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By email  

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To whom it may concern  

Submission on the National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families from National Aboriginal and Torres Strait Islander Leadership in Mental Health  

Thank you for agreeing to an extension to the deadline for receipt of our submission.  

By way of introduction, the National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH) comprises a core group of senior Aboriginal and Torres Strait Islander people working in leadership positions in social and emotional wellbeing, mental health and suicide prevention. Most are based in, or associated with, the Australian mental health commissions or other nationally important mental health bodies. Additionally, the National Aboriginal Community Controlled Health Organisation and the National Aboriginal and Torres Strait Islander Healing Foundations are members. For further information about NATSIMLH, including biographical information about our members, please see Appendix 1 to this submission.  

The focus of this submission is on mental health, suicide prevention and social and emotional wellbeing services within the broader context of health services.  

Part 1: Background  

(a) A mental health crisis among Aboriginal and Torres Strait Islander people  

There is an entrenched mental health crisis among Aboriginal and Torres Strait Islander peoples that must be addressed. Mental health problems, self-harm and suicide have been reported at double the rate of that of non-Indigenous people for at least a decade, as set out below:  

- Psychological Distress: In 2012–13, 30 per cent of respondents to the Australian Bureau of Statistics (ABS) Australian Aboriginal and Torres Strait Islander Health Strategy (ATSIHS 2012-13) over 18 years of age reported high or very high psychological distress levels in the 4 weeks before the survey interview.¹ That is nearly 3 times the non-Indigenous rate.²  
  
- Mental Health Conditions: Over the period July 2008 to June 2010, Aboriginal and Torres Strait Islander males were hospitalised for mental health-related conditions at 2.2 times the rate of non-Indigenous males; and Aboriginal and Torres Strait Islander females at 1.5 times the rate of non-Indigenous females.³ Rates of psychiatric disability (including conditions like schizophrenia) are double that of non-Indigenous people.⁴
• Suicide: The overall Aboriginal and Torres Strait Islander suicide rate was twice the non-Indigenous rate over 2001-10. Around 100 Aboriginal and Torres Strait Islander deaths by suicide per year took place over that decade. In 2012, 117 suicides were reported. The *Overcoming Indigenous Disadvantage* 2014 report finds that hospitalisations for intentional self-harm increased by 48 percent since 2004-2005.

NATSILMH believe that the high rates of mental health problems reported among Aboriginal and Torres Strait Islander peoples underpin a range of other problems and disadvantage. This includes higher rates of chronic disease, unemployment, family breakdown, alcohol and other drug abuse, smoking, and the high rates of imprisonment and crime victimisation. Further, that improving the mental health of Aboriginal and Torres Strait Islander peoples, as well as being an important issue in its own right, is important to achieving the Indigenous Affairs priorities of the Australian Government (improved education, employment and community safety outcomes), as well as the COAG Closing the Gap Strategy.

**(b) Understanding Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing**

For Aboriginal and Torres Strait Islander peoples, there are specific cultural, historical, and political considerations that contribute to the higher prevalence of mental health conditions among them, and that require the rethinking of conventional models and assumptions.

In particular, Aboriginal and Torres Strait Islander peoples conceive of physical and mental health in different terms to other Australians – as part of a broader concept called social and emotional wellbeing (SEWB). The SEWB concept is not limited to Aboriginal and Torres Strait Islander peoples, but their concepts of SEWB are broader than non-Indigenous concepts.

For Aboriginal and Torres Strait Islander peoples, SEWB is a ‘whole of life’ perspective on wellbeing that includes mental health, but is not limited or equivalent to it. Thus, as for non-Indigenous people, the Aboriginal and Torres Strait Islander SEWB concept acknowledges the importance of employment, housing and education to wellbeing. Additionally, it takes into account:

• the unique historical events and impacts associated with colonisation, and the resulting present day social determinants faced by Aboriginal and Torres Strait Islander people; and

• cultural differences, in particular the unique structures and belief systems underpinning family, community, culture and cultural practice, relationships to country and spirituality (including ancestors).

For Aboriginal and Torres Strait Islander mental health, SEWB is critically important for two reasons:

• First, as a source of resilience. Resilience is important because (as discussed further on in the specific context of children and families) Aboriginal and Torres Strait Islander peoples experience adverse childhood experiences and stressful life events at higher rates than non-Indigenous people. Further, these stressful and traumatic life experiences tend to occur concurrently and have a cumulative impact.

• Second, because as with Aboriginal and Torres Strait Islander health in general, a holistic ‘whole of person’ approach that includes working with cultural needs should underpin mental health service and programme delivery for Aboriginal and Torres Strait Islander peoples. This includes, but is not limited to, ensuring mainstream mental health practitioners, services and programs are culturally competent and culturally safe.

NATSILMH proposes that strengthening SEWB, building resilience and reducing psychological distress is of direct import to achieving better mental health outcomes for Aboriginal and Torres Strait Islander peoples, and, in particular, children and families. That is, in addition to a focus on expanding culturally appropriate mental health services and programmes for children and families as we will discuss below.
Such a ‘whole-of-government’ preventative emphasis requires a consideration of employment, access to education and community safety – the current priorities of the Australian Government. Further, it requires a broader address identity, physical health, family, culture and community life aligned with the Aboriginal and Torres Strait Islander concept of SEWB. And critically, an overall approach based on empowerment is required. For Aboriginal and Torres Strait Islander peoples, just as disempowerment is associated with greater vulnerability to psychological distress and mental health issues, so empowerment is associated with resilience and better mental health.

