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Senate Select Committee on Regional and Remote Indigenous Communities

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The Queensland Aboriginal and Islander Health Council (QAIHC) welcomes the opportunity to provide a submission to the inquiry into the impact of government policies and programs affecting Aboriginal and Torres Strait Islander persons in rural and remote parts of Queensland, especially as these actions pertain to mental health; linkages in education and employment; and Indigenous contact with the criminal justice system.

As the peak body for Community Controlled Health Services in Queensland, QAIHC represents the state-wide voice for this sector and its Member Services. QAIHC is committed to addressing and responding to government decisions and agreements that pertain to the health of Aboriginal and Torres Strait Islander people and to representing the voice of its Members and their communities within the context of these discussions.

The attached submission summates QAIHC's response to the stated matters above and the position that has been assumed by the community control sector in these discussions.

QAIHC looks forward to hearing of the findings and results from this inquiry, which will be important in identifying future directions forward for Aboriginal and Torres Strait Islander communities in rural and remote areas of Queensland.

Yours Sincerely

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## 1. Summary

This is the Queensland Aboriginal and Islander Health Council's response to the Senate Select Committee on Regional and Remote Indigenous Communities' inquiry into the impact of government policies and programs affecting Indigenous people in regional and remote parts of Queensland.

The submission will address the key interest areas identified by the Senate Select Committee, including, mental health; linkages in education and employment; and Indigenous contact with the criminal justice system. This will entail providing an initial summation of Queensland population and health data, followed by a more detailed assessment of the above areas and the sorts of impacts and specific issues that need to be considered for regional and remote policy and service design.

Other points of relevance may be mentioned where appropriate, given the connectedness of the above stated topics and their links to other key issues concerning Aboriginal and Torres Strait Islander health and disadvantage in regional and remote areas of Queensland.

It should be stipulated that this submission represents the state-wide response for the community control health sector on these matters and that QAIHC's response has been written to account for the interests and views of the sector and its Member Services in responding to the Senate Select Committee's inquiry.

## 2. Background

A brief summation of key population and health figures is provided to contextualize this submission; the Aboriginal and Torres Strait Islander populations that it refers to; and the unique circumstances experienced by these populations in regional and remote areas of Queensland.

### 2.1. Population overview

In 2006, there were 146, 400 people in Queensland who identified as Aboriginal and Torres Strait Islander from a total state population of 4, 091, 500 (ABS 2007). Similarly to other States and Territories, this Indigenous population has a much younger age structure than the Queensland population as whole; with 48% of Indigenous persons aged 19 years or younger and only 2% of the population aged 65 years or over.

These figures alone are indicative of the co-occurring high rates of premature death and fertility within Aboriginal and Torres Strait Islander populations and the need to consider the different health needs of Indigenous persons compared to other Australians given these structural differences.

In terms of population distribution, on a national scale more than one-quarter of the Indigenous population reside in remote areas compared to 2.4% of the total Australian population (ABS 2003). Census data for 2006 indicates that a third of Queensland's Aboriginal and Torres Strait Islander population live in the Brisbane Region; 5% in Townsville; 14% in Cairns; 12% in Rockhampton; and 11% in Cape York and Torres Strait. This indicates the dispersed presence of Aboriginal and Torres Strait Islander populations across remote, regional and urban areas and the subsequent need for policy and service planning in each of these jurisdictions.

### 2.2. Health status and Indigenous burden of disease

The gap in health outcomes between Aboriginal and Torres Strait Islander persons and other Australians continues to exist and is identifiable across a range of indicators and state and national-level data sets.

In 2008, the median age at death for Indigenous males was 53.2 years and 62.3 years for Indigenous women (ABS 2010). This is comparatively lower than what was recorded for non-Indigenous men (77.3 years) and non-Indigenous women (83.7 years) and is reflective of the enduring gulf between Indigenous and non-Indigenous health outcomes.

The infant mortality rate for the 2006-2008 period was considerably higher for Aboriginal and Torres Strait Islander people (7.9 infants per 1,000 live births) and outweighed what was recorded for the same period for the non-Indigenous population (5.1 infants per 1,000 live births) (ABS 2010).

