Part Two: Aboriginal and Torres Strait Islander People

21. In the *Social Justice Report 2004* the Aboriginal and Torres Strait Islander Social Justice Commissioner signalled that addressing the mental health concerns of Indigenous Australians would be a priority throughout his term. In the report he noted:

> … that there is very little infrastructure or expertise in addressing mental health issues facing Indigenous peoples. It is a forgotten issue. Mental health issues are often masked through passive welfare or dealt with, inappropriately, through the criminal justice system. I have no doubt that mental health issues contribute to the crisis of family violence, anti-social behaviour, substance misuse and confrontation with the legal system, in Indigenous society.

22. The Social Justice Comissioner would like to congratulate the Select Committee for including Indigenous issues within the Terms of Reference. For Indigenous peoples and communities mental health is a central concern. It is also an issue on which there is limited research and data.

23. The Commission therefore urges the Committee to conduct specific consultations with Indigenous groups and communities in order to reach a deeper understanding of the issues facing Aboriginal and Torres Strait Islander people in relation to their mental health needs.

24. This part of the Commission's submission will address the terms of reference in a broad collective manner in relation to the mental health of Indigenous Australians. The Commission will therefore present a general outline of the mental health concerns facing Indigenous peoples and communities and make submissions across a number of terms.

Overview of Indigenous Mental Health Policy Development

25. When *Ways Forward – A National Consultancy Report on Aboriginal and Torres Strait Islander Mental Health* was release in 1993 it was the first significant report to articulate an Indigenous perspective of mental health. The report was also the first national plan to acknowledge the historical impact of colonisation and subsequent dispossession on Indigenous people's health. The connection between historical factors and contemporary social issues were expressed as such:

> Any delineation of mental health problems and disorders must encompass a recognition of the historical and socio-political context of Aboriginal mental health including the impact of colonisation; trauma, loss and grief; separation of families and children; the taking away of land; and the loss of culture and identity; plus the impact of social inequity, stigma, racism and ongoing losses.[1]

26. This submission reiterates this position. In order to develop and maintain a holistic view of Indigenous mental health it is critical that the historical and socio-political contexts of Indigenous Australians are embraced. The adoption of this context is

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[1] Swan, P. & Raphael, B. *Ways Forward – National Consultancy Report on Aboriginal and Torres Strait Islander Mental health*, National Mental Health Strategy, AGPS, Canberra, 1995.

fundamental to understanding contemporary mental health concerns of Indigenous communities.

27. Earlier in 1987 a Joint Ministerial Forum on Indigenous Health was established between health and Aboriginal affairs ministers from the commonwealth and state/territory governments. The forum led to the formation of a National Aboriginal Health Strategy Working Party (NAHSWP) which went forth to examine the issues pertaining to funding, Indigenous participation, inter-sectoral coordination and monitoring of Indigenous health programs and services.

28. In 1989 the NAHSWP delivered its report to the Ministerial Forum. The *National Aboriginal Health Strategy* (NAHS) considered a landmark in Indigenous health policy, was the first document to be developed following broad consultations with, and articulated the health concerns of, Aboriginal and Torres Strait Islander peoples.

29. The report establishes that:

> "Health" to Aboriginal peoples is a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease or incapacity.
>
> Prior to colonisation Aboriginal peoples had control over all aspects of their life. They were able to exercise self-determination in its purest form. They were able to determine their "very-being', the nature of which ensured their psychological fulfilment and incorporated the cultural, social and spiritual sense. [2]

30. The NAHS not only attempted to define what health meant to Aboriginal and Torres Strait Islander people, it situated Indigenous health issues in a political and social context. In doing so the strategy examined a range of health issues affecting Indigenous people and communities, including mental health. The NAHS noted:

> Advances in the understanding and treatment for mental health problems have been impressive since World War II; this progress has yet to benefit Aboriginal people. Culturally appropriate services for Aboriginal people in the mental health area 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.[3]

31. Another landmark report handed down in 1991, the Royal Commission into Aboriginal Deaths in Custody (RCIADIC),concluded that there was an urgent need to address Indigenous mental health, an problem which had significantly contributed to the over-representation of Aboriginal people in the criminal justice system, and had

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[2] National Aboriginal Health Strategy Working Party, *A National Aboriginal Health Strategy*, NAHSWP, 1989, p.ix.
[3] *ibid*, p172.

been an overwhelming factor in the majority of suicides in custody. The RDIADIC urged that any approach to Indigenous mental health must be respectful and sensitive to the legacy of 200 years of history.

