

Central Australian Aboriginal Congress



Submission to the Northern Territory Suicide Prevention Strategic Review

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Executive summary

The Central Australian Aboriginal Congress (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 14 000 Aboriginal people living in and nearby Alice Springs each year as well as the remote communities of Ltyentye Apurte (Santa Teresa), Ntaria (Hermannsburg) and Wallace Rockhole, Utju (Areyonga), Mutitjulu and Amoonguna.

The suicide rate for Aboriginal Australians is almost twice the rate for non-Aboriginal Australians (AIHW, 2016). This submission to the Northern Territory Government's development of a Suicide Prevention Strategic Plan addresses suicide prevention from a social determinants, population health and primary prevention perspective, as well as from a mental health service delivery perspective. Particular attention is given to young Aboriginal people who have highest national rates of suicide, which can be largely attributed to unhealthy early childhood development, linked to disadvantage.

Key issues raised in this submission are:

- That suicide in Aboriginal communities is fundamentally linked to disempowerment, disadvantage and the social determinants of health.
- Unhealthy brain development, self-regulation and coping skills in early childhood are linked to suicide. This is a key issue for young Aboriginal people who are falling well behind in the Australian Early Development Census (AEDC) by age 5.
- Contact with the justice system and out-of-home care is a major risk factor for suicide in young Aboriginal people. There are currently more than 1000 Aboriginal children in out of home care in the NT and the incarceration of young Aboriginal people is at least 28 times the national average.
- Alcohol misuse by parents is related to the unhealthy development of children and lack of self-regulation, and is also a direct catalyst for suicide.
- Due to the ongoing impact of colonisation and policies such as the forcible removal of children from their families, there is a need for trauma-informed, culturally secure services provided by Aboriginal community-controlled health services.
- There is a need for holistic and integrated services across physical, mental and social and emotional wellbeing, delivered by one provider. For Aboriginal people this should be through Aboriginal community-controlled health services.
- Detailed data on suicide and suicide attempts, made available to services at a local level, is needed for service improvement and to properly assess the impact of government policies

Recommendations:

1. *That the Strategic Plan addresses both the specific historical and contemporary issues experienced by Australia's Aboriginal peoples, and recognises the link between the social determinants of health, inequity and risk for suicide.*
2. *That the Strategic Plan endorses:*
 - a) *The ongoing investment in evidence-based early childhood development and parenting programs for families at risk of having developmentally vulnerable children to support healthy brain development, resilience and self-control*
 - b) *A commitment to aim for all children to be developmentally equal by age 7 with intensive support for children who are developmentally vulnerable on the Australian Early Development Census, which will need to be done annually*
 - c) *Appropriately resourced and designed education for all school students in the Northern Territory, including by ensuring that students that require them have individual learning plans that include access to family support and therapeutic services provided by Aboriginal community controlled health services, and by supporting the re-establishment of Aboriginal Parents Groups and a Northern Territory Aboriginal Education Advisory Group*
 - d) *The trials of evidence-based school programs in primary and secondary schools that develop improved regulation and executive functions.*
3. *That the Strategic Plan recognises the link between contact with the criminal justice system and risk of youth suicide and endorses preventive and diversion measures to reduce the numbers of Aboriginal young people being incarcerated, as well as therapeutic approaches for those where detention is necessary.*
4. *That the Strategic Plan recognises the need to address the number of Aboriginal children in out-of-home care as part of a suicide prevention strategy by:*
 - a) *Endorsing of SNAICC's five-point strategy for addressing the rising numbers of Aboriginal children being removed from their families and supporting the implementation of the Aboriginal Child Placement Principles.*
 - b) *Supporting the development of a comprehensive strategy to address Out of Home Care for Aboriginal children in the Northern Territory, including Family Group Conferencing.*
5. *That the Strategic Plan endorses measures to reduce the supply of alcohol as the best way to reduce alcohol-related harm, including suicide. In particular this means:*
 - a) *NT Government take action on price through a minimum per unit (or floor) price based on the price of full strength beer (\$1.50 per standard drink) and lobby the Commonwealth government for a volumetric tax, to reduce the availability of cheap alcohol and raise funds to address alcohol-related harm*

- b) reducing trading hours, including for take-away alcohol sales and for late night on-premises trading*
- 6. That the Strategic Plan includes a commitment to addressing trauma-informed and culturally-secure services by:**
- a) Supporting Aboriginal Community Controlled Health Services as the preferred providers of culturally-secure social and emotional wellbeing services, mental health and suicide prevention services to Aboriginal people*
 - b) Supporting healing approaches run by the Aboriginal community*
 - c) Supporting living on country*
 - d) Developing strategies for a high-quality, culturally-competent mental health workforce with a focus on building an Aboriginal health workforce.*
- 7. That the Strategic plan:**
- a) Recognises that integration of services for holistic, collaborative care is best achieved under a single comprehensive primary health care provider and single funding stream.*
 - b) Supports needs-based planning through established collaborative structures that include significant representation from the Aboriginal Community Controlled Health Service sector, to ensure the effective distribution of resources and collaboration across providers.*
 - c) Supports five year block funding for comprehensive primary health care services including ACCHSs.*
- 8. That the Strategic Plan ensures the robust and transparent data is collected on suicide, suicide attempts and self-harm, and is used for service improvements.**

Introduction and context for this submission

The Central Australian Aboriginal Congress (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 14 000 Aboriginal people living in and nearby Alice Springs each year as well as the remote communities of Ltyentye Apurte (Santa Teresa), Ntaria (Hermannsburg) and Wallace Rockhole, Utju (Areyonga), Mutitjulu and Amoonguna.