(c) Specific mental health and related challenges for Aboriginal and Torres Strait Islander families and children

At the 2011 Census, Aboriginal and Torres Strait Islander individuals under 15 years of age comprised 35.9 percent of the total Aboriginal and Torres Strait Islander population, compared with 18.3 percent of the non-Indigenous population. From a policy perspective then, a focus on children is critical. Not only will improving the health and wellbeing of children have direct and beneficial impact on the health of the future adult population, but such a focus also represents a more efficient way of spending health dollars. As noted in the recently released report of the Forrest Review:

*If we get early childhood development and school education right, we don’t need to invest in or waste money by the billions in other areas as we do now. Measures relating to early childhood and school education are a long-term fix.*

The wellbeing of families is critical to the wellbeing of the children raised in those families and, as such, are considered as almost identical issues in this submission. Yet it is important to recognise that Aboriginal and Torres Strait Islander families can view their structures and relationships differently to non-Indigenous families: for example, with child rearing managed more collectively. Aboriginal and Torres Strait Islander families can also help define identity and build a sense of connectedness to kinship and culture. Any national framework that aims to address the health service needs of Aboriginal and Torres Strait Islander families must recognise, respect and work with these cultural differences.

However they function, supportive families operate can help family members cope with disadvantage and stressful life experiences. Good family functioning is also associated with better outcomes for children. Children can benefit from having positive role models for building relationships and an environment that fosters the development of high self-esteem.

Too many Aboriginal and Torres Strait Islander families are under stress, and children suffer as a result. In 2012–13, Aboriginal and Torres Strait Islander children were eight times as likely as non-Indigenous children to be receiving child protection services. The most common type of substantiated abuse for Aboriginal and Torres Strait Islander children was neglect, which represented 40 per cent of substantiations; emotional abuse, (34 percent) and sexual abuse (9 percent).

NATSILMH believe that entrenched poverty and disadvantage lies at the core of the stress on our families. Addressing this is beyond the reasonable scope of a framework for health services, but nonetheless NATSILMH believe it would be remiss not to acknowledge the impacts of such poverty and disadvantage.

The Productivity Commission’s working paper *Deep and Persistent Disadvantage in Australia* (2013) notes that shifting entrenched social exclusion and disadvantage among Aboriginal and Torres Strait Islander peoples is a major challenge facing Australian Governments. The paper uses the Social Exclusion Monitor populated with HILDA survey data to identify the size of the problem. It found that in 2010 9.1 per cent of Aboriginal and Torres Strait Islander peoples were estimated to suffer deep and persistent social exclusion in Australia compared to approximately 5% in the general population. Long-term sickness and disability, unemployment and receiving income support, single parenthood and living in public housing are all things associated with deep and persistent social exclusion and family stress in Aboriginal and Torres Strait Islander Australia.
Developmental challenges

Low birth weight and exposure to alcohol and smoking in the womb are associated with cognitive and developmental challenges in babies that if unaddressed can impact on adult life with symptoms that can include a lack of emotional control and poorer intellectual and language development as well as other health impacts. In 2011, babies born to Aboriginal and Torres Strait Islander mothers were twice as likely as those born to non-Indigenous mothers to be of low birth weight: 12.6 percent of babies born to Aboriginal and Torres Strait Islander mothers weighed less than 2,500 grams compared with 6 percent of babies born to non-Indigenous mothers.

Some of the key determinants for low birth weight babies are access to and use of antenatal care; smoking by mothers while pregnant and ‘passive’ exposure to smoke; pre-term births; the mother’s diet and nutritional status at conception and during the pregnancy; and the age of mothers. Poverty (as discussed above, in terms of ‘deep and persistent disadvantage’) in turn, determines many of these determinants. Mothers living in poverty are more likely to have low birth weight babies because they are more likely to face challenges such as getting adequate nutrition and accessing maternal health services while also having higher rates of smoking and other risk behaviours.

In particular, drug and alcohol consumption during pregnancy is a critical determinant of low birth weight. And further, alcohol consumption while pregnant can lead to Fetal Alcohol Spectrum Disorders (FASD) in children. It is estimated that the FASD for Aboriginal and Torres Strait Islander people is between 2.76 and 4.7 per 1,000 births compared to between 0.06 and 0.68 per 1,000 births for all Australians. Alcohol misuse by parents, of course, has other impacts on children and families. For example, evidence demonstrates that high-levels of alcohol misuse is associated with family violence in Aboriginal and Torres Strait Islander communities.

Adverse Childhood Experiences

Adverse childhood experiences (ACEs) refer to stressful and traumatic life events for children. They can include a death in the family; injury; household alcohol or drug problems; parental violence; child neglect and abuse, living in out-of-home care; and being bullied at school. The more recorded ACEs the greater the risk of mental health problems and mental illness later in life.

Exposure to ACEs is associated with a range of ‘emotional and behavioural difficulties’ and mental health problems during childhood and adolescence with diverse patterns of symptoms including anxiety, depressive disorders, drug and alcohol misuse, psychosis and suicidal behaviour. Aboriginal and Torres Strait Islander families have a much higher recorded prevalence of ACEs compared to non-Indigenous families.