32. The report asserted:

> The elimination of Aboriginal health disadvantaged requires a broad national commitment. It requires a comprehensive, well-articulated, national strategy, adequately resourced in terms of funds and expertise. The strategy must cover health promotion, disease prevention and treatment, along with research, program evaluation and statistical monitoring. As Aboriginal people emphasise, their effective involvement in the design and implementation of action aiming to improve the health of their people is crucial. Furthermore, the strategy will only be effective if it is accompanied by action that helps to redress the social and economic disadvantage that Aboriginal people routinely experience. Without such strategies, the standard of Aboriginal health will remain at levels that the international community rightly describes as being totally unacceptable in a society as affluent as Australia's. [4]

33. In 1993 the Burdekin Inquiry (see further Part 1 of this submission) highlighted, among other things, the issues confronting Indigenous people with a mental illness. The report found that while there was a paucity of statistical data available on the prevalence of mental illness among Indigenous people, that the removal of children from their families, the dispossession of land and the continuing social and economic disadvantage experienced by Indigenous people, has contributed to widespread mental health problems.[5]

34. The report also found that mental health professionals, at the time, had little understanding and/or experience of Indigenous communities and culture, which resulted in frequent misdiagnosis and inappropriate treatment.[6] The Inquiry also heard that many Indigenous people who come into contact with the criminal justice system have an undiagnosed and/or untreated mental illness. Within the criminal justice system people are labelled as socially deviant (not mentally ill) and their psychological problems are exacerbated. [7]

35. In 1994, five years after the development and implementation of the National Aboriginal Health Strategy, an evaluation was undertaken. The evaluation found that there had been little progress made in the improvement of Indigenous health, and further, that the NAHS was 'never effectively implemented' and that 'governments have grossly under-funded NAHS initiatives in remote and rural areas..' .[8]

36. The evaluation recommended the Commonwealth reaffirm its commitment to the principles of the NAHS including an:

- acceptance of Aboriginal people's holistic view of health

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[4] *Royal Commission into Aboriginal Deaths in Custody*, Vol 3, Conclusion 23.5.24
[5] Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness – Report of the National Inquiry into the Human Rights of People with Mental Illness*, HREOC, Sydney, 1993, vol.2, ch.23.
[6] *ibid*, p.701.
[7] *ibid*, p.697.
[8] *National Aboriginal Health Strategy- An Evaluation*, Evaluation Committee, December, 1994, p.3.

- recognition of the importance of local Aboriginal community control and participation …[9]

37. Following a 1993 National Aboriginal Mental Health Conference, a national consultancy was established and in 1995 the findings were published. The report, *Ways Forward – A National Consultancy Report on Aboriginal and Torres Strait Islander Mental Health* was the first specific critical examination of mental health of Indigenous people and its affects on communities. The report contained a series of goals (recommendations) including the establishment of a mechanism for developing, overseeing and monitoring a National Aboriginal Mental Health Policy including the development of baseline data encompassing indicators of mental health for Indigenous people.

38. The report, above all, emphasised the interrelation of poor mental health and social disadvantage. It stressed the critical need to view Indigenous health holistically as opposed to dissecting health into separate spheres of the individual.

> Hence there is a focus on *social* well being or mental health in contrast to an emphasis on *individual* mental health with its connotations of individual pathology.[10]

39. In response to *Ways Forward*, the *Aboriginal and Torres Strait Islander Emotional and Social Well Being (Mental Health) Action Plan* (1996-2000) was introduced in 1996. The *Action Plan* set out priority areas for Commonwealth expenditure for Indigenous mental health initiatives as well as creating a policy framework that aimed to ensure a coordinated approach to serviced delivery. The Plan committed $20 million in funding throughout the period 1996/7 to 1999/2000.

40. The *Action Plan* also emphasised the importance of the relationship between the Commonwealth and State/Territory governments. It proposed to establish Commonwealth/State Aboriginal and Torres Strait Islander Health Framework Agreements which 'will provide a mechanism to inform policy development, planning and priority setting.' State and Territory forums will also be established under the Agreements which will 'be encouraged to set and achieve targets for access by Aboriginal and Torres Strait Islander peoples to mental health services …'.[11]

41. When in 1997 the Human Rights and Equal Opportunity Commission, released *Bringing them home – National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families*[12], the findings of this inquiry once again highlighted, inter alia, the mental health consequences of government child removal policies, as well as the inadequacy and inaccessibility of existing mental health services.

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[9] *The National Aboriginal Health Strategy – An Evaluation*, Evaluation Committee, Dec 1994, p. 2.
[10] Urbis Keys Young, *Evaluation of the Emotional and Social Well Being (Mental Health) Action Plan*, Commonwealth Department of Health and Aged Care, Canberra, 2001, p.2.
[11] *Future Directions in Aboriginal and Torres Strait Islander Emotional and Social Well-Being (Mental Health) Action Plan*, Appendix A 'The Action Plan', in Urbis Key Young, *Evaluation of the Emotional and Social Well Being (Mental Health) Action Plan*, Commonwealth Department of Health and Ageing, Canberra, 2001.
[12] Human Rights and Equal Opportunity Commission, *Bringing them home – National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families*, HREOC, Sydney, 1997.

42. The report found that racial discrimination, cultural ignorance and the inability to recognise or understand the complex causes for mental health among Indigenous people remain as predominant concerns. Many of the recommendations made by the report regarding mental health substantiated and reiterated the findings of *Ways Forward.*

43. The Commonwealth responded to the recommendations of the inquiry by providing $63 million over four years (1998-2001), including $34 million for mental health counselling, $11.25 million for family reunion services and $5.9 million for parenting support programs. The federal government allocated a further $54 million over 4 years in 2002.

44. With regards to specific mental health provisions $17 million was allocated for Regional Health Centres which had been established under the 1996 Mental Health Action Plan.

