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Aboriginal Congress
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Input into the *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023*

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Aboriginal health in Aboriginal hands.

Connection to family, community, country, language and culture

Experiences, ideas and evidence

Background

- The experience of colonisation (dispossession, exclusion, discrimination, marginalisation, the forcible removal of children, racism and the ongoing experience of inequity) continues to impact on poor physical and social and emotional wellbeing outcomes for Aboriginal people.[1]
- 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 (Atkinson 2013).
- There is growing evidence that unresolved intergenerational trauma underpins many health and wellbeing issues in Aboriginal communities including family violence, addictions, and early childhood developmental vulnerabilities (see for example Dockery 2012).
- A response to the experience of colonisation and intergenerational trauma must be based on decolonisation through community control of Aboriginal services and programs and a formal settlement between Aboriginal people and the Australian state as part of the constitutional reform process, 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.

Trauma Informed services

- The experience of trauma may manifest in many different ways such as in mental health issues, or addiction, or violence. 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).

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).
- 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).

[1] Throughout the paper the term Aboriginal will be used to refer to all Aboriginal and Torres Strait Islander peoples. The use of the term Indigenous is not supported by the Central Australian Aboriginal Congress.

Culturally secure SEWB programs

- 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 and Torres Strait Islander 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 and Torres Strait Islander community is critical.
- As an ACCHS, Congress makes cultural security a core component of our services. Our SEWB service integrates "three streams of care": medical care; psychological care; and social and cultural support.

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).

Key recommendations

1. ***Ensure that preference is always given to Aboriginal community control of services and programs and that all agencies delivering services to Aboriginal people use approaches that are trauma-informed to allow an effective response to the many ways that trauma can manifest, and to protect clients and staff;***
2. ***Support the development and appropriate evaluation of the effectiveness of healing programs under local Aboriginal control;***
3. ***Ensure secure and dedicated funding for community controlled, culturally secure models of delivering SEWB and mental health services;***
4. ***Support for Aboriginal groups that wish to live on their traditional lands to do so, given the clear physical, social and emotional wellbeing benefits that result;***
5. ***Support the outcome of the current consultation process with Aboriginal people on constitutional reform***

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Racism

Experiences, ideas and evidence

Background

- The experience of racism is overwhelmingly common for Aboriginal people (Ferdinand et al 2012).
- Racism is an acknowledged determinant of poor health and wellbeing.
- The experience of racism may affect the physical, social and emotional wellbeing of Aboriginal people through the stress and other negative emotions it creates, or through the direct experience of racially-motivated violence, or through increased use of tobacco, alcohol and other drugs (Paradies et al 2008).
- By being embedded in the ways that the health system operates, systemic racism further contributes to ill health through creating a barrier to access for Aboriginal people, and through differential access to timely health procedures (e.g. Cunningham 2002, Valery et al 2006).
- Systemic differences in care provided by hospitals contribute to Aboriginal people's low level of trust for hospitals as institutions and the fact that Aboriginal people are many times as likely to take their own leave or leave hospital against medical advice or be discharged at their own risk compared to other Australians.

Developing and reporting on a set of performance indicators

- A critical way forward to improve access to and quality of hospital services to the Aboriginal community is to universally establish and report on a set of national key performance indicators as a basis for Continuous Quality Improvement (CQI), to include:
  - ⇒ *Discharge summary timeliness*
  - ⇒ *Rates of sentinel procedures disaggregated by Aboriginality*
  - ⇒ *Take Own Leave (TOL) and Leave Against Medical Advice (LAMA)*
  - ⇒ *Medication Dispensing*
  - ⇒ *Cultural Competency*
  - ⇒ *Employment of Aboriginal staff including Aboriginal staff in leadership positions*
  - ⇒ *Partnerships with local Aboriginal communities / organisations*

Accreditation and KPIs linked to funding.

