Central Australian
Aboriginal Congress
ABORIGINAL CORPORATION | ICN 7823

Central Australian Aboriginal Congress submission to the Draft Fifth National Mental Health Plan

1 Summary of Recommendations

1. That the Mental Health Drug and Alcohol Principal Committee include a new Priority Area in the Fifth National Mental Health Plan that is focused on prevention of mental illness and promotion of mental health and positive social and emotional wellbeing, including through population health initiatives.

2. This new priority area needs to address *both* the link between disadvantage and poor mental health as experienced by all peoples *and* the specific historical and contemporary issues experienced by Australia's Aboriginal and Torres Strait Islander peoples.

3. Actions to support the priority area of mental ill health prevention should include:

    a. Governments invest in evidence-based early childhood development programs for developmentally vulnerable children to reduce future rates of mental illness

    b. Governments commit to reducing the impact of alcohol abuse through pricing regulation as a key investment in mental health now and the prevention of mental ill health in the future

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

4. That the Mental Health Drug and Alcohol Principal Committee also include the following actions in the Fifth Plan:

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

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

c. Amend Action 12 within the draft Plan to include ACCHS in the planning and service delivery process for Aboriginal and Torres Strait Islander people at a regional level.

d. Governments commit to five year block funding for comprehensive primary health care services including ACCHSs.

e. Governments recognise the need to combine medical care, psychological therapies and social and cultural support with intensive case management as the best practice model for integrated care.

f. Governments recognise that integration of services for holistic care, including complex care and physical health, is best achieved under a single comprehensive primary health care provider and single funding stream.

g. Governments develop strategies to develop a high-quality, culturally-competent mental health workforce, taking into account rural and remote distribution and workforce development especially for Aboriginal people.

h. Governments further develop the core mental health service framework with corresponding core performance indicators, underpinned by common coding practices and continuous quality improvement processes.

2 Background

2.1 Central Australian Aboriginal Congress

Central Australian Aboriginal Congress (Congress) welcomes the opportunity to comment on the draft Fifth National Mental Health Plan (the Fifth Plan), currently being developed by the Australian Health Ministers' Advisory Council's (AHMAC's) Mental Health Drug and Alcohol Principal Committee (MHDAPC).

Congress is the largest Aboriginal community-controlled health service (ACCHS) in the Northern Territory, providing a comprehensive, holistic and culturally-appropriate primary health care service to more than 13 000 Aboriginal people[1] living in and nearby Alice Springs each year.

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

Congress has pioneered a 'three streams' approach to mental health services, which integrates social and cultural matters, physical health, and mental health, including attention to alcohol and other drug

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

issues and suicide prevention. Detail on the model is provided in **Appendix A**. Additionally, Congress runs primary prevention programs in early childhood, and is active in advocacy for population health measures such as alcohol control.

2.2 Aboriginal Community Controlled Heath Services

Aboriginal Community Controlled Heath Services (ACCHSs) such as Congress function within the framework of a comprehensive primary health care (CPHC) model, which aims to address health inequities and close the health gap between Aboriginal and non-Aboriginal people through providing high quality, accessible, multidisciplinary clinical care as well as taking action to address the broader underlying, social determinants of health.

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

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

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

> *... are improving outcomes for Aboriginal people, and … that they achieve outcomes comparable to those of mainstream services, but with a more complex caseload*[2]*.*

The key role of ACCHSs is supported by the fact that Aboriginal people show a clear preference for their use, leading to greater access to care and better adherence to treatment regimes[3].

This comprehensive model of service delivery and advocacy for public health and system reform has been the foundation for much of the relative success of the Northern Territory in 'closing the gap' in health between Aboriginal and non-Aboriginal communities.[4]

3 Strengthening the Fifth National Mental Health Plan

Congress welcomes the inclusion of Aboriginal mental health and suicide prevention as a priority in the Fifth Plan. This acknowledges the specific issues and requirements around service provision for Aboriginal people, particularly in remote and regional areas, and the importance of Aboriginal participation in the planning, design and implementation of services.

Congress also acknowledges the focus of the Fifth Plan on better integration in service delivery. People living with mental health issues are likely to need a number of different providers to meet their physical, social and mental health needs. Also, with the emergence of the National Disability Insurance Scheme, coordination of service providers across multiple sectors will be imperative for people with complex needs.

