reduced substance abuse and violence[19].

Addressing racism

Aboriginal people have been consistently excluded from mainstream health services, originally through overt racist practices of exclusion, and more recently through covert racist practices that isolate and inhibit access e.g. failing to provide culturally secure and safe care that reflects an understanding of Aboriginal social and emotional wellbeing.

Racism can be structured into how institutions operate, through policies and assumptions which disadvantage Aboriginal people. Racism in health care institutions contributes to the lack of trust in mainstream health and social services and a corresponding lack of use of services, and Aboriginal people are less likely to receive the care they need.[20]

Racism is also a determinant of mental illness as it debilitates confidence and self-worth, creates psychological distress, depression and anxiety, and exacerbates health risk behaviours such as smoking and alcohol and substance misuse.[21]The experience of racism is overwhelmingly common for Aboriginal and Torres Strait Islander people: a 2012 study found that 97% of Aboriginal Victorians reported experiencing racism in the previous year, with over 70% of those surveyed reporting eight or more such incidents in the previous twelve months.[22]

Governments have a responsibility to eliminate systemic and institutionalised racism, and ensure all services are non-discriminatory and accessible, by being, for example culturally competent.

Service design: Culturally safe, integrated programs delivered by Aboriginal Community Controlled Health Services

The evidence points to ACCHSs as a highly effective model for addressing Aboriginal health, and they are therefore recognised as the best practice model for primary health care services for Aboriginal people in all the key national strategy documents including the National Aboriginal and Torres Strait Islander Health Plan (NATSIHP). A key recent study concluded:

> *... are improving outcomes for Aboriginal people, and ... that they achieve outcomes comparable to those of mainstream services, but with a more complex caseload[23].*

The key role of ACCHSs is supported by the fact that Aboriginal people show a clear preference for their use, leading to greater access to care and better adherence to treatment regimes[24].

As an ACCHS, Congress is able to provide fully integrated mental health services as part of comprehensive primary health care and are not stand alone, specialist and separate services, then it is more possible to treat the whole person. Congress has pioneered the '3 streams' approach to mental health services which integrates: a) social and cultural support b) medical care and c) psychological therapy including AOD and suicide prevention including an intensive case management approach when needed.

This integrated approach is supported by the use of a single Clinical Information System that all professionals use including GPs, psychologists, social workers, and Aboriginal Health Workers. All members of the multidisciplinary team treating the whole patient can access the patient's medical record so there is a consistent approach to treating the patient.

Within a comprehensive primary health care service the 3 streams of care service model is possible and the whole person is treated recognising the root causes of poor physical health and poor mental health are the same, and comorbidities are interrelated. This also assists to ensure that the physical health needs of mentally ill patients are not neglected as severely mentally ill people are at risk of dying prematurely of untreated physical health problems such as coronary heart disease and diabetes, rather from their mental illness.[25] Under this service model, patients are able to have both their mental health and physical needs addressed in one visit in the one place.

The benefits of locating a mental health specific service within a comprehensive primary health care service have also been realised with the Congress headspace service where young people are able to access sexually transmitted infection treatments, contraception advice, health checks etc along with mental health and substance misuse diagnosis, treatment and support. Because the service is integrated in this way many young people present in the first place as they access the bulk billing medical service which is the first point of contact for the most disadvantaged young people. They then access services for mental health issues.

Challenges to this service model

Competitive tendering for short-term funding leads to complex service delivery environments with multiple providers of health services rallying for funds in relatively small, sparsely populated areas. This is further detailed under X. The impact of competition also comprehensively discussed in Congress' submission to the Productivity Commission's Preliminary Findings Report: Introducing Competition and Informed User Choice into Human Services; Identifying Sectors for Reform

Recommendation:

That governments

1) improve accessibility of mental health services to Aboriginal people by addressing intergenerational trauma. This means:

- ***a) ensuring that all agencies delivering mental health and social and emotional wellbeing services to Aboriginal people use approaches that are trauma-informed and that validate and support Aboriginal culture and ways of being***
- ***b) supporting healing approaches run by the Aboriginal community***
- ***c) eliminating systemic and institutionalised racism.***

2) recognise the need to combine medical care, psychological therapies and social and cultural support with intensive case management as the best practice model for integrated mental health services to Aboriginal people.