The Western Australian Aboriginal Child Health Survey 2004 (WAACHS) surveyed approximately 5300 Aboriginal children: around 25 per cent of WA’s Aboriginal and Torres Strait Islander child population and 15 percent of WA non-Indigenous children as a comparator. It made a number of disturbing findings about the impact of ACEs on our children and young people.

The factor most strongly associated with high risk of clinically significant emotional or behavioural difficulties in the children included in the WAACHS was the number of ACEs. In the WAACHS, those measured included illness, family break-up, arrests or financial difficulties experienced by the family in the 12 months prior to the survey.

Further, Aboriginal children who experienced ACEs reported lower rates of excellent/very good health than those who had not experienced stressors (73 percent compared with 83 percent). Aboriginal children who experienced stressors also reported to missing more days of school in the week prior to the survey (29 percent compared with 21 percent).

Trauma

Trauma is a complex phenomenon and has many causes and symptoms in Aboriginal and Torres Strait Islander people. Trauma in general population mental health practice typically refers to symptoms associated with
particularly intense stressful life events that overwhelm a person’s ability to cope. These can include intense life stressors and ACEs. For Aboriginal and Torres Strait Islander adults and children, however, trauma must be understood in broader terms. The sustained periods of interpersonal and structural violence upon entire groups and communities associated with colonisation in particular has resulted in intergenerational, trans-generational, or historical trauma. This is trauma transmitted through pathways that include familial, biological, psychological and social mechanisms.\(^36\)

Perhaps the best-known example of this is the intergenerational mental health and related impacts reported in the children cared for by Stolen Generations Survivors. The WACCHS reported that the children of Aboriginal carers who had been forcibly separated from their natural family by a mission, the government or welfare:

- were 2.3 times more likely to be at high risk of clinically significant emotional or behavioural difficulties after adjusting for age, sex, remoteness and whether the primary carer is the birth mother of the child.
- were more likely to be at high risk of clinically significant emotional symptoms, conduct problems and hyperactivity.
- had significantly higher rates of overall emotional or behavioural problems in the 6 months prior to the survey.
- had levels of both alcohol and other drug use that were approximately twice as high as children whose Aboriginal primary carer had not been forcibly separated from their natural family\(^37\)

Responses in children to trauma can include over-compliance, emotional and behavioural difficulties and chronic disassociations.\(^38\) Some experts believe that the impact of trauma on Aboriginal and Torres Strait Islander children and their families is a major undetected, underestimated and misunderstood determinant of mental health conditions in the Aboriginal and Torres Strait Islander adult population. Early childhood services, primary schools, high schools, general practitioners, child protection services, child mental health services and juvenile justice services\(^39\) might fail to detect an Aboriginal and Torres Strait Islander child’s distress or trauma or otherwise know how to intervene effectively. Instead, a child or young person might be placed in the ‘too hard basket’ because of aggressive behavior and low educational attainment rather than this being understood as distress.\(^40\)

**Suicide and self-harm**

As highlighted in the National Children’s Commissioners’ chapter on *Intentional self-harm, with or without suicidal intent, in children and young people under 18 years of age*, published in the *Children’s Rights Report 2014*, Aboriginal and Torres Strait Islander children and young people are a ‘vulnerable group’.\(^41\) Thus while Aboriginal people and Torres Strait Islanders represent only 3 percent of Australia’s population, they account for 28.1 percent of all the recorded deaths in children and young people under 18 years of age due to intentional self-harm.\(^42\) Further, that ‘death due to intentional self-harm for Aboriginal and Torres Strait Islander children and young people is more likely to occur in clusters’ (than for non-Indigenous children and young people).\(^43\)

**Part 2: Mental health and wellbeing services for Aboriginal and Torres Strait Islander children and families**

**a) The need for more services**

In the abovementioned report, the National Children’s Commissioner notes the gross under-reach of mainstream mental health and related services to our children and young people, reflecting the lack of mental health services for Aboriginal and Torres Strait Islander people as a whole. As a particularly telling example, the Report notes shockingly low rates of uptake of the Kids Helpline by our children and young people. In particular, in 2012-2013, only 133 out of 6703 (less than two percent) of calls to Kids Helpline were from children and young people who identified as Aboriginal or/and Torres Strait Islander.\(^44\) Further, only 41 out of 4380 contacts (less than one percent) where the person identified that self-injury and self-harm were their main concern were from Aboriginal and Torres Strait Islander children and young people.
NATSILMH believe that this lack of access is likely to be the case across many general population mental health and related services.46 Because of this, NATSILMH particularly welcome the development of a dedicated health services framework for our children and families. Indeed, there are significant risks involved in NOT doing so, including potentially allowing the particular needs of our children and young people to be overlooked in general population service and programme models.