However, the Fifth Plan could be strengthened by the inclusion of prevention of mental illness as a new priority area, alongside a number of actions outlined below to support achieving the goals of the Plan. Additionally, we believe there is insufficient attention in the draft Plan to some of the systemic issues that undermine service integration, and in particular funding that is based on competitive tendering processes.

3.1 Prevention

The Fifth Plan states that one of its underpinning values is promotion, prevention and early intervention (page 17). However, there is very little in the Plan that gives practical effect to these values particularly in relation to Aboriginal people, except for the particular case of suicide prevention. This is a major gap in the Plan which needs to be addressed.

Prevention approaches need to recognise and address the links between disadvantage in the social determinants of health and poor mental health, as well as the historical and contemporary issues specifically experienced by Australia's Aboriginal people that contribute to their poor mental health and social and emotional wellbeing.

3.1.1 The social determinants of health

In its paper the *Social determinants of mental health*, the World Health Organization (WHO) recognises that many common mental disorders are heavily associated with social inequalities, and that the greater the inequality the higher the risk is for mental illness.[5] The WHO calls for actions to improve the conditions of everyday life across the stages of life from prenatal to old age as the key approach to preventing mental ill health.

The social determinants of poor physical and mental health – such as poverty, poor education, poor housing, lack of nutrition, lack of meaningful employment and racism –have a powerful effect on the health of Aboriginal people: between one-third and one-half of the gap in health is estimated to be due to these determinants.[6] Approaches based on the promotion of health and the prevention of illness, injury and disease – rather than just the treatment of them once they have arisen – must begin with the social determinants of health.

Recommendations 1 & 2:

1. ***Adding a new Priority Area that is focused on the prevention of mental illness and promotion of mental health and positive social and emotional wellbeing, including through population health initiatives.***

2. ***This new priority area needs to address both the link between disadvantage and poor mental health as experienced by all peoples and the specific historical and contemporary issues experienced by Australia's Aboriginal and Torres Strait Islander peoples.***

While action across the full range of social determinants is necessary, evidence-based early childhood programs and control of the supply of alcohol should be particularly acknowledged by the Plan because both have a strong effect on mental health and social and emotional wellbeing, and both have highly evidence-based approaches that can make demonstrable impacts over the long term.

3.1.2 Evidence-based early childhood programs impact on rates mental illness in adulthood

We note that the Plan includes indicators including the proportion of children developmentally vulnerable as measured through the Australian Early Development Census (AEDC), and the rate of access to early childhood support programs. However there are no actions within the Plan that address the critical area of early childhood development.

Adverse childhood experiences are a strong predictor for poor social functioning, impaired well-being, health risks and disease, and contribute powerfully to many major public health and social problems. [7] There is a strong association between adverse childhood experiences and increased levels of depression, suicide attempts, sexually transmitted infections, smoking, alcoholism, higher levels of violence and antisocial behaviour, school underperformance and lower IQs, economic underperformance and poor physical health.[8]

Aboriginal children are at a higher risk than non-Aboriginal children for mental health issues later in life. According to the Australian Early Development Census, 60 per cent of Aboriginal children are developmentally vulnerable on at least one measure of childhood development. Aboriginal children are twice as likely as non-Aboriginal children to be developmentally vulnerable in at least two measures.[9] Furthermore, children living in very remote areas are 2.6 times more likely to be developmentally vulnerable than children living in major cities. This makes them at greater risk of poor physical and mental health, wellbeing and academic success later on in life. The AEDC data are not broken down by Aboriginality at a state, regional or local level which masks the much greater level of disadvantage of Aboriginal children.[10]

It is now well established that in the first few critical years, children need stimulation and positive relationships with care givers to develop neural systems crucial for adult functioning and positive mental health. Longitudinal studies show that parenting support programs and targeted early childhood educational programs reduce the risk factors for children that may lead to poor mental health in adulthood. Such evidence-based programs have, for example, reduced rates of alcohol and other substance use by young adults, improved educational and employment outcomes, reduced the

proportion of teen pregnancies, and are associated with more active lifestyles and reduced incarceration rates.[11,12,13]

As part of its comprehensive primary health care approach, Congress operates an integrated child and family service that incorporates early childhood learning and secondary interventions. See **Appendix A** for further details.