2. The higher rate of suicide in rural and remote Australia

The suicide rate for Aboriginal Australians is almost twice the rate for non- Aboriginal Australians.[26] High rates of suicide are closely linked to social and economic disadvantage: the greater the inequality, the higher the risk is for mental illness.[27]In other words, the need to address inequality cannot be ignored as a fundamental measure to reduce suicide rates in Aboriginal communities. This has been known in the literature since the classic work on Suicide by Emile Durkheim published in 1897 and the key findings in this study have been confirmed by modern social epidemiology yet there continues to be attempts to address suicide through programs and services without the need to address extreme structural inequalities. This will not be sufficient.

For Australian Aboriginal people, these inequalities include poverty, poor education, poor housing, lack of nutrition and lack of meaningful employment. Lack of control over one's life, continual anxiety and insecurity has a powerful effect on health and well-being.[28] Between one-third and one-half of the gap in health between Aboriginal and non- Aboriginal people is estimated to be due to these determinants.[29]

Strengthening community-led initiatives to reduce the rates of suicide requires recognising the impact of colonisation, intergenerational trauma and loss of control. This includes supporting community control of Aboriginal services and programs, connection to family, community, country, language and culture and support for trauma-informed services; healing programs; culturally secure SEWB programs; and where appropriate Aboriginal families living on country.

Action across the full range of social determinants is necessary to reduce rates of suicide in Aboriginal communities by improving resilience and capacity to self-manage at an individual and community-level. This requires a whole-of-government commitment. For example, early childhood development and learning, primary and secondary education accompanied by psychosocial support measures (e.g. positive role models, healthy activities); support for workforce participation and development of skills; healthy relationships and community participation, are all measures that can strengthen social and emotional wellbeing and prevent suicide.[30,31]

Brain development, self-regulation and suicide

Between 2008-2012 the suicide rates for Aboriginal people 15–19 year olds were five times as high as the non-Aboriginal rate.[32] Suicide rates are a key measure of the health and well-being of young people, and an indicator for youth development i.e. the status of young people and their capacity to contribute to and benefit from society[33].

As children's brains and social-emotional skills develop, they learn to regulate their emotions, attention and behaviour. Disruptions to healthy neurodevelopment lead to problems with the brain's executive functions such as impulsivity due to poor emotional self-regulation, problem solving, coping and decision-making skills. This also includes conditions that can occur in utero, such as Foetal Alcohol Spectrum Disorders (FASD). For some young people, underdeveloped self-regulation and coping skills can mean suicidal thoughts quickly escalate as an immediate solution to an emotional life crisis.[34]

Suicide in children, adolescents and young adults is therefore more often related to impulsive behaviour and poor problem-solving skills, such as the inability to deal with an emotionally- stressful life event, rather than depressive illnesses.[35] It is not effective to wait to diagnose "depression" or even depressive symptoms as most young people who suicide do not show these symptoms but act impulsively, often but not always under the influence of alcohol which further reduced the capacity for emotional self-regulation.

Aboriginal children are at a higher risk than non-Aboriginal children for unhealthy brain development and therefore impulsive behaviours. According to the Australian Early Development Census (AECD), 60 per cent of Aboriginal children are developmentally vulnerable on at least one measure of childhood development. Aboriginal children are twice as likely as non-Aboriginal children to be developmentally vulnerable in at least two measures[36]. Furthermore, children living in very remote areas are 2.6 times more likely to be developmentally vulnerable than children living in major cities. One of the key domains of developmental vulnerability is the emotional domain that includes self-control or self-regulation.

Additionally, adverse childhood experiences such as family violence, are a strong predictor for poor social functioning, impaired well-being, health risks and disease, and contribute powerfully to many major public health and social problems.[37] There is a strong association between adverse childhood experiences and increased levels of depression, suicide attempts, sexually transmitted infections, smoking, alcoholism, higher levels of violence and antisocial behaviour, school underperformance and lower IQs, economic underperformance and poor physical health.