45. In 2001 Urbis Keys Young delivered its *Evaluation of the Emotional and Social Well Being (Mental Health) Action Plan* to the Federal Government.[13] The Evaluation reported that:

> There has been a great deal of activity in the area of emotional and social well being over the past four years. The level of activity is particularly significant given the very low base from which the field started. Four years ago, emotional and social well being was generally not distinguished from mental health. Today it is seen as a rich, complex and holistic way of understanding wellbeing which has a mental health dimension. At the very least, the Action Plan has played a major role in raising the profile of emotional and social well being amongst mental health professionals.[14]

46. Another area where positive achievements had occurred was in the development of educational curriculum for mental health workers. The Evaluation noted that where curriculum relating to emotional and social wellbeing was previously 'non-existent', there was now at least 15-20 curricula, 'characterised by significant community input and control.'[15]

47. Also noted is that although there had been moderate progress in some areas, improvements still need to be made in others, including cross-agency and cross-sectoral linkages, worker supports and professional supervision.

48. The Evaluation goes on to observe that issues relating to data collection and information system development had been given a low priority and that considerably more work needs to be undertaken in this area.

49. The Evaluation concludes that a significant factor impacting on the implementation of the Action Plan as being:

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[13] Urbis Keys Young , *op cit*.
[14] *ibid*, p.iii.
[15] *ibid*.

> … the inherent tension between the conceptual models of traditional *mental health* and *emotional and social well being*, and between the structures, institutions and professional groups associated with both.
>
> In many instances it has been difficult for emotional and social well being issues to develop a profile within mainstream mental health units which explicitly state that their focus continues to be on moderate and severe mental illness. In the resource-constrained contexts in which mental health professionals work, often this means social health (seen as the 'soft' end of the mental health spectrum) misses out. In other words, it is so hard to gain support for emotional and social well being initiatives where those who are in a position to assist operate according to a different conceptual model.[16]

50. The current document for the delivery of Indigenous health services is the *National Strategic Framework for Aboriginal and Torres Strait Islander Health* (2003) The Framework was developed by the National Aboriginal and Torres Strait Islander Health Council (NATSIHC) and is based on the 1989 *National Aboriginal Health Strategy* (NAHS). It is not meant as a replacement to the NAHS but rather to complement it. The Framework also took into consideration the recommendations of the *Royal Commission into Aboriginal Deaths in Custody* (1991) and the *Bringing them Home – the National Inquiry into the separation of Aboriginal and Torres Strait Islander children from their families* (1997), as well as incorporating the findings of *Health is Life – the report on the Inquiry into Indigenous Health* (2000). The Framework also considered (where existing) State/Territory policy frameworks for the delivery of Indigenous health services.

51. The Framework has received the support of Federal, State and Territory governments. The implementation of the Framework relies on each jurisdiction developing its own 'specific initiatives, priorities and timeframes.'[17] These individual implementation plans will form the basis on the reporting of progress and will be examined later in this paper. State and Territory implementation plans are critical to advancing the aims of the National Framework because each jurisdiction is more able to identify priorities and develop benchmarks.

> This *National Strategic Framework* sets agreed directions for reform in Aboriginal and Torres Strait Islander health without imposing specific targets or benchmarks on individual governments in recognition of the different histories, circumstances and priorities of each jurisdiction. Therefore annual reporting will record progress against each government's implementation plan, consistent with this *National Strategic Framework* and will, over time, chart each government's progress against their own baselines.[18]

52. In 2003 the Social Health Reference Group[19], released a *Consultation Paper for the Development of the National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Well Being 2004-2009.*

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[16] *ibid*, p.69.
[17] National Aboriginal and Torres Strait Islander Health Council, *National Strategic Framework for Aboriginal and Torres Strait Islander Health – Context*, NATSICH, Canberra, July 2003, p.ii.
[18] *ibid*, p.vii.
[19] The Social Health Reference Group has a membership reflecting interests within Aboriginal and Torres Strait Islander health, mental health and community sectors. It was formed to oversee the revision of the Social and Emotional Well Being Action Plan. The prime terms of reference for the

53. The consultation paper was the result of consultations held in April and May 2003 with a view to developing a National Strategic Framework that all governments would commit to.

54. The consultation paper explained that the aim of the process was to outline a broad National Strategic Framework that:

> can be implemented by all governments, the Aboriginal Community Controlled Health Sector and other non-government organisations over the next five years. It emphasises support for community control and autonomy and the development and delivery of State, Territory and local partnerships that are consistent with national policy and process.[20]

55. The Strategic Framework aims to improve social and emotional well being and mental health service delivery.

> As such, the document touches on a range of issues that must be addressed in order for social and emotional well being to be improved, including broad issues such as socio-economic status and racism, and the work of various sectors such as employment, education, housing, justice, Aboriginal and Torres Strait Islander affairs, and family and children's services. It is written this way in recognition of the need for a coordinated, whole-of-government approach led by the community. [21]

56. The National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Well Being 2004 – 2009 has been signed off by the Australian Health Ministers Advisory Council (AHMAC) and was due for release in March 2005 however, at the time of writing, it had still not been released.

Submission 1: That the Government release the National Strategic Framework and for relevant authorities to commence implementation of framework initiatives.

Submission 2: That the Framework initiatives be adequately resourced, monitored and evaluated.