Evidence-based early childhood development programs are thus an essential contributor to raising children who are better equipped to meet challenges to their health and wellbeing and are therefore an important part of preventing mental ill-health in the Aboriginal and broader communities. Governments should therefore support universal access to high quality, evidence-based ECD programs, developed and implemented with appropriate local adaptations in collaboration with ACCHSs and/or other Aboriginal community controlled organisations.

Recommendation 3a

That the Fifth Plan includes the following action:

That Governments invest in evidence-based early childhood development programs for developmentally vulnerable children to reduce future rates of mental illness.

3.1.3 Reducing the impact of alcohol abuse to prevent mental ill health.

Alcohol is a major contributor to mental ill health and poor social and emotional wellbeing. Alcohol abuse is directly associated with at least 8 per cent of the burden of disease and injury borne by Aboriginal people, including through homicide, violence and suicide.[14] This does not include the indirect health effects of alcohol abuse acting through social determinants such as poverty, mental health problems and childhood neglect.

A reduction in the supply of alcohol is one of the most cost effective initiatives that could be undertaken in the primary and secondary prevention of mental illness, particularly among young people and the heaviest drinkers, who are the most disadvantaged and vulnerable to mental illnesses. [15] In particular, there is clear evidence that increasing the price of alcohol reduces consumption and alcohol related harm; it is also a highly cost effective intervention.[16,17,18]

An increase in the price of 25 cents per standard drink in Alice Springs has reduced population alcohol consumption by 10 per cent and has prevented a large number of hospital admissions including admissions for assault.[19] Photo licensing at the point of sale and the Banned Drinkers Register which has targeted the heaviest drinkers has also led to a major reduction in hospital admissions. Also, children in their early years are less exposed to the type of violence and trauma which leads to the development of mental illness, especially depression, in later life.[20]

As well as focusing on interventions specifically targeting alcohol supply, demand reduction strategies are also need also to focus on broad-based interventions which address the underlying social determinants of health and alcohol and other drug use, including early childhood development, education and employment programs.

Recommendation 3b

That the Fifth Plan includes the following action:

That Governments commit to reducing the impact of alcohol abuse through pricing regulation as a key investment in mental health now and the prevention of mental ill health in the future.

3.1.4 Healing, intergenerational trauma and the contemporary experience of racism

The colonisation of Australia and its ongoing process and impacts must be acknowledged to understand the status of Aboriginal mental ill health and social and emotional wellbeing today. Dispossession, exclusion, discrimination, marginalisation, the forcible removal of children from their families, and ongoing inequities has led to and continue to impact on poor physical and mental health outcomes for Aboriginal people.[21,22]

Intergenerational trauma

This historical and ongoing experience is now recognised as resulting in 'intergenerational trauma' whereby traumatic experiences of the first generation are passed on to the next generation and the next.[23] Intergenerational trauma can manifest in many symptoms of poor mental health and social and emotional wellbeing and adverse behaviours including panic attacks, anxiety, sleep disturbance, severe obesity; smoking, illicit drug use, alcoholism; and intercourse at an early age.[24]

There is growing evidence that unresolved intergenerational trauma underpins many of the social and emotional wellbeing issues and mental illnesses experienced in some Aboriginal communities. For example, a recent study examined the health and wellbeing of Aboriginal people who had either been removed from their families as children, or who had parents, grandparents/great-grandparents or siblings who had been removed. This group is 50 per cent more likely to have been charged by police, 15 per cent more likely to consume alcohol at risky levels and 10 per cent less likely to be employed than the wider Aboriginal and Torres Strait Islander community.[25]

Trauma informed services

There is growing recognition in Australia that policies and service providers must address and respond to traumatic life events appropriately to ensure better outcomes. [26] This includes providing services in a safe way and creating the opportunities for people affected by trauma to regain a sense of control and empowerment. [27] Moreover, a trauma informed service is cognisant of the effects on staff who are exposed to this trauma and, if Aboriginal, may have also had traumatic experiences in their own or their families background.