ACCHSs such as Congress provide high quality, accessible, evidence-based, multidisciplinary clinical care within a culturally secure setting, based on local knowledge, an Aboriginal governance structure and workforce, and strong historical relationships with the communities that they serve. Aboriginal people consistently prefer to use ACCHS over mainstream services giving them a strong advantage in addressing access issues (Freeman et al 2016).

ACCHSs 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 by providing clinical care as well as addressing the broader determinants of health, for example, through advocacy for improved policies on overcrowding and housing, early childhood, education and alcohol and other drugs.

This submission to the Northern Territory Government's development of a Suicide Prevention Strategic Plan therefore addresses suicide prevention from a social determinants, population health and primary prevention perspective, as well as from a mental health service delivery perspective. Particular attention is given to young Aboriginal people who have highest national rates of suicide, which can be largely attributed to unhealthy early childhood development, linked to disadvantage.

The submission is arranged around the four priority areas outlined in the discussion *paper Northern Territory Suicide prevention: A critical conversation for all our community*"

- 1) Priority Area 1: Engage the Territory community to explore strengths-based and community-led initiatives to ensure that the diversity of the NT is reflected in the strategy
- 2) Priority Area 2: Identify ways to improve the skills of people in our services to deliver culturally safe, trauma-informed practices
- 3) Priority Area 3: Improve collaboration to ensure access to appropriate support for those identified at risk
- 4) Priority Area 4: Evaluate what we all do so that initiatives and interventions align with best practice, and enable all Territorians to benefit

1. Priority Area 1: Engage the Territory community to explore strengths-based and community-led initiatives to ensure that the diversity of the NT is reflected in the strategy

1.1. Disempowerment, disadvantage and the social determinants of health: The fundamental factors that underpin suicide in Aboriginal communities.

The suicide rate for Aboriginal Australians is almost twice the rate for non-Aboriginal Australians (AIHW, 2016). High rates of suicide are closely linked to social and economic disadvantage: the greater the inequality, the higher the risk is for mental illness (WHO, 2014). In other words, the need to address inequality cannot be ignored as a fundamental measure to reduce suicide rates in Aboriginal communities. This has been known in the literature since the classic work on Suicide by Emile Durkheim published in 1897 and the key findings in this study have been confirmed by modern social epidemiology yet there continues to be attempts to address suicide through programs and services without the need to address extreme structural inequalities. This will not be sufficient.

For Australian Aboriginal people, these inequalities include poverty, poor education, poor housing, lack of nutrition and lack of meaningful employment. Lack of control over one's life, continual anxiety and insecurity has a powerful effect on health and well-being (WHO, 2003): between one-third and one-half of the gap in health between Aboriginal and non-Aboriginal people is estimated to be due to these determinants (AHMAC, 2012).

Fundamental to these inequities is the historical and ongoing impact of colonisation which has led to dispossession; exclusion; discrimination; marginalisation; the forcible removal of children from their families; and the contemporary public policies that continue to disempower Aboriginal communities. The combined impact of these social forces is intergenerational trauma, which has made it more and more difficult for parents to provide their children with the best start to life.

1.1.1. Empowering communities and addressing the social determinants

Strengthening community-led initiatives to reduce the rates of suicide requires recognising the impact of colonisation, intergenerational trauma and loss of control. This includes supporting community control of Aboriginal services and programs, connection to family, community, country, language and culture and support for trauma-informed services; healing programs; culturally secure SEWB programs; and where appropriate Aboriginal families living on country. This is further addressed under Priority Three.

Action across the full range of social determinants is necessary to reduce rates of suicide in Aboriginal communities by improving resilience and capacity to self-manage at an individual and community-level. This requires a whole-of-government commitment. For example, early childhood development and learning, primary and secondary education accompanied by psychosocial support measures (e.g. positive role models, healthy activities); support for workforce participation and development of skills; healthy relationships and community participation, are all measures that can strengthen social and emotional wellbeing and prevent suicide (National Aboriginal and Torres Strait Islander Health Plan 2013-2023, Robinson et al, 2012).

Recommendation 1

That the Strategic Plan addresses both the specific historical and contemporary issues experienced by Australia's Aboriginal peoples, and recognises the link between the social determinants of health, inequity and risk for suicide.