In fact, overall, the burden of mental health problems and mental illness among the broader Aboriginal and Torres Strait Islander population is far greater than the services and programs currently available. For example, a lack of access to primary mental health care - including promotion, prevention early detection and treatment in primary health care settings - leads to significantly higher per capita levels of expenditure on acute inpatient care, the most expensive part of mental health treatment. This is illustrated by the much higher ratio of Aboriginal and Torres Strait Islander per capita hospital expenditure for mental health conditions compared with other Australians in 2010–11.46

In the face of this mental health services gap, the role of Aboriginal Community Controlled Health Services (ACCHS) is critical. (In 2012–2013, 260 services delivered primary health-care, substance-use rehabilitation and treatment services, and SEWB (including Bringing Them Home and Link-Up counselling and family reunion) services primarily to Aboriginal and Torres Strait Islander people. They report to the Australian Government and these services reports are published regularly.47 Of these, 205 are defined as Indigenous Primary Health Care Organisations (IPHCOS) including 175 ACCHS.48)

With their model of comprehensive primary health care and community governance, ACCHS have reduced barriers to access to health care, and are progressively improving individual health outcomes for Aboriginal and Torres Strait Islander people. Clinical services, health promotion, cultural safety, community engagement all underpinned by research, evaluation and planning activity are the essential components in these models.49

In their 2014 analysis of the performance of ACCHS, Panaretto and colleagues looked at the evidence supporting Aboriginal and Torres Strait Islander peoples’ relative use of ACCHS and general practice in Queensland by comparing ABS 2011 Census data and ACCHS service use data. They report that ‘access to services is critical and, where ACCHSs exist, the community prefers to and does use them’.50,51

Yet mental health and related services gaps in ACCHS and other Aboriginal and Torres Strait Islander-specific health services are evident. In the abovementioned service report for 2012–2013, the most common service gaps reported by all 260 organisations, including ACCHS, were around mental health and SEWB (62 percent of organisations).52 Nearly half of all 260 organisations reported alcohol, tobacco and other drugs (48 percent) and youth services (47 percent) as service gaps.53 That these gaps exist provides support for an increased focus on expanding mental health and social and emotional wellbeing services within these services.

That these services are expanded and otherwise properly resourced as primary mental health services is important because mainstream GPs and frontline mental health services are not meeting the remaining need. Yet, at time of writing, approximately 50% of the Aboriginal and Torres Strait Islander population are reliant on GPs and other service providers for primary mental health care.54 As such the ability of GPs and other front line mainstream mental health services to provide a culturally safe and culturally competent service is critical to how the mental health system responds to greater Aboriginal and Torres Strait Islander mental health needs.

More broadly, the current package of mental health services and programmes is ineffective at the system level because of problems at the service and programme level. This includes because of:

• **How individual services and programs are designed.** In particular, many do not work within a broader context of SEWB. As noted, this requires consideration not only to the mental health of individuals, but to their broader wellbeing and the wellbeing of their families, communities and cultures. Otherwise, many offer neither culturally safe service environments or culturally competent mental health professionals and/or workers.
• How the services and programs work together. In short, they do not ensure a connected transition through the mental health system for Aboriginal and Torres Strait Islander peoples. In particular, between the Commonwealth-funded primary mental health components and specialist clinical services components delivered largely by the States and Territories.

In relation to the latter point, NATSILMH recommend that there be a greater focus on ensuring patient transitions from family and community to primary and specialist mental health care, and then back into the community. Further, that a particular focus of policy makers should be addressing the lack of dedicated Aboriginal and Torres Strait Islander specialist care that is able to support the above patient transition and otherwise help ensure transitions across culturally appropriate parts of the mental health system.

Finally for this part of our submission, developing the much needed mental health services will involve training and employing the Aboriginal and Torres Strait Islander workforce needed to populate the additional services proposed and to change the culture of mainstream services. This should involve:

• identifying minimal mental health, social and emotional wellbeing, suicide prevention, and alcohol and other drug use prevention personnel requirements per population catchment area;

• setting and achieving national training and employment targets based on the above;

• strengthening opportunities for Aboriginal and Torres Strait Islander health workers to attain advanced qualifications by strengthening educational pathways from the Vocational Education Training sector to the university sector;

• relevant professional associations and education providers increase the numbers of Aboriginal and Torres Strait Islander students undertaking mental health and related training and entering the mental health professions and workforce. Progress is benchmarked against standards developed by professional associations and education providers; and

• relevant professional associations and education providers develop specialist Aboriginal and Torres Strait Islander mental health courses based on Djirruruang Program (Charles Sturt University) and roll them out nationwide.

(b) Specific approaches to mental health and wellbeing services for Aboriginal and Torre Strait Islander communities, families and children

Over 2014, NATSILMH was involved in the development of the draft National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2014-2019. As a part of this (and other) work, NATSILMH made recommendations some of which are adapted here for the development of the services framework.

1. Mental health and social and emotional wellbeing teams should be located in in Indigenous Primary Health Care Organisations and Aboriginal Community Controlled Health Services

In practice, an Aboriginal and Torres Strait Islander child and/or their carer/family member attending a primary health care provider is likely to present with a range of risk factors relating to their SEWB, and be experiencing multiple ACEs and/or stressful life events. They may also present with cognitive impairments and disabilities, psychological distress, trauma and mental illnesses. All must be addressed if the child or their carer/ family member is to achieve mental health and SEWB.

Working with such children and their carers and/or families requires the coordinated efforts of many agencies including, but not limited to, mental health services. Such a holistic approach is critical to success. It may include ACCHS, education and employment programs, housing agencies, community groups, Link Up services, and the involvement of cultural mentors.
Because of this, NATSILMH proposes that mental health and SEWB teams are fully integrated in Indigenous Primary Health Care Organisations and ACCHS as a part of their existing comprehensive primary health care service package. These could provide:

- medical care, including pharmacotherapies and preventive health care and health checks to promote, maintain and treat physical health;
- structured interventions using evidence based therapy; and
- social and cultural support., including access to housing, support with issues of cultural identity and support from local Aboriginal people via Aboriginal Health Workers and Aboriginal Mental Health Workers.

