AMSANT submission to the Senate Community Affairs References Committee Inquiry: Accessibility and quality of mental health services in rural and remote Australia

August 2018

Recommendations

1) Mental health and alcohol and other drug (AOD) services need to be integrated into the Social & Emotional Wellbeing (SEWB) programs of Aboriginal Community Controlled Health Services (ACCHSs), as an integral component of comprehensive primary health care.

2) AMSANT recommends that ACCHSs are prioritised for any targeted Aboriginal mental health funding, in order to support the growth and development of SEWB programs that meet community needs.

3) That the funding of SEWB programs is decided based on an equitable needs based approach, which is overseen by jurisdictional forums, such as the NT Aboriginal Health Forum within the NT.

4) AMSANT believes that the growth and support of SEWB programs within ACCHSs would be supported by SEWB/ Mental health / AOD funding moving back into the Indigenous Health Division of the Commonwealth Health Department.

5) Key features of SEWB programs that ensure appropriate, effective and consistent mental health service delivery within Aboriginal communities include:
   - They are developed and delivered with strong Aboriginal leadership;
   - Are in accordance with Aboriginal understandings of SEWB;
   - Include mental health professionals; and
   - The support and professional development of a local Aboriginal workforce.

6) Trauma Informed Care (TIC) is embedded within SEWB policy, its systems and procedures. From the top-down and bottom-up approach TIC is integrated within all aspects of an organisation to determine SEWB. This process needs to be Aboriginal led and tailored to the local context.

7) Funding for training for Aboriginal people in the SEWB/ Mental health/ AOD workforce must be a priority with accessible and culturally appropriate training freely available from entry level to post graduate qualifications.

AMSANT and our member services believe that this model is more effective overall and more cost-effective, including providing more culturally safe and accessible services, than a model that relies on visiting service providers.
Our organisation - AMSANT

AMSANT is the peak body for NT Aboriginal Community Controlled Health Organisations (ACCHSs). AMSANT has 26 members of whom 21 deliver primary health care services. ACCHSs provide primary health services to communities right across the NT in Darwin, Alice Springs, Katherine, Nhulunbuy, Tennant Creek and many remote locations. Approximately half of our 25 ACCHSs have Social and Emotional Wellbeing/ Mental Health programs, of various sizes, staffing compositions and funding sources.

Some AMSANT programs involve the provision of support and involvement with NT Department of Health Remote Clinics as well as ACCHSs.

AMSANT’s overarching recommendation for enhancing the accessibility and quality of mental health services for Aboriginal communities in rural and remote Australia

Please note that AMSANT has prepared this submission with specific focus on the mental health needs of Aboriginal people throughout the NT. AMSANT believes strongly in the benefits of integrating mental health services into the Social & Emotional Wellbeing (SEWB) programs of ACCHSs, as an integral component of comprehensive primary health care.

Please find attached two important documents that identify the need and rationale for integrating mental health services into comprehensive primary health care:

- ‘Core functions of primary health care: a framework for the NT’ developed for the NT Aboriginal Health Forum

- ‘A model for integrating alcohol and other drug, community mental health and primary health care in Aboriginal Medical Services in the Northern Territory’ AMSANT Policy document

The First Nations Peoples of Australia maintained health and mental health through beliefs, practices and ways of life that supported their social and emotional wellbeing across generations and thousands of years. A model for Social and Emotional Wellbeing, as developed by the Australian Indigenous Psychologists’ Association, in consultation with communities throughout Australia, is illustrated in Figure 1.
In keeping with this Indigenous model of SEWB, AMSANT believes that integrating SEWB, Mental health and AOD, which work toward preventing and addressing these issues, into Primary Health Care (PHC) Services is the most cost-effective approach to the delivery of mental health services throughout rural and remote NT. In keeping with the model, SEWB programs require funding for multidisciplinary, culturally and trauma informed teams with expertise across these various aspects of wellbeing for Aboriginal communities. SEWB services are designed to support individuals, families and communities in all aspects of life that strengthen wellbeing.

A review conducted by Dudgeon et al (2014) for the Closing the Gap Clearinghouse, ‘Effective strategies to strengthen the mental health and wellbeing of Aboriginal and Torres Strait Islander people’, found that programs that show promising results for Indigenous social and emotional wellbeing are those that encourage self-determination and community governance, reconnection and community life, and restoration and community resilience. The defining features of ACCHSs guarantee these components are central within SEWB, mental health and AOD programs based within these Services.