1.2. Brain development, self-regulation and suicide

Between 2008-2012 the suicide rates for Aboriginal people 15–19 year olds were five times as high as the non-Aboriginal rate (AIHW, 2016). Suicide rates are a key measure of the health and well-being of young people, and an indicator for youth development i.e. the status of young people and their capacity to contribute to and benefit from society (Australian Youth Development Index, 2016).

As children's brains and social-emotional skills develop, they learn to regulate their emotions, attention and behaviour. Disruptions to healthy neurodevelopment lead to problems with the brain's executive functions such as impulsivity due to poor emotional self-regulation, problem solving, coping and decision-making skills. This also includes conditions that can occur in utero, such as Foetal Alcohol Spectrum Disorders (FASD). For some young people, underdeveloped self-regulation and coping skills can mean suicidal thoughts quickly escalate as an immediate solution to an emotional life crisis (Robinson et al 2016).

Suicide in children, adolescents and young adults is therefore more often related to impulsive behaviour and poor problem-solving skills, such as the inability to deal with an emotionally- stressful life event, rather than depressive illnesses (NATSISPS, 2013). It is not effective to wait to diagnose "depression" or even depressive symptoms as most young people who suicide do not show these symptoms but act impulsively, often but not always under the influence of alcohol which further reduced the capacity for emotional self-regulation.

Aboriginal children are at a higher risk than non-Aboriginal children for unhealthy brain development and therefore impulsive behaviours. According to the Australian Early Development Census (AEDC), 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 (AED Census Report 2015). Furthermore, children living in very remote areas are 2.6 times more likely to be developmentally vulnerable than children living in major cities. One of the key domains of developmental vulnerability is the emotional domain that includes self-control or self-regulation.

Additionally, adverse childhood experiences such as family violence, 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 (Anda et al, 2006). 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 (Anda and Felitti, 2012).

1.2.1. Early childhood care, support, education and healthy brain development

Improving cognitive development, resilience and self-control, lies in the area of early childhood, especially in the years from pre-birth to 4 years of age. It is well established that in the first few critical years, children need responsive care and stimulation including strong, positive relationships with primary care givers to develop neural systems crucial for adult functioning and positive mental health. Longitudinal studies show that parenting support 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 (Tremblay, et al, 2008; Campbell, et al, 2008).

1.2.2. Parenting programs to support healthy development

Parenting programs support and enhance the skills of parents to allow for healthy child development, and reduce exposure to adverse childhood experiences which negatively impact on development and increase the risk of suicide in later life (Robinson et al 2016). For example, the Nurse Family Partnership and Parenting Under Pressure (PUP) programs are cost effective programs that promote healthy development in early childhood (Olds et al, 1997; Bronfenbrenner, 2009) and prevent the development of mental and physical health problems in later life.

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

1.2.3. School-based identification and intervention for children with lack of self-control and regulation and other related impairments

Aim for developmental equality by 7 years of age or year 2.

Engagement and participation in school is one of the key protective factors for youth suicide. However, the Northern Territory education system is failing Aboriginal children. The proportion of Aboriginal school children who meet the national reading writing, spelling, grammar and punctuation, and numeracy benchmarks is greatly lower than that for non-Aboriginal children in the Northern Territory, and the Northern Territory has the widest attendance gap in Australia, with the gap widening in the higher grades (AIHW, 2015). One of the major reasons for the very poor educational outcomes being achieved in the Northern Territory is that children are not school ready by age 5 due to their disadvantaged early childhoods.

This is the key gap that needs to be closed as it is the foundation of the life long Life Expectancy Gap. Addressing early childhood as outlined above therefore provides a 'bottom up' pathway to improved school attendance and better outcomes as children are better able to understand what they are being taught and find learning an empowering experience.

Notwithstanding early childhood development the education system has a responsibility to improve educational engagement and results in Northern Territory schools for Aboriginal children. In Canada, for example they have had a goal for decades to try to ensure that all children are developmentally equal by age 7 or year 2. The NT should adopt this goal in education policy. This would require intensive follow up of all the children identified as developmentally vulnerable in the AEDC which would need to be done annually.

Individual learning plans and support

There are examples of schools in different parts of Australia that have children on individual learning plans with appropriate support services and are able to make a significant difference to learning outcomes even when children begin school developmentally vulnerable on a number of domains in the AEDC scores (see for example (Milligan L 2015)). There needs to be attempts to replicate this approach in primary schools in the NT.

This has been well described in the *Revolution School* TV series on Kambrya College in Melbourne. An excerpt from the series website is very informative:

In 2008 Kambrya's Year 12 results put it in the bottom ten per cent of secondary schools in Victoria. Making the Grade follows the transformation of the school under the leadership of principal Michael Muscat, to the point where it is in the top 25% of schools. Muscat and his colleagues manage more than 1000 students, including those struggling to cope with school and home life. Making the Grade gives a raw and honest insight into the challenges facing these teenagers, while also showcasing what really works in classrooms to improve academic results. The series highlights the internationally renowned research of Professor John Hattie, and one of the world's top ranked education institutions, the University of Melbourne's Graduate School of Education. During 20 years of research analysing more than 70,000 studies involving a third of a billion students from around the world, Professor Hattie has established what is most effective to improve student learning (ABC Online 2016).

