29 July 2011

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600
Australia

CONFIDENTIAL SUBMISSION

Dear Committee Secretary

Senate Inquiry into the funding and administration of mental health services

The Australian Indigenous Psychologists Association (AIPA) is pleased to make the following submission. AIPA consents to this submission being uploaded to the Committee website.

Yours sincerely

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The Australian Indigenous Psychologists Association (AIPA) welcomes the opportunity to make this submission. AIPA is the national body which represents Aboriginal and Torres Strait Islander psychologists in Australia. AIPA is committed to improving the social and emotional well-being and mental health of Aboriginal and Torres Strait Islander people by increasing the number of Indigenous psychologists and by leading the change required to deliver equitable, accessible, sustainable, timely and culturally safe psychological care to Aboriginal and Torres Strait Islander peoples in urban, regional and remote Australia. AIPA currently receives no Government funding, operating with limited funds provided by the Australian Psychological Society.

Where possible we have referred to the Inquiry's specific Terms of Reference and made some recommendations for further action.

The adequacy of mental health funding for disadvantaged groups (ToR (f)(ii))

Mental health issues have been identified as one of the leading causes of the Indigenous health gap (18% - second only to cardiac disease). When combined with intentional and unintentional injuries (13%) the two issues account for almost one third (31%) of the total health gap (Vos et al, 2007). In addition, nearly one-third (32%) of Indigenous Australians aged 18 years or over experience serious psychological distress - twice the rate for non-Indigenous Australians (ABS and AIHW 2010). There is an inverse relationship between Indigenous wellbeing and psychological distress: the more distress, the less positive wellbeing (AIHW, 2008 p15). Among those reporting psychological distress, 21% indicated they had been unable to work or carry out their normal activities because of the distress for at least one day during the previous month. However, only one in ten (12%) reported they saw a health professional in relation to the issue. The Western Australia Aboriginal Child Health Survey collected information on the social and emotional wellbeing of Aboriginal children and found 24% of Aboriginal children aged 4 to 17 years surveyed were assessed as being at high risk of clinically significant emotional or behavioural difficulties compared with 15% of all children (Zubrick et al 2005). Given the high levels of psychological distress it is not surprising to find that anxiety and depression (10%) have been identified as accounting for more than half of the total burden of mental illness (18%) among Indigenous adults (Vos et al, 2007). As well as experiencing higher rates of disability and reduced quality of life due to mental health conditions, Indigenous Australians are also more likely to require hospitalisation and to die at higher rates due to mental health conditions compared to others.

The relative availability of ambulatory or primary mental health care services can influence the use of hospitals for mental health conditions (AIHW, 2008). The rate of Indigenous admissions to psychiatric hospitals for serious acute conditions is almost twice (1.8) the rate of others, with 11 admissions per 1,000 population compared to 5.8 admissions for others

(SCRGSP, 2011). Mental and behavioural disorders due to psychoactive substance use is the most common diagnosis (36%) followed by schizophrenia, schizotypal and delusional disorders (25%). Admission rates for these diagnoses are 9.3 and 5.7 per 1,000 population and 4 and 2.5 times the rates of others respectively. Other diagnoses are mood disorders (15%) and stress-related disorders (13%) with admission rates of 4.2 and 3.4 per 1,000 population. During the period 1998 to 2006, the rate of admissions for mental health conditions increased by 14% for Indigenous people, while decreasing by 7% for others. This represents a relative and absolute increase in the size of the gap in hospitalisation rates for mental health related conditions compared to others. Being admitted for a mental health condition was the strongest predictor that an Indigenous patient would be discharged against medical advice (ie would abscond) and this was 4 times more likely compared to others. Some of the more serious mental illnesses, such as schizophrenia also constitute a chronic disease and can give rise to life-long disability with associated support needs. It is estimated mental health conditions contribute 3% of the burden of chronic disease among Indigenous Australians (AIHW, 2010). Indigenous people are also hospitalized for injuries related to self-harm at a rate of 2.5 per 1,000 population, a rate 2.5 times that of others, and for injuries related to assault at 11 per 1,000 population, a rate 12 times that of others (SCRGSP, 2011).

Mental health conditions are the eleventh most common cause of death of Indigenous people and are responsible for approximately 2.5% of all deaths. This is twice the rate for other Australians. Differences are most marked in the 25 to 54 year age group, where Indigenous males and females die at 12 and 13 times the rates of other males and females respectively.

Suicide is responsible for another 4.7% of all deaths, with Indigenous people dying from self-harm at 2.5 times the rate of others. The suicide rate for the years 2004 – 2008 was 23.8 per 100,000 compared to 9.5 per 100,000 for others (SCRGHSP, 2011). Deaths due to assaults constitute a further 1.5% of deaths, with Indigenous people dying from assault at 10 times the rate of others.

Mental health related conditions, assault and self-harm together are responsible for 8.7% of all deaths of Aboriginal and Torres Strait Islander people.