Critically, such teams are also important supports for the activities listed under points 2 - 4 (below) and that require community knowledge, cultural understanding, and a capacity to work across other sectors and contexts beyond the health sector. We believe such a flexible and community-based model of health service is critical to achieving better mental health and related outcomes for Aboriginal and Torres Strait Islander families and children.

2. Services are required to support the empowerment and wellbeing of communities as the foundation of better mental health and wellbeing for Aboriginal and Torres Strait Islander families and their children.

By the SEWB concept as it applies to Aboriginal and Torres Strait Islander peoples, the mental health and wellbeing of Aboriginal children and families must be considered in the context of the communities in which they live.

NATSILMH believe that any framework for health services aimed at families and children must account for the importance of community if the health and wellbeing of families and children is to be supported. This requires services to be actively engaged with communities and provides further support for the expansion of ACCHS. As set out above, such are the best ‘fit’ for having oversight responsibility to promote SEWB, including even acting as ‘hubs’ for cultural and language reclamation activities in their communities.

NATSILMH welcomes that the Australian Government broadly supports ‘empowered communities’ as a defining feature of its approach to Indigenous Affairs, although notes that what constitutes community empowerment can be understood in different ways.

Community empowerment is an important intermediate step to communities addressing their problems including the challenges facing families and children. In itself it brings benefits by counteracting the pervasive disempowerment of many communities that followed colonisation. This in turn supports the SEWB of families and children in that community.

NATSILMH believe the community empowerment model promoted by and through services should include:

- Aboriginal and Torres Strait Islander leadership and oversight at the community level.
- Bringing community members together to identify problems, priorities and responses.
- Communities participating on a voluntary basis.
- Supporting broader self-governance in communities.
- Engaging elders and senior community members as key stakeholders and role models to champion culturally appropriate choices and approaches to health and wellbeing.
- Focusing on practical outcomes: employment of community members (including in programs), school attendance and educational attainment, safe communities.
- Supporting community controlled alcohol and drug use reduction and supply restriction programs.
- Supporting community-based language and cultural reclamation programs.

A further important part of building community and family wellbeing for Aboriginal and Torres Strait Islander peoples involves integrating healing into health service models. This could involve services:

- Working to integrate the healing programmes of the National Aboriginal and Torres Strait Islander Healing Foundation into their activities;
- Supporting the access of Aboriginal and Torres Strait Islander individuals, families and communities to traditional and contemporary healing practices and healers as part of their healing journeys
- Working with Link-Up services and other that reconnect Stolen Generations’ Survivors to their families, communities and cultures
- Supporting healing programs for Stolen Generations’ Survivors

The National Empowerment Project (NEP) is an example of an Aboriginal-led community empowerment program that already works with communities to support them to heal and to strengthen their social and emotional wellbeing. In its first report, the NEP collated and ranked priorities to address as indicated by eight communities. These included social and emotional wellbeing problems such as drugs and alcohol, violence and problems with young people, and social determinants such as health and mental health and a lack of employment opportunities, as their main challenges. Each community had different priorities - highlighting the need for programs to work at the community level.

3. Services work to support the wellbeing of families, recognising this is critical to the wellbeing of Aboriginal and Torres Strait Islander children.

Once again, NATSILMH believe that ACCHS are best placed to deliver family social and emotional wellbeing support programs and services in our communities because of their local knowledge and cultural understanding. Activities undertaken by these services could include:

- Supporting community-led anti-family violence and child abuse campaigns
- Increasing access to appropriate parenting programs and services in relation to early childhood development, family support, health and wellbeing, alcohol and other drugs (including e-mental health materials).
- Promoting family re-unification programs for Stolen Generations’ Survivors, prisoners, children removed from their families into out-of-home care and young people in juvenile detention
- Increasing family-centric and culturally safe services for families and communities.
- Increasing the support and services available for grandparent and kinship carers through family support services.
- Supporting single parent Aboriginal and Torres Strait Islander families
- Supporting the role of fathers, partners and husbands in family life
- Supporting the role of Elders in family life
The role of families as carers, and children acting as carers, should also be supported by the services framework. Areas of focus could include:

- Ensuring that carer respite and other support programs (such as the Mental Health Respite: Carer Support program) have Aboriginal and Torres Strait Islander carers as a priority group and that they have reach into communities.
- Supporting Elders in carer roles
- Ensuring that children and adolescents caring for people with mental health conditions are supported and able to fully participate in school and education.

4. **Services should adopt an across the lifecycle approach that includes particular focus on the health and wellbeing of mothers and children and requires these services to engage beyond the health sector.**

The above could include:

**Mothers and child development**

- Improve targeted programmes for children including: New Directions: Mothers and Babies, Australian Nurse Family Partnership, Strong Fathers Strong Families and Healthy for Life.
- Support programs to promote cognitive development including health literacy and promotion programs to pregnant women to tackle substance and alcohol consumption and misuse
- Broaden antenatal care to include support for perinatal depression screening and evidence-based intervention strategies to reduce maternal stress.
- Continue implementation of the National Early Childhood Development Strategy, including the strengthening of universal maternal, child and health services. Promote the measurement of developmental milestones of Aboriginal and Torres Strait Islander infants.
- Promote attachment and security in childhood by increasing access to appropriate parenting programs and services in relation to early childhood development, family support, health and wellbeing, alcohol and other drugs.