Schools are often the first place that become aware that young people are having difficulties and appropriate, evidence based action needs to be taken well before young people either drop out or are expelled as this creates a significantly higher risk for suicide. There is a very strong evidence base to what needs to be done to improve outcomes in schools and yet this is not being systematically implemented in the Northern Territory. Professor John Hattie from the University of Melbourne is a world leader in this field (Hattie J 2009) and yet the NT Education Department has not to our knowledge ever sought advice from an expert like him to assist them to address their very poor outcomes. There is a long tradition in the health sector of using evidence to inform practice and collecting data that enables improvements to be measured. It is high time this type of scientific rigor was applied to education.

Identifying impulsivity and learning self-regulation

While it is vital to try to prevent potential disabilities due to impulsivity and lack of self-regulation there are some promising approaches to addressing issue of self-regulation and executive functioning in early

primary school. The Alert Program® is for children five to seven years of age and is based on the analogy of the body being like a car engine to teach self-regulation. The body can run at different levels of alertness such as high, low or just right. Children are taught five ways to change their level of alertness through:

- listening
- moving
- touching
- looking
- putting something in their mouth

Developed in the USA (Nash et al, 2014), the program has been adapted to honour the cultural and contextual uniqueness of Fitzroy Valley, so that the concepts can be most effectively taught. It is also vital that the model of program training and delivery is sustainable after the research project is completed.

New school programs have also recently been tested to identify older school children at around age 12 who have the traits for impulsive and addictive behaviours, and provide targeted interventions by trained school teachers so that high risk children are able to cope with negative internal states (Conrad et al, 2003). These programs have been shown to be effective and indicate long-term benefits in areas such as alcohol consumption and risky behaviors. Additionally, the trials showed a possible herd effect of the program, where by the wider group of children exhibited fewer long-term drinking rates and less binge drinking. It is worth exploring the transfer of these programs into a local context, provided they are supported by specialist services who can work with schools to appropriately assess young people and ensure appropriate interventions are in place for individuals.

Recommendation 2

That the Strategic Plan endorses:

- a) The ongoing investment in evidence-based early childhood development and parenting programs for families at risk of having developmentally vulnerable children to support healthy brain development, resilience and self-control***
- b) A commitment to aim for all children to be developmentally equal by age 7 with intensive support for children who are developmentally vulnerable on the Australian Early Development Census, which will need to be done annually***
- c) Appropriately resourced and designed education for all school students in the Northern Territory, including by ensuring that students that require them have individual learning plans that include access to family support and therapeutic services provided by Aboriginal community controlled health services, and by supporting the re-establishment of Aboriginal Parents Groups and a Northern Territory Aboriginal Education Advisory Group***
- d) The trials of evidence-based school programs in primary and secondary schools that develop improved regulation and executive functions.***

1.3. Contact with the justice system and out-of-home care: Key risk factors for suicide in young Aboriginal people.

1.3.1. Reducing contact with, and the impact of, the justice system to reduce the risk for suicide in young Aboriginal people

A young person's risk of suicide is increased if they have been involved in criminal justice system (e.g. being arrested, charged or sentenced) in the previous three months and in particular the last week (Robinson et al 2016). This has a disproportionate effect on Aboriginal young people who are held in criminal detention at much higher rates than non-Aboriginal young people, while around one half of young people in detention at any point in time are Aboriginal (AIHW 2015).

Prevention approaches, and those that divert young offenders away from detention, are the most important strategies to deal long-term with the issue of youth detention. Australia's leading criminologist, Don Weatherburn has very clearly outlined the two key strategies to prevent incarceration evidence based early childhood programs and reducing the supply of alcohol (Weatherburn 2015). For Aboriginal young people, diversion programs have been shown to lead to reduced drug and substance use and reoffending, especially if programs include culturally appropriate treatment and rehabilitation and Aboriginal and community Elders or facilitators (Closing the Gap Clearinghouse, AIHW & AIFS, 2013).

For that small number of young people where detention is necessary, the focus should be on therapeutic treatment in smaller residential units rather than punishment in large institutions. Such an approach has been shown to achieve exceptional reductions in juvenile recidivism (McGuinness & McDermott 2010).

Congress' [submission](#) to the Royal Commission into the Protection and Detention of Children in the Northern Territory outlines in detail the measures necessary to reduce contact with the justice system and to reduce the impact when children are detained.

Recommendation 3

That the strategic plan recognises the link between contact with the criminal justice system and risk of youth suicide and endorses preventive and diversion measures to reduce the numbers of Aboriginal young people being incarcerated, as well as therapeutic approaches for those where detention is necessary.