Those with a mental illness are also at a higher risk of suicide, serious psychological distress and cardiovascular disease when compared to the general population (AIHW, 2008). In its paper 'An Overview of Factors Impacting on the Social and Emotional Wellbeing of Aboriginal and Torres Strait Islander People: Risk and Protective Factors and Serious Psychological Distress', AIPA found the major individual risk factors identified as contributing to the health gap - such as obesity and the use of tobacco – tended to be strongly associated with serious psychological distress (Kelly, Gee, Dudgeon & Glaskin, 2009). The National Aboriginal and

Torres Strait Islander Health survey 2004-05 also found an association between chronic disease and psychological distress. Chronic serious illness or disability affected almost one in three (28%) respondents to the survey, with 33% of these reporting four or more long-term health conditions. The majority (62%) of those with four or more health conditions also reported serious psychological distress (AIHW, 2009 p23). The combination of multi-morbidity and serious psychological distress has been shown to inhibit the capacity to manage chronic diseases in primary care settings, unless support to manage psychological distress is provided as part of general health care (Fortin et al, 2006). Primary mental health care interventions targeted to manage high levels of serious psychological distress should therefore make a major contribution to closing the gap in life expectancy between Indigenous and other Australians.

The purpose of analyzing the differentials in the burden of disease between Indigenous and other Australians is to provide policy makers and health care providers with the evidence base they require to prioritize investments in Indigenous health and to target and measure the effectiveness of strategies to address deeply entrenched health inequalities (Vos et al, 2007). The available data clearly demonstrate the risk factor profile for developing psychological distress and common mental health conditions such as anxiety and depression is far worse for Indigenous people when compared to others, including those living in regional and remote Australia. The ability to access appropriate health care services when sick is in itself one of the social determinants of health. Effective primary health care has a documented capacity to offset the effects of disadvantage by detecting illness early and restoring health (Griew, 2008). As well as population level strategies to address the social determinants, immediate health gains could be made if culturally appropriate primary mental health care was available to address the burden of psychological distress, anxiety and depression amongst Indigenous people.

The National Aboriginal Health Strategy first noted in 1989 (16 years before psychological distress was measured in the National Aboriginal and Torres Strait Islander Health Survey in 2004):

> *'Mental distress is a common and crippling problem for many Aboriginal people and appropriate services are a pressing need. Culturally appropriate services for Aboriginal people are virtually non-existent. Mental health services are designed and controlled by the dominant society for the dominant society. The health system does not recognise or adapt programs to Aboriginal beliefs and law, causing a huge gap between service provider and user. As a result, mental distress in the Aboriginal community goes unnoticed, undiagnosed and untreated'* (1989, p 171).

Similar findings have been reported by the Royal Commission Into Aboriginal Deaths in

Custody (1991), the first national Aboriginal Mental Health conference (1993), the Burdekin Report on Human Rights and Mental Illness (1995); the Ways Forward National Aboriginal and Torres Strait Islander Mental Health Policy: National Consultancy Report (1995) and the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families (1995). Little has changed in the intervening 22 years.

The first national initiative to recognise and address mental health service provision within the social and emotional wellbeing framework advocated by Indigenous people was the Emotional and Social Wellbeing (Mental Health) Action Plan 1996-1997 and 1999-2000 developed by the Australian Government Office of Torres Strait Islander Health Services (now OATSIH). The Action Plan was implemented in response to the Ways Forward Report (1995) and supported the development of innovative models of service delivery which reflected Indigenous concepts of social and emotional wellbeing. The Mental Health Service Delivery Projects in Aboriginal Community Controlled Health Services supported the development and establishment of innovative projects in 19 locations nationally, to evaluate culturally appropriate approaches to service delivery. While innovative when established, these are now mature services which are highly valued by the communities they serve. An evaluation of these projects in 2007 reported high levels of client satisfaction and long waiting lists (Wilczynski et al, 2007). Despite their success, these models of service delivery have not been extended to the network of 140 Aboriginal Community Controlled Health Services throughout Australia. The Mental Health Service Delivery projects have been supplemented by a national network of Bringing Them Home Counselors and additional Link-up services established in response to the Bringing Them Home Report (1997) to provide the specialized support that members of the Stolen Generations require. In recognition of the high rates of social and emotional wellbeing problems experienced by Aboriginal and Torres Straits Islander people, the Social Health Reference Group for the National Aboriginal and Torres Strait Islander Health Council and National Mental Health Working Group developed a National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2004 – 2009 which reflected the recommendations made in the Ways Forward Report (1995). The SEWB Framework was designed to complement the Third National Mental Health Plan and the National Strategic Framework for Aboriginal and Torres Strait Islander Health (NSFATSIH 2003 - 2013).

While all Australian governments have recognized that an effective, efficient and equitable health system is an essential component of any whole of government effort to improve Indigenous health, there has been a notable lack of effort or activity on the part of the mental health sector to close the gap in social and emotional wellbeing and mental health outcomes between Indigenous and non-Indigenous Australians. Investment in Indigenous-specific social and emotional wellbeing services - beyond increasing numbers of the workforce provided to support the Stolen Generations - effectively stalled 11 years ago, in 2000. Instead

of investing in Indigenous-specific strategies to address mental health within a social and emotional wellbeing framework or in primary mental health services delivered by Aboriginal Community Controlled Health Services, the Australian Government has relied almost exclusively on funding mainstream services to administer mainstream mental health programs which target Indigenous communities and populations. At the same time there has been an absence of investment in strategies to improve the accessibility, appropriateness and responsiveness of mainstream mental health services. Although highly valued by Aboriginal and Torres Strait Islander people, the SEWB Framework 2004 – 2009 was not fully implemented and has now expired. Good practice guidelines relevant to increasing the cultural safety and competence of mainstream mental health services, such as the National Practice Standards for the Mental Health Workforce (Department of Health and Ageing, 2002) and the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004-2009 (Australian Health Minister's Advisory Council on Aboriginal and Torres Strait Islander Health Working Party 2004) have not been implemented nationally.