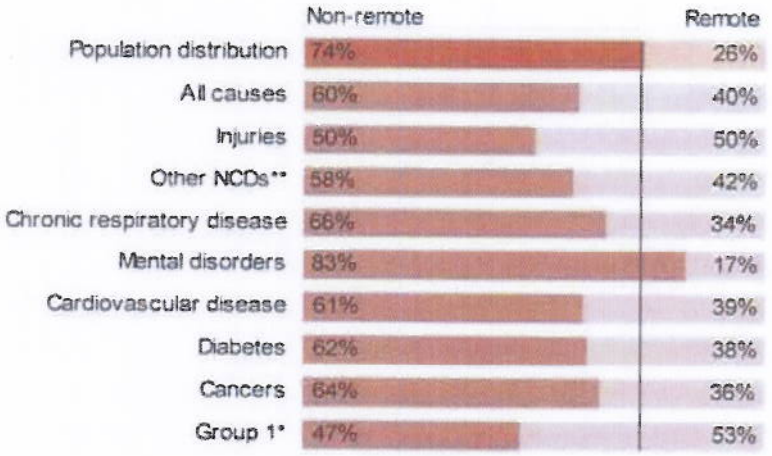
Further measures of inequity exist at the level of individually identified conditions and diseases, especially as these figures pertain to chronic and non communicable conditions (AIHW 2008; Von et al. 2007).

Cardiovascular disease and mental disorders are the leading causes of disease burden in Australia's Aboriginal and Torres Strait Islander population, accounting for 32% of the disease burden (Vos et al. 2007). This is followed by chronic respiratory disease, diabetes, and cancers, which account for an equal proportion (8% each) of the total Aboriginal and Torres Strait Islander burden of disease.

### 2.3. Indigenous health status by remoteness

In terms of the differences between urban and remote burden of disease levels, the *Aboriginal and Torres Strait Islander Burden of Disease and Injury* report (Vos et al. 2007) indicates that relative to population size, Indigenous persons experienced a disproportionate amount of the health gap major disease areas, apart from mental disorders (see figures1 and 2 below).

**Table 1 – Indigenous health gap (DALYs) by selected causes expressed as proportions by remoteness**




* Communicable diseases, maternal and neonatal conditions
** Other non-communicable diseases

Table 2 – Indigenous health gap (DALYs) due to selected causes expressed as proportion of total excess burden by remoteness

| | Non-remote (%) | | | | | Remote (%) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Cause | 0–14 | 15–34 | 35–54 | 55+ | All ages | 0–14 | 15–34 | 35–54 | 55+ | All ages |
| **All causes** | **19** | **24** | **33** | **24** | 100 | **15** | **26** | **36** | **22** | 100 |
| **Group I[a]** | **6** | **2** | **3** | **1** | **12** | **9** | **4** | **5** | **2** | **20** |
| Infectious & parasitic diseases | 1 | 1 | 2 | 1 | 4 | 2 | 2 | 3 | 1 | 8 |
| Acute respiratory infections | 1 | 0 | 1 | 0 | 3 | 3 | 1 | 1 | 1 | 6 |
| Neonatal causes | 4 | 0 | 0 | 0 | 4 | 4 | 0 | 0 | 0 | 4 |
| Other group I | 0 | 1 | 0 | 0 | 1 | 1 | 1 | 0 | 0 | 2 |
| **Non-communicable diseases** | **11** | **15** | **27** | **23** | 76 | **4** | **10** | **28** | **20** | 62 |
| Cancers | 0 | 0 | 2 | 4 | 6 | 0 | 0 | 3 | 2 | 5 |
| *Tobacco related cancers[b]* | 0 | 0 | 1 | 3 | 5 | 0 | 0 | 2 | 2 | 3 |
| *Other cancers* | 0 | 0 | 1 | 1 | 1 | 0 | 0 | 1 | 1 | 2 |
| Diabetes | 0 | 3 | 6 | 4 | 12 | 0 | 2 | 5 | 4 | 12 |
| Cardiovascular disease | 0 | 3 | 11 | 9 | 24 | 1 | 4 | 11 | 7 | 23 |
| *Ischaemic heart disease* | 0 | 1 | 8 | 8 | 16 | 0 | 2 | 7 | 4 | 13 |
| *Stroke* | 0 | 0 | 1 | 2 | 3 | 0 | 0 | 1 | 1 | 3 |
| *Other cardiovascular disease* | 0 | 1 | 2 | 1 | 5 | 1 | 2 | 3 | 1 | 7 |
| Mental disorders | 4 | 6 | 3 | 1 | 14 | 1 | 1 | 2 | 0 | 4 |
| *Substance use disorders* | 1 | 3 | 2 | 1 | 7 | 0 | 1 | 2 | 0 | 4 |
| *Other mental disorders* | 3 | 3 | 1 | 0 | 7 | 0 | 0 | 0 | 0 | 0 |
| Chronic respiratory disease | 2 | 1 | 4 | 3 | 10 | 0 | 1 | 4 | 3 | 8 |
| Other NCD[c] | 4 | 2 | 2 | 1 | 10 | 3 | 2 | 3 | 2 | 10 |
| **Injuries** | **2** | **7** | **3** | **0** | **12** | **2** | **12** | **4** | **1** | **18** |
| Road traffic accidents | 0 | 1 | 1 | 0 | 2 | 1 | 3 | 2 | 0 | 5 |
| Suicide | 0 | 3 | 1 | 0 | 4 | 0 | 4 | 0 | 0 | 5 |
| Homicide & violence | 0 | 2 | 0 | 0 | 2 | 0 | 3 | 1 | 0 | 4 |
| Other injuries | 1 | 1 | 1 | 0 | 4 | 1 | 2 | 1 | 0 | 4 |

