Contributing lives, thriving communities

Specific challenges for Aboriginal and Torres Strait Islander people

A summary from the Report of the National Review of Mental Health Programmes and Services

30 November 2014
About this summary

This document is a summary of the Aboriginal and Torres Strait Islander elements of the National Mental Health Commission’s Review of national mental health programmes and services, including extracts from two volumes of the four-volume Review report. All four volumes can be downloaded from www.mentalhealthcommission.gov.au.

A number of electronic fact sheets and a summary document of the national review report are also available on our website.

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Commissioner Professor Pat Dudgeon provided her significant expertise to inform the Review and development of this summary. The Commission also thanks Chris Holland for his drafting efforts and guidance, and the Commission staff for their work.

What is in this summary

The Review report was published in four volumes of which two are considered here: Volume 1: Strategic Directions Practical Solutions 1-2 years and Volume 2: Every Service is a Gateway; Response to Terms of Reference.

The Executive Summary (p.1) is an extract from Chapter 4, Volume 2: Aboriginal and Torres Strait Islander peoples’ mental health, which includes five action areas to transform the mental health outcomes for Aboriginal and Torres Strait Islander peoples. This is informed by commissioned research and consultation including that of Health Management Australia (HMA). The five action areas are embodied in Recommendations 5 and 18 from Volume 1 of the Review, which are the main recommendations specific to Aboriginal and Torres Strait Islander peoples. This document also includes extracts from other recommendations that are highly relevant to Aboriginal and Torres Strait Islander peoples.

The remainder of Chapter 4, Volume 2: Aboriginal and Torres Strait Islander peoples’ mental health appears as an extract at pages 21 to 39.

A table is also included from Chapter 11, Volume 2: Implementation of a better mental health system, which outlines areas for action from the mid-to-long-term (three to ten year) policy directions.

Other areas of the Review (for example, Chapter 6, Volume 2: Suicide prevention) also contain material that is highly relevant for Aboriginal and Torres Strait Islander communities, but is not included in this summary. Also not included here are extracts from Volume 3, that summarised submissions received by the Review including those from Aboriginal and Torres Strait Islander organisations; and Volume 4 that contains supporting papers upon which the Review relied.

Commissioned papers including HMA’s report are published separately on our website. See: http://www.mentalhealthcommission.gov.au/our-reports/review-of-mental-health-programmes-and-services.aspx for the full Review report and supporting papers.
Executive summary

The report of the National Review of Mental Health Programmes and Services revealed a wide gap between the wellbeing and mental health of Indigenous Australians to other Australians; in particular, the death from suicide being twice that of non-Indigenous Australians.

The Review made recommendations across five areas identified in Chapter 4, Volume 2, which are aimed at transforming the mental health outcomes for Aboriginal and Torres Strait Islander peoples, and creating an effective and efficient mental health system.

These are:

1. Make Aboriginal and Torres Strait Islander mental health a national priority

In Volume 1, the Review proposes making Aboriginal and Torres Strait Islander mental health a national priority and that this should be supported by agreeing an additional COAG Closing the Gap target specifically for mental health. Critically, dedicated national Aboriginal and Torres Strait Islander mental health planning and service and programme design is needed because mainstream mental health policy, service and programmes are often not culturally appropriate for Aboriginal and Torres Strait Islander people. This work would support a dedicated national Aboriginal and Torres Strait Islander mental health plan.

In doing this, it is important that Australian governments work with a credible Aboriginal and Torres Strait Islander leadership and stakeholder partnership mechanism for mental health, social and emotional wellbeing, suicide prevention, and alcohol and other drugs use prevention. The basis of this should be the Aboriginal and Torres Strait Islander Mental health and Suicide Prevention Advisory Group.

There are several components to advancing Aboriginal and Torres Strait Islander social and emotional wellbeing:

- Establish mental health as a priority within the COAG Closing the Gap framework and within the Indigenous Advancement Strategy.
- Additional costs could be offset by the significant reductions in the costs associated with addressing chronic disease, unemployment, family breakdown, alcohol and other drugs abuse, smoking, and high rates of imprisonment in Aboriginal and Torres Strait Islander peoples. In part this could occur through a justice reinvestment programme.

Achievement of this will require activation of existing frameworks for national Aboriginal and Torres Strait Islander mental health planning and service and programme design over the next 12 to 18 months through the implementation of:

- the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2014–2019
- the National Aboriginal and Torres Strait Islander Health Plan 2013–2023
- the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2013
- the National Aboriginal and Torres Strait Islander Peoples’ Drug Strategy.

This will require assessment of what funding from mainstream programmes could be diverted into the new approach to offset costs. This must be subject to the outcome of individual programme reviews. All such planning must occur in partnership with Aboriginal and Torres Strait Islander peoples and under the guidance of the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group (ATSIMHSPAG).
Monitoring implementation of this new approach and ensuring accountability of government departments and jurisdictions for progress will be essential.

In considering the funding needs of this approach within current fiscal circumstances, the following points should be considered.

- Suicide prevention expenditure