Despite mental health conditions being identified as one of the leading causes of the Indigenous health gap, there is a distinct lack of any Indigenous-specific mental health programs developed with the stated intent of closing the gap in social and emotional wellbeing and mental health between Indigenous and other Australians. The magnitude of the gap and the failure to acknowledge or to contribute to national efforts to overcome Indigenous disadvantage indicates a lack of commitment on the part of the mental health sector. The lack of commitment to overcoming the inequities is further evidenced by: the lack of strategies to increase parity within the mental health professions; the absence of Indigenous mental health practitioners (psychiatrists, psychologists, social workers and Aboriginal Mental Health Workers) on key decision making bodies; the lack of consultation with Aboriginal and Torres Strait Islander stakeholders in mental health reforms; the reluctance to fund Aboriginal Community Controlled Health Services to deliver Indigenous-specific social and emotional wellbeing services; the lack of partnerships with Aboriginal Community Controlled Health Services to participate in the design and delivery of mental health services; and the lack of research to adapt mainstream assessment tools and treatments used in primary mental health care or to develop Indigenous-specific social and emotional wellbeing assessments and interventions.

It is unlikely that improvements in Indigenous social and emotional wellbeing and mental health will be achieved while the mental health system and the mental health professions who work within it remain indifferent to the plight of Indigenous people. There is an urgent need to actively review the attitudes, structures, policies and practices that have contributed to the failure of the mental health system to: respond to the inequities in mental health outcomes; meet the expressed needs of Aboriginal and Torres Strait Islander people; or support

Indigenous-led initiatives such as those proposed in Ways Forward (1995) and the SEWB Framework 2004 – 2009.

The accountability and transparency of the mental health system must be increased by implementing a structure to monitor and report its performance against a set of indicators to assess how well it is meeting the needs of Aboriginal and Torres Strait Islander people. This should use the same domains used in Tier 3 of the National Health Performance Framework: effective, appropriate and efficient; responsive; accessible; safe; continuous; capable; and sustainable.

There is an urgent need to develop a schedule of cost-effective social and emotional wellbeing and mental health interventions, priorities and actions to assist policy makers and communities to decide which interventions would provide the best value for money or resources, by demographics, by regions, by mental health conditions and social and emotional wellbeing risk factors for Indigenous people, in order to close the gap in mental health outcomes between Indigenous and non-Indigenous Australians.

The ultimate aim would be to design and implement a national Indigenous mental health policy and plan that focuses on improving Indigenous social and emotional wellbeing, rather than simply reducing the disparity between Indigenous and non-Indigenous Australians across mainstream indicators. The risks to mental health associated with unresolved grief and loss, removal from family, racism, discrimination and social disadvantage are not shared equally with the non-Indigenous population. In addition, Indigenous cultural concepts such as connection to land, culture, spirituality, ancestry and family and community can serve as protective factors to moderate the impact of identified risk factors at individual, family and community levels. These social and emotional wellbeing factors should be integrated into a national mental health policy for Indigenous populations and communities.

In June 2010 the Senate Community Affairs References Committee released its report The Hidden Toll: Suicide in Australia. In its response to the report, the Australian Government accepted Recommendation 27, that the Australian Government develop a separate suicide prevention strategy for Indigenous communities within the National Suicide Prevention Strategy, including programs to rapidly implement post-vention services to Indigenous communities following a suicide to reduce the risk of further suicides. It is crucial that Aboriginal concepts of social and emotional wellbeing underpin this strategy and that it draw upon the risk and protective factors unique to Indigenous communities and populations.

AIPA Recommendations	That COAG urgently establish a working group of Indigenous social and emotional wellbeing and mental health stakeholders to begin working toward the development of a COAG Close the Gap

	National Partnership agreement between the Australian Government and the States/Territories to advance reforms to the mental health system to better serve Indigenous Australians. The development of a Closing the Gap: National Partnership Agreement on Social and Emotional Wellbeing and Mental Health could deliver: a) Targeting of existing and future investments in social and emotional wellbeing and mental health to address serious psychological distress and common mental health issues such as anxiety and depression in Aboriginal and Torres Strait Islander communities and populations in urban, regional and remote areas. b) Improved access by Indigenous people to better coordinated and targeted primary mental health care and social and emotional wellbeing and mental health services; c) Local need/place-based approaches enabling social and emotional wellbeing and mental health initiatives to be delivered in a manner appropriate to needs in a particular location; d) Strengthened Indigenous capacity, engagement and participation in strategies to promote positive social and emotional wellbeing and strengthen individual, family and community resilience as a necessary strategy to prevent self harm and suicide; e) More effective program accountability and sustainability, with governments required to enhance statistical collection services and other information sources to improve the detail and accuracy of reporting on social and emotional wellbeing and mental health service provision and outcomes; and f) COAG monitoring progress in utilising Indigenous-specific and mainstream National Partnerships to improve outcomes in social and emotional wellbeing and mental health with jurisdictions required to report to COAG on progress. That the Australian Government end past neglect of Indigenous social and emotional wellbeing and mental health by developing a National Aboriginal and Torres Strait Islander Mental Health Plan as part of the next Closing The Gap package to be endorsed by

	COAG in 2013. This must be done in partnership with Indigenous mental health practitioners and other key stakeholders. Recognising that Indigenous Australians continue to be hospitalized at twice the rate with mental health conditions that a proportional share of the early intervention measures funded in the 2011 Budget be earmarked for Indigenous-specific models. That Indigenous social and emotional wellbeing and mental health is made a research priority under funding included in the 2011 Budget.

