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Submission to the Senate Select Committee Inquiry into Mental Health Services

Central Australian Aboriginal Congress is a large Aboriginal community controlled health service in Alice Springs in the Northern Territory. We deliver comprehensive primary health care services to a resident population of about 6000 people and about 1500 visitor annually. We operate a clinic, pharmacy, transport service, dental service a women's health and birthing service, a Children's program, a Male Health program, a Frail Aged and Disabled Program, Aboriginal Health Worker Training Program, a child care centre and a range of public health, policy and advocacy services. We also run a Social and Emotional Health Branch (SEHB) which provides a range of counselling and other services including a youth program. The SEHB employs a psychologist, social workers, counsellors, an Aboriginal Mental Health Worker and other staff.

Congress has highlighted key issues in relation to Aboriginal social and emotional well being services which have informed key reports including the National Aboriginal Health Strategy Working Party Report, the Royal Commission into Aboriginal Deaths in Custody, the Human Rights and Equal Opportunities Commission report and the Dr. Yellowlees' Report on the Review of Mental Health Services in Central Australia. We attached copies of the submissions Congress made to the Human Rights and Equal Opportunities Commission and the Yellowlees Inquiry as some of the issues are still relevant.

There have been some successes in recent years. Some initiatives in the promotion of people with social and emotional well being problems into the workforce have been useful. Some of the initiatives to continue the development of community based crisis teams have been positive. The continuing development of partnerships with community based organisations in general, and Aboriginal community controlled health services (ACCHS) in particular, is heading in the right direction. Some initiatives around suicide prevention including school based programs under Mind Matters also look promising. Some initiatives for carers are working reasonably well.

We will specifically respond to the terms of reference.

a. To what extent has the National Mental Health Strategy achieved its aims and objectives? What are the barriers to its progress?

The National Mental Health Strategy recognised the need to integrate mental health services with primary medical care and primary health care services. The Northern Territory Aboriginal Health Forum has developed a Strategic Plan for Social and Emotional Well Being Services in the NT (2003) and there is a lot of relevant information in this plan for consideration by the select committee (see attached). One of the main strategic aims in this plan is the need to ensure that there are multidisciplinary social health teams working within Aboriginal primary health care services including psychologists, social workers, Aboriginal mental health workers and liaison officers.

The way in which General Practice services in the mainstream are structured, largely in accordance with the private practice model, does not readily provide opportunities to co-locate or fully integrate social and emotional well being services. However, where comprehensive primary health care services already exist, such as in the Aboriginal health context, this possibility is there but the way in which mental health funding is separated from health service funding is a key barrier to the realisation of this model. A key issue for the future development of social and emotional well being services within the Comprehensive primary health care sector, such as our Social and Emotional Well Being Service, is the need to get State and Territory governments to contribute recurrent funding into the centres using mental health specific funds.

The Commonwealth / State mental health agreements ensure that the bulk of all mental health monies are given to the States and Territories and there is no mechanism to provide direct funding to ACCHS. Even though these agreements suggest that States and Territories should provide funds to NGOs, including ACCHS, this has not happened to any significant extent in the NT.

This is in spite of the fact that the following reports recommend that resources be provided to Aboriginal community controlled health services for culturally appropriate social and emotional well being services:

1. The National Aboriginal Health Strategy (1989)
2. The Royal Commission into Aboriginal Deaths in Custody (1991)
3. The Human Rights and Equal Opportunities Commission report (1993)
4. Dr. Yellowlees' Report on the Review of Mental Health Services in Central Australia (1994)
5. Strategic Plan for Social and Emotional Well Being Services in the NT (2003)
6. (Draft) Aboriginal & Torres Strait Islander National Strategic Framework for Mental Health & Emotional and Social Wellbeing (2005)

A research project by the *Menzies School of Health Research* into mental health services in Central Australia revealed that there are major inefficiencies in the way mental health resources are being allocated, especially in the community sector, because the services are not meeting the needs of Aboriginal people. This is especially apparent for the ‘community’ mental health services run by the Northern Territory Department of Health and Community services (DHCS). There are a significant number of psychologists and other mental health staff in this sector who are seeing very few Aboriginal clients each year. Positions are left unfilled in spite of the fact that the Aboriginal community has a large unmet need for these services. In contrast to the lack of access that Aboriginal people have to DHCS community social and

emotional well being services they have high levels of access to ACCHS but these services do not have specific mental health resources.