- Performance indicators for Aboriginal health CQI systems should be incorporated into current hospital accreditation systems, and thereby to hospital funding formulas. Some jurisdictions already have a system where hospitals receive weighted funding for Aboriginal Diagnostic Related Groups. A uniform national system that agreed to provide weighted additional funding to those hospitals accredited as having Aboriginal health CQI in place would provide a powerful incentive not just for the better identification of Aboriginal patients, but also for culturally secure practice (Australian Institute for Primary Care 2002; Otim et al 2002).
- Any accreditation system needs to include the views and endorsement of local Aboriginal community controlled health services as a key measure.

The relationship of primary health care and hospital care

- Access to appropriate, quality primary health care is essential to drive health gains in Australia. However, an appropriate level of primary health care also reduces hospitalisations, in particular through the early detection and ongoing management

of chronic disease. While the relationship between episodes of primary health care and hospitalisations is not a simple one, it is clear that inadequate access to primary health care leads to higher rates of hospitalisation especially for sick populations– which increases cost and capacity pressures on hospitals.

Key recommendations

6. ***Establish a national CQI system to reward quality improvement processes for hospitals in meeting the needs of the Aboriginal communities they serve, including through:***
   - **a.** ***establishing an agreed national set of KPIs to measure appropriateness and quality of care for Aboriginal people in hospitals***
   - **b.** ***regular public reporting on these KPIs for all jurisdictions and hospitals***
   - **c.** ***establishing accreditation systems such that hospitals that meet certain benchmarks and have the endorsement of local Aboriginal community controlled health services (ACCHS) receive access to higher levels of funding***
7. ***Prioritise investment in well-resourced, needs based, high quality, community controlled primary health care services to reduce the pressure on hospital care by avoiding preventable hospitalisations particularly through the early detection and management of chronic disease before it requires hospital treatment (including dialysis).***

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Early childhood development, education and youth

Experiences, ideas and evidence

Early childhood development

- In 2015 Aboriginal children were twice as likely as non-Aboriginal children to be developmentally vulnerable on one or more domains (42% compared to 21%) and two-and-a-half times as likely as non-Aboriginal children to be developmentally vulnerable on two or more domains two or more domains (26% compared to 10%).
- The inequity is much greater in remote areas and in Alice Springs 43% of Aboriginal children are developmentally vulnerable on two or more domains compared with 7% of non- Aboriginal children and in some remote parts of Central Australia it is up to 80%.
- Social and environmental influences in early childhood shape health and wellbeing outcomes across the life course. Adverse childhood experiences are highly correlated to a wide range of physical health problems, as well as to increased levels of depression, suicide attempts, sexually transmitted infections, smoking, and alcoholism (Anda & Felitti 2012).
- It is too late to wait until a child is ready for school at around age five to address vulnerabilities in development, as by this point many developmental gateways have been passed, and a child's developmental trajectory already set. After this point, interventions require increasing amounts of resources and produce diminishing returns as the child gets older (Ramey & Ramey 2004).
- Investments in early childhood development are a corner-stone for economic development and productivity with the Organisation for Economic Co-operation and Development (OECD) has advised that investing in early childhood is the single most important thing Australia can do to grow its economy and be competitive in the future (Equality Trust 2016, Hutchens 2016).
- Well-designed, evidence-based early childhood development programs are a highly cost-effective intervention to address and offset the effects of poor early childhood experience. There is very strong evidence that such programs can lower the risk of chronic disease; reduce the use of alcohol and other substances by young adults; increase school retention rates; and dramatically reduce youth incarceration rates. This evidence has been collated, developed and championed by the Nobel Laureate, Prof James Heckman (https://heckmanequation.org/)
- Congress operates a range of programs within a framework for early childhood development and family support that make up an integrated and comprehensive approach to this critical area. These are both primary and secondary prevention programs to be followed by, or in conjunction with, two years of preschool from age's three to five.

School education

- Education is a major determinant of lifelong health and wellbeing. A particularly strong relationship has been demonstrated internationally between maternal education and child health (Ewald and Boughton 2002).
- The proportion of Year 3, 5, 7 and 9 students at or above the national minimum standards for reading, writing, numeracy, spelling, and grammar and punctuation is significantly lower for Aboriginal and Torres Strait Islander than for non-Aboriginal

students. School attendance rates are lower for Aboriginal children, widen as they age, and are significantly worse in remote and very remote areas (AIHW 2015).