Early childhood care, support, education and healthy brain development

Improving cognitive development, resilience and self-control, lies in the area of early childhood, especially in the years from pre-birth to 4 years of age. It is well established that in the first few critical years, children need responsive care and stimulation including strong, positive relationships with primary care givers to develop neural systems crucial for adult functioning and positive mental health. Longitudinal studies show that parenting support and targeted early childhood educational programs reduce the risk factors for children that may lead to poor mental health in adulthood.

Such evidence- informed programs have, for example, reduced rates of alcohol and other substance use by young adults, improved educational and employment outcomes, reduced the proportion of teen pregnancies, and are associated with more active lifestyles and reduced incarceration rates (Tremblay, et al, 2008; Campbell, et al, 2008).

Parenting programs to support healthy development

Parenting programs support and enhance the skills of parents to allow for healthy child development, and reduce exposure to adverse childhood experiences which negatively impact on development and increase the risk of suicide in later life.[38] For example, the Nurse Family Partnership and Parenting Under Pressure (PUP) programs are cost effective programs that promote healthy development in early childhood.[39] [40] and prevent the development of mental and physical health problems in later life.

Reducing contact with, and the impact of, the justice system to reduce the risk for suicide in young Aboriginal people

A young person's risk of suicide is increased if they have been involved in criminal justice system (e.g. being arrested, charged or sentenced) in the previous three months and in particular the last week[41]. This has a disproportionate effect on Aboriginal young people who are held in criminal detention at much higher rates than non-Aboriginal young people, while around one half of young people in detention at any point in time are Aboriginal.[42]

Prevention approaches, and those that divert young offenders away from detention, are the most important strategies to deal long-term with the issue of youth detention. Australia's leading criminologist, Don Weatherburn has very clearly outlined the two key strategies to prevent incarceration evidence -informed early childhood programs and reducing the supply of alcohol[43] For Aboriginal young people, diversion programs have been shown to lead to reduced drug and substance use and reoffending, especially if programs include culturally appropriate treatment and rehabilitation and Aboriginal and community Elders or facilitators.[44].

For that small number of young people where detention is necessary, the focus should be on therapeutic treatment in smaller residential units rather than punishment in large institutions. Such an approach has been shown to achieve exceptional reductions in juvenile recidivism.[45]

Congress' submission to the Royal Commission into the Protection and Detention of Children in the Northern Territory outlines in detail the measures necessary to reduce contact with the justice system and to reduce the impact when children are detained.

Reducing and limiting the impact of Out of Home care to reduce the risk for suicide in young Aboriginal people

Statutory care of children has a direct link with suicide – a recent report notes that more than half of young people who had left out of home care within twelve months had reported that they had experienced suicidal thoughts, and more than a third had attempted suicide.[46] This is deeply concerning for Aboriginal children who are nearly 10 times as likely as non-Aboriginal children to be in Out of Home care due to child protection issues.[47]

The Secretariat of National Aboriginal and Islander Child Care (SNAICC) has recommended a five-point strategy for addressing the rising numbers of Aboriginal children being removed from their families and supporting the implementation of the Aboriginal Child Placement Principles (SNAICC 2014):

- increasing community participation in decisions for the care of Aboriginal and Torres Strait Islander children, supported by community-controlled service design and delivery,
- re-orienting service delivery to early intervention and family support,
- ensuring that funding and policy support holistic and integrated family support and child protection services,
- recognising the importance of supporting and maintaining cultural connection, and
- building capacity and cultural competence for effective service delivery to Aboriginal and Torres Strait Islander children and families.

Additionally, it has been recommended Family Group Conferencing be established as legislated mechanism to ensure that all kinship care options are properly explored prior to foster care arrangements being made.[48]

The contribution of alcohol to suicide

Harmful alcohol use by parents and carers is known to be associated with a lack of responsive care and stimulation in early childhood. Children brought up in these environments often lack the necessary skills for effective emotional regulation and self-control and other executive brain functions that have been shown in longitudinal studies to lead to addictions including alcohol.[49]

Alcohol is also a related and major contributor to mental ill health and poor social and emotional wellbeing, risky behaviour and is a precursor for suicide. Alcohol abuse is directly associated with at least 8 per cent of the burden of disease and injury borne by Aboriginal people, including through homicide, violence, and suicides.[50,51]

A reduction in the supply of alcohol is one of the most cost effective initiatives that could be undertaken in the primary and secondary prevention of mental illness and suicide, particularly among young people and the heaviest drinkers, who are the most disadvantaged and vulnerable to mental illnesses.[52] In particular, there is clear evidence that increasing the price of alcohol reduces consumption and alcohol related harm; it is also a highly cost effective intervention.[53,54,55]

Following the Northern Territory Alcohol Policies and Legislation Review, the Northern Territory Government has committed to introducing a floor price based on the price of full strength beer ($1.30 per standard drink. A commitment by the Commonwealth Government to reduce alcohol supply through taxation would further support this approach, and allow for hypothecation of funds back into addressing the root causes of suicide.