The service system must recognise the prevalence of intergenerational trauma not only on the wellbeing of individuals, but populations and communities as a whole.[28] All services accessed by Aboriginal people should therefore aim to be 'trauma-informed' such that they are able to recognise the different ways that the experience of unresolved trauma can manifest (for example, in mental health issues, or addiction, or violence) and address them in an informed way.[29]

Healing programs

Culture and spirituality is highly important in supporting resilience and positive social and emotional well-being and good mental health and living a life free of addiction to alcohol and drugs[30]. Cultural is a source of strength, identity, structure and continuity in the face of ongoing change, stress and adversity, and as a protection against suicide.[31]

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

There is an emerging body of evidence which demonstrates that in this context, healing programs are an effective way of addressing the effects of intergenerational trauma. In Canada for example, healing centres – spaces which supports healing work for Aboriginal people – are proven to be effective in preventing the negative health and wellbeing outcomes, including suicide, associated with intergenerational trauma experienced by Aboriginal communities.[32]

> *"Healing works best when solutions are culturally strong, developed and driven at the local level, and led by Aboriginal and Torres Strait Islander people."*[33]

Healing will often make use of both mainstream and traditional knowledge and practices, but valuing Aboriginal knowledge and leadership is a prerequisite for adaptive solutions to be developed.[34] Effective healing programs must be:

- Locally led and driven
- Evidence-based
- Include a combination of Western methods and traditional healing
- informed about and understand the impact of colonisation and intergenerational trauma and grief
- build upon individual, family and community capacity.[35]

Addressing racism

Racism is a determinant of mental illness as it debilitates confidence and self-worth, creates psychological distress, depression and anxiety, and exacerbates health risk behaviours such as smoking and alcohol and substance misuse.[36]The experience of racism is overwhelmingly common for Aboriginal and Torres Strait Islander people: a 2012 study found that 97% of Aboriginal Victorians reported experiencing racism in the previous year, with over 70% of those surveyed reporting eight or more such incidents in the previous twelve months.[37]

Racism can also be structured into how institutions operate, through policies and assumptions which disadvantage Aboriginal people. Racism in health care institutions contributes to the lack of trust in mainstream health and social services and a corresponding lack of use of services, and Aboriginal people are less likely to receive the care they need.[38]

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

Recommendation 3c

That the Fifth Plan includes the following action:

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

3.2 Funding and integrated service delivery

3.2.1 Competitive tendering undermines integration

Competitive tendering for short-term funding leads to complex service delivery environments with multiple providers of health services, creates a culture of competition rather than cooperation amongst those providers, promotes an emphasis on individual care rather than population health and short term outcomes rather than long term gains in health, drives increased reporting costs for agencies, and leads to a system that is difficult to navigate for Aboriginal clients (especially where language, literacy and cross-cultural service delivery are issues)[39].

Government funding, policies and processes based on competitive tendering have unfortunately been a major driver of the disconnected, inefficient and hard-to-navigate mental health and social and emotional wellbeing system for Aboriginal communities. As a result of such policies, for example, a remote community in Central Australia receives social and emotional wellbeing programs from 16 separate providers, mostly on a fly-in fly-out or drive-in drive-out basis, for about 400 people. There is little in the way of communication or coordination with the local ACCHS with providers often turning up unannounced and demanding information on and assistance with locating clients, use of buildings and vehicles etc. The result is fragmentation and duplication of service delivery, lack of coordination, waste of resources and suboptimal outcomes for clients.[40]

Recommendation 4a

That the Fifth Plan includes the following action:

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

3.2.2 The need for collaborative, needs based funding

The alternative to competitive tendering is collaborative needs-based planning. Collaborative, well-resourced and sustainable processes for needs-based health system planning are now well-recognised

as critical foundations for health system effectiveness.[41] This is alluded to in the draft plan, though Action 12 fails to ensure that ACCHS and other Aboriginal organisations are included as essential participants in the planning process.

In the NT, the Northern Territory Aboriginal Health Forum (NTAHF), established after the signing of the Framework Agreement on Aboriginal Health in 1998, brings together government and the community controlled sector to work collaboratively to[42]:

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

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

Using this agreed approach, the NTAHF has overseen the development of the NT Aboriginal health system in a way that is now delivering results in terms of improved health outcomes for Aboriginal people.[43]The NTAHF has also helped to ensure that the social determinants of health are addressed through high level collaboration and advocacy outside the health system.