- Schools that have children on individual learning plans with appropriate support services 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 2015).
- Australia's public schools are the major provider of education for disadvantaged students (including Aboriginal students) but are significantly inadequately resourced compared with non-government schools which draw heavily upon public funding (Boston 2017).

Adult literacy

- The evidence suggests that at least 35% of the Aboriginal adult population have minimal English language literacy, with the figure rising much higher in rural and remote areas (Boughton 2009).
- Adult literacy is fundamental to developing 'literacy practices' (reading, writing, interpreting text) within families, which then support children to engage and perform well at school.
- Adult literacy courses delivered through formal education providers are unable to reach a large enough number of people to have a population level effect on literacy. An alternative approach being implemented in Aboriginal communities of Western NSW by the Literacy for Life Foundation is the mass campaign model, which uses local leaders and literacy facilitators to help adults in the community to achieve a basic level of English language literacy proficiency and build a culture of community literacy to support everyone, adults and children, to value learning (Boughton et al 2011)

Key recommendations

8. ***A commitment to long-term, ongoing investments in evidence-based, culturally secure, early childhood development programs for Aboriginal children, integrated with family support services. This includes the key parenting support program, the Australian Nurse Family Partnership program as adapted for Aboriginal communities as well as play based, early childhood learning centres for non-working families utilising the adapted Abecedarian approach.***
9. ***A commitment to evidence-based, appropriately resourced and designed education for all school students, 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.***
10. ***Education funding reform is required to ensure that government funding is distributed according to need, and in particular that public schools are adequately resourced to meet the needs of their students.***
11. ***Support for the extension of the Literacy for Life adult literacy campaign across Australia to improve adult literacy, support literacy practices in families, and build a culture that values learning amongst adults and children.***

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Employment and income

Experiences, ideas and evidence

- Risk factors for disease and illness are not evenly distributed across a society: the distribution of ill health in a population is strongly correlated with a social gradient, where those with lower incomes tend to be significantly sicker and die significantly earlier than those with higher incomes (Wilkinson & Marmot 2003)
- As well as absolute deprivation (poverty) strongly determining health and wellbeing, there is also good evidence that relative deprivation (inequality) is related to higher infant and adult mortality rates, to reduced life expectancy, and to higher rates of illness (Baum 2007).
- Only 35 per cent of Aboriginal people living in remote areas of workforce age are employed (ABS 2016). The failure to reach the COAG Closing the Gap targets including reading and writing; school attendance; early childhood learning; and health outcomes, means many Aboriginal people in remote areas are not workforce ready.
- Aboriginal people's use of income support is therefore at disproportionally higher rates than non-Aboriginal people. Although only three per cent of the total population, Aboriginal people represent 10 per cent of Newstart Allowance recipients and 19 per cent of those on Youth Allowance. Both allowances fall below the poverty line (ACOSS/SPRC 2016).
- Not only do Aboriginal people suffer high levels of absolute poverty but they do so in a wealthy, highly developed country: action to reduce poverty and inequality of income should therefore be central to attempts to address Aboriginal health and to 'close the gap'. Conversely, any policies which are liable to increase poverty or to increase the gap between rich and poor are likely to affect Aboriginal people disproportionately, and to drive poorer health and wellbeing outcomes.

Key recommendations

1. ***That the Implementation Plan notes the strong international evidence linking absolute and relative income deprivation with poorer health and wellbeing outcomes.***
2. ***A more highly progressive taxation system, which would see the well-off pay proportionately more of their income in tax than those on lower incomes, is fundamental to closing the gap in Aboriginal health and wellbeing. This would contribute to better health for Aboriginal people by:***
   - **a.** ***providing the revenue foundation for a well-resourced health system including additional funding specifically to address Aboriginal and Torres Strait Islander health; and***
   - **b.** ***reducing both absolute poverty and relative inequality of income, thus addressing some of the leading drivers of ill health at a population level.***