The access issues are complex and there are a number of levels to be considered. Firstly, issues of physical access are important – it is difficult to recruit and retain an adequate supply of health professionals in remote areas, including mental health professionals. Congress has been successful in recruiting and retaining a stable primary health care workforce of GPs, AHWs, nurses etc. Congress has also been successful in recruiting and retaining a psychologist, social workers and other counsellors. Congress provides an interesting and challenging work environment that offers the opportunity for health professionals to be well supported as part of a multidisciplinary team within a comprehensive primary health care service. In contrast to this situation, community mental health has had very high staff turnover amongst similar types of health professionals.

Access to psychiatrists is a special issue. For the last 15 years the principal psychiatrist in Central Australia has been an overseas trained specialist who has considerable language difficulties in English. We have been fortunate in having a very good community psychiatrist, however, a psychiatric registrar position, although funded, has never been able to be filled. Given the population of Central Australia there should be around 4 full time psychiatrists and the Department of Health and Community Services (DHCS) has only been able to recruit and retain one Australian trained psychiatrist. This is a major workforce issue that needs to be considered by the select committee. There are insufficient psychiatrists being trained and those that are trained are choosing to work in the private sector in capital cities. This is a generic issue across many specialties but it is time to consider greater regulation by government of the medical workforce to ensure better access for Aboriginal people especially in remote areas. Congress has been proposing for many years the need to use non financial incentives as a means to address the inequity in the distribution of the medical workforce. In the case of psychiatry there should be preferential access to training given to doctors who have demonstrated that they can work in rural and remote areas and Aboriginal health as some of these are likely to return once trained. In addition, some psychiatry places should be bonded so that entry is contingent on a commitment to work in areas of need, especially where there are large numbers of Aboriginal people.

The second access issue is culture and gender access. These issues are probably the main reason why Aboriginal people do not utilise community mental health – they do not feel comfortable or culturally safe going to such services for two reasons. Firstly, they are mainstream services that are not specifically set up to service Aboriginal people. Secondly, many patients do not want to identify as having a social and emotional well being problem and are often much more likely to access a GP or an AHW in an ACCHS as their first point of contact rather than a specific social and emotional well being service. These issues can be partly overcome when social and emotional well being professionals work within ACCHS, are retained for long periods and get to know their patients and the community they are working in very well.

Finally, there is the issue of economic access. It is imperative that social and emotional well being services are available without a co-payment from patients at the time of using the service. Given the access difficulties already discussed it would be

tragic indeed if the inability to pay is an additional barrier. In many ways this is the access issue that is the easiest for government to address. Congress has achieved very high levels of access for Aboriginal people in Alice Springs and the surrounding region to our service in which there is no payment at the point of service delivery and transport is available.

In addition to the access issues to primary health care and social and emotional well being specific services there is the further issue of access to program funding. In 1997 when Alice Springs began experiencing a major upsurge in the rate of youth suicides Congress called a meeting of all Aboriginal organisations in Alice Springs and established an Aboriginal youth committee to discuss the problem and help to develop potential solutions. In spite of this process Congress was unable to access any of the national youth suicide prevention funds to establish programs in accordance with community proposals because all of this money had been given to the states and territories.

Congress met with Dermot Casey in Canberra to discuss this problem (Harvey Whitehead was in the US at the time). He informed Congress that all the youth suicide prevention money had been given to the NT but that the Commonwealth expected that the NT would provide some funds to community organisations such as Congress. This did not occur and additional monies then went into the NT Life Promotion program which is not within Aboriginal community controlled health services and is not directly informed by Aboriginal community needs and actions. These funds have since been transferred to a non Aboriginal mental health NGO but given that the principal need is in the Aboriginal community we do not think this is the best option. Aboriginal community controlled organisations have the best chance of providing such programs in a manner which will meet the needs of their communities and achieve health outcomes.

Because of the difficulties that Aboriginal people are experiencing in accessing funding for social and emotional well being services and programs OATSIH are having to primarily use their PHC resources to fund the delivery of social and emotional well being services within Aboriginal community controlled PHC services. Such services should be funded with mainstream Mental Health specific funds.

There is also an ongoing need to address the broader social determinants of mental illness including alcohol and other drug use and unemployment. This is added to by a crisis in public housing services to meet known need and lack of adequate shelter is known to be a major life stressor. We have a growing crisis in Central Australia of a homeless transient Aboriginal population with dual diagnosis who are really struggling. They are also causing distress and problems to other families and the general community. There is growing political pressure to criminalise and imprison this group of mostly male, inhalant or poly drug taking people who are sometimes cognitively impaired and who experience psychotic episodes.