Quantifying the problem

57. While there is anecdotal evidence that mental health issues significantly affect the lives of Indigenous people, very little quantification has occurred:

Reference Group are to: develop a revised strategic framework for Aboriginal and Torres Strait Islander emotional and social wellbeing that incorporates a five year plan for action in the Aboriginal community controlled health sector and links to the recently endorsed National Mental Health Plan with a focus on implementation of existing policies and commitments.

[20] Social Health Reference Group (2003) *Consultation paper for development of the Aboriginal and Torres Strait Islander National Strategic Framework for Mental Health and Social and Emotional Well Being 2004- 2009*, Commonwealth Department of Health and Ageing, Canberra, p.vii.

[21] *ibid*, p.3.

- The 1996 national consultancy, *Ways Forward,* reported that mental health problems significantly affected at least 30% of Indigenous communities[22].

- Urban studies in the 1990s reported that between about one quarter and 54% of people attending Aboriginal medical services had a mental health disorder. Women tended to present earlier, while men's first presentation was often following involuntary admission into acute psychiatric care[23].

58. The Western Australian Aboriginal Child Health Survey (WAACHS) Vol. 2, released in April 2005 marks a watershed in the quantification of Indigenous mental health problems. The sample was 5,289 children surveyed through their primary carers and, when appropriate, through self-assessment. It reported that 1 in 4 Indigenous children are at high risk of developing clinically significant emotional or behavioural difficulties. This compares to about 1 in 6 to 7 of non-Indigenous children. [24]

59. Research has also indicated that children with poor mental health have a greater tendency to develop into adults with poor mental health.

- *Suicide and other forms of self-harm*: In 1998, Indigenous males committed suicide at 2.6 times the rate in the non-Indigenous population; for females the rate is double that of females in the non-Indigenous population[25]. In 2000-01, Indigenous males were hospitalised at 2.2 times the rate of males in the general population and females at 2.0 times the rate of females in the population for intentional self-injury[26]. The National Health Survey in 2001 reported 10% of Indigenous people were likely to consume alcohol at risk or high-risk levels, compared with 11% of non-Indigenous people[27]. However, this finding contrasts with other sources that report Indigenous people consuming alcohol at risk levels twice that of the non-Indigenous community[28]. Apart from alcohol, substance abuse is reported to be higher in Indigenous communities[29].

- *Indicators for other forms of harm behaviours:* Violence is symptomatic of poor mental health in perpetrators and is associated with substance abuse. It is also stressor to the mental health of victims. Violence kills Indigenous people at four times the rate of the non-Indigenous population. Reported physical, or threatened physical, violence, appears to have doubled over 1994 - 2002: 12.9% of respondents in 1994 identifying as victims, compared to 24.3% of respondents in

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[22] Swan P, Raphael B, *Ways Forward: National Consultancy Report on Aboriginal and Torres Strait Islander Health*, National Mental Health Strategy, AGPS, Canberra, 1995.
[23] Hunter, E, 'Mental Health' (eds) Thomson, *The Health of Indigenous Australians, O*xford University Press, Melbourne, 2004, p. 141.
[24] Telethon Institute for Child Health Research, *The Social and Emotional Wellbeing of Aboriginal Children and Young People*, Perth, Summary, 2005, p.8.
[25] Cuzos, S. & Murray, R., *Aboriginal Primary Health Care – An evidence based approach*, Oxford University Press, Melbourne, 2003, p.618.
[26] Australian Bureau of Statistics, Mental Health in Australia, a snapshot, Cat no. 4824.0.55.001, 2004
[27] Australian Bureau of Statistics, *National Health Survey, Aboriginal and Torres Strait Islander Results, Australia 2001*, cat no 4715.0, p 33, Table 14.
[28] *ibid.*
[29] Australian Bureau of Statistics, AIHW, *The Health and Welfare of Aboriginal and Torres Strait Islander People 2003*, series cat no. 4704.0, Commonwealth of Australia, Canberra p176, table 8.11.

2002[30] in Indigenous social surveys. In 2001, Indigenous females were 28.3 times more likely to be hospitalised for assault than non-Indigenous females; males at 8.4 times the non-Indigenous rate[31].

60. While the WAACHS identifies Indigenous children to be at risk, these indicators suggest that there are significant mental health problems in the Indigenous adult population. However, in the absence of adequate data collections, it is not possible to ascertain the extent. A first step in any address to Indigenous mental health is to address the paucity of data collections in this area.

61. There are many reasons as to why obtaining accurate detailed information is difficult. First, there is an incomplete identification of Indigenous people in census data (i.e. people not identifying) as well as in administrative data (i.e. hospital records). Second, it is difficult to collect data from remote communities. Third, primary health care providers such as Aboriginal health workers and drug and alcohol workers do not have a uniform process whereby to collect data. In other words there is currently no national data collection process that is able to provide accurate information on the incidence of mental health disorders or treatment occurring among Aboriginal and Torres Strait Islanders.

62. The Australian Institute for Health and Welfare (AIHW) in identifying these problems believe that poor and inadequate data collection methods can be improved if efforts are made at all levels. Accordingly the AIHW proposed that the 2004-2005 National Aboriginal and Torres Strait Islander Health Survey include a model to access various aspects of the social and emotional wellbeing of Aboriginal and Torres Strait Islander people.