(a) Communicable diseases, maternal and neonatal conditions
(b) Mouth and oropharynx, oesophagus, lung, larynx, pancreas, bladder, kidney, stomach, and uterine cancers
(c) Other non-communicable diseases

This illustrates that both remote and non-remote areas have important, but different health needs and priorities, which will need to be accounted for accordingly within service planning and delivery 2007). This places an emphasis on the need to develop locally-based and need-response plans and programs, that reflect local priorities and the contextual factors unique to that community and location.

### 3. Mental health and co-occurring disadvantage in regional and remote communities

Mental disorders occur in Indigenous Australians at 1.6 times the rate of the total Australian population (Vos et al. 2007). In 2003, mental disorders accounted for 15.5% of the total disease burden experienced by Aboriginal and Torres Strait Islander persons, with anxiety and depression, alcohol and substance misuse, and schizophrenia representing the broader categories of illness that contributed to this measurement.

The complexity of mental health issues and the increasing prevalence of dual diagnosis (i.e. co-occurring alcohol or substance misuse) can complicate treatment pathways for Indigenous persons and accentuate existing problems associated with access to comprehensive and appropriate health care in regional and remote areas (Commonwealth of Australia 2008).

This is reflected in the fact that more than one-third of mental disorders in Aboriginal and Torres Strait Islander persons can be attributed to alcohol, illicit drugs, child sex abuse and intimate partner violence (Vos et al. 2007); which in turn holds implications for the sorts of services that will be required to both prevent and comprehensively treat mental disorders in Indigenous persons.

The impact of historical and familial issues, as well as the increased likelihood of social and economic disadvantage in remote areas for Indigenous persons, can also be linked to Indigenous experiences of mental ill-health and mental disorder and the heightened prevalence of the above named risk factors (AIHW 2008).

### 3.1. Issues of access

Aboriginal and Torres Strait Islander people encounter unique circumstances in rural and remote locations which heavily contribute to the perpetuation of mental health issues and other associated conditions and vulnerabilities (i.e. drug and alcohol misuse; violence and abuse; and other forms of criminal activity in regional and remote areas.

Access features as one of the key barriers for Indigenous persons in remote locations when it comes to achieving sustainable improvements in health and wellbeing. This can be linked to scarcity of available services; issues of cost and affordability; the lack of transport options coupled with factors of distance; a lack of education and self-informed awareness about individual health and wellbeing; and problems pertaining to cultural appropriateness and relevance of the available care options and its providers (ABS & AIHW 2008).

Social and economic disadvantage also becomes more prominent as remoteness increases and this is capable of both compounding the inability of the individual to effectively access and utilize services, and of contributing to increased instances of family and community instability, which in turn can perpetuate and fuel mental health problems and the risk of destructive co-occurring behaviors such as drug use or criminal activity (ABS & AIHW 2008; Commonwealth of Australia 2008).

Low levels of employment and opportunities for education, coupled with remote living and limited forms of entertainment for youths can also be linked to enhanced vulnerability to partake in risk behaviors such as drinking and drug use. This can also be linked to youths relocating to urban and metropolitan areas; which in itself can lead to other risk factors and negative outcomes such as homelessness and poverty.

### 3.2. Challenges for service planning and delivery

Challenges surround the ability to adequately deliver and resource comprehensive health care in Queensland's regional and remote Indigenous communities. Issues of access and a lack in presence of health care options often go hand in hand in regional and remote areas and this means that the complex care needs of Aboriginal and Torres Strait Islander persons frequently remain under serviced.