The National Mental Health Commission’s 2015 Review of Mental Health Programmes and Services led to the recommendation that integrated mental health and SEWB teams are established in all ACCHSs. The Commission concluded that mainstream mental health services had largely let down Aboriginal communities.
Investing in growing mental health & SEWB programs within ACCHSs, which are developed and delivered with strong Aboriginal leadership, in accordance with Aboriginal understandings of SEWB, include mental health professionals and the support and professional development of a local Aboriginal workforce, ensures appropriate, effective and consistent mental health service delivery within Aboriginal communities. AMSANT and our member services believe that this model is more effective overall and more cost-effective, including providing more culturally safe and accessible services, than a range of inconsistent, uncoordinated and unsustainable visiting services and Mental Health professionals.

To support the growth and development of SEWB programs, as is required to meet community needs in these areas, AMSANT recommends that ACCHSs are prioritised for any targeted Aboriginal mental health funding. The funding of SEWB programs requires an equitable needs based approach, which is overseen by jurisdictional forums, such as the NT Aboriginal Health Forum within the NT. AMSANT believes that the growth and support of SEWB programs within ACCHSs would be supported by SEWB/mental health / AOD funding moving back into the Indigenous Health Division of the Health Department. Currently, funding comes from the Department of Prime Minister and Cabinet but also through the Primary Health Networks. This causes duplication and confusion. We believe it would increase efficiency and equity of funding if Aboriginal specific funding for mental health/AOD and SEWB was all directed through the Commonwealth Department of Health and went directly to ACCHSs with input and advice on equitable distribution through the jurisdictional forums.

Aboriginal Community Controlled Health Service SEWB programs address:

a) the nature and underlying causes of rural and remote Aboriginal Australians accessing mental health services at a much lower rate

Colonisation of Australia has directly involved the disruption and severing of the many connections, illustrated in figure 1 above, which are at the heart of SEWB, health and mental health for Aboriginal people. Historical and present day experiences of trauma, which result in disconnections in the aspects of life that keep people well and strong, underlie the complex health, SEWB, mental health and AOD issues within our communities. There is a high burden of mental health, SEWB and AOD issues throughout Aboriginal communities in the NT and the current funding and provision of mental health services is not commensurate with need. This discrepancy between need and service provision/funding is particularly problematic for more remote communities and this is a key issue in relation to people in rural and remote areas of the NT not accessing mental health services.

In addition to inadequate funding and provision of services, the small amount of funding that has been available has often gone to service providers who lack local and cultural expertise. In the NT, often large NGOs have been provided with funding to provide mental
health services. Mental health services that have been designed and delivered without local Aboriginal governance and leadership are usually ineffective and inappropriate for Aboriginal communities and this will result in people not accessing these services. For as long as services are designed and delivered in ways which privilege non-Aboriginal belief systems and practices, these services continue to replicate some of the harmful aspects of colonisation and this has significant implications for the accessibility of services from Aboriginal communities’ points of view.

AMSANT understands that Culturally Responsive Trauma Informed Care (CRTIC) to be an approach of best practice that will safeguard staff and organisations from further traumatisation. Evidence is suggesting that with time and resources put towards embedding CRTIC into all aspects of service delivery including organisational policy, systems and practices, then efficiency and effectiveness will be enhanced and as a result achieve better health outcomes long term (Browne et al. 2016, Atkinson 2013).

There are vast differences between Aboriginal community’s belief systems, their languages and also historical experiences of colonisation. It follows that a generic and mainstream model of trauma informed care will be unsuitable and potentially harmful in its delivery to rural and remote communities. By including Culturally Responsive Trauma Informed Care the approach becomes contextually tailored and localised to the nuances of each place, thus determining the outcome of equality (Browne et al. 2016).

b) the higher rate of suicide in rural and remote Australia

From 2011-15, the Indigenous suicide rate was twice that of the non-Indigenous population (AHMAC 2017). Much has been written about the higher rates of suicide amongst Indigenous peoples throughout the world and amongst our Aboriginal communities in rural and remote Australia. As mentioned above, the history of colonisation and the consequent past and present experiences of trauma and intergenerational trauma are understood to underlie some of the most complex health and mental health issues within our communities. High rates of suicide can be understood as one tragic symptom of many of these complex issues.