Submission 3: Data collections in relation to Indigenous mental health should be funded to enable the extent of mental health problems in communities and among Indigenous peoples to be quantified to provide an adequate evidence base for policy makers and an adequate basis for the funding of Indigenous mental health programs and facilities.

Prevention

63. Public health emphasises prevention above cure. Understanding the causes of poorer mental health among Indigenous peoples is the key to prevention. In that regard Indigenous peoples have asserted that their health, including mental health, cannot be treated as a discrete issue; the *National Aboriginal Health Strategy* (NAHS, 1989) proposing that:

> Health to Aboriginal peoples is a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self-

[30] *ibid*, p.32 - please note that this could indicate a greater propensity on the part of respondents to identify themselves as victims, rather than an actual increase.
[31] *ibid*, p.176-177.

> esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity.[32]

64. Since the NAHS it has been identified that the stress caused by the social environment operates as a physical and mental health determinant. It is referred to as a 'psychosocial' because it involves the interaction the 'objective' social environment and the 'subjective' perceptions a person might have about it. The greater the degree of control a person has over their life and the greater the degree they feel they can participate in (influence) the way their social environment operates, the better their physical and mental health will be[33].

65. Two individuals living in an identical social environment may not experience the same level of psychosocial stress: this relates to personal resilience. An important variable that impacts on this is social cohesion and support.

66. In terms of the mental health of Indigenous people in Australia, it is important to consider the impacts of the community environment and the wider environment, including its political dimensions.

Environment within communities

67. The Royal Australian College of Physicians recently reported that the combination of problems suffered within Indigenous communities is *the* prime example of negative social determinants of health in Australia[34]. Violence and addiction in communities undermines the resilience of members and erodes the capacity of communities to support the mental health of members. The impact of addiction on communities has been most closely observed in relation to alcoholism[35], although petrol sniffing and other substance abuse must be considered in relation to some communities.

68. Social support and social cohesion are associated with good mental health. Studies show that people in long-term, familial relationships and close-knit communities are better able to deal with stress and will live longer than those who do not[36]. While dysfunctional communities have been the subject of media attention over the past few years, it is interesting to note that the WAACHS found that the environmental safety and health (ESH) of Indigenous children improved with isolation (i.e. in remote communities). Children living in Perth had significantly poorer (five times worse) ESH than those living in very remote communities. The WAACHS evaluation concludes that traditional cultures and ways are protective against poor ESH. The WAACHS also reported that 1 in 4 Indigenous children were being raised in families with a 'poor quality of parenting'; 1 in 5 in families that functioned poorly. Thirty four per cent of children were being raised in single parent families. These children had twice as high rates of poor ESH as those living with both original parents.[37]

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[32] National Aboriginal Health Strategy Working Group, *National Aboriginal Health Strategy,* AGPS, Canberra, 1989, p. ix.
[33] Marmot, M, *Status Syndrome*, Oxford University Press, London, 2004, p3.
[34] *ibid.* http://www.racp.edu.au/hpu/policy/richer/partic1.htm
[35] Stansfeld, S. 'Social Support and Social Cohesion', in Marmot, M. and Wilkinson. R., *The Social Determinants of Health*, Oxford University Press, New York, 1999, p155.
[36] *Ibid*, p. 266.
[37] Telethon Institute of Child Health Research (Telethon), *op cit*, p.9.

69. Particular traumas: war, natural disasters, large-scale human rights violations and so on are psychosocial stressors on individuals (*Bringing them home*, 1997, reported the forced removal of Indigenous children affected the majority of Aboriginal families throughout Australia, in one or more generations and to have had a range of traumatic mental health impacts).[38] The WAACHS reported that the children in the care of carers who were forcibly removed were 2.3 times more likely to be at high risk of clinically significant emotional or behavioural difficulties than in the care of carers not removed.[39]

70. Strengthening communities and culture clearly has potentially positive implications for the mental health of community members. Likewise, policies and programs that erode the strength and culture of communities can be considered as having negative impacts on community members.

Non-Indigenous Australia as a social environment

71. Racism, and related forms of discrimination, can be considered examples of a health determinant with a collective dimension. It can be thought of as having three inter-dependent layers:

- Institutionalised racism: evidenced by differences in socio-economic status and 'ghettoes' it is usually the outcome of historical events in which one race was subjugated to the will of another (for example, the enslavement of Africans in the United States and the dispossession of Indigenous peoples in Australia);

- Personally mediated racism: police brutality, disrespect, name calling, and so on;

- Internalised racism: hatred of self and other members of group.[40]

72. Some of the dimensions of racism, through policies involving the reconciliation of racial groups, are amenable to change. Living free of racism and racial discrimination is a fundamental human right. To the degree human rights can inform policies to combat racism they can be thought of as health measures. In respect to this, *Health is Life* reported that 'a meaningful reconciliation' would be 'likely to contribute to long term improvements in [Indigenous peoples] health and welfare'[41].