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Housing, environment and infrastructure

- Housing and overcrowding is a key determinant of health and wellbeing, affecting:
    - poor physical health especially communicable diseases
    - mental health and social and social and emotional wellbeing including family and domestic violence (Reeves et al 2016, Bailie & Wayte 2006)
    - early childhood development and school attendance due to overcrowding (Silburn et al 2014)
    - smoking related illnesses related to exposure to tobacco smoke (Thomas and Stevens 2014)
    - respiratory illnesses due to exposure to particulates from wood fires for cooking, dust unsealed roads etc. (Clifford et al 2015)
- The housing situation for Aboriginal particularly in remote communities remains very poor. Whilst additional government investment in housing through National Partnership Agreement on Remote Indigenous Housing (NPARIH) and other programs has reduced overcrowding, the level of need remains high due to an increasing population (AIHW 2014a, ABS 2016).
- To maximise the health and social returns on the investment in housing in Aboriginal communities all housing should be (Congress 2017):
    - designed to fit with Aboriginal ways of living e.g. provision of outside living areas, space for extended families and visitors, second bathrooms etc., supported by access to well- maintained public facilities, relevant to local communities.
    - well-constructed with independent oversight of certification and completion processes.
    - include adequate resources for repairs and maintenance
    - take into account needs for local Aboriginal health staff to support their important role in the effectiveness of local primary health care services.
- Aboriginal people are hugely represented amongst the homeless: in 2011, 1 in 20 Aboriginal Australians was homeless, 14 times the rate for non-Aboriginal Australians. About 4 in 10 Aboriginal homeless people were aged 18 or under (AIHW 2014b).
- Cultural values mediate Aboriginal homelessness; those without a home are often taken in by kin, which while avoiding 'primary homelessness' can lead to or exacerbate severe overcrowding (AHURI 2010).

Key recommendations

1. ***Increased investment in housing stock for Aboriginal communities (including in urban areas) to reduce overcrowding, take account of population growth and ensure adequate resources for repairs and maintenance.***
2. ***The regular collection of data and reporting on housing stock and overcrowding to monitor implementation and drive strategic investment and planning.***

3. ***Establishment of Aboriginal community-controlled housing organisations, to manage new and existing housing stock to ensure culturally appropriate decision making, and provide opportunities for local skills and employment.***
4. ***Resource the employment of environmental health officers in independent Aboriginal controlled organisations to monitor housing needs and standards.***
5. ***Develop Aboriginal housing strategies to address Aboriginal homelessness in collaboration with Aboriginal communities and organisations, to ensure access to sufficient affordable housing and resource families to accommodate kin.***

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Interaction with government systems and services

Experiences, ideas and evidence

Mainstreaming, competition and contestability

- The recent policy emphasis on competition and contestability by Australian governments has stalled health gains for Aboriginal people living in the Northern Territory by undermining Aboriginal community controlled services (ACCHS) and favouring mainstream Non-Government Organisations which are unable to duplicate the advantages of ACCHS in service delivery.
- Independent reviews of the 2014 Indigenous Advancement Strategy (IAS) which was based upon a competitive grant-funding process showed both the process and policy direction to be significantly flawed. The IAS was found to have disadvantaged Aboriginal and Torres Strait Islander organisations, failed to recognise the enhanced outcomes from Aboriginal led service delivery, and failed to distribute resources effectively to meet regional or local needs (Australian Senate 2016).
- The IAS led to only half (55%) of its $4.8 billion in funding going to Aboriginal organisations (Schokman & Russel 2017)
- Competitive tendering has also led to a fragmented and disjointed service system, marked by competition rather than collaboration, and action at the level of individual agencies rather than coordinated strategic action across the health and wellbeing system.