(a) The Government's 2011-12 Budget changes relating to mental health;

AIPA is optimistic that the next round of mental health reforms delivered under the stewardship the Honourable Mark Butler, Minister For Mental Health and Ageing will deliver a more equitable set of reforms. However, since many of the initiatives introduced under the COAG National Action Plan on Mental Health (2006-2011) will be continued under the 2011-12 Budget initiatives, it is important to understand the mechanisms that have contributed to the $5.5 billion investment in the first round of COAG mental health reforms creating a sizeable gap in the primary mental health care system for Indigenous people and increasing the size of the existing gap between Indigenous and non-Indigenous Australians.

Since the COAG National Action Plan For Mental Health 2006 – 2011 was developed to focus on areas of need and service gaps, it presented an unprecedented opportunity to address the inequities evident in the mental health system for Aboriginal and Torres Strait Islander people. However, the lack of strategies to ensure that Aboriginal and Torres Strait Islander people would benefit proportionally across the National Action Plan, the failure to target investments to those most in need, and the lack of integration of Indigenous concepts of social and emotional wellbeing into any of the measures, has simply served to exacerbate the Indigenous inequities which existed prior to the implementation of the COAG National Action Plan.

For example while three of the eighteen measures were said to have focused on Aboriginal and Torres Strait Islander people, these strategies tended to be based on mainstream concepts of mental illness rather than Indigenous concepts of social and emotional wellbeing, and were largely delivered by mainstream mental health service providers who repeated the same pattern of behaviours that have given rise to existing inequities. That is, they failed to engage or partner effectively with Indigenous communities, populations and clients, and delivered mainstream mental services that focused on individual pathology rather than

providing care within a social and emotional wellbeing framework that took into account the effects of the social determinants, the on-going impact of colonisation and the risk and protective factors within the Indigenous social and emotional framework.

There are numerous examples which demonstrate the lack of commitment on the part of the mental health system and mental health professional bodies to meet the needs of Aboriginal and Torres Strait Islander people or to apply the additional investments made available by the National Action Plan to close the gap in mental health outcomes between Indigenous and non-Indigenous Australians. For example:

COAG Action Area 4: Increasing Workforce Capacity

Improving the Capacity of Workers in Indigenous Communities initiative ($20.8 million).

- Mental Health in Tertiary Curricula ($5.6 million):
    - The reviews of undergraduate curricula for social workers, occupational therapists, osteopaths, dietitians, dentists and chiropractors did not include content in relation to meeting the mental health needs of Aboriginal and Torres Strait Islander people;
    - While there is an acknowledged need to review psychology undergraduate curricula to include content about Indigenous social and emotional wellbeing and mental health, this did not occur.
- Mental health first aid training is based on mainstream concepts of mental illness and does not take account of the lack of mental health service providers in Indigenous communities to refer to, or the lack of cultural competence of mental health service providers;
- The contract to develop a Mental Health Toolkit including culturally appropriate mental health assessment screening tools was awarded to a TAFE and an outcome was not achieved;
- 5 additional Puggy Hunter Scholarships: the number of additional scholarships is inadequate given the lack of parity across the five mental health professions. For example,

COAG Action Area 2: Integrating and Improving The Care System

The Access to Allied Psychological Services initiative (ATAPS) funded Divisions of General Practice to allow GPs to refer patients who have been diagnosed as having a mental disorder of mild to moderate severity to an allied health professional to provide short term Focused Psychological Strategies, without cost to the consumer.

Both the ATAPS and the Mental Health Services in Rural and Remote Areas initiative were seen to complement the Better Access initiative by extending primary mental health care services to those on low incomes, to areas where Medicare (MBS) is not readily available

(rural & remote areas), and to hard to reach populations such as Aboriginal and Torres Strait Islander people. The following issues limited the benefit Aboriginal and Torres Strait Islander people received under these programs:

- While the ATAPS program is acknowledged to have potential to meet the needs of Aboriginal and Torres Strait Islander people, opportunities to maximise this potential were lost by not including Indigenous mental health representatives or stakeholders on the ATAPS Expert Reference Group;
- The Focused Psychological Strategies delivered under the Better Access initiative, the ATAPS programs and the Mental Health Services in Rural and Remote Areas offer some potential to benefit Indigenous Australians. However no investment was made to adapt Focused Psychological Strategies to suit Aboriginal and Torres Strait Islander people or to subject them to a process of cultural validation. Since mental health service providers are required to deliver only evidence based interventions, the delivery of Focused Psychological Strategies to Indigenous Australians remains moot - as it has been over the life of the Action Plan – unless this issue is addressed, it will continue to constrain the delivery of primary mental health care to Aboriginal and Torres Strait Islander people in urban, regional and remote areas of Australia;
- The Mental Health Professionals' Association was established to provide **mental health stakeholder support** and a forum for **issues affecting the four key professional groups** involved in the Better Access initiative. However, membership was restricted to the Royal Australian and New Zealand College of Psychiatrists, Royal Australian College of General Practitioners, Australian Psychological Society, and the Australian College of Mental Health Nurses. Indigenous mental health practitioners, service providers or other stakeholders such as consumer groups, were excluded from membership of this key body;
- A Steering Group established to oversee the work of the Mental Health Professional's Assoc was restricted to the executive officers of the four organizations, and did not include Indigenous representatives from these professions. It appears the Steering Group failed to engage in consultation about the delivery or nature of Better Access mental health services outside of their own members, who stood to benefit from the initiative. This could be seen to have provided an incentive to provide expensive, inefficient care irrespective of health outcomes;
- There were no mechanisms for Aboriginal and Torres Strait Islander people to have input into initiatives implemented under the National Action Plan for Mental Health 2006-2011 or for regular review and adjustment of financing arrangements to ensure that programs/initiatives remained consistent with government priorities such as closing the gap or in ensuring continual improvement in efficiency and effectiveness in targeting Indigenous communities and populations;
- The Better Access Evaluation Project Steering Committee did not include Indigenous representatives;