73. Other collective dimensions go deeper. The sense of *individual* personal control and power is one dimension of control; collective control is a further one. In relation to Indigenous peoples, it may be that *collective* control constitutes a dimension of psychosocial determinants. Collective control is linked to the human right to self-determination. This idea that psychosocial determinants have a collective dimension remains at the cutting edge of research:

> A… complex problem involves the potential health impacts associated with violating individual and collective dignity. The Universal Declaration of Human Rights

[38] Swan P, Raphael B, *op cit.*, p.37.
[39] Telethon, *op cit.* p.11-13
[40] Jones C, *Maori-Paheka Health Disparities*: *Can Treaty Settlements Reverse the Impact of Racism*, Ian Oxford Fellowships Office, Wellington, 1999.
[41] HRSCFCA, *Health Is Life: Report on the Inquiry into Indigenous Health*, Commonwealth of Australia, Canberra, 2000, p.7, Rec 2

> considers dignity, along with rights, to be inherent, inalienable and universal. While important dignity-related impacts may include such problems as the poor health status of many indigenous peoples, a coherent vocabulary and framework to characterize dignity and different forms of dignity violations are lacking. A taxonomy and an epidemiology of violations of dignity may uncover an enormous field of previously suspected, yet thus far unnamed and therefore undocumented damage to physical, mental and social well being.[42]

74. Indigenous peoples have asserted that their health is influenced by psychosocial factors arising from their socio-political situation. The NAHS proposed that:

> The Australian state by way of its Governments must address the very real issue of Aboriginal Peoples' indigenous rights. If this is not done in the implementation of this report will see much of the same of what colonialist-Australia's history now tells us, and at the very most, only marginal improvements [in health] are likely to occur.[43]
>
> In order to achieve the necessary improvement in Aboriginal health, Aboriginal people believe they must again be able to control their destiny and to accept responsibility for their own decision-making.[44]

75. Internationally, Indigenous peoples have linked their health to the recognition of their human rights. The *Geneva Declaration on the Health and Survival of Indigenous People* (1999) issued after an international consultation on the health of Indigenous peoples, organised by the World Health Organization declared Indigenous health to be a 'collective and individual inter-generational continuum encompassing a holistic perspective'[45] and that the:

> philosophy and principles contained in the *United Nations Draft Declaration on the Rights of Indigenous Peoples* and all existing international instruments dealing with human rights and fundamental freedoms [were] essential for the attainment of the health and survival of Indigenous Peoples.[46]

76. There have been very few studies undertaken or completed to provide an evidence base to support the idea of these collective dimensions to psychosocial determinants. However, a number of reports have made the association for Indigenous peoples in Australia:

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[42] Mann J, Gostin L, Gruskin S, (*et al*) 'Health and Human Rights', *Health and Human Rights: An international journal* Vol 1, No 1, Fall 1994 http://www.hsph.harvard.edu/fxbcenter/V1N1.htm (Accessed 5 May 2003.)

[43] National Aboriginal Health Strategy Working Party, *National Aboriginal Health Strategy*, AGPS, Canberra, 1989, p. xiii.

[44] *ibid*

[45] *Geneva Declaration on the Health and Survival of Indigenous People* (1999), World Health Organization consultation on indigenous health, Geneva, 23-26 November 1999, Part II: http://www.healthsite.co.nz/hauora_maori/resources/feature/0001/002.htm

[46] *ibid*, Part I.

- Cumulative mental health impacts caused by failures to protect and respect rights including those stemming from racism, discrimination and marginalisation were noted in the report of the *Royal Commission into Aboriginal Deaths in Custody* (1991).[47]

- *Ways Forward* (1996) reported the following stressors acting upon Indigenous mental health:

    - Collective and intergenerational trauma and loss as a direct result of colonisation and the ensuing disruption to cultural well-being;

    - Failure to respect Indigenous people's human rights. This was described as constituting a continuous disruption to Aboriginal well being resulting in increasing mental ill health'.[48] In particular, 'self determination is central to Aboriginal people's well-being and 'denial of this right contributes significantly to mental ill-health':[49]

    - Racism, stigma, environmental adversity and social disadvantage. The report stated that these 'constitute ongoing stressors and impact in very negative ways on… mental health and well being'. It recommended that 'any strategies to improve mental health and well-being must address these structural issues'.[50]

77. Research into these areas remains inadequate as was noted recently:

> Research into the health status of [Indigenous] peoples must begin to focus beyond statistical data… Some researchers have observed that 'there is abundant evidence that psychosocial factors have a profound impact on health', but that 'little research to date has targeted the possible biopsychosocial pathways by which social, environmental and contextual conditions of living affect health'. Indeed, the Australian Institute of Health and Welfare, while recognising the multiplicity of factors that might account for poor health status, relies predominantly on biomedical indicators of health. This fails to embrace the less easily measured aspects of community living and wellbeing, now deemed to be of prime importance by Indigenous peoples and public health researchers alike.[51]

78. The Commssion's fourth submission therefore is to address the paucity of research into the causes of poor Indigenous mental health:

Submission 4: That research is conducted in relation to Indigenous mental health to enable the identification of social, environmental and contextual causes of poor Indigenous mental health and the implications for governments.