Collaborative needs based planning

- The alternative to competitive tendering is collaborative needs-based planning which:
    - ensures appropriate resource allocation relative to need
    - maximises Aboriginal community participation and control as a key element of sustainable, viable, effective and efficient health services
    - encourages better service responsiveness to / appropriateness for Aboriginal people
    - promotes quality, evidence-based care
    - improves access for Aboriginal people to both mainstream and Aboriginal specific health services
    - increases engagement of health services with Aboriginal communities and organisations
- A commitment to such planning processes – at a national level, jurisdictional level, and regional or local levels – requires investment of time and resources. Needs-based planning requires effective funding models and formulas that pool Federal, State/Territory funds and allocates according to remoteness, populations, disease prevalence so that core services can be adequately resourced.

ACCHS as preferred providers of health services to Aboriginal people

- Any commissioning of health services for Aboriginal people should recognise ACCHS as the preferred provider/s. Outcomes of commissioning should address local needs identified through collaborative needs-based planning and more broadly contribute to Closing the Gap.
- The advantage of ACCHS include:

- achieving health outcomes that are comparable or better than mainstream services despite having a more complex and high needs population
- preferential use by Aboriginal people by providing access to quality, culturally secure primary health care services which is central to achieving longer term health improvements for Aboriginal people
- cost effectiveness
- empowering communities in the planning and delivery of health services which is linked to better health
- An Aboriginal workforce which enhances the acceptability and accessibility of services to Aboriginal clients, and also provides employment and training across a range of career opportunities
- Ongoing improvements driven by robust Continuous Quality Improvement (CQI) practices, achieving general practice standards and Australian Standards
- A "both/and" approach to health care that includes action on the social determinants of health as outlined in this paper thereby enabling a much greater contribution to health improvement than can be achieved by clinical services and programs alone.

Monitoring and accountability of government inquiries

- Australia has held numerous inquiries into issues surrounding the health and wellbeing of the nation's First Peoples. Over the last three decades these have included most significantly the *National Aboriginal Health Strategy* (1989), the *Royal Commission Into Aboriginal Deaths In Custody* (1991) and the *Bringing Them Home* report (1997). There have also been many parliamentary inquiries into issues surrounding Aboriginal disadvantage.
- However, the record of implementation of the recommendations flowing from these inquiries has been very poor (Aboriginal and Torres Strait Islander Peak Organisations 2016).

Key recommendations

1. ***That commissioning for health and wellbeing services to Aboriginal communities explicitly recognise ACCHS as preferred providers through direct tender processes due to a range of inter-linked structural advantages they have in delivering services and hence improved health and wellbeing outcomes compared to non-Aboriginal services (government or private). Competitive tendering should be a last resort option when there is no suitable ACCHS.***
2. ***That well-resourced, collaborative, needs-based planning and resourcing processes as essential to make population-level gains in health and wellbeing. Such processes must involve all major resource streams, and involve both levels of government, the ACCHS sector, and other key players such as Primary Health Networks.***
3. ***The development of appropriate and robust accountability systems including measures for the sustainable monitoring of recommendations made in government inquiries. Given the overwhelming over-representation of Aboriginal people and families in these systems, any monitoring process must involve Aboriginal communities and organisations from the beginning.***

This should include an independent, statutory body directly accountable to the Australian Parliament that has the resources and powers to make all governments, funders and service providers more accountable.

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Law and justice

Congress has provided a comprehensive submission to the Royal Commission into the Protection and Detention of Children in the Northern Territory, which includes evidence-informed recommendations on child protection and youth justice in the Northern Territory which can be adapted to other jurisdictions (Congress 2016). The analysis and recommendations in this section are drawn from that submission, and focus on child protection, and law and justice as it applies to young Aboriginal people.

Experiences, ideas and evidence

Child protection

- Aboriginal children are nearly 10 times as likely as non-Aboriginal children to be in out-of-home care due to child protection issues. Furthermore, the rate by which children are being removed from their families due to abuse and neglect is increasing: by 22% for period 2011 to 2015, compared to 6% for non-Aboriginal children (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 in particular, 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).

Juvenile detention

- Aboriginal young people are held in detention in the criminal justice system at hugely higher rates than non-Aboriginal young people. Around one half of young people in detention at any point in time are Aboriginal, with their over-representation increasing: up from 19 to 26 times the non-Aboriginal rate from 2011 to 2015 (AIHW 2015).