Recommendation 4b

That the Fifth Plan includes the following action:

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

Recommendation 4c

That the Fifth Plan includes the following action:

That Action 12 within the draft Plan is amended to include ACCHS in the planning and service delivery process for Aboriginal and Torres Strait Islander people at a regional level.

3.2.3 A commitment to long term, stable funding

Programs and services developed with short timeframes, limited funding periods and program support do not address health in a holistic manner and ultimately fail patients.[44] Policies, programs and mental health planning and investment directed towards supporting and sustaining locally-based, culturally-

relevant programs and services could bring sustainable change in mental health and wellbeing outcomes in Aboriginal populations.

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

Congress has repeatedly experienced the problem encountered when short term funding leads to loss of professional staff.[45] The uncertainty created by tendering processes at 2 or 3 year intervals for example, often means the loss of key staff and all of the experience and expertise they have gained in Aboriginal health.

Recommendation 4d

That the Fifth Plan includes the following action:

That Governments commit to five year block funding for comprehensive primary health care services including ACCHSs.

3.2.4 Case management

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

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

Within a comprehensive primary health care service the 3 streams of care service model is possible and the whole person is treated recognising the root causes of poor physical health and poor mental health are the same, and comorbidities are interrelated. This also assists to ensure that the physical health needs of mentally ill patients are not neglected as severely mentally ill people are at risk of dying prematurely of untreated physical health problems such as coronary heart disease and diabetes, rather from their mental illness.[46] Under this service model, patients are able to have both their mental health and physical needs addressed in one visit in the one place.

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

Recommendation 4e

That the Fifth Plan includes the following action:

That Governments recognise the need to combine medical care, psychological therapies and social and cultural support with intensive case management as the best practice model for integrated care.

3.2.5 Integration through a single comprehensive primary health care provider and single funding stream

The Fifth Plan recognises the importance of co-location of services to integrate services. Unless services are provided by one organisation, rather than several organisations or individual providers, co-location alone does not necessarily make for integration and collaboration of services. There also needs to be other measures in place such as joint governance, shared IT systems and multidisciplinary teams with shared incentives, priorities and values. This is best achieved through a single comprehensive primary care provider and a single funding stream.[47]

Congress' co-located SEWB service, AOD and suicide prevention model outlined above works as it operates under the one employer, which enables for example, the multidisciplinary team to be supported by a common clinical IT system and case coordinators (See Appendix A). The risk of stigma and discrimination is also reduced as care is provided by the same provider that everyone else in the community goes to, rather than a separate mental health service.

Multi-disciplinary, comprehensive primary health care services are essential for better service integration and improved patient care and thus for a more efficient and effective health system. However, a risk to the integrated model is multiple funding streams for the individual services. Even for a single provider, multiple funding streams creates uncertainty and instability in the integrated model. Adding to this complexity is multiple different performance indicators, reporting systems and data bases and reporting requirements creating administrative burdens on clinical staff. A single funding stream, or bundled payment, would strengthen this model and allow for a degree of flexibility of services to address patient need.

Recommendation 4f

That the Fifth Plan includes the following action:

That Governments recognise that integration of services for holistic care, including complex care and physical health, is best achieved under a single comprehensive primary health care provider and single funding stream.

3.3 Workforce development

3.3.1 An Aboriginal mental health workforce

While the fifth Plan acknowledges the importance Aboriginal mental health workers, there is little else on workforce development, particularly for rural and remote areas. A high quality Aboriginal workforce

is important to ensure the system is able to meet the health needs of Aboriginal communities: they are able to bring together professional training with community and cultural understanding to improve patient care and increase cultural safety across the organisation in which they work[48.]

While Aboriginal people remain under-represented in the health workforce, the role of the Aboriginal community controlled health sector in their training and employment has been an important part of the improvements that have been made[49].

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

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

Additionally, recruitment and retention of health professionals, particularly doctors and clinical psychologists, remains a challenge in rural and remote areas. There is still a need to address their maldistribution, through a combination of incentives to practice in these areas and support for ACCHSs and other primary health care agencies to employ and train registrars as well as considering increased regulations to ensure more practitioners work where they are most needed. [50] The inclusion of MBS items for psychological assessment and intervention for specific mental health clinicians via e-health technologies will assist in the delivery of services to rural and remote areas, where appropriate. This will also help to further bolster on-the-ground services with the addition of specialist mental health services input (i.e. clinical psychology).