Further, difficulties or barriers are in the areas of accommodation and treatment capacity in the acute care, step down or crisis care areas, and in medium and longer term supportive communities for people with a history of admission to a psychiatric admission centre

b. Comment on the adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care

Prevention:
Congress believes that the ongoing counselling, support and education we do in the community assists in the area of secondary prevention. Such counselling includes art therapy, narrative therapy, family therapy as well as general counselling. Our team attend interagency forums that discuss key issues etc in central Australia and participate in joint case management of difficult clients. Working with young people and families in the community, about social and emotional well being and keeping your mind healthy also helps to prevent problems getting worse.

Primary prevention requires a greater focus on the social determinates of mental illness amongst Aboriginal people. This includes the need to recognise and address the historical trauma created by the experience of colonisation and dispossession as well as the specific trauma of the Stolen Generations. It has been suggested that the extent of this trauma is such that many Aboriginal people are suffering from symptoms suggestive of Post Traumatic Stress Disorder. This has been more extensively described for Aboriginal people in Canada but is almost certainly true in Australia as well.

Early Intervention:
The new 710 Adult health check for Aboriginal people provides an opportunity for the early detection and referral of patients with social and emotional well being problems. All health professionals however need to be adequately trained to make this assessment and refer appropriately. When patients are referred with the early diagnosis of mental illness it is also important that they are able to access evidence based treatment including Cognitive Behaviour Therapy which teaches good problem solving skills. This is an area where many different types of health professionals need better training.

There are a range of services in Alice Springs, such as Central Australian Youth Link Up Service, Youth Outreach Team at Congress, Reconnect, and Tangentyere that are working well with young people and families in relation to social and mental health early intervention in an effort to prevent the development of more serious social and emotional well being problems. On Track at ASYASS has short term accommodation options for young people affected by substance misuse but they are unable to complete construction due to funding. Many of these services are working with young people to promote resilience and good social and emotional well being so they do not turn to AOD misuse habits.

Acute Care:
The only Acute care options in Central Australia are the Mental Health Ward at Alice Springs Hospital. Although there have been significant improvements in the quality of care being provided in recent years, especially since the development of the new mental health Act, we feel this option is still in-adequate for Aboriginal clients given its current staffing. There needs to be greater attention given to the language and cross cultural barriers that arise when psychiatrists are employed who have English as a

second language. We have discussed the barriers to access to psychiatrists earlier but there is also a need to address the shortage in mental health nurses working in remote areas. Acute care facilities need to have access to interpreters and Aboriginal liaison officers who can ensure that there is good communication between inpatients and there families. There also needs to be close liaison with the primary health care sector and many patients should have pre-discharge care plans developed with their primary health care provider to ensure that follow up is collaboratively planned. Congress has re-developed the job description of our mental health worker position to make this the prime focus of his job and we hope this will lead to better coordination of care and follow up of our patients who are in and out of ward 1.

Community Care:
Community care is undertaken by both Government and NGO services in Central Australia although there are many more staff in the government sector and they are not accessing the Aboriginal community to the level that is needed. There needs to be a re-distribution of existing resources in this area.

After hours crisis services and respite care:
Aboriginal people in Alice Springs primarily access after hours care through Congress. Our clinic is open until 8pm weeknights and a GP is on call until 10.30pm. ON weekends and public holidays our clinic is open from 8.30am until 12.30 am and then the GP is on call until 10.30pm. After 10.30pm the hospital provides cover for our patients with back up arrangements from our GPs. The majority of patients with a social and emotional well being crisis will access Congress first and then be referred to the specialist services even though there is a specific on-call mental health worker through the hospital. This on –call mental health worker is largely protected from the workload in the Aboriginals community and this again highlights the need to integrate specific mental health resources into primary health care. It is often quite problematic to contact this worker and patients are mostly referred directly to the ED. This also applies to mental health crisis that occur during hours. It is mostly Congress GPs who are called to these situations and make decisions about the need to section people for acute care. There are no mental health specific respite services in Alice Springs.

c. Outline opportunities for improving coordination and delivery of funding and services at all levels of government

As mentioned earlier there needs to be better mechanisms for ensuring that mental health specific funding is able to flow into Aboriginal community controlled health services. This could be either achieved through direct Commonwealth funding of ACCHS with mental health specific funds or greater reporting requirements on state and territory governments to ensure that they use a proportion of the mental health funding to fund ACCHS. There also needs to be one reporting mechanism for both state and Commonwealth funding as is being developed in the NT for primary health care services more generally. There needs to be better coordination of substance misuse programs to target tenants in public housing in an attempt to avoid problems leading to eviction. There needs to be more funding into services that support families and carers with mental illness.