Recommendations:

That governments

3) recognise and address the link between the social determinants of health, inequity and risk for suicide.

4) continue to invest in evidence- informed early childhood development and parenting programs for families at risk of having developmentally vulnerable children to support healthy brain development, resilience and self-control.

***5) recognise the link between contact with the criminal justice system and risk of youth suicide and endorses preventive and diversion measures to reduce the numbers of Aboriginal young people being incarcerated, as well as therapeutic approaches for those where detention is necessary*.**

6) ***recognise the need to address the number of Aboriginal children in out-of-home care as part of a suicide prevention strategy.***

7) undertake measures to reduce the supply of alcohol as the best way to reduce alcohol-related harm, including suicide. In *particular this means introducing a* ***minimum floor price and a volumetric tax, to reduce the availability of cheap alcohol and raise funds to address alcohol-related harm.***

3. The nature of the mental health workforce

A high quality Aboriginal workforce is important to ensure the system is able to meet the health needs of Aboriginal communities: they are able to bring together professional training with community and cultural understanding to improve patient care and increase cultural safety across the organisation in which they work.[56.]

While Aboriginal people remain under-represented in the health workforce, the role of the Aboriginal community controlled health sector in their training and employment has been an important part of the improvements that have been made.[57]

Nevertheless, particularly in rural and remote areas, substantial barriers remain. Access to adequate pre-school, primary and secondary education is critical for forming the foundation for future workforce gains. Once this foundation is laid, specific training in mental health disciplines must be both culturally appropriate for the trainees, and result in skilled, competent professionals who are enabled to make a contribution to the health of their communities.

Furthermore, there is a need to ensure that all mental health staff (especially non-Aboriginal staff) working for Aboriginal people and communities are able to address the specific health and wellbeing needs of Aboriginal people. This means equipping health professionals with the knowledge, skills, attributes and cultural understanding to competently design and deliver health services and programs and policies for Aboriginal communities. It is particularly important for those service providers in remote

areas (i.e. nurses/Aboriginal Health Workers and GPs) undertaking risk assessments to have the competency to manage and work with clients, and to have the knowledge of available resources.

Additionally, recruitment and retention of health professionals, particularly doctors and clinical psychologists, remains a challenge in rural and remote areas. There is still a need to address their maldistribution, through a combination of incentives to practice in these areas and support for ACCHSs and other primary health care agencies to employ and train registrars as well as considering increased regulations to ensure more practitioners work where they are most needed. [58]

Clinical psychology training needs

In Congress' experience, one of the most important strategies to build a competent local mental health workforce is to build upon the training of psychologists. It is important that there is the support of paid AHPRA approved psychology supervisors located within the services which provisional or registrar psychologists can access in order to complete their training and/or gain their respective endorsements.

The supervision of psychology students requires a high level of clinical oversight and time commitment, particularly for those enrolled in the vocational models of training (4+2 and 5+1 models). If supervisors are unpaid, or not funded, as part of the model this will lead to a lack of commitment to the role as it will interfere with their own work commitments i.e. the provisional of psychological services. This used to occur in the GP training system before supervisors were remunerated properly and trained properly.

It is important that the costs of supervision do not fall upon the training institutes or students as this will lead to ongoing barriers to the development of the workforce, such as increased course costs and lack of incentive for training institutes to continue to run postgraduate level psychology courses which are already operating at a significant loss to the University.