- In Australia, children as young as 10 years old can be held criminally responsible for their actions, and consequently placed in detention if convicted of offences. This does not meet the minimum age recommended by the UN Committee on the Rights of the Child (12 years) and is lower than the minimum age adopted by most western democracies (Australian Child Rights Taskforce 2016).

- Specialist and therapeutic courts have been successful in keeping young Aboriginal people out of gaol. Such courts aim to be culturally safe; to involve senior Aboriginal community members to assist with understanding the factors driving offending behaviours and in determining effective sentencing; and to include access to specialist therapeutic advice to assist with understanding any mental health or other issues related to offending and ensure referral of offenders to appropriate services such as drug and alcohol treatment or mental health services. Such courts are not, however, universally available. (DOJ Victoria 2010).

- Punitive approaches to detention are well-established to be ineffective and expensive, with youth justice beds costing around $200,000 per year in Australia (Jones & Guthrie 2016).

- Prevention approaches, and those that divert young offenders away from detention are therefore the most important strategies to deal long-term with the issue of youth detention. Fort 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 Torres Strait Islander community Elders or facilitators (AIHW & AIFS 2013).

- For that small number of young people where detention is necessary, the focus should be 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 (McGinness & McDermott 2010).

- Those in youth detention require long-term, individualised support to address the range of issues contributing to their offending behaviour; and the young person's family and community may also need support to assist them to support reintegration into the community (Jones & Guthrie 2016).

Key recommendations

1. ***That the implementation plan include an endorsement 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.***

2. ***Specifically relating to the Northern Territory, that a comprehensive strategy to address Out of Home Care for Aboriginal children be developed, to include consideration of:***

    a. ***recommendations made by the* Child Protection and Out of Home Care (OOHC) Workshop *hosted by AMSANT in 2016***

    b. ***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***

    c. ***adequate reimbursement and support for Aboriginal kinship carers, particularly in comparison to 'professional foster carers'***

    d. ***transition of responsibility for Out of Home Care from government to Aboriginal community controlled organisations, and***

    e. ***establishment of an Aboriginal Controlled Child Care Support Service in the Northern Territory with two regional operational centres (Top End and Central Australia) to act as sector-support hubs, providing evidence-***

based, cultural safe, trauma-informed training and support services to the community-controlled service providers.

3. ***That to address the rising numbers of Aboriginal young people being incarcerated, the Implementation Plan recommends:***
   - **a.** ***raising the minimum age of criminal responsibility to 12 years in line with recommended international standards.***
   - **b.** ***universal access to specialist and therapeutic courts for young Aboriginal people***
   - **c.** ***well-resourced diversionary options for Aboriginal young people in contact with police or courts with Aboriginal Elders or mentors an integral part of the diversionary process.***
   - **d.** ***that all jurisdictions legislate to explicitly commit the youth detention system to a primary aim of therapeutic rehabilitation, and establish small secure Youth Development Centres focussed on therapeutic approaches that include on staff Aboriginal cultural mentors, therapists, social workers and others.***
   - **e.** ***sustained rehabilitative programs within youth detention centres, including ongoing access to and care for those in detention by community-based services, support for literacy and education programs, and reintegration programs that work with offenders, their families and communities post-release.***

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Healthy choices

Experiences, ideas and evidence

Background

- Unhealthy choices (i.e. tobacco, alcohol and other drug use, lack of physical activity, unsafe sexual activity) are underpinned by inequities and the social determinants of health. For example:

  - Misuse of alcohol, nicotine or other drugs is closely related to social and economic disadvantage (See section on Income and Employment).

  - The consumption of energy-dense, nutrient poor foods leading to the both obesity and malnutrition is linked to lower incomes. (See section on Food Security).

  - Daily smoking and sedentary lifestyles are related to lower levels of educational attainment (see figure 2 from AIHW 2015).