- While Aboriginal Health Workers are eligible to provide Focused Psychological Strategies under ATAPS programs, they were excluded from providing the same strategies under the Better Access initiative. This decision was made without consultation with Indigenous stakeholders and the rationale has yet to be made public;
- The reliance on GP structures to extend primary mental health care to the Australian population created a risk that the huge investment in fee-for-service mental health services provided under the Better Access initiative will replicate the inverse care law (Hart, 1971; Furler et al, 2002) which has plagued primary health care provision to Aboriginal and Torres Strait Islander communities and populations and stimulated the establishment of Aboriginal Community Controlled Health Organisations in the 1970's in order to gain access to medical care, and which has been a primary driver for the need to reform the primary health system;
- The delivery of primary mental health services using Better Access and mental health care plans developed by GPs ($753.8 million), ATAPS programs with funds held by Divisions of General Practice ($142.7 million), Mental Health Services in Rural and Remote Areas program ($60.4 million) through fund-holding arrangements by Divisions of General Practice, and the Mental Health Nurse Incentive Program ($79.8 million) using psychiatrists, GP practices and Divisions of General Practice, fails to recognise the historical and contemporary lack of service provision, relationship, engagement or partnering of GP Divisions, fee-for-service GPs and psychiatrists with Aboriginal and Torres Strait Islander communities or populations (as evidenced by poor MBS uptake, the mal-distribution of GPs, and the inverse need law which sees an oversupply of fee-for-service GPs located in wealthy urban localities and nowhere near high-need Indigenous populations and communities);
- The additional components of special purpose ATAPS funding targeted to drought affected communities, suicide prevention, perinatal depression, telephone cognitive behavioural therapy, bush fire and flood disaster responses – all using Divisions of General Practice as fund-holders - failed to include an Indigenous component to service provision;
- Other programs such as Improved Services for People With Drug and Alcohol Problems and Mental Illness, Support for Day to Day Living in the Community and the Personal Helpers and Mentors Program also lacked reach into Indigenous populations and communities;
- The evaluation and pattern of uptake of Better Access mental health care services suggests the inverse care law has been replicated in relation to Aboriginal and Torres Strait Islander communities and populations in urban, regional and remote areas;
- While the ATAPS program has successfully extended mental health care services to regional and remote populations it has failed to reach the Indigenous proportions of these populations;

- No attempt was made to site ATAPS or Mental Health Services in Rural and Remote Areas services in areas with high numbers or proportions of Aboriginal and Torres Strait Islander people or areas of greatest need;
- Only one of the 39 organisations funded under the Mental Health Services in Rural and Remote Area initiative was an Aboriginal Community Controlled Health Service;
- The evaluation of the Mental Health Services in Rural and Remote Area initiative reported that:
    - Data relating to uptake by Aboriginal and/or Torres Strait Islander people was not collected by organisations;
    - Non-Aboriginal and Torres Strait Islander health professionals faced difficulties in gaining community support and acceptance and this resulted in under-utilisation of services.
- The Mental Health Professional Online Development (MHPOD) platform and online learning modules to facilitate continuing education for mental health professionals failed to include consultation or input from Indigenous mental health practitioners.

In summary, the mental health reforms have failed to adhere to the National Framework of Principles For Delivering Services to Indigenous Australians and in so doing has vastly increased the size of the gap in social and emotional wellbeing an mental health outcomes for Aboriginal and Torres Strait Islander people. This is most notable in relation to the following service delivery principles:

Sharing responsibility

- Committing to cooperative approaches on policy and service delivery between agencies, at all levels of government and maintaining and strengthening government effort to address indigenous disadvantage.
- Building partnerships with Indigenous communities and organisations based on shared responsibilities and mutual obligations.
- Committing to indigenous participation at all levels and a willingness to engage with representatives, adopting flexible approaches and providing adequate resources to support capacity at the local and regional levels.

Harnessing the mainstream

- Ensuring that indigenous-specific and mainstream programs and services are complementary.
- Lifting the performance of programs and services by:
  - reducing bureaucratic red tape;
  - increasing flexibility of funding (mainstream and indigenous-specific) wherever practicable;
  - demonstrating improved access for indigenous people;
  - maintaining a focus on regional areas and local communities and outcomes; and

- identifying and working together on priority issues.

Establishing transparency and accountability

- Strengthening the accountability of governments for the effectiveness of their programs and services through regular performance review, evaluation and reporting.
- Ensuring the accountability of organisations for the government funds that they administer on behalf of indigenous people.

Developing a learning framework

- Sharing information and experience about what is working and what is not.
- Striving for best practice in the delivery of services to indigenous people, families and communities.

While the primary health care sector has been grappling with inequities in service provision and health outcomes for Aboriginal and Torres Strait Islander people for a number of years, the mental health sector has yet to develop or demonstrate competence in this area. It is clear the mental health system currently lacks both the commitment and the capacity to meet the needs of Aboriginal and Torres Strait Islander people and requires urgent and thorough-going reform if it is to make a meaningful contribution to Closing the Gap.