Additionally there is lack of training options, such as post graduate courses, for psychology in the Northern Territory. This means that the majority of trainees leave the Northern Territory to attend training in the metropolitan areas. Unfortunately the amount of psychologists returning to the NT after training is limited. The Northern Territory has the lowest amount of psychologists, and clinical psychologists, in Australia. Additionally, even in other states, there is a lack of psychologists in rural and remote areas. There needs to be incentives to bring psychologists and trainees to rural and remote areas.

Recommendation:

That governments

8) develop strategies for a high-quality, culturally-competent mental health workforce, taking into account rural and remote distribution and Aboriginal health workforce development.

4. The challenges of delivering mental health services in the regions

Competitive tendering undermines integration and leads to fragmented and ineffective service systems

Competitive tendering for short-term funding leads to complex service delivery environments with multiple providers of health services, creates a culture of competition rather than cooperation amongst those providers, promotes an emphasis on individual care rather than population health and short term outcomes rather than long term gains in health, drives increased reporting costs for agencies, and leads to a system that is difficult to navigate for Aboriginal clients (especially where language, literacy and cross-cultural service delivery are issues)[59].

Government funding, policies and processes based on competitive tendering have unfortunately been a major driver of the disconnected, inefficient and hard-to-navigate mental health and social and emotional wellbeing system for Aboriginal communities. As a result of such policies, for example, a remote community in Central Australia had received social and emotional wellbeing programs from 16 separate providers, mostly on a fly-in fly-out or drive-in drive-out basis, for about 400 people. There is little in the way of communication or coordination with the local ACCHS with providers often turning up unannounced and demanding information on and assistance with locating clients, use of buildings and vehicles etc. The result is fragmentation and duplication of service delivery, lack of coordination, waste of resources and suboptimal outcomes for clients.[60]

Needs based planning

The alternative to competitive tendering is collaborative needs-based planning. Collaborative, well-resourced and sustainable processes for needs-based health system planning are now well-recognised as critical foundations for health system effectiveness.[61]

In the NT, the Northern Territory Aboriginal Health Forum (NTAHF), established after the signing of the Framework Agreement on Aboriginal Health in 1998, brings together government and the community controlled sector to work collaboratively to[62]:

- ensure appropriate resource allocation
- maximise Aboriginal community participation and control as a key element of sustainable, viable, effective and efficient health services
- encourage better service responsiveness to / appropriateness for Aboriginal people
- promote quality, evidence- informed care
- improve access for Aboriginal people to both mainstream and Aboriginal specific health services
- increase engagement of health services with Aboriginal communities and organisations.

The NTAHF has been fundamental to ensuring new and existing mental health services are integrated into existing primary health care services and allocated in a planned manner according to need. NTAHF includes the NT Primary Health Network (PHN), ACCHSs, the NT Department of Health, the Commonwealth Department of Health and the Department of Prime Minister and Cabinet.

Using this agreed approach, the NTAHF has overseen the development of the NT Aboriginal health system in a way that is now delivering results in terms of improved health outcomes for Aboriginal people.[63]The NTAHF has also helped to ensure that the social determinants of health are addressed through high level collaboration and advocacy outside the health system.

Short term funding periods

Programs and services developed with short timeframes, limited funding periods and program support do not address health in a holistic manner and ultimately fail patients.[64] Policies, programs and mental health planning and investment directed towards supporting and sustaining locally-based, culturally-relevant programs and services could bring sustainable change in mental health and wellbeing outcomes in Aboriginal populations.

Additionally, a stable, long term funding model is vital for the recruitment and retention of professional staff. Greater funding certainty in rural and remote areas is needed to attract and retain professional staff that will simply not come or leave if a service has to be tendered for every few years.

Congress has repeatedly experienced the problem encountered when short term funding leads to loss of professional staff.[65] The uncertainty created by tendering processes at 2 or 3 year intervals for example, often means the loss of key staff and all of the experience and expertise they have gained in Aboriginal health.

Recommendations:

That governments

9) reject open competitive tendering processes for the funding of mental health and social and emotional wellbeing services for Aboriginal communities as an ineffective approach that undermines integration and leads to fragmented and ineffective service systems.

10) support and resource needs-based planning through established collaborative structures that include significant representation from the ACCHS sector, to ensure the effective distribution of resources and appropriate service models to address Aboriginal mental health and social and emotional wellbeing.

11) commit to long term block funding for comprehensive primary health care services including ACCHSs.