1.3.2. Reducing and limiting the impact of Out of Home care to reduce the risk for suicide in young Aboriginal people

Statutory care of children has a direct link with suicide – a recent report notes that more than half of young people who had left out of home care within twelve months had reported that they had experienced suicidal thoughts, and more than a third had attempted suicide (Robinson et al, 2016). This

is deeply concerning for Aboriginal children who are nearly 10 times as likely as non-Aboriginal children to be in Out of Home care due to child protection issues (AIHW 2016).

The Secretariat of National Aboriginal and Islander Child Care (SNAICC) has recommended a five-point strategy for addressing the rising numbers of Aboriginal children being removed from their families and supporting the implementation of the Aboriginal Child Placement Principles (SNAICC 2014):

- increasing community participation in decisions for the care of Aboriginal and Torres Strait Islander children, supported by community-controlled service design and delivery,
- re-orienting service delivery to early intervention and family support,
- ensuring that funding and policy support holistic and integrated family support and child protection services,
- recognising the importance of supporting and maintaining cultural connection, and
- building capacity and cultural competence for effective service delivery to Aboriginal and Torres Strait Islander children and families.

In the Northern Territory a *Child Protection and Out of Home Care (OOHC) Workshop* hosted by the Aboriginal Medical Services Alliance of the Northern Territory (AMSANT) in April 2016, adopted a wide range of recommendations to address the system's failings (AMSANT 2016). These recommendations included the establishment of Family Group Conferencing as the legislated mechanism to ensure that all kinship care options are properly explored prior to foster care arrangements being made. While the evaluation of the Family Group Conferencing Pilot in Alice Springs highlighted the potential of the program in reducing the need for child protection matters to be determined through court processes, the program has not received ongoing funding (Arney, et al 2012).

Recommendation 4

That the Strategic Plan recognises the need to address the number of Aboriginal children in out-of-home care as part of a suicide prevention strategy by:

- a) Endorsing of SNAICC's five-point strategy for addressing the rising numbers of Aboriginal children being removed from their families and supporting the implementation of the Aboriginal Child Placement Principles.***
- b) Supporting the development of a comprehensive strategy to address Out of Home Care for Aboriginal children in the Northern Territory, including Family Group Conferencing.***

1.4. The indirect contribution of alcohol to suicide

Harmful alcohol use by parents and carers is known to be associated with a lack of responsive care and stimulation in early childhood. Children brought up in these environments often lack the necessary skills for effective emotional regulation and self-control and other executive brain functions that have been shown in longitudinal studies to lead to addictions including alcohol (Moffitt et al, 2011).

1.5. Alcohol as a catalyst for suicide

Alcohol is a related and major contributor to mental ill health and poor social and emotional wellbeing, risky behaviour and is a precursor for suicide. 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 suicides (AIHW, 2016; Tsey et al 2011).

1.5.1. Limiting the supply of alcohol to prevent suicide

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 and suicide, particularly among young people and the heaviest drinkers, who are the most disadvantaged and vulnerable to mental illnesses (Coghlan, 2008). 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 (WHO, 2008; Godfrey, 1997; Babor, 2005).

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 (Symons et al, 2012). 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 (Anda et al, 2002).

Congress has provided a detailed submission with a suite of evidence-based recommendations to the Northern Territory Alcohol Policies and Legislation Review. The submission can be viewed [here](#).

Recommendation 5

That the Strategic Plan endorses measures to reduce the supply of alcohol as the best way to reduce alcohol-related harm, including suicide. In particular this means:

- a) NT Government take action on price through a minimum per unit (or floor) price based on the price of full strength beer (\$1.50 per standard drink) and lobby the Commonwealth government for a volumetric tax, to reduce the availability of cheap alcohol and raise funds to address alcohol-related harm***
- b) Reducing trading hours, including for take-away alcohol sales and for late night on-premises trading***

2. Priority Area 2: Identify ways to improve the skills of people in our services to deliver culturally safe, trauma-informed practices

2.1. The need for culturally secure, trauma-informed practice

The ongoing impact of colonisation, dispossession; exclusion; discrimination; marginalisation; the forcible removal of children from their families, 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 (Atkinson, 2013). 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 (Wall, 2016).

The service system must recognise the prevalence of intergenerational trauma not only on the wellbeing of individuals, but populations and communities as a whole (The Healing Foundation, 2012). 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 (Atkinson, 2013).

Trauma-informed organisations are able to recognise the presence of underlying trauma, and ensure that their services contribute to addressing them using strengths-based approaches that emphasise the physical, psychological, and emotional safety of clients and helps them rebuild a sense of control and empowerment. Trauma-informed services are also better able to protect their staff and board members from potential vicarious effects of working with traumatised people (Atkinson 2013).

2.1.1. Trauma-informed care and the provision of culturally secure services by Aboriginal Community-controlled health services (ACCHSs)

ACCHSs should be the preferred providers of trauma-informed care to Aboriginal people. Aboriginal people access and choose to use ACCHSs over mainstream services wherever they are available. Additionally, due to a range of inter-linked structural advantages ACCHSs have in delivering services, they are improving health and wellbeing outcomes. For a detailed description of the effectiveness of ACCHS, see **Appendix B**.