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[47] Johnston E, *Royal Commission into Aboriginal Deaths in Custody, National Report, Volume 4, (Five volumes)*, AGPS, Canberra, 1991, para. 31.3.4 and 31.2.40.
[48] Swan P, Raphael B, *op cit.* p13.
[49] *ibid*, p.21.
[50] *ibid*, p.14.
[51] Atkinson J, Graham J, Petit G *(et al*): 'Broadening the focus of research into the health of Indigenous Australians', *Medical Journal of Australia* Vol 177, 16 September 2002, p.286.

Impact of the New Arrangements in Indigenous Affairs

79. The new arrangements for Indigenous affairs, as are being currently implemented, provide an opportunity for an improved and enhanced coordination of service delivery as well as an opportunity for improvement to funding processes. On 30 June 2004 the Government announced that more than $1 billion of former ATSIC/ATSIS programs have been transferred to mainstream government agencies. The emphasis of the mainstreaming was, and is, to provide better coordination of services and programs between and across agencies. Further goals of the new arrangements are the development of a coordinated and flexible approach to resource allocation and closer interface between bureaucracy and Indigenous clientele. The latter would foster a more collaborative approach to addressing the economic and social issues experienced by Indigenous peoples.

80. This is intended to involve developing ways to use funds more flexibly—for example, by pooling funds for cross-agency projects or transferring them between agencies and programs so they better address the needs and priorities of communities. The single budget submission for Indigenous affairs will promote this approach.

81. The Office of Indigenous Policy Coordination (OIPC) will be responsible for coordinating whole of government policy, program and service delivery across the Australian Government; developing new ways of engaging with Indigenous people at the regional and local level; brokering relationships with other levels of government and the private sector; reporting on the performance of government programs and services for Indigenous people to inform policy review and development; managing and providing common services to the ICC network; and advising the Minister and Government on Indigenous issues.[52] The OIPC also has a state office in each State and Territory to coordinate activities at the state level.

82. Indigenous Coordinating Centres (ICCs) will coordinate the service-delivery of all federal departments at the regional level. They are intended to provide Indigenous people and communities with a single point of contact with Australian government departments. The Government has described each ICC as a whole of Australian government office, with staff from multiple agencies, headed by a manager who is the focal point for the engagement with stakeholders and who is responsible for coordinating the efforts of all agencies in their dealings with clients on a whole of government basis.[53]

83. In the Social Justice Report 2004, the Social Justice Commissioner expressed concern about the consequences for existing planning and coordination structures which have involved Indigenous representation through ATSIC. He noted:

> A consequence of the proposed abolition of ATSIC is that there are challenges raised for existing framework agreements and structures which rely on the ATSIC structure to ensure Indigenous participation and representation. This is noticeable in relation to health and housing issues.
>
> The *National Strategic Framework for Aboriginal and Torres Strait Islander Health* (National Strategic Framework), sets the policy direction in Indigenous

52 *ibid*, p7.
53 *ibid.*

health until 2013[54]. It is a guide for local, regional and state/territory planning by health sector planning forums established under the *Framework Agreements for Aboriginal and Torres Strait Islander Health* in each state and territory. The planning forum partners are the Commonwealth (the Office of Aboriginal and Torres Strait Islander Health - OATSIH), the state/territory (the relevant Department of Health), the state/territory affiliate of the National Aboriginal Community Controlled Health Organisation (NAACHO)[55] and ATSIC.

NACCHO has expressed concern that the abolition of ATSIC 'removes an Aboriginal representative voice from the… [planning] forums… with potentially significant consequences'[56]. These include the undermining of the forums partnership processes by virtue of Aboriginal representative bodies suddenly assuming a minority position. This is critical because this balance allowed for accountability in the forums. As NACCHO note: '[t]he buck passing between Commonwealth and States has always been a major impediment to reform in Aboriginal health… the Framework Agreements are intended to address this area'[57].

Submission 5: That federal and state and territory governments work collaboratively with Indigenous peoples at the community level to identify and address mental health issues as well as to develop and implement education and preventive programs in relation to mental health needs of the community.

84. The Government needs to provide more detail to communities and services deliverers regarding the impact of the new arrangements. Currently there seems to be little information among individual Indigenous communities on how the specifics of the new arrangements such as funding models and operations will be implemented. There is a need to maintain focus on issues of national importance such as mental health, which may not be voiced at a regional level. It is not yet clear as to how the new arrangements will integrate mental health funding and services.

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[54] National Aboriginal and Torres Strait Islander Health Council, *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013*, Commonwealth of Australia, 2004, p.10.

[55] Ensuring Aboriginal and Torres Strait Islander peoples' access to primary health care is considered a key to reducing the gross and long standing health and life expectation inequality between them and the non-Indigenous population. Aboriginal Community Controlled Health Services (ACCHS) are universally acknowledged as the best ways to deliver primary health care to Aboriginal and Torres Strait Islander peoples. ACCHS are represented nationally by the National Aboriginal Community Controlled Health Organisation (NAACHO), with state and territory affiliates.

[56] NACCHO, *Submission to the Senate Select Committee on the Administration of Indigenous* Affairs, August 2004, p9. http://www.aph.gov.au/Senate/committee/indigenousaffairs_ctte/submissions/sub179.pdf (Accessed, December 1, 2004)

[57] *Social Justice Report 2004*, p.101.