5. Attitudes towards mental health services;

See response under term one.

6. Opportunities that technology presents for improved service delivery

The inclusion of MBS items for psychological assessment and intervention for specific mental health clinicians via e-health technologies will assist in the delivery of services to rural and remote areas, where appropriate. This will also help to further bolster on-the-ground services with the addition of specialist mental health services input (i.e. clinical psychology). While Congress is telehealth enabled we have the capacity to provide clients in remote communities with a face to face outreach service. There is a risk

that telehealth will provide greater access to patients by service providers who are not culturally aware nor trauma informed.

Recommendation:

That governments

12) continue to work with remote and rural service providers particularly ACCHS in developing culturally safe technological solutions, and the delivery of psychological assessments via telehealth.

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[1] Thompson S C, Haynes E, et al. (2013). Effectiveness of primary health care for Aboriginal Australians. Canberra, Unpublished literature review commissioned by the Australian Government Department of Health.

[2] Census: Aboriginal and Torres Strait Islander population http://www.abs.gov.au/ausstats/abs@.nsf/MediaRealesesByCatalogue/02D50FAA9987D6B7CA25814800087E03?OpenDocument

[3] 2071.0 - Census of Population and Housing: Reflecting Australia - Stories from the Census, 2016 Available: http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2071.0~2016~Main%20Features~Aboriginal%20and%20Torres%20Strait%20Islander%20Population%20Data%20Summary~10

[4] Issues paper no. 12 produced for the Closing the Gap Clearinghouse Pat Dudgeon, Roz Walker, Clair Scrine, Carrington Shepherd, Tom Calma and Ian Ring November 2014 Effective strategies to strengthen the mental health and wellbeing of Aboriginal and Torres Strait Islander people

[5] SCRGSP (Steering Committee for the Review of Government Service Provision) 2016, Overcoming Indigenous Disadvantage: Key Indicators 2016, Productivity Commission, Canberra.

[6] Atkinson J (2013). Trauma-informed services and trauma-specific care for Indigenous Australian children. . : . Canberra / Melbourne, Australian Institute of Health and Welfare & Australian Institute of Family Studies

[7] Wall L, Higgins D and Hunter C (2016). Trauma-informed care in child/family welfare services. Melbourne, Australian Institute of Family Studies.

[8] Dockery A M (2012). Do traditional culture and identity promote the wellbeing of Indigenous Australians? Evidence from the 2008 NATSISS. Survey Analysis for Indigenous Policy in Australia: Social Science Perspectives. Boyd Hunter and Nicholas Biddle, Australian National University, Centre for Aboriginal Economic Policy Research. Research Monograph No. 32

[9] Wall L, Higgins D and Hunter C (2016). Trauma-informed care in child/family welfare services. Melbourne, Australian Institute of Family Studies.

[10] The Healing Foundation Available" http://healingfoundation.org.au/community-healing/

[11] The Healing Foundation (above).

[12] Atkinson J (2013) (above)

[13] Dudgeon P, Walker R, Scrine C, Shepherd CCJ, Calma T and Ring I (2014). Effective strategies to strengthen the mental health and wellbeing of Aboriginal and Torres Strait Islander people. Canberra / Melbourne, Produced for

the Closing the Gap Clearinghouse. Australian Institute of Health and Welfare / Australian Institute of Family Studies. Issues paper no. 12

[14] Dudgeon, P., Milroy, J., Calma, T. Luxford, Y., Ring, I., Walker, R., Cox,A., Georgatos, G., and Holland, C. (2016) Solutions That Work: What The Evidence And Our People Tell Us Aboriginal And Torres Strait Islander Suicide Prevention Evaluation Project Report

[15] Aboriginal Healing Foundation (Canada) (2006). Final report of the Aboriginal Healing Foundation. Ottowa, Aboriginal Healing Foundation.

[16] The Healing Foundation Available" http://healingfoundation.org.au/community-healing/

[17] Healing Foundation. Healing Centres, Final Report 21 December 2012. Canberra, Aboriginal and Torres Strait Islander Healing Foundation.

[18] McKendrick, J., Brooks, R., Hudson, J., Thorpe, M, and Bennett, P (2013). Aboriginal and Torres Strait Islander Healing Programs: A Literature Review. Canberra, Aboriginal and Torres Strait Islander Healing Foundation.