d. Identify the appropriate role of the private and non-government sectors;

As discussed above Aboriginal community controlled health services, which are part of the NGO sector, are the best vehicles for the delivery of social and emotional well being services to Aboriginal people. This is consistent with the recommendations of the Royal Commission into Aboriginal Deaths in Custody and the National Aboriginal Health strategy Working Party Report and the vision of Primary Health Care in the WHO Alma Ata Declaration (1978) and the Ottawa Charter (1986). In terms of equity of access to services it is imperative that there is an adequate public sector and not for profit NGO sector, in addition to the private sector, to ensure good access for low socio economic groups.

We believe that the community social and emotional well being services should be provided by ACCHS for Aboriginal people. This includes the majority of non-medical based social and emotional well being care as well as GP services. The amount of funding in NGO's to support families and communities in supporting sufferers in the homes is inadequate. Govt services should deliver specialised medical based services and acute care facility options.

e. Comment on the extent to which unmet need in supported accommodation, employment, family and social support services, is a barrier to better mental health outcomes;

There is limited supported accommodation for sufferers of mental illness in Central Australia, apart from the Bill Braitling flats. These flats are usually full to capacity. This is a major issue, people who are recovering from mental illness episodes and released from the hospital ward have no post ward care options but to return to the community. There needs to be better support options for post ward release into the community such as a "halfway" or supported accommodation house with support workers. Such a house could also be used as part of a respite option. There are many people with mental illness who have ended up on town camps simply because they cannot keep jobs and pay rent etc. Remote community people are sent to town and some are not allowed to return to their country because the community classify them as "mad".

f. Comment on the special needs of groups such as children, adolescents, the aged, Aboriginal Australians, the socially and geographically isolated and of people with complex and co-morbid conditions and drug and alcohol dependence;

There is one position at community mental health that provides specialist psychologist services for children. There is a schools guidance officer for children in schools. There is no specific youth service or services for young people who suffer from social and emotional well being disorders. Youth services in Alice Springs are expected to pick these clients up as part of their workload. As discussed earlier Aboriginal people in Central Australia are disadvantaged due to a lack access to mainstream services both because of their geographic remoteness and isolation as well as the fact that these services are not culturally appropriate. If funded appropriately Congress could expand its Social and Emotional model of service delivery to remote Aboriginal communities. We are aware of only two funded positions in the community mental health unit who work with remote communities and this is inadequate for the area being covered and the number of clients. In order to address the special needs of Aboriginal people there

needs need to be more Aboriginal people trained and working in this area, including those with language speaking skills.

Comprehensive primary health care services, such as Congress, treat all people with complex and co-morbid conditions and alcohol and drug dependence. There is no "buck passing" of such patients to other service providers. Tis is a major reason to support the model of comprehensive primary health care because it is more efficient and effective to treat the whole person within the one service rather than require such patients to negotiate their way between multiple service providers who each only deal with one aspect of the patients problem. The advent of EPC multidisciplinary care plans have also enabled better coordination of team care arrangements for such patients, especially the coordination of GP involvement with the necessary allied health professionals such as psychologists and other counsellors who provide holistic care to these patients.

g. Comment on the role and adequacy of training and support for primary carers in the treatment, recovery and support of people with a mental illness;

There needs to be more education and awareness of services for families including putting information into various languages for community people and the use of other mediums, such as movies, radio, theatre, multimedia etc. Carers need to become involved in the process of EPC care planning much more than they have been up to now.

h. What is the role of primary health care in promotion, prevention, early detection and chronic care management;

The National Mental health Strategy did not fully outline the important role that primary health care services have in the screening, early detection and treatment of patients with mental illness. The foundation of effective an efficient social and emotional well being services is to have a well resourced primary health care sector. Such services are essential for the screening, early detection, intervention and referral for social and emotional well being disorders. This now occurs as part of the new 710 Aboriginal adult health check for patients between the ages of 15 and 55. For example, Congress sees about 8000 Aboriginal people each year and we endeavour to screen all adults for social and emotional well being conditions. Once screened patients identified with social and emotional well being problems are referred to our Social and Emotional Well being Unit where specialist staff undertake a more detailed assessment of the patients and determine the appropriate treatment option. As mentioned previously, comprehensive primary health care services are also essential in the development EPC care plans and other management plans so that patients with multiple health problems and co-morbidities can be managed holistically and not simply as an isolated "mental health problem". In addition such services provide after hours cover for all patients and the point of access to health services for a significant number of patients with a social and emotional well being problem is an after hours GP service. The Select Committee therefore needs to recommend that Aboriginal primary health care services are adequately funded, in particular, this requires the full funding of the Primary Health Care Access Program, as an essential part of providing

comprehensive social and emotional well being services to Aboriginal and Torres Strait Islander people. The combination of properly funded core Aboriginal primary health care services (OATSIH/Medicare) and social and emotional well being specific services funded by dedicated mainstream mental health funds will together ensure comprehensive social and emotional well being services are available to Aboriginal people.