**Children**

- Promote culturally appropriate and age appropriate mental health literacy in schools and programs to address the impact of racism and otherwise build resilience in children.
- Support children with cognitive and developmental impairments and disabilities to achieve their potential
- Support the cultural adaptation of Kidsmatter and Kidsmatter Early Childhood particularly in schools with high numbers of Aboriginal and Torres Strait Islander students. In particular, teachers and front line workers should be sensitive to distress and trauma in children and be able to make appropriate referrals.
- Educate and engage communities about child abuse and neglect and strategies for protecting children, and supporting the three strategic responses under ‘Supporting Action 5’ for Aboriginal and Torres Strait Islander children of the National Framework for Protecting Australia’s Children 2009-2020:

  5.1 Expand access to Indigenous and mainstream services for families and children;
  5.2 Promote the development of safe and strong Indigenous communities;
  5.3 Ensure that Indigenous children receive culturally appropriate protection services and care.
• Develop culturally appropriate and age appropriate alcohol and drug use reduction strategies aimed at children as part of the implementation of a renewed alcohol and drug strategy.

• Implement initiatives that promote the social and emotional wellbeing of children and young Aboriginal and Torres Strait Islander peoples by strengthening pride in identity and culture.  

• Support and expand diversion programs to keep children and young people from contact with the criminal justice system and to protect them from the risk of substance abuse.

5. Additional dedicated Aboriginal and Torres Strait Islander specialist mental health services are established to support patient transitions across the mental health system and ensure the cultural appropriateness of services at different stages of their transition.

In particular, the transition from primary mental health care settings into mainstream specialist mental health services and programs needs greater focus. Some jurisdictions could choose to establish such services along the lines of the Western Australian State-wide Specialist Aboriginal Mental Health Service model. Regardless, all Aboriginal and Torres Strait Islander people (including children) admitted to a specialist (mainstream) mental health service should be in the target group for this service and NATSILMH recommend that the following features/capabilities should be standard:

• ensuring each referred/admitted patient is linked from IPHCOs/ACCHS to the mainstream service and back again on discharge;

• cultural support during admission;

• access to traditional healers and healing services;

• maintain links to family; and

• facilitation of patient access to community support on return to community.

6. General population (mainstream) mental health, suicide prevention, and alcohol and other drug use prevention professionals (including general practitioners) are accountable for better mental health outcomes for Aboriginal and Torres Strait Islander peoples including by providing culturally competent services, and ensuring their services are culturally safe.

The entire mental health system is accountable for better Aboriginal and Torres Strait Islander mental health, suicide prevention, and related outcomes - including among our children. Therefore, the delivery of primary and other mental health services to Aboriginal and Torres Strait Islander people outside of IPHCO/ACCHS settings and specialist Aboriginal and Torres Strait Islander mental health services and programs needs to be culturally competent and culturally safe.

Every jurisdiction should consider ways to make such services more accountable for delivering better mental health outcomes for Aboriginal and Torres Strait Islander people. These may include:

• Legislative, and/or policy approaches;

• Development of quality and professional standards with professional organisations;

• Setting targets and key performance indicators in funding agreements as a way of holding mainstream service providers accountable for the development of culturally responsive services;
• Partnership agreements being established at a local level between the leadership of mainstream services and the IPHCOS/ACCHS;

• Requirements to develop Aboriginal mental health service plans and/or professional development strategies;

• Developing clinical pathways in partnership with the local IPHCOS/ACCHS for mental health patients defining how the services will support patients in their transition from primary care to acute care and the provision of ongoing care for people with a chronic mental illness as part of a mental health cycle of care; and

• Ensure professional development programs are being delivered to support mainstream staff develop cultural competencies.

This initiative should be complemented by a commitment from all levels of government to publish annual information on the proportion of resources they allocate to supporting Aboriginal and Torres Strait Islander people’s mental health needs. The report card should encompass both specialist Aboriginal and Torres Strait Islander and mainstream services and include funding and activity data.

Thankfully, NATSILMH notes that there are examples of mental health services that Aboriginal and Torres Strait Islander peoples are taking up in high numbers: in particular in the Department of Social Services’ Targeted Community Care Programme (the Personal Helpers and Mentors, Mental Health Respite and Family Mental Health Support Services).

NATSILMH believe this framework for health services should be informed by an understanding of what has contributed to the high uptake. For example, does it relate to culturally competent professionals and workers, effective promotion of the programmes, or the connections of the programmes to the ACCHS? If the framework is able to identify what works, it will contribute lessons to be applied more widely, and result in more effective and efficient services in mental health, health and in other areas.

Part 3: The broader context of a National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families

The approach to health services for Aboriginal and Torres Strait Islander children and families set out in a national framework cannot be developed or implemented in isolation, but must occur in the broader context of coherent and connected national Aboriginal and Torres Strait Islander mental health planning and service and programme design over the next 12 to 18 months.