[19] Amnesty International 2011

[20] Cunningham J, Cass A and Arnold P C (2005). "Bridging the treatment gap for Indigenous Australians. Demands for efficiency should not be met at the expense of equity." Med J Aust 182(10): 505-506.

[21] Australian Government. National Aboriginal and Torres Strait Islander Health Plan 2013–2023

[22] Ferdinand A, Paradies Y and M. Kelaher (2012). Mental Health Impacts of Racial Discrimination in Victorian Aboriginal Communities: The Localities Embracing and Accepting Diversity (LEAD) Experiences of Racism Survey. Melbourne, The Lowitja Institute.

[23] Mackey P, Boxall A, et al. (2014). The relative effectiveness of Aboriginal Community Controlled Health Services compared with mainstream health service. Deeble Institute Evidence Brief No.12, Deeble Institute / Australian Healthcare and Hospitals Association. Page 6

[24] Vos T, Carter R, et al. (2010). Assessing Cost-Effectiveness in Prevention (ACE–Prevention): Final Report. Melbourne, ACE–Prevention Team: University of Queensland, Brisbane and Deakin University.

[25] Hert, M., Correll, C. U., Bobes, J., Cetkovich-Bakmas, M., Cohen, D., Asai, I.,& Newcomer, J. W. (2011). Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. World psychiatry, 10(1), 52-77

[26] Australian Institute of Health and Welfare 2016. Australian Burden of Disease Study: Impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011. Australian Burden of Disease Study series no. 6.

[27] World Health Organization and Calouste Gulbenkian Foundation (2014). Social determinants of mental health. Geneva, World Health Organization.

[28] World Health Organization (2003) Social Determinants of Health – The solid facts (2nd edition) Wilkinson, R and Marmot, M (eds)

[29] Australian Health Ministers Advisory Council (2012). Aboriginal and Torres Strait Islander Health Performance Framework 2012 Report. AHMAC. Canberra. Page 8

[30] Robinson, G., Leckning, B. & Silburn, S. (2012). Suicide among young people in Indigenous Communities: Approaches to prevention. CCDE Discussion Paper. Darwin: Centre for Child Development and Education, Menzies School of Health Research.

[31] Australian Government, Department of Health National Aboriginal and Torres Strait Islander Health Plan 2013-2023

[32] Australian Institute of Health and Welfare 2016. Australian Burden of Disease Study: Impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011. Australian Burden of Disease Study series no. 6.

[33] Australian Youth Development Index, 2016

[34] Robinson, J, Bailey, E, Browne, V, Cox, G, & Hooper, C. Raising the bar for youth suicide prevention. Melbourne: Orygen, The National Centre of Excellence in Youth Mental Health, 2016.

[35] Australian Government, Department of Health National Aboriginal and Torres Strait Islander Health Plan 2013-2023

[36] Australian Early Development Census Report 2015.

[37] Anda RF, Felitti VJ, Walker J, Whitfield CL, Bremner JD,Perry BD, Dube SR, Giles WH (2006) The enduring effects of

[38] Robinson, J, Bailey, E, Browne, V, Cox, G, & Hooper, C. Raising the bar for youth suicide prevention. Melbourne: Orygen, The National Centre of Excellence in Youth Mental Health, 2016.

[39] Olds D L, Eckenrode J, et al. (1997). "Long-term effects of home visitation on maternal life course and child abuse and neglect. Fifteen-year follow-up of a randomized trial." JAMA 278(8): 637-643

[40] Bronfenbrenner, U. (2009) Bronfenbrenner's Ecological Theory. The ecology of human development. Harvard University Press Parents Under Pressure (PuP) program website: http://www.pupprogram.net.au/

[41] Robinson, J, eta l 2016

[42] Australian Institute of Health and Welfare (AIHW) (2015). Youth detention population in Australia 2015. AIHW, Canberra.

[43] McGinness A and McDermott T (2010). Review of Effective Practice in Juvenile Justice: Report for the Minister for Juvenile Justice. Manuka, ACT, Noetic Solutions Pty Limited.