3.3.2 Clinical psychology training needs

In Congress' experience, one of the most important strategies to build a competent local mental health workforce is to build upon the training of psychologists. It is important that there is the support of paid AHPRA approved psychology supervisors located within the services which provisional or registrar psychologists can access in order to complete their training and/or gain their respective endorsements. The supervision of psychology students requires a high level of clinical oversight and time commitment, particularly for those enrolled in the vocational models of training (4+2 and 5+1 models). If supervisors are unpaid, or not funded, as part of the model this will lead to a lack of commitment to the role as it will interfere with their own work commitments i.e. the provisional of psychological services. This used to occur in the GP training system before supervisors were remunerated properly and trained properly. It is important that the costs of supervision do not fall upon the training institutes or students as this will lead to ongoing barriers to the development of the workforce, such as increased course costs and lack of incentive for training institutes to continue to run postgraduate level psychology courses which are already operating at a significant loss to the University.

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

A similar "on the job" training program should be required for anyone who wants to aspire to Medicare eligibility to provide structure therapies including social workers and other professionals. There also needs to be quality improvement programs that focus on regular auditing of therapy and assessment of ongoing skills. Congress acknowledges the steps made by the psychology professional bodies down this training pathway. If it is to become systematised in the way that is needed it will require substantial government investment.

Recommendation 4g

That the Fifth Plan includes the following action:

That Governments develop strategies to develop a high-quality, culturally-competent mental health workforce, taking into account rural and remote distribution and Aboriginal health workforce development.

3.4 Monitoring and reporting

It is important that governments ensure the ongoing development of the core mental health service framework alongside corresponding core performance indicators. This approach has improved access to quality and safe primary health care services in the NT for all citizens wherever they live. A similar approach is needed to ensure there is transparent, equitable access to mental health services and programs and that there is adequate accountability for process and outcome measures to ensure quality.

The common set of core mental health service indicators, outlined in the Fifth Plan is a good start. At a local, service delivery level, there needs to be more detail. For example, it should be clear whether people who have been through an alcohol treatment program have reduced their alcohol consumption at 12 months in a similar way that a service is able to know whether a diabetic has good glucose control 12 months after diagnosis. Funding should be contingent on the outcomes of mental health treatments being measured along with a requirement for continuous quality improvement processes. There will also need to be regular audits of therapy so that there is confidence that a particular therapy has been delivered and coded appropriately and that an appropriate outcome measure has been used.

As it stands, the capacity to link outcomes to particular structured therapies is very limited and is not done in a systematic way. Further development of standards will require effective change management as therapists themselves are not always clear which therapy they are using in a particular session, sometimes documenting "multiple" therapies at once. Current coding practices do not indicate whether a particular therapy has in fact been used and what "dose" the patient has had. This makes it difficult to

know what the patient has actually been exposed to and what outcomes are linked to which therapies. There can be major variations in practice. This is the key challenge for the entire mental health service system and there is a need to develop a systematic, coherent approach to best practice treatment of common conditions.

Recommendation 4h

That the Fifth Plan includes the following action:

That Governments further develop the core mental health service framework with corresponding core performance indicators, underpinned by common coding practices and continuous quality improvement processes.

APPENDIX A

Primary and secondary prevention: An integrated model for child and family services[51]

Early childhood development programs are an essential contributor to raising children who are resilient and thus better equipped to meet challenges to their health and wellbeing. Early childhood education and support are an essential part of the answer to preventing mental illness in Aboriginal communities.

Congress believes that primary health care services are best placed to deliver the key services and programs from pregnancy through to Age 3. Health services regularly interact with young children and their families through a range of core services and programs and are ideally placed to expand on these into newer areas such as the 3a approach (see below) and programs that support children and their families through Pre-school.