Congress' Social and Emotional Wellbeing (SEWB) service is specifically modeled for Aboriginal people and integrates "three streams of care": medical care; psychological care including suicide risk assessment; and social and cultural support. The three streams recognises the importance of social and cultural factors in Aboriginal health including exploring issues of cultural identity and reconnecting with parts of their culture which may have become less strong. Services may include family support, cultural support, cultural brokerage, advocacy and linking with traditional healing services. For further information on the three streams service model see **Appendix C**.

The National Mental Health Commission's National Review of Mental Health Programmes and Services found numerous barriers to adequate social and emotional wellbeing and mental health services for Aboriginal people, significantly including a lack of access to and clear funding processes for preferred community controlled, culturally capable models of care (NHMC 2014). Secure and dedicated funding for community-controlled, culturally appropriate mental health and social and emotional wellbeing services for the wider Aboriginal community is critical.

Additionally, the current focus on competitive tendering rather than needs-based funding is a major risk to the effectiveness of ACCHSs. This is discussed further under Priority Three.

2.1.2. Support Healing Programs

Culture and spirituality are important in addressing intergenerational trauma through supporting resilience, positive social and emotional well-being, and living a life free of addiction to alcohol and drugs. In this context, healing programs are an effective way of addressing the effects of intergenerational trauma (Dudgeon et al 2014).

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. 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 (Aboriginal Healing Foundation, Canada, 2006).

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 (Healing Foundation 2012).

“Healing works best when solutions are culturally strong, developed and driven at the local level, and led by Aboriginal and Torres Strait Islander people.” (The Healing Foundation)

2.1.3. Support for living on country

Where appropriate and desired, living on traditional lands with strong connection to family, community, country, language and culture has physical, mental and emotional health benefits, including reduced substance abuse and violence (Amnesty International 2011).

2.1.4. Support and grow an Aboriginal health workforce

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 (AHMAC, 2012):

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 in Aboriginal health in the Northern Territory (NACCHO, 2014).

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.

2.1.5. Develop a culturally-secure mental health workforce

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.

Recommendation 6

That the Strategic Plan includes a commitment to addressing trauma-informed and culturally-secure services by:

- a) Supporting Aboriginal Community Controlled Health Services as the preferred providers of culturally-secure social and emotional wellbeing services, mental health and suicide prevention services to Aboriginal people***
- b) Supporting healing approaches run by the Aboriginal community***
- c) Supporting living on country***
- d) Developing strategies for a high-quality, culturally-competent mental health workforce with a focus on building an Aboriginal health workforce.***

3. Priority Area 3: Improve collaboration to ensure access to appropriate support for those identified at risk

3.1. The need for holistic and integrated services across physical and mental and social and emotional wellbeing, by one provider.

The model of comprehensive primary care delivered by ACCHS as a single provider allows for primary health care integrated with social and emotional wellbeing services, provided by a multidisciplinary team using a single clinical information system, is able to support complex patients with multiple health and social needs. The breadth of care alongside effective screening and referral pathways, coordination of services through shared records, reduces the potential for patients to ‘fall through the gaps’ as they often do in mainstream services. For further information on ACCHS model see **Appendix B**.

For example, 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 to 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 including assessment of suicide risk without the stigma normally associated with presenting to a “mental health” service.

3.1.1. Support needs based funding rather than competitive tendering

The current practice of competitive tendering for short-term funding leads to complex service delivery environments with multiple providers of health services. Creating a culture of competition rather than cooperation amongst those providers leads to a system that is difficult to navigate for Aboriginal clients- especially where language, literacy and cross-cultural service delivery are issues.

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. The result is fragmentation and duplication of service delivery, lack of coordination, waste of resources and suboptimal outcomes for clients.

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 (WHO, 2007). In the Northern Territory, 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 (NTAHF, 2014).

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.

3.1.2. Provide long term funding for certainty and stability of services

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 (Closing the Gap Clearing House, 2014). 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 (D'Abbs et al 2013). 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 7

That the Strategic plan:

- a) Recognises that integration of services for holistic, collaborative care is best achieved under a single comprehensive primary health care provider and single funding stream.*
- b) Supports needs-based planning through established collaborative structures that include significant representation from the Aboriginal Community Controlled Health Service sector, to ensure the effective distribution of resources and collaboration across providers.*
- c) Supports five year block funding for comprehensive primary health care services including ACCHSs.*

4. Priority Area 4: Evaluate what we all do so that initiatives and interventions align with best practice, and enable all Territorians to benefit

4.1. Collect detailed data on suicide and suicide attempts, and make it available to services at a local level.

The *NT Suicide Prevention Strategic Action Plan 2015-2018* includes actions for the NT Department of Health around data collection, monitoring and evaluation including the production of annual NT suicide prevention report cards on the Action Areas outlined in the Plan. These report cards are not readily accessible online, and would be useful for needs identification and service planning at a local level.