AIPA Recommendation	That the Australian Government support Indigenous participation in policy decision-making and the development of the 10 year road map by: a) Resourcing a consortium of Indigenous mental health practitioners to draw together evidence and develop policy advice to contribute to the reform process, including the development of a COAG Close the Gap National Partnership Agreement on Social and Emotional Wellbeing. b) Partnering with this Consortium to develop: • A National Aboriginal and Torres Strait Islander Social & Emotional Wellbeing & Mental Health Plan as part of the next Closing the Gap package to be endorsed by COAG in 2013; • A separate suicide prevention strategy for Indigenous communities and populations within the National Suicide Prevention Strategy, which includes programs to rapidly implement post-vention services to Indigenous communities following a suicide to reduce the risk of further suicides. c) Ensuring at least one Commissioner on the new National

	Mental Health Commission is an Indigenous representative (more below).

The delivery of a national mental health commission (ToR (g))

The Commission will have nine Commissioners and a Chair and will provide independent advice to the Government on the effectiveness of the mental health system in meeting the needs of people with a mental illness, their families and carers.

AIPA Recommendation	Ensuring Closing the Gap is a priority for the Commission, that: a) An Indigenous commissioner is appointed amongst the first nine commissioners. In addition, that person should be advised and accountable to a panel of Indigenous experts in the fields of mental health and social and emotional well-being. b) That the Commission has an Indigenous specific unit, which monitors Indigenous data and assesses the quality and coverage of mental health services and infrastructure for Indigenous people living in urban, regional and remote areas. c) That the terms of reference for the Commission includes Closing the Gap as a priority and that assessments of the mental health sector include reports against Indigenous specific criteria / indicators in relation to the effectiveness, appropriateness and efficiency; responsiveness; accessibility; safety; continuous; capability; and sustainability of services provided to Aboriginal and Torres Strait Islander communities and populations.

Changes to the Better Access Initiative (ToR (b))

The Better Outcomes in Mental Health Care program was introduced by the Australian Government in 2001 to purchase psychological treatment services under the Access to Allied Psychological Services (ATAPS) program. The ATAPS program has been implemented through the network of Divisions of General Practice using fund-holding arrangements to deliver Focused Psychological Strategies for those with common mental health disorders such as anxiety and depression.

The ATAPS program laid the foundations for the Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (Better Access) initiative. From November 2006, the Better Access initiative gave GPs, psychiatrists, psychologists, social workers and occupational therapists access to new Medicare items, which allowed Focused Psychological Strategies to be funded through the MBS. ATAPS is meant to operate in a complementary manner to provide mental health services to those unable to access MBS funded Better Access services. However, It should be noted that the Focused Psychological Strategies delivered in the Better Access and ATAPS programs are the same strategies, delivered by the same group of professions, apart from Aboriginal Health Workers who (for reasons unknown) have been excluded from providing services under the Better Access initiative. Reports of Better Access and ATAPS operating in the same location, with the same allied health providers providing identical services, illustrate the similarities of both programs.

Over the life of the Mental Health Action Plan, the Better Access initiative has come to be seen as the 'preferred program to provide the majority of primary mental health services to the broader population' while the ATAPS program has come to be seen as being 'better suited to Indigenous mental health initiatives, since the provision of services can be tailored to more community focused and less formal, time-driven services' (Littlefield, 2008). Yet, as has been noted earlier in this submission, no effort has been made to ensure equitable distribution of Better Access mental health services to Indigenous people, the majority (76%) of whom live as dispersed minorities within mainstream populations in urban and regional Australia.

AIPA applauds the allocation of nearly 17% of ATAPs funding in the 2011 Budget to provide mental health care services to up to 18,000 Indigenous people in recognition that the Better Access initiative has failed to reach Aboriginal and Torres Strait Islander populations and communities. However, AIPA is concerned that Aboriginal and Torres Strait Islander people - particularly for those living in urban areas - should still have equitable access to MBS subsidized mental health services through the Better Access initiative. This is particularly important since it has been recommended that ATAPS programs cease to operate in urban locations (Littlefield, 2008). AIPA is concerned that unless urgent remedial action is taken, a 'two tiered' system will develop where Better Access mental health service providers will feel no responsibility to meet the needs of Aboriginal and Torres Strait Islander people, and Indigenous Australians will be excluded from receiving Focused Psychological Strategies under the Better Access initiative now and in the future.

Despite there being ample data and analysis of the disease burden and the health gap, by sex, age, and location, to empower the mental health system to prioritise investments in Indigenous social and emotional wellbeing and mental health, it was with alarm that AIPA noted that the sole strategy used to ensure equitable distribution of the $753.8 million

investment in the Better Access initiative was the Mental Health Professional Network ($15 million) initiative which aimed to *improve community access* to quality primary mental health services by hosting lunches and dinners for Better Access mental health service providers and the GP's who referred to them. While promoted as fostering inter-disciplinary collaboration and including a case discussion, the millions invested in a single strategy seems bizarre and wasteful when weighed against the more urgent priorities to say, increase Indigenous access to primary mental health care by implementing cultural competence training with those providing MBS funded mental health services, or by adapting Focused Psychological Strategies so they suit Indigenous clients. This extraordinary oversight has resulted in a pattern of uptake of Better Access mental health services that mirrors the inverse care law associated with GP fee-for-service primary health care to Indigenous communities and populations – a primary driver of the ten-year gap in life expectancy and the push to reform the primary health system.