Congress has outlined the core services and programs that together make up an integrated and comprehensive approach to this critical area. These are both primary and secondary prevention programs and are delivered either in the home or in a dedicated centre:

	Primary Prevention Targets children with no current problems but who are at risk of developing problems – identified risk usually based on low SES or maternal education level		**Secondary Prevention** Targets children with current problems identified early in life when most likely to respond to intervention and before gets worse – determined by screening or referral to services	
	Child Focus	**Carer Focus**	**Child Focus**	**Carer Focus**
Centre Based Most work is done at a centre where child or families come in to access service	• **Abecedarian educational day care** • Immunisations • Child health checks • Developmental screening	• Health advice to parents in clinic (e.g. nutrition, brushing teeth, toilet training)	• Child-centred play therapy • Therapeutic day care • Preschool Readiness Program • Antibiotics	• Filial therapy • Circle of security • Parenting advice / programs • Parent support groups
Home Visitation Most work is done in the homes of families where staff outreach to children and families	• Mobile play groups	• **Nurse home visitation** • Families as first teachers (home visiting learning activities)	• Child Health Outreach Program • Ear mopping	• Targeted Family Support • Intensive Family Support • Case management models for children at risk • Parents under Pressure (PUPS)

Early Childhood Learning Centre

Congress is establishing an Early Childhood Learning Centre for Aboriginal children from disadvantaged, non-working families living in Alice Springs. The Centre will be based on an international evidence-based program modified for the Australian context and adapted in language for Aboriginal communities known as the Abecedarian Approach Australia or 3a. This approach has shown a major impact on the developmental, educational and health outcomes across the lifespan for children from at-risk and vulnerable families.

The Centre will be designed for 6 months to 3 year olds, where the adapted program includes learning games, conversational reading (using local, traditional stories) and enriched care giving, with local languages being spoken at the Centre. The aim of the Centre is to achieve the above health outcomes and by involving parents, break the cycle of disadvantage.

This program will be rigorously monitored and evaluated to determine achievement of the outcomes

Based on longitudinal studies of the approach, expected long term benefits are:

- improved education and employment outcomes (doing better at school, improved school retention, better employment outcomes)
- increased health and wellbeing as young adults (including reduced smoking and drug use, reduced proportion of teen pregnancies, more active lifestyles)
- reduced risk of chronic disease in later adulthood (lower prevalence of risk factors for cardiovascular and metabolic diseases)

Preschool Readiness Program[52]

As part of the *Preschool Readiness Program*, Congress has been using the 3a approach in an intensive 7 week program for children at around age 4 who have been found to have language delay following comprehensive developmental assessments as part of Child Health Checks. This program has enabled children to enter a phase of accelerated development prior to enrolment in Pre-school. The most children who go through this program significantly improved their vocabulary as measured by the Peabody test – a good sign of improved cognitive development. The average level of improvement on baseline vocabulary levels was 6 months in a 7 week program.

Australian Nurse Family Partnership

The Australian Nurse Family Partnership program is cost effective and is involved in the primary prevention of mental illness by promoting healthy development in early childhood so there is an increased opportunity for children to have well developed emotional regulation and self-control.

The focus of this program is on the primary carer of the child, usually the mother. Congress is using this approach in our pre-school readiness program and seeing some children make very large gains very quickly.

Secondary prevention

The Congress Targeted Family Support Service (TFSS) works with many other services in Alice Springs to provide maximum support to high needs families where children are disadvantaged. Some of the parents in these families have significant mental illnesses. TFSS works with a large number of external agencies and coordinates the care being provided to high needs families including case management as required.

Congress also operates an Intensive Family Support Service for families with children aged 0-12 years of age, where neglect has been identified and provides intensive support in the home and community, to help improve children's health, safety and wellbeing. The final report (to be published) has noted that IFFS is working and should be continued.[53]

Primary mental health care: the Social and Emotional Well Being service model.

Congress's Social & Emotional Wellbeing (SEWB) service provides Aboriginal people and their families including children and adolescents with holistic and culturally appropriate primary health care for social and cultural wellbeing, mental health and community connectedness including:

- confidential counseling and psychological services including psycho-education;
- social and cultural support including case management, Women's and Men's bush trips, art therapy, access to local language speakers and connection to country;
- drug and alcohol treatment for Aboriginal people experiencing the effects of harmful alcohol and alcohol use; and
- a dedicated GP service offering:
- Health checks
- Mental health care plans
- Access to free medications
- Medical care for illness and disease
- Nutrition support – education on good and bad foods and exercise
- Referrals to care coordination
- healthy lifestyle promotion

SEWB services are co-located within a primary health care setting in one location which allows for better management of clients to support physical wellness and to address comorbidities.