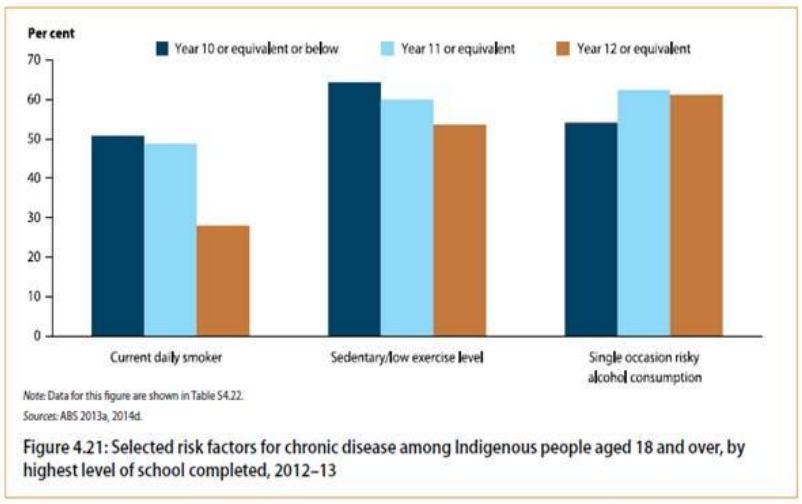

Figure 4.21: Selected risk factors for chronic disease among Indigenous people aged 18 and over, by highest level of school completed, 2012–13

Figure 2

Multi-sectorial, multifaceted approach to supporting healthy choices.

- While health education may be effective in informing people about the harm associated with unhealthy choices, little will change if responsibility is placed wholly on the person to make healthy choices (i.e. blaming the victim).

- The Ottawa Charter for Health Promotion sets out five key areas for action to support healthy behaviours: building healthy public policy, creating settings and environments that are supportive of good health, supporting community action, educating and informing the community, and reorienting health services towards these approaches (WHO 1986).

- Actions for effective health promotion are multifaceted and may involve activities including health education, skills development, social marketing, community action and advocacy at the local and system-wide levels. This includes the

integration of health care, community education, community development, and advocacy.

- Health promotion measures are therefore multi-sectorial and many lie outside the direct responsibility of health sector. For example, fiscal and regulatory measures that aim to change behaviour include the taxation of sugary drinks and tobacco to increase costs to consumers and reduce consumption (NTAHF 2011).

Key recommendations

That the Implementation Plan includes measures to promote health that are underpinned by the principles of the Ottawa Charter for Health Promotion and which take account of the social determinants of health.

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Food Security

Experiences, ideas and evidence

Background

- Aboriginal people living in remote areas are more likely to experience food insecurity than non-Aboriginal people, and Aboriginal people living in urban areas.(NRHA, 2016) This is attributable to: affordability; inadequate supply of healthy food; and inadequate infrastructure that does not allow for storage, refrigeration and preparation of food (Rosier, 2011).
- Prices for healthy, fresh foods, particularly fresh fruit, vegetables and dairy foods can be over 40 per cent higher in remote communities than in urban areas (Lee et al, 2016). In contrast, energy-dense, nutrient-poor foods are relatively inexpensive, leading to higher consumption and poorer health (Drewnowski, 2007). Furthermore there is a proliferation of foods high in sugar, fat and salt, such as sugar sweetened drinks, meat pies and potato chips for sale, in remote stores in Aboriginal communities.
- Many Aboriginal people living in remote communities are on low incomes and therefore purchase a higher proportion of energy-dense and nutrient-poor foods compared with healthy foods. This can lead to a double burden of malnutrition and obesity (WHO, 2015).
- The incapacity to feed the large number of people wanting to eat when a meal is cooked means many people prefer to buy ready to eat meals and eat them in the shop so they are more in control of ensuring they get the food they purchase.