i. Describe the opportunities for reducing the effects of iatrogenesis and promoting recovery-focussed care through consumer involvement, peer support and education of the mental health workforce, and for services to be consumer-operated;

The model of Aboriginal community controlled comprehensive primary health care provides the strongest expression of consumer involvement and control over health services, including social and emotional well being services. This model has been pioneered in Australia by Aboriginal people and helps to ensure that all practitioners are working in a manner which best meets the needs of consumers. The quality assurance mechanisms and systems that services like ours have been able to put in place are unique and ensure that all practitioners are accountable through management back to consumers for the quality of the work they are doing. In addition, Congress provides representatives to sit on key committees relating to social and emotional well being issues and has produced multiple submissions and policy documents advocating the views of Aboriginal consumers. Congress was also involved in the redrafting of the Northern Territory Mental Health Act.

j. Comment on the overrepresentation of people with a mental illness in the criminal justice system and in custody. the extent to which these environments give rise to mental illness, the adequacy of legislation and processes in protecting their human rights and the use of diversion programs for such people;

There are too many people being incarcerated for crimes because of mental illness. Prison officers are not trained in social and emotional well being. There should be a specialised facility for these clients although prisoners do have access to social and emotional well being professionals but their daily care is undertaken by health professionals who are not specifically trained in mental health. Perhaps there could be a social and emotional well being unit in the prison complex which would cater for their special needs.

k. **Comment on the practice of detention and seclusion within mental health facilities and the extent to which it is compatible with human rights instruments, humane treatment and care standards, and proven practice in promoting engagement and minimising treatment refusal and coercion**;

There were a number of new checks and balances set up under the new NT Mental Health Act to monitor these types of practises in ward 1. The community visitors and the statutory committee that were established have both added a degree of protection

of patients and in the view of Congress this system is working well in the interests of our patients and is respectful of their human rights

l. Comment on the adequacy of education in de-stigmatising mental illness and disorders and in providing support service information to people affected by mental illness and their families and carers;

There needs to be more work on de-stigmatising mental illness in the wider community and especially the Aboriginal communities. People need to know that people who suffer with a mental illness can be supported effectively in the community. We need to educate the community so to reduce the incidence of out-casting and labelling sufferers as being "mad".

Anecdotal evidence suggests that some families feel helpless and confused when faced with social and emotional well being issues. Awareness needs to start happening within the school system as part of the curriculum, maybe life health studies in years 10 and 11. The unit could cover pregnancy/parenting, Alcohol and other drugs, social and emotional well being etc.

m. Comment on the proficiency and accountability of agencies, such as housing, employment, law enforcement and general health services, in dealing appropriately with people affected by mental illness;

We believe that housing, employment and law enforcement sectors need to work more closely together to initiate strategies to address the lack of services they provide for people with mental illness.

n. Comment on the current state of mental health research, the adequacy of its funding and the extent to which best practice is disseminated;

Congress is a core partner in the Cooperative Research Centre in Aboriginal Health and through this CRC we have been directly involved in a number of useful research project in this area and we know of others that are currently underway. The CRC is also researching comprehensive primary health care and workforce which are critical health system issues in the delivery of social and emotional well being services. Apart from the CRC however, there has been limited application of mainstream research funds into social and emotional well being or primary health care research amongst Aboriginal people. The NH&MRC has been taking steps to address these shortcomings in recent years.

o. Comment on the adequacy of data collection, outcome measures and quality control for monitoring and evaluating mental health services at all levels of government and opportunities to link funding with compliance with national standards;

Primary health care services need support in developing specialised data systems that will enable them to effectively evaluate the quality and effectiveness of their services. There needs to be specific accreditation systems that are accessible to assist in the

monitoring of quality and the application of standards. We are not aware of any systems that may be in place in regard to data collection within government services.

p. Provide comments on the potential for new modes of delivery of mental health care, including e-technology.

Congress believes that the major gain to be made is in the integration of social and emotional well being specific services into comprehensive primary health care services as discussed earlier.