'3 streams of care'

In 2007, Congress received funding from the National Drug Research Institute (NDRI) to conduct a 12-month trial of an innovative, non-residential alcohol treatment program. This trial became the foundation a primary treatment program inclusive of biological, behavioural and social dimensions.[54]

The program's "3 streams of care" approach now includes mental health services which integrates: a) social and cultural support b) medical care and c) psychological care. This requires treatment of the whole person and recognition that mental health, physical health and social and cultural health are all interrelated. This means that rather than having separate service responses, there is one comprehensive service that provides:

1. *Medical care*

Medical care includes: Preventive health care such as health checks to promote, maintain and treat physical health; Chronic Disease Management; Mental Health Treatment Plans; Podiatry; Dental; Pharmacy; and Men and Women's health. Medical care also includes pharmacotherapies for addiction specific medicines such as acamprosate and naltrexone which are often complimented by the medicines used to treat other mental illnesses

2. *Psychological support*

This includes clinical assessment, neuropsychological assessment, clinical reports, and evidence-based, culturally appropriate structured therapies to treat a wide range of disorders/such as CBT, mindfulness therapy, relaxation training, family therapy, narrative therapy etc.

3. *Social and cultural support*

This recognises the importance of social and cultural factors in Aboriginal health. Some patients need basic social, environmental and economic needs such as housing met before they are in a position to focus on structured therapeutic interventions. Other patients in a cross cultural context need to be supported to explore issues of cultural identity and reconnect with parts of their culture which may have become less strong. Service may include family support, cultural support, cultural brokerage, advocacy and linking with traditional healing services.

Holistic care

Services provided by Aboriginal AOD workers or Aboriginal Family Support Workers across a broad range of areas that respond to the needs of the client and the community. Such services include assistance with education and training, finding employment, accommodation, Centrelink, strengthening relationships with kin and country, enhanced cultural identity, group work and many other services.

There is evidence that all of these services provided together are important and all Aboriginal alcohol treatment programs provide these types of services. There are demonstrated less substance use and fewer physical and mental health problems as well as improved social functioning when standard treatments are supplemented with social service supplemented treatment programs[55]

GP Mental health care plans make this treatment more accessible as psychological services are now publicly funded through Medicare

The multidisciplinary team

Congress' SEWB co-located Multidisciplinary Team includes:

1. *Medical*

   A GP along with the regular Congress Clinics

   Allied health services

2. *Psychological support*

   Three Clinical Psychologists

   One Clinical/Neuro Psychologist

   Two General Psychologist (1.6) + 1 Clinical Psychologist Registrar (0.4)

   One Mental Health Social Worker

   Occupational Therapist

3. *Social support*

   One Senior Social Worker

   Two Social Workers

   Three Remote AOD workers

   One Aboriginal Cultural Integration Practice Advisor

   Five Care Managers

Aboriginal Family Support Workers, Aboriginal Community Workers, Aboriginal AOD workers, Aboriginal case workers play a key role alongside trained mental health professionals. They are able to address social and cultural issues and assist other mental health professionals to understand the patients. All staff are engaged in clinical supervision.

Components of integration

Comprehensive Assessment: A comprehensive initial assessment of clients includes identifying background information; relevant history; presenting issue and establishing client goals. Supplementary assessments including AOD; violence; mental health; and cognitive behaviour.

Care Plans: The development of care plans allows for working across the 3 streams and increase accountability by supporting: Client treatment goals; treatment team responsibilities; Case management Multi-disciplinary client review groups; ongoing review of active care plans.

Clinical information systems linked with other primary health care services: Access to clinical information system across wider primary health care service is allowed through Communicare clinical IT systems. This allows for: Enhanced communication between practitioners; better management of risk; generation

of internal referrals; better coordination of care; clinical item creation specific to SEWB; outcome measures specific to SEWB; and Alerts. The complete information about a patient is in the one place with all practitioners caring for the patient aware of all of the patients' issues. Progress notes can be hidden for selected consults but not the key diagnostic and treatment data for the consultation. Common data collection systems are used across all functional areas of SEWB including common assessment tools such as the K10 and AUDIT as well as common mental health care planning templates.

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