The sporadic and inconsistent presence of health specialists under current outreach programs in regional and especially remote communities, can present challenges for the delivery of streamlined and integrated health care to Aboriginal and Torres Strait Islander persons. The issue of trust between patients and providers and potential cultural incompatibilities can be linked to this issue, as can the topics of inadequate cultural awareness training; changes in who the visiting health professionals are; and the brevity of stay, as well as lapses in time between visits.

These are important factors to consider, given that in the context of both the NHHRC report and the recent reforms and initiatives outlined under the National Indigenous Health Reform (NIRA), comprehensive and multidisciplinary primary health care is outlined as a key requirement for combating high rates of burden of disease and Indigenous disadvantage.

For Aboriginal and Torres Strait Islander persons who are experiencing co-occurring mental disorders; substance or alcohol misuse problems; or who are in the process of rehabilitation post contact with the criminal justice system, these lapses or voids in treatment can contribute to perpetuating the cycle of ill-health; which in turn holds ramifications for family and community and the health and wellbeing of others around them.

The inability of services around the individual to adequately deal with the patient's mental disorders; co-morbidities; and the risk factors that might be connected back to family and community, means that sustainable health improvements become difficult and risks of re-exposure to negative influences and behaviors often remains high and unresolved.

Inadequate resource availability and issues surrounding training, education and workforce capacity represent additional challenges within this discussion and require similar attention within the planning and delivery of primary health care and community service.

## 4. Implications and recommendations for Indigenous health in regional and remote areas

### 4.1. Transition to community control and the need to develop a supporting Policy Framework

Innovative; locally-focused; and need and priority-based responses are required to tackle inequity and Aboriginal and Torres Strait Islander disadvantage. This comes from the proven understanding that previous top-down and externally driven and planned responses have done little to promote real and enduring improvements for the health and wellbeing of Aboriginal and Torres Strait Islander people; whether this has been in remote or non-remote locations.

Transition to community control in remote communities and the move toward locally owned, planned and coordinated primary health care and community services, constitutes a key direction for improvements in Aboriginal and Torres Strait Islander health and wellbeing in Queensland.

For government, this means upholding commitments and agreements in sites where transition arrangements have been made and agreed to (including Cape York and Yarrabah in Queensland's North); as sustained inaction and a lack of follow-up in already committed sites has delayed and stagnated progress in these areas.

Part of this problem can be linked to the absence of a Queensland-specific policy framework that can support Aboriginal communities to plan, develop and manage primary health care and community services that are effective, sustainable, appropriate, and equitable to what is being delivered to

other Australians. The Northern Territory already as its own *Pathways to Community Control* document to enable and assist with such processes and it is QAIHC's recommendation that a similar road-map be developed, which is specific to the circumstances and experiences of Queensland and that be used in the context of Queensland's remote Aboriginal and Torres Strait Islander communities.

This is attached to the need for financial reform and to develop improved and new directions in financial modeling that can best promote cost-effective and sustainable health and community practices. In 2008, QAIHC commissioned a report (which it has tabled here today) to calculate the level of public funding required to implement the transition to community control in Cape York and Yarrabah and to achieve both increased utilization and improved health outcomes across the continuum of care for Indigenous persons.

This will be essential to both allow Indigenous persons equal access to evidence-based and equitable health and community care; and to realize and have the opportunity to fully utilize the expanded opportunities that now exist through MBS and PBS.

**4.2. Innovative directions to address Indigenous contact with the criminal justice system**

Intersecting with the above recommendations and the need for new and innovative thinking around service and funding models, is the suggestion made in the latest Australian Human Rights Commission Social Justice report (2009) regarding opportunities for reinvestment of corrections money.

On the matter of addressing the disproportionately high incarceration rates experienced by Aboriginal and Torres Strait Islander people, the report posits the idea of retargeting and channeling a portion of the monies that is tied to Indigenous contact with the criminal justice system into preventative activities and to address the issues before the crimes are committed. This symbolizes an opportunistic direction capable of breaking the cycle of incarceration at the source of where these actions and behaviors are occurring, which in turn means channeling efforts toward localized and community responses and programs.