Combining taxes and subsidies to support healthy eating

- A tax on sugar has been shown to be effective in reducing consumption is and projected to lead to the biggest health gains, particularly for people on the lowest incomes (WHO 2015).
- Taxes work best in combination with subsidies that increase the affordability of healthy foods such as fruit and vegetables (Cobiac et al 2017). The impact on additional food costs for consumers can be offset by hypothecating the tax to subsidise fresh fruit and vegetables in rural and remote areas.
- The evidence suggests taxation for sugar and sugar sweetened drinks should be 20 to 40 per cent to reduce consumption (Duckett et al, 2016; Veerman et al, 2016).
- Further modelling that takes into account the additional costs of fresh food and vegetables in rural and remote Aboriginal communities will be needed to accurately develop a taxation/subsidy package that ensures that families on low incomes are not financially disadvantaged.

Key recommendations

That the Implementation Plan includes measures to:

1. **Develop a national nutrition strategy to address food insecurity and support locally-led solutions developed by Aboriginal communities. Implementation of such as strategy should be coordinated with other agencies such as housing and infrastructure.**

2. **Support the development of a taxation and subsidy model designed to increase the consumption of healthy foods such as fresh fruit and vegetables and decrease consumption of high energy, nutrient-poor foods, with particular consideration to remote Aboriginal communities. This needs to include access to healthy, ready to eat options such as cheap, vacuum sealed meals as are provided through "meals on wheels" programs in many urban centres.**

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Alcohol

Experiences, ideas and evidence

Background

- Alcohol is a social determinant of health as outlined in the WHO list of the ten social determinants (Marmot and Wilkinson 1999). It is also very conservatively, 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 (AIHW, 2016).

- Congress has been a strong and consistent advocate for the reduction of alcohol in Alice Springs and surrounding communities. Congress is a founding member of the Peoples Alcohol Action Coalition (PAAC) which has successfully advocated for the major supply reduction measures (see for example, the PAAC *Submission to the Inquiry into the harmful use of alcohol in Aboriginal and Torres Strait Islander communities;* and Congress' submission into *to the Draft Fifth National Mental Health Plan*.).

Reducing supply:

- A reduction in the supply of alcohol is one of the most cost effective initiatives that can be undertaken in primary and secondary prevention of alcohol related harm, particularly in young people (Coghlan, 2008). Increasing the price of alcohol reduces consumption and alcohol related harm; and is highly cost effective (WHO, 2008; Godfrey, 1997; Babor et al, 2005).

- For example, an increase in the average wholesale price of 25 cents per standard drink in Alice Springs, achieved through doublking the minimum price, has reduced population alcohol consumption by 18 per cent and has prevented a large number of hospital admissions including admissions for assault (Symons et al, 2012).

- Population-level measures to reduce alcohol consumption are also the most effective ways of preventing Foetal Alcohol Spectrum Disorder (FASD).

Reducing demand and providing effective treatment:

- Evidence-based early childhood development programs are an effective approach to offsetting the developmental deficits caused by alcohol use within the family (whether incurred before or after birth). As noted in the Section on Early Childhood Development, Education and Youth, early childhood development programs also break the inter-generational cycle of disadvantage and alcohol abuse that affects many Aboriginal families.

- Treatment for alcohol-related health issues for Aboriginal must be focused on sustained, quality treatments that are known to work, and adapted to be effective in the Aboriginal context (see PAAC *Submission to the Inquiry into the harmful use of alcohol in Aboriginal and Torres Strait Islander communities* 2014).

Key recommendations

That the Implementation Plan includes measures to:

1. ***Reduce the supply of alcohol as the best way to reduce alcohol-related harm. In particular this means:***

   a. ***take action on price through a combined minimum per unit (or floor) price based on the price of full strength beer ($1.30 per standard drink) and a volumetric tax, to reduce the availability of cheap alcohol and raise funds to address alcohol-related harm***

   b. ***reduce trading hours, including for take-away alcohol sales and for late night on-premises trading***

2. ***Invest in the key, evidence based early childhood development programs mentioned in this section earlier to break the inter-generational cycle of disadvantage and alcohol abuse that affects many Aboriginal families.***

3. ***Effective treatment for Aboriginal people, focused on sustained, quality treatments that we know work, adapted to be effective in the Aboriginal context and delivered by Aboriginal Community Controlled service providers where available. These include the integration of 3 streams of care including medical care, psychological therapy and social and cultural support with intensive case management as required.***

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