In particular, the design of the national framework should complement the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2014-19 and should be implemented through it alongside with the National Aboriginal and Torres Strait Islander Health Plan 2013 – 2023, the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2013 and the National Aboriginal and Torres Strait Islander Peoples’ Drug Strategy.

The vehicle for this overall, coordinated implementation process should be a dedicated, national Aboriginal and Torres Strait Islander mental health plan. While it is critical that the priority focus of each of the above strategies is maintained in implementation, a coordinated implementation process for all four is not to avoid duplication and be more efficient while also ensuring holistic and connected services.

NATSILMH recommend that an important starting point for such planning should be the agreeing an additional COAG Closing the Gap target specifically for mental health using a range of indictors including rates of psychological distress, hospitalisation for mental health conditions and suicide.

Finally, a critical part of the above planning process should involve Australian governments partnering with appropriate Aboriginal and Torres Strait Islander leaders, stakeholders and experts. To this end, NATSILMH support
the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group (ATSIMHSPAG) in this role. This body advised the Minister for Indigenous Affairs, Minister for Health, and Assistant Minister for Health in these areas. The future of this body is, however, uncertain as its mandate expired in December 2014.

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Thank you again for the opportunity to make this submission.

Mr Christopher Holland, NATSILMH’s Executive Officer, is the best point of contact for office-to-office communications, and if you have any questions. His contact details are cholland@internode.on.net or 0438 409 149.

Yours sincerely

[Signature]

Professor Pat Dudgeon

Chair NATSILMH – and on behalf of the members: Dr Tom Calma AO, Mr Tom Brideson, Ms Adele Cox, Ms Sandy Gillies, Ms Vickie Hovane, Professor Gracelyn Smallwood, Dr Robyn Shields, Ms Lisa Briggs and Mr Richard Weston.
Appendix 1 – the National Aboriginal and Torres Strait Islander Leadership in Mental Health

NATSILMH’s aim is to help restore, maintain and promote the social and emotional wellbeing and mental health of Aboriginal and Torres Strait Islander peoples by advocating and providing advice and leadership in these areas. It also aims to reduce the high rates of suicide among Aboriginal and Torres Strait Islander peoples.

NATSILMH’s priority work is to lead and provide advice in the above areas for the mental health commissions of Australia. That is the:

- National Mental Health Commission;
- Mental Health Commission of New South Wales;
- Queensland Mental Health Commission; and the
- Western Australian Mental Health Commission.

NATSILMH’s origins start with the Sydney Declaration made at the Sydney meeting of Australian and international mental health commissions on 11 and 12 March 2013. Here, the Australian mental health commissions agreed to support the international Wharerātā Declaration on Indigenous peoples’ mental health and its vision of healthy Indigenous individuals, families and communities.

Following six months of developmental activity, NATSILMH was established and first met on 14 November 2013 at a two-day ‘Aboriginal and Torres Strait Islander Leaders in Mental Health Forum’ that was supported by the Mental Health Commission of New South Wales.

NATSILMH has coalesced around a core group of senior Aboriginal and Torres Strait Islander people working in social and emotional wellbeing, mental health and suicide prevention. Most are based in, or associated with, the Australian mental health commissions or other nationally important mental health bodies. Additionally, the National Aboriginal Community Controlled Health Organisation and the National Aboriginal and Torres Strait Islander Healing Foundations are members.

It is anticipated that NATSILMH’s membership will grow over time.

In March 2014, NATSILMH established a Secretariat that operates one day a week. This is administered from the Mental Health Commission of New South Wales with the financial support of the four Australian mental health commissions.

For further information see: www.natsiilmh.org.au.

Our members

Professor Dudgeon is from the Bardi people of the Kimberley. She is well known for her leadership in Indigenous higher education and Indigenous mental health. Currently she is a research fellow and professor at the School of Indigenous Studies at the University of Western Australia. She is actively involved with the Aboriginal community, having an ongoing commitment to social justice for Indigenous people. Professor Dudgeon is a Commissioner with the National Mental Health Commission, the Chair of the National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH) and is currently Co-chair of the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group. She is Project Director of the Aboriginal and Torres Strait Islander Suicide Prevention Project and the National Empowerment Project at University of Western Australia.
Mr Tom Brideson
Mental Health Commission of NSW Community Advisory Council

Mr Brideson is a Kamilaroi man and the NSW State-wide Coordinator of the Aboriginal mental health workforce program. The position is located at Bloomfield Hospital in Orange, NSW. He has a broad interest in health policy development, social and emotional wellbeing, clinical mental health care, suicide prevention and educational matters across these domains. He is member of the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group.

Ms Lisa Briggs
CEO, National Aboriginal Community Controlled Health Organisation

Ms Briggs is an Aboriginal Health Worker by trade and worked in the field of Aboriginal health for the last 25 years. She has been part of the National Coalition for the Close the Gap Campaign for Indigenous Health Equality. She is member of the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group.

Dr Tom Calma AO

Dr Calma is an Aboriginal elder from the Kungarakan tribal group and a member of the Iwaidja tribal group in the Northern Territory. He has been involved in Indigenous affairs at a local, community, state, national and international level for over 40 years. Dr Calma was the Aboriginal and Torres Strait Islander Social Justice Commissioner from 2004 – 2010 and the founding Chair of the Close the Gap Campaign for Indigenous Health Equality. He was also Chair of the Aboriginal and Torres Strait Islander Suicide Prevention Advisory Group that oversaw the development of the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy, and is currently Co-chair of the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group, National Coordinator for the Closing the Gap Tackling Indigenous Smoking measures, Chancellor of the University of Canberra, Co-chair of Reconciliation Australia and an Ambassador for Suicide Prevention Australia.