The investment in the Better Access initiative resulted in 3.8 million MBS funded mental health services provided by psychologists, psychiatrists, GPs and other allied health professionals in 2008-09. This was equivalent to 286.7 services per 1,000 population, which could be broken down to 115.0 psychologist services, 90.9 psychiatrist services, 73.9 GP services and 6.9 other allied health services per 1,000 people in Australia.

Figures in relation to the Indigenous uptake of MBS-funded mental health services are not available. However closer examination reveals that while 359 MBS-funded services were provided per 1,000 population in major cities, only 49 per 1,000 population were provided in very remote areas where Indigenous people form 45% of the population. Rates for MBS-funded mental health services were highest (395 per 1,000) in the richest suburbs (where only 1% of the Indigenous population live) and lowest (246 per 1,000) in the most disadvantaged locations, (nationally 31% of the Indigenous population live in the most disadvantaged quintile compared to 9% of the non-Indigenous population) (SCRGSP, 2011).

While 5.7% of the Australian population received Medicare-funded mental health care services in the private sector, 1.6% received public State and Territory clinical mental health care services. In 2008 – 2009 Aboriginal and Torres Strait Islander continued to be over-represented in community mental health contacts from publicly funded State and Territory community mental health services. Aboriginal rates were 2.7 that of others, with 731 contacts per 1000 population compared to 272 per 1000 population for others. Nationally, the proportion of the population using State or Territory mental health services in 2008-09 is higher for Indigenous (4%) than non-Indigenous (1.5%) people (SCRGSP, 2011).

It appears the Better Access initiative has created a two-tiered primary mental health care system. It is important that strategies are urgently implemented to improve the accessibility of

Focused Psychological Strategies for Aboriginal and Torres Strait Islander people under the Better Access initiative as well as using ATAPS programs to better target Aboriginal communities and populations without access to GPs or bulk-billing mental health service providers. This reflects the COAG service delivery principle of 'harnessing the mainstream' to close the gap in health outcomes.

AIPA advocates that Tier 2 special purpose ATAPS funding be quarantined for the development and implementation of an Aboriginal and Torres Strait Islander specific service model to address high prevalence disorders in Indigenous populations and communities in regional, remote and very remote Australia, with funds to be held by Aboriginal Community Controlled Health services. At the local level, many of these services are able to document better health outcomes for the communities they serve. Most importantly, Aboriginal Community Controlled Health services bring the essential infrastructure required to support service delivery based on Indigenous concepts of social and emotional wellbeing and mental health: i) comprehensive primary health care based on holistic understandings of health and wellbeing and ii) service delivery through organisations aligned with and managed by language groups/nations which share culture-based concepts of social and emotional wellbeing with the communities and populations they serve. This will allow the development of universal, indicated and targeted social and emotional wellbeing strategies to build resilience, identify and respond to current risk factors and to harness unique culture-based protective factors in a way that respects, protects and strengthens the cultural integrity of each language group/nation.

A supporting infrastructure needs to be established within this sector and benchmarks developed to underpin service delivery, efficiency, quality, and to support information exchange on best practice models and to provide professional support for service providers.

AIPA recommendations	That the Australian Government enable Indigenous decision-making in planning processes around all ATAPs funding, including the identification of priority locations. That Aboriginal Community Controlled Primary Health Care Organisations receive ATAPS Tier 2 special purpose funding from in 2011-12 to consult, plan and develop the infrastructure required to support social and emotional wellbeing and mental health strategies to be delivered as part of comprehensive primary health care from July 2012. That the Australian Government work with AIPA and other

	key Indigenous stakeholders to develop a funding and evaluation criteria for services seeking funds from both Tier 1 and Tier 2 ATAPs. That a supporting infrastructure be established within the Aboriginal Community Controlled Health Sector to support the delivery of Indigenous-specific ATAPs programs, which includes benchmarks for service delivery, supports information exchange on best practice models and supports service providers. That all Better Access and ATAPS service providers should be required to complete cultural competence training in order to maintain their access to Medicare Benefits Schedule items.

Mental health workforce issues – training and qualifications (ToR (e)(i))

The entire mental health workforce in urban and regional Australia needs to have the cultural competence required to meet the needs of Aboriginal and Torres Strait Islander people in their client base.

All psychologists should have Indigenous cultural competence as part of a requirement of registration, as is the case in New Zealand and the USA. As noted previously, the opportunity to review undergraduate psychology training was missed during the National Action Plan 2006-2011 and this omission needs to be addressed. A curriculum framework for Indigenous health in core medical curricula was endorsed by all Australian medical schools and the Australian Medical Council (LIME Project). A similar project needs to be undertaken in the field of psychology.

All Better Access and ATAPS service providers should be required to complete cultural competence training in order to maintain their access to Medicare Benefits Schedule items.

Those providing Better Access or ATAPS mental health services in Divisions of General Practice or Medicare Locals where 20% or more of the population is Indigenous should be targeted for immediate cultural competence training to support the delivery of primary mental health services to Indigenous Australians.

Good practice guidelines relevant to increasing the cultural safety and competence of mainstream mental health services, such as the National Practice Standards for the Mental Health Workforce (Department of Health and Ageing, 2002) and the Cultural Respect

Framework for Aboriginal and Torres Strait Islander Health 2004-2009 (Australian Health Minister's Advisory Council on Aboriginal and Torres Strait Islander Health Working Party 2004) need to be implemented nationally.