It is therefore important that a new Strategy supports the ongoing development of a consistent and reliable source of data on suicide, suicide attempts, and self-harm, including Aboriginal status and other demographic variables, to better understand at risk groups and service needs. This includes the provision of detailed, transparent data at a local level so that services and funders can plan, be responsive, improve quality, and be accountable.

All suicide events where the person had recently come into contact with a health service should be audited and an assessment of what could be done to improve and prevent further suicides undertaken. Much can be learned from the ACCHS' model of Continuous Quality Improvement (CQI), evidence-based innovation and responsiveness to population and service needs through research evidence and data collection. Data collected by ACCHSs are used to fulfill reporting requirements as well as support local decision-making to improve the delivery of primary health care services through the CQI program.

Furthermore, all services that support mental health and seek to prevent suicide should be measured through performance indicators with funding contingent of the achievement of outcomes. All new initiatives and interventions should of course be independently evaluated and scaled up and transferred across communities if successful.

The evaluation of the Strategy should also consider data collected through the Closing the Gap framework reports and align with the goals for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023 as a framework for measuring and determining the achievement of the social determinants of health.

Recommendation 8

That the Strategic Plan ensures the robust and transparent data is collected on suicide, suicide attempts and self-harm, and is used for service improvements.

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Appendix A

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

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		Secondary Prevention	
	Child Focus	Carer Focus	Child Focus	Carer Focus
	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		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	
Centre Based Most work is done at a centre where child or families come in to access service	<ul style="list-style-type: none"> • Abecedarian educational day care • Immunisations • Child health checks • Developmental screening 	<ul style="list-style-type: none"> • Health advice to parents in clinic (e.g. nutrition, brushing teeth, toilet training) 	<ul style="list-style-type: none"> • Child-centred play therapy • Therapeutic day care • Preschool Readiness Program • Antibiotics 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Mobile play groups 	<ul style="list-style-type: none"> • Nurse home visitation • Families as first teachers (home visiting learning activities) 	<ul style="list-style-type: none"> • Child Health Outreach Program • Ear mopping 	<ul style="list-style-type: none"> • Targeted Family Support • Intensive Family Support • Case management models for children at risk • Parents under Pressure (PUPS)

Early Childhood Learning Centre

Congress has established an Early Childhood Learning Centre for Aboriginal children from disadvantaged, non-working families living in Alice Springs. The Centre is 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.

Preschool Readiness Program

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.

APPENDIX B**The success of Aboriginal Community Controlled Services in health service delivery and health outcomes.*****a) Effectiveness***

Although they have a more complex and high needs population, ACCHSs are achieving health outcomes that are comparable or better than mainstream services (Mackay, 2014; AIHW 2015; Freeman, 2016). Evidence points to improved health outcomes in mortality, sexual health, smoking cessation and cardiovascular programs, as well as maternal and child health outcomes, including birth weights, anaemia and immunisations (Panaretto, 2014; Congress CQI data).

The effectiveness of ACCHSs is particularly clear in the Northern Territory where their comprehensive model of service delivery and advocacy for public health and system reform has been the foundation for much of the relative success in the Northern Territory in reducing mortality rates and 'closing the gap' in health between Aboriginal and non-Aboriginal communities (AIHW, 2015).

ACCHS are also cost effective. An economic evaluation of Danila Dilba Health Service in the Darwin region showed that in 2015-16 services were estimated to contribute \$5.60 million in incremental benefits based on improved health outcomes for its clients in three areas, type 2 diabetes, chronic kidney disease and maternal and child health (Deloitte Access Economics, 2016). This is comprised of \$0.43 million in avoided health and other financial costs, and \$5.17 million in improved value of life.

b) Comprehensive, integrated primary care services that seek to address health inequities.

ACCHSs function within comprehensive primary health care service framework which aims to address health inequities and close the health gap between Aboriginal and non-Aboriginal people. This includes providing high quality, accessible, multidisciplinary clinical care as well as care that goes beyond the treatment of individual clients for discrete medical conditions (Thompson et al 2013). ACCHSs are 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, 2013-23).

The ACCHS service model spans a range of curative, promotive, preventive and rehabilitative health care to individuals to make them well and keep them well, as well as action at a population level to address the broader underlying social determinants of ill health. Congress, for example, has expanded its role to include early childhood learning, nutrition, mental health including alcohol rehabilitation and family support as well as education and employment. Over half of Congress' clients have reported they received help from Congress staff with issues not directly related to health e.g. transport, housing, accessing benefits, job training and childcare (Southgate 2016).

c) Access and choice

Primary health care is associated with a more equitable distribution of health outcomes in populations - more or better primary care and improved health outcomes (Starfield, 2005). There continues to be sound evidence that supports the link between strong primary care activities such as prevention, early intervention and comprehensive care and improved health outcomes for Aboriginal people (Zhao, 2014; Starfield 2005; Panaretto,2014).