“High Indigenous suicide rates arise from a complex web of interacting personal, social, political and historical circumstances. While some of the causes and risk factors associated with Indigenous suicide cases can be the same as those seen among non-Indigenous Australians, the prevalence and interrelationships of these factors differ due to different historical, political and social contexts” (Dudgeon and Holland, 2018, p.166).

In ‘Recent developments in suicide prevention among the Indigenous peoples of Australia’, Dudgeon and Holland (2018) note that one of the quality indicators of suicide prevention services is culturally safe services and that: ‘These are optimally provided by Aboriginal Community Controlled Health Organisations that are based in communities’ (p. 168). They
also identify ‘Cultural competent practitioners’ and ‘Trauma-informed services’ as quality indicators and again, SEWB programs within Aboriginal Community Controlled Health Organisations are well placed to support both of these areas.

c) the nature of the mental health workforce

AMSANT believes that services which are governed, designed, delivered and staffed by a local Aboriginal workforce are more accessible and effective for Aboriginal people living in rural and remote areas of the NT. SEWB programs within ACCHSs are well placed to grow and develop local Aboriginal mental health and SEWB workforces, as well as support the non-Aboriginal workforce to work in accordance with culturally informed and trauma informed principles. Aboriginal community controlled health services are in a unique position to support and develop both an Aboriginal and a non-Aboriginal ‘mental health’/SEWB workforce that will enhance the accessibility and effectiveness of SEWB services for Aboriginal communities in rural and remote Australia. It is critical that Aboriginal people working in this area have access to culturally appropriate training from entry level to post graduate training, with funding for traineeships, scholarships and mentoring schemes. Entry level training needs to be available within communities and all training must be culturally safe and have strong Aboriginal input.

d) the challenges of delivering mental health services in the regions

SEWB programs within ACCHSs are quite literally well placed to face the challenges of delivering mental health/SEWB services in remote regions, as they are placed within the regions, thus enhancing accessibility and effectiveness. In the circumstances where visiting specialist services are required to supplement and support SEWB/mental health service delivery, Dudgeon and Holland (2018, p.168) recommend that ‘Practitioners should consider providing outreach services through ACCHSs as an effective way of reaching Indigenous clients in a culturally safe setting’. Training local workforce within communities is central to effective service delivery.

e) attitudes towards mental health services

Having the Indigenous concept of SEWB at the heart of SEWB programs within ACCHSs ensures that the attitudes and objectives of the programs align with attitudes and understandings of the local community, thus ensuring shared understandings, cultural safety and sensitivity and destigmatising programs aimed at enhancing mental health and SEWB within rural and remote Aboriginal communities.

f) opportunities that technology presents for improved service delivery

Many ACCHSs throughout rural and remote NT have significant experience using various examples of telehealth technology to enhance the accessibility and effectiveness of health services in rural and remote regions. One service has routinely accessed specialist psychiatrist and clinical psychologist consultations for clients with complex mental health
issues using video-conferencing and teleconferencing facilities. Videoconferencing and teleconferencing is also used to network and train the workforce working in these services, providing meaningful opportunities for professional development and support. AMSANT is in support of enhancing opportunities for telehealth but not at the expense of the further development of the local workforce. It is also critical that providers using telehealth have a strong cultural orientation which should be undertaken on country and that telehealth should supplement and expand visiting services rather than replace those visiting services. Working on site and being mentored and supported by local Aboriginal workforce is critical to the visiting provider being able to provide culturally safe effective services. Regions without access to high quality fast internet continue to be prevented from benefiting from these kinds of opportunities. Ensuring that the NBN is provided in all rural and remote regions of Australia would enhance accessibility and effectiveness through enabling these opportunities.

References

AMSANT, 2011. A model for integrating alcohol and other drugs, community mental health and primary health care in Aboriginal Medical Services in the Northern Territory.


Australian Health Ministers’ Advisory Council (AHMAC) 2017, Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report. AHMAC, Canberra.


National Mental Health Commission. Review of Mental Health Programmes and Services. Fact Sheet 2 – What this means for Aboriginal and Torres Strait Islander people.