Ms Adele Cox

Ms Cox is a Bunuba & Gija woman from the Kimberley region of Western Australia. She started her working life in media and in suicide prevention. Adele is a former member of the WA Ministerial Council for Suicide Prevention and currently a member of the Australian Suicide Prevention Advisory Council, the National Senior Consultant to the National Empowerment Project and a member of the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group.
Ms Gillies is a Gungarri woman from southwest Queensland. She is currently the Director, Engagement and Reporting for the Queensland Mental Health Commission and has over 25 years’ experience in senior management roles both within the government and Aboriginal Community Controlled Health care sectors across Queensland. She completed her Graduate Certificate in Health Management in 2009 at Griffith University, Queensland. Ms Gillies has been a strong advocate and leader in the provision of cultural awareness training over many years to both government and non-government organisations. She has co-authored a number of academic papers highlighting the need for the evaluation of cultural awareness training and its effectiveness in changing organisational culture and practice.

Ms Hovane is an Aboriginal woman from Broome in the Kimberley region of WA. She holds a First Class Honours Degree in Psychology. Ms Hovane is a Director on the board of the new National Centre for Excellence in Research for the prevention of violence against women and children. She is a former Co-chair of the Australian Indigenous Psychologists Association and a member of the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group.

Professor Smallwood is a prominent Aboriginal leader with 45 years’ experience, nationally and internationally, as a nurse, midwife and human rights activist. She has devoted her career to advocating for the empowerment of Indigenous communities through education, health and economic sustainability working in some of the most remote parts of Australia. Professor Smallwood has completed a certificate in Indigenous mental health, a Master of Science in Public Health and a PhD thesis Human rights and first Australians’ wellbeing. In 1975 Gracelyn was a graduate with four other Indigenous students in culturally appropriate mental health training. She anticipates doing a post doctorate in culturally appropriate mental health services next year. In 2007 she received the Deadly Award for Outstanding Achievement in Indigenous Health and an Australia Medal for 25 years’ service in public health. She has been an editorial board member for Health and Human Rights at Harvard University for the past 20 years and in 2013 received the United Nations Association of Queensland Award for her contribution to public health and education. She is currently an adjunct Professor at James Cook University and the first Elder in Residence in the Indigenous Health Unit.

Dr Shields as a proud Aboriginal person of the Bundjalung people. She has worked in the mental health sector for many years, and is now undertaking specialist training as a psychiatrist. She is a member of the NSW Mental Health Review Tribunal, member, Aboriginal Health & Medical Research Ethics Committee and has an Order of Australia (AM division) for development of Aboriginal mental health services, 2004. She has concentrated on raising the status of mental illness in the public consciousness, and developing new models of care for the mentally ill people in the most disadvantaged groups, particularly Aboriginal people and forensic patients.
Mr Weston is a descendant of the Meriam people of the Torres Strait. He has lived and worked for 27 years in urban, regional and remote settings where he gained a unique insight into grass roots Indigenous issues. He led the successful Maari Ma Health Aboriginal Corporation in Far West NSW as CEO from 2000-2009. He spent 12 months with the Indigenous Health Service in Brisbane from 2009-2010. His current role is as CEO of the Aboriginal and Torres Strait Islander Healing Foundation based in Canberra which commenced in September 2010.

Mr Weston sits on a number of committees in Indigenous Affairs representing the Healing Foundation – National Health Leadership Forum (NHLF), The Close the Gap Steering Committee, National Aboriginal and Torres Strait Islander Leaders In Mental Health (NATSILMH), National Empowerment Project (NEP) and ANU Medical School Aboriginal and Torres Strait Islander Advisory Group.

The work of the Healing Foundation in its short life has delivered 90 projects into Aboriginal and Torres Strait Islander Communities across Australia that have employed 738 Aboriginal and Torres Strait Islander people, delivered 1675 activities to 16,000 people and have improved Social And Emotional Wellbeing to 94% of participants.

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3 Based on combined data from New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory. Australian Institute of Health and Welfare, Aboriginal and Torres Strait Islander Health Performance Framework 2012: detailed analyses, Cat. no. IHW 94. Canberra, 2013, p.639.
13 Forrest, A, above note 147, p 20.
As above, p 11.

25 As above.

26 As above, p 14.


28 Steering Committee for the Review of Government Service Provision, above note 4, pp.488, 49.0.


38 Correspondence with Professor Helen Milroy, 13/8/14.


41 pp. 61, 105 and 125

42 p151

43 p81

44 p142

45 p148


48 As above, p.5.

49 Panaretto et al, above note 46.

50 Panaretto et al, above note 46, p 650.

51 Panaretto et al, above note 46, p 650.


Supporting anti-discrimination initiatives aimed at identifying and combating the impact of racism on the well being of Aboriginal and Torres Strait Islander peoples’ was Action 1.2.3 of: Social Health Reference Group, *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Well Being (2004 – 2009)*, Commonwealth of Australia, Canberra, 2004.