[44] Closing the Gap Clearinghouse (AIHW & AIFS) (2013). Diverting Indigenous offenders from the criminal justice system. Produced for the Closing the Gap Clearinghouse. Resource sheet no. 24. Canberra / Melbourne, Australian Institute of Health and Welfare / Australian Institute of Family Studies.

[45] McGinness A and McDermott T (2010) (above)

[46] Robinson, J et al 2016. (above)

[47] Australian Institute of Health and Welfare (AIHW) (2016). Child protection Australia 2014- 15. Canberra, AIHW.

[48] Arney, F, McGuinness, K., Westby, M. (2012) Report on the Implementation of Family Group Conferencing with Aboriginal Families in Alice Springs, Centre for Child Development and Education Menzies School of Health Research June 2012

[49] Moffitt, T.E., et al., A gradient of childhood self-control predicts health, wealth, and public safety. Proceedings of the National Academy of Sciences, 2011. 108(7): p. 2693-2698.

[50] Australian Institute of Health and Welfare 2016. Australian Burden of Disease Study: Impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011. Australian Burden of Disease Study series no. 6.

[51] Tse R; Sims N; Byard RW (2011) Alcohol ingestion and age of death in hanging suicides. Journal of Forensic Sciences. 56(4):922-4, 2011 Jul.

[52] Coghlan, A. (2008). "WHO considers global war on alcohol abuse." New Scientist (19 April 2008).

[53] World Health Organisation (2008). Strategies to reduce the harmful use of alcohol, Geneva, World Health Organization.

[54] Babor, T. F., R.Caetano, et al. (2005). "Alcohol: No Ordinary Commodity. Research and Public Policy." from see http://www.ias.org.uk/resources/publications/theglobe/globe200303/gl200303.pdf for a summary.

[55] Symons, M., Gray,D., Chikritzhs, T., Skov, S., Saggers, S., Boffa, J., Low, J. A longitudinal study of influences on alcohol consumption and related harm in Central Australia: with a particular emphasis on the role of price, National Drug Research Institute Curtin University, October 2012.

[56] Australian Health Ministers Advisory Council (2012). Aboriginal and Torres Strait Islander Health Performance Framework 2012 Report. AHMAC. Canberra.

[57] National Aboriginal Community Controlled Health Organisation (NACCHO) (2014). Economic Value of Aboriginal Community Controlled Health Services. Unpublished paper. Canberra, NACCHO.

[58] Boffa J (2002). "Is there a doctor in the house?" Australian and New Zealand Journal of Public Health **26**(4): 301-304.

59 See for example Dwyer, J., O'Donnell K, et al. (2009). The Overburden Report: Contracting for Indigenous Health Services. Darwin, Cooperative Research Centre for Aboriginal Health.

[60] Aboriginal Medical Services Alliance NT, submission to the Productivity Commission's Preliminary Findings Report: Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform 2016. Available: http://www.pc.gov.au/inquiries/current/human-services/identifying-reform/preliminary-findings/human-services-preliminary-findings-overview.pdf

[61] World Health Organization (2007). Everybody business : strengthening health systems to improve health outcomes : WHO's framework for action. Geneva, World Health Organization.

[62] Northern Territory Aboriginal Health Forum (2014). Northern Territory Aboriginal Health Forum Work Plan 2014/15 to 2016/17 (unpublished, final draft).

[63] Thomas, D; Condon, J; Anderson, Ian; Li, Shu Q; Halpin, S; Cunningham, J and Guthridge, S L. (2006) Long-term trends in Indigenous deaths from chronic diseases in the Northern Territory: a foot on the brake, a foot on the accelerator, MJA; 185 (3): 145-149

[64] Issues paper no. 12 produced for the Closing the Gap Clearinghouse Pat Dudgeon, Roz Walker, Clair Scrine, Carrington Shepherd, Tom Calma and Ian Ring November 2014 Effective strategies to strengthen the mental health and wellbeing of Aboriginal and Torres Strait Islander people.

[65] D'Abbs, P., Togni, S., Rosewarne, C and Boffa, J. (2013), The Grog Mob: Lessons from an evaluation of a multidisciplinary alcohol intervention for Aboriginal clients Aust. & NZ J of Pub Health Vol 37 no 5: 450-56