Effective primary care also reduces the reliance of more expensive acute care, particularly for chronic conditions. A review of evidence shows that access to effective primary health care is strongly associated with the rates of hospitalisation for avoidable conditions i.e. admissions to hospital that could have potentially been prevented through the provision of appropriate non-hospital health services. Potentially Avoidable Hospitalisations (PAHs) are an indicator of accessible and effective primary healthcare (NHPA, 2013-14). There are higher rates of avoidable hospitalisation when there is:

- Poorer self-reported access to medical care
- Higher costs for the consumer
- Lower ratios of GPs to population
- Increasing socioeconomic disadvantage
- Lower numbers of GP consultations
- Greater remoteness.

Access to quality, culturally secure primary care services is therefore central to achieving longer term health improvements for Aboriginal people (Mackey, 2014). Evidence shows that there is a preference by Aboriginal people to attend ACCHSs, alongside increased patient satisfaction, adherence and compliance with treatment regimens (Freeman, 2016; Vos, 2010). Where ACCHSs exist, the community prefers to use them:

- According to the Aboriginal and Torres Strait Islander Health Performance Framework 2014 report, 73 per cent of Aboriginal Australians reported that they would prefer to go to an Aboriginal Medical Service or community clinic (AIHW, 2014)
- Between 1999 and 2013 the number of Aboriginal primary health-care services increased from 108 to 205.
- In the same period, the number of episodes of health care increased by 152% from 1.2 million to 3.1 million episodes (AIHW, 2014).
- Between 2009 and 2014, the number of Congress clients increased by 15 per cent, from 8600 to 10000 (Flinders University, 2016).
- Almost half of Congress clients rated the quality of services 4 out of 5, and 35 % gave a rating of 5 out of 5 (Flinders University, 2016).

d) Community engagement

There are clear links between community empowerment, overcoming disadvantage, and improving health outcomes (Panaretto, 2014). As members of ACCHSs, individuals and communities are directly

involved in the planning and delivery of services that are acceptable and used by communities. As noted above in 4.2, every Aboriginal person over the age of 18 years of age in the Congress catchment is eligible to become a member of Congress and community is consulted in the development and cultural security of programs.

e) Aboriginal Workforce

The employment and training of Aboriginal Health Workers to work as 'cultural brokers' alongside non-Aboriginal doctors, as well as training Aboriginal people to be administrative staff, enhances the acceptability and accessibility of services to Aboriginal clients (Flinders University, 2016). Aboriginal health professionals are better able to ensure culturally appropriate care in the services they deliver and improve the patient care (AHMAC, 2015). An Aboriginal workforce is also another way to address the social determinants of health through increased training and employment. As an ACCHS, Congress provides education and training opportunities to Aboriginal people in the community including traineeship, cadetship and Aboriginal Health Practitioner training.

f) Continuous Quality Improvement and evidence-base.

ACCHSs drive improvements in the quality and safety of their services through Continuous Quality Improvement (CQI) practices, by achieving general practice standards and Australian Standards (Sibthroe,2016). Quantitative data is used for local decision making and to report to funders using NT Aboriginal Health Key Performance Indicators (NTAHKPIs) and national KPIs (nKPIs). The submission of these data is compulsory and de-identified results are publically reported.

Congress CQI processes have in one year, for example, reduced rates of anaemia in children less than 5 years from 18 to 13 per cent in urban clinics, and from 13 to 2 per cent in a remote clinic. Improvements have been due to a collaborative effort by clinic staff including goal setting, outcome measures, evidenced-based clinical interventions, innovative organisational and practice change, and reviewing outcomes to see how they have worked.

Patient surveys also provide useful information on the patient experience that allows responsiveness to user needs.

The Congress CQI program also sits within the broader system of clinical governance which includes:

- The CQI Clinical governance committee which undertakes a root cause analysis of incidents and complaints, leads CQI priority areas and oversees the development and review of clinical policies and procedures essential for CQI.
- Staff credentialing and registration.
- Complaints, incidents and suggestions and CQI registers.
- Clinical audits.
- Development and review of the clinical information system (Communicare)
- Development of operational plans with appropriate KPIs for all programs and services.

Congress programs have a strong evidence base, and a research subcommittee of the Board that facilitates studies to be undertaken in our service area. New programs and innovations are also rigorously evaluated.

Appendix B References:

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APPENDIX C

Congress' 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.¹

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 programs²

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.

¹ D'Abbs, P; Togni, S; Rosewarne, C; Boffa, J., (2013) The Grog Mob : lessons from an evaluation of a multi-disciplinary alcohol intervention for Aboriginal clients. Australian and New Zealand Journal of Public Health, v.37, no.5, Oct: 450-456

² McLellan, A.T., et al., (1998) Supplemental social services improve outcomes in public addiction treatment. Addiction, **93**(10): p. 1489-99.