85. The following submissions (6-9) made in relation to the new arrangements in Indigenous affairs are replicated from the *Social Justice Report 2004.*

Submission 6: That the Office of Indigenous Policy Coordination conduct a comprehensive information campaign for Indigenous people and communities explaining the structures established by the new arrangements and the processes for engaging with Indigenous people. This information must be disseminated in forms that have regard to literacy levels among Indigenous peoples and English as a second language.[58]

Access to Services

86. Analysing available data the *Consultation Paper for the Development of the National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Well Being 2004-2009* was able to surmise that:

- 74% of residents of discrete Aboriginal and Torres Strait Islander communities have inadequate access to visiting or resident mental health workers (communities more than 10km from hospital services, and with less than once per month).[59]
- Aboriginal and Torres Strait Islander people have disproportionately low access to general practitioners and private medical specialists, such as psychiatrists.[60]
- Aboriginal and Torres Strait Islander people, like other low socio-economic groups, over-utilise free services such as public hospital services and community health services, rather than private practitioner services where co-payments are required, such as Medicare and Pharmaceutical Benefits.[61]

87. The consultation paper reveals that:

> …despite high rates of need, low access to community based public or private mental health services, and service preference, only 38% of Commonwealth funded Aboriginal Community Controlled Health Services have a dedicated mental health or social and emotional well being worker (OATSIH/NACCO 2001 Service Activity Reports).[62]

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[58] *ibid*, Recommendation 3.

[59] Social Health Reference Group, *Consultation Paper for the Development of the National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Well Being 2004-2009*, Commonwealth Department of Health and Ageing, Canberra, 2003, p.10. (unpublished ABS data provided to DOHA).

[60] Keys Young, *Market Research into Aboriginal and Torres Strait Islander Access to Medicare and the Pharmaceutical Benefits Scheme*, Health Insurance Commission, Canberra, 1997 as cited in [60] Social Health Reference Group, *Consultation Paper for the Development of the National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Well Being 2004-2009*, Commonwealth Department of Health and Ageing, Canberra, 2003, p.11.

[61] Australian Institute of Health and Welfare, *Expenditure on health services for Aboriginal and Torres Strait Islander People*, AIHW, Canberra, 2001, Cat No.IHW7 as cited in Social Health Reference Group, *Consultation Paper for the Development of the National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Well Being 2004-2009*, Commonwealth Department of Health and Ageing, Canberra, 2003, p.11.

[62] Social Health Reference Group, *Consultation Paper for the Development of the National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Well Being 2004-2009, op cit*, p11.

88. This submission supports the following priorities as identified by the Social Health References Group's consultation paper.

- Ensuring that inpatient care is culturally sensitive and takes account of comorbidities
- Increase resources to Aboriginal Community Controlled Health Services to meet the increasing mental health and social and emotional well being needs placed upon the Aboriginal and Torres Strait Islander primary health care sector.
- Reforming mainstream and private provider community based mental health care to better meet the needs of Aboriginal and Torres Strait Islander consumers.
- Taking cross-sectoral action to reduce the impact of socio-economic and health disadvantage on the social and emotional well being of future generations.[63]

89. Government also needs to deal directly with Aboriginal and Torres Strait Islander people and communities as well as collaborate with primary health care providers in order to develop and deliver culturally appropriate services.

90. Consultation with community and providers will ensure that there is a focus on integrated primary mental health care services (incorporating mental health, family violence and substance abuse services) being accessible to Indigenous Australians. These are most likely to be provided through the rolling out of comprehensive primary health care services through the PHCAP[64] scheme and through the *National Strategic Framework for Aboriginal and Torres Strait Islander Health.*

Submission 7: That services delivered directly by government and those funded to by governments ensure broad access to Indigenous people and communities to those services.

Submission 8: That services developed for Indigenous people and communities are done so in consultation with Indigenous people and primary health care providers.

Submission 9: That services ensure care is culturally sensitive and takes account comorbidities

Conclusion

91. There is still much to be done in order to improve and advance the social and emotional well being of Aboriginal and Torres Strait Islander people who, for a variety of reasons, experience poorer mental health relative to non-Indigenous

[63] *ibid*

[64] The Primary Health Care Access Program (PHCAP) provides a framework for ensuring needs-based planning and allocation of funding; for collaboration between mainstream and Indigenous providers – see Review of the Australian Governments Aboriginal and Torres Strait Islander Primary Health Care Program of the Office for Aboriginal and Torres Strait Islander Health (OATSIH) website http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-oatsih-pubs-reviewphc.htm-copy8

Australians. There is a body of evidence that suggests systemic discrimination and disempowerment and economic and social disadvantage are contributing to this situation. Unless these broad issues are addressed, there may not be an improvement to the mental health of Indigenous Australians.

92. In the meantime, attention must be paid to ensuring integrated primary mental health care services (incorporating mental health, family violence and substance abuse services) are accessible to Indigenous Australians. These are most likely to be provided through the rolling out of comprehensive primary health care services through the PHCAP scheme and through the *National Strategic Framework for Aboriginal and Torres Strait Islander Health.* There is also a need for a significant increase in funding to clinical services for Indigenous Australians, particularly attention needs to be paid to ensuring they are physically and culturally accessible. Programs must be put in place to address the needs of Indigenous carers of the long-term mentally ill living in the community.