These new modes of thinking are especially relevant to remote areas, whereby the availability of resources and services targeted at halting and addressing Indigenous contact with the criminal justice system are lacking and frequently located in removed and inaccessible locations. The need to link these activities with other programs and activities in the community is also vital, given the frequent co-occurrence of risk behaviors with mental disorders and other related health and wellbeing issues.

**4.3. Training and education and enhanced workforce capacity – contributions needed here**

Linking enhanced efforts around education and training to increase the capacity and ability of the primary health care and community sector workforce is necessary to tackling Indigenous disadvantage.

Some of the major health workforce activities being conducted on a National level to develop and support the Aboriginal and Torres Strait Islander Health Worker Profession ensuring a more efficient health service delivery include:

- Practitioner Regulation National Law 2009, which will include National Registration and Accreditation of Aboriginal Health Workers as of 2012.

An Exposure Draft has been released and NACCHO and Affiliates have developed submissions to include into the draft regulations to ensure the protection of ATSIHW affected by the new laws. Some of the main issues of concern were in relation to;

  - Accreditation
  - Registration
  - Indemnity coverage
  - Criminal History

- Australian Industrial Relation Commission Modern Award

The modern award commenced January 1, 2010 and is in line with the federal government's new work place relations system.

As a result of health service Awards not meeting the uniqueness of the ACCHS governance structures including cultural dimensions, existing workforce and complex service provision NACCHO and Affiliates sought to establish a single modern award for the ACCHS sector. Submissions to the AIRC were successful and on the 25th October the Commission decided to grant the ACCHS sector a separate award.

- National Aboriginal and Torres Strait Islander Health Worker Association

  - The NATSIHWA CEO was appointed in March 2010
  - All governance structures have been developed
  - Interim Board has been developed
  - Currently each state and territory are in the process of a promotion drive for the recruitment of members to the Association and for elections for the state territory branch/committees

- Queensland ATSIHW Assessment

  - Currently ACCHS and QH are assessing their ATSIHW within an RPL process into the new HLT Aboriginal and Torres Strait Islander Primary Health Care qualifications.

The provision of funding to support the *Bringing Them Home* and *Link Up* initiatives and the delivery of training and support in communities for the counsellors attached to these programs represents a further positive and much needed step forward to develop health workforce capacity in the area of mental health. Funding has been provided by the Department of Health and Ageing for the establishment and operation of a Workforce Support Unit to provide a range of services to support Bringing them Home Counsellors, Link-Up Counsellors and Case Workers and Mental Health and Substance Use staff employed in organisations funded by OATSIH.

**4.4. Linking the COAG NPAs to prevent disjointed and dislocated planning**

There is a particularly strong need to *avoid* disconnected and isolated decision making and action as part of Indigenous Health reform in Queensland. To date, there has been a failure to link the different National Partnerships Agreements (NPA) that have been developed under the National

Indigenous Reform Agreement (NIRA) and the manner in which each of these NPAs are being planned and implemented in both Queensland remote and non-remote areas.

This has been in spite of the visible relatedness that exists between each of the seven COAG Building Blocks (including: Early Childhood; Schooling; Health; Economic Participation; Health Homes; Safe Communities; and Governance and Leadership) and their NPAs;, and in many instances the dependency that exists between the different measures for the achievement of desired and targeted outcomes in other areas.

It is QAIHC's position and recommendation that pathways and avenues be developed to enable cross-sector communication; collaboration; and input across these areas. This is aligned with the view that integrated and multi-pronged responses are essential to produce sustainable change for Aboriginal and Torres Strait Islander people. The social, emotional and physical needs of Aboriginal and Torres Strait Islander persons and communities are so complex and interlinked, that any responses need to reflect and mirror these levels of connectedness to ensure both comprehensiveness and responsiveness of targeted measures and resources.

This also aligns with the need for consistency in policy and process, especially in terms of the use of language which is used to describe how resources and funding will be targeted. This links in with discussions around urban, regional and remote Indigenous communities and the need for there to be a clear and consistent set of guidelines about how these terms and classifications are applied to community in the context of resource targeting.

## 5. Conclusion

The Queensland Aboriginal and Islander Health Council have welcomed the opportunity to speak on these issues and to posit the above response to the Senate Select Committee's inquiry.

These represent some of the critical directions that the community control sector identify as necessary for closing the gap in Indigenous disadvantage in Queensland. Ongoing and continued commitment to actions across these and other areas are going to be critical to reducing disadvantage and to promoting a better and more equitable future for Aboriginal and Torres Strait Islander people across all aspects of health and wellbeing.

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