AIPA Recommendations	That the Australian Government support a project to "Indigenise" the psychology curriculum (similar in scope to the LIME project). The National Practice Standards for the Mental Health Workforce (Department of Health and Ageing, 2002) and the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004-2009 (Australian Health Minister's Advisory Council on Aboriginal and Torres Strait Islander Health Working Party 2004) be implemented nationally.

Mental workforce issues – workforce shortages (ToR (e)(ii))

Indigenous people make up 2.5% of the Australian population, and are over-represented in statistics of suicide, self-harm, mental illness and psychological and emotional distress – as well as statistics on hospitalisation for mental health conditions. However Indigenous psychologists form only 0.3% of the psychology profession (ABS, 2006). This is about one tenth of what it should be.

Only 39 Aboriginal and Torres Strait Islander psychologists were identified at the last census, when 625 would be expected if parity existed within the profession. Psychology did not produce its first Aboriginal graduate until 1987 and in the 20 years to 2007, it has graduated an average of 2 Aboriginal and Torres Strait Islander psychologists per year. At the current rate, it will take another 293 years to graduate sufficient Aboriginal and Torres Strait Islander psychologists to achieve parity within the existing psychology workforce. Clearly, 'business as usual' will not achieve national benchmarks and special measures are required to achieve equity.

In 2006 there were 149 Indigenous people enrolled in psychology courses. AIPA members recognize the need to provide support and encouragement to students to complete their psychology training and the two years of supervised practice they require to achieve national registration (the lack of parity within the psychology profession attests to the lack of support given to Indigenous psychology students and new graduates). AIPA has a stated aim to provide mentoring and support to Indigenous psychology students, however, AIPA is under-resourced and has been unable to achieve this goal to date.

In addition, AIPA notes that no specific work has been undertaken by the Department of Health and Ageing or nationally to assess or address the distribution or accessibility of the regional and remote mental health workforce.

AIPA Recommendation	That the Australian Government invest in strategies to increase the number of Indigenous students entering and graduating psychology and other mental health courses; That AIPA is supported to implement a program to provide mentoring and support to Indigenous undergraduate psychology students and interns.

Services available for people with severe mental illness and the coordination of those services (ToR (d))

The Budget 2010 – 2011 included funding for regional bodies to help coordinate services for people with severe mental illness and to act as a single point of contact.

It would be important that Aboriginal Community Controlled Health Services (ACCHS) be able to tender for funding through this initiative to increase mental health care support for those with a serious mental illness. Currently serious mental illness constitutes 3% of the chronic disease burden of Indigenous Australians.

The additional investment in Personal Helpers and Mentors program is welcomed. A significant share of this investment should be ear-marked for Indigenous communities and populations in urban, regional and remote areas. In addition, the Government should broaden its use of the Indigenous-designed version of that program (rather than just adding an Indigenous worker to a mainstream model). A significant share is justified given that the first rounds of PHAMs missed much of urban, regional and remote Indigenous Australia.

Non-Indigenous workers in PHAMs programs targeted to Indigenous populations and communities should be required to complete cultural competence training.

AIPA Recommendation	That a significant share of the new PHaMS funding be dedicated to addressing Indigenous need in urban, regional and remote Australia, using the Indigenous designed model of the program. That the funding for coordination of services for people with severe mental illness prioritise Indigenous patients, and target

	Aboriginal Community Controlled Health Services.

The impact of online services for people with a mental illness, with particular regard to those living in rural and remote locations and other hard to reach groups (ToR (h))

While likely to benefit from this initiative, since there are substantial challenges to service delivery posed by small, dispersed Aboriginal and Torres Strait Islander communities in remote Australia, where 92,960 Aboriginal people live on traditional lands, the lack of infrastructure to support service delivery and the extreme poverty found in many of these communities.

However, careful consideration needs to be given to whether existing 2011 Budget measures, including the emphasis on online services, will aid or discriminate against this part of the Aboriginal and Torres Strait Islander population. In particular:

- An obvious obstacle to accessing an online service is not having access to the internet. In the event that an individual has no access to the internet in their home, they would have to rely on access to public internet. There may be no privacy if the public internet was located at the local shop, or community centre, in a public area.
- English can be a second, third or fourth language in some remote communities, and cultures also differ by language group and community.

AIPA Recommendation	That the Australian Government give particular attention to how the 2011 Budget measures will support Aboriginal and Torres Strait Islander peoples living in remote areas.

Single Mental Health Online portal

The budget included $14.4 million / 5 years to help establish a single mental health online portal, which will both enable consumers to more easily identify and access services and provide online training and support to GPs, Aboriginal health Workers, and other clinicians delivering mental health services.

AIPA Recommendation	That Indigenous stakeholderstake a leading role in the development of Indigenous components to the new Single Mental Health Online portal. That the Australian Government support Indigenous mental

	health research and policy developments to be collated online through a clearinghouse.

Endnote:

The 2011 Budget includes research funding to be administered by the National Health and Medical Research Council and that a consultation process managed by the Department of Health and Ageing will establish research priorities. AIPA would like to emphasise the following priorities:

- The need to adapt Focused Psychological Strategies to suit Indigenous Australians to increase accessibility of the Better Access intiative and the ATAPS and Mental Health in Rural and Remote Areas programs;
- The existing lack of research to adapt and culturally validate mainstream mental health screening tools for use with Indigenous Australians;
- The need to develop Indigenous-specific social and emotional wellbeing assessment tools and measurements;
- The lack of research into best practice service provision of primary mental health strategies for Indigenous people or the development of evaluation strategies to assess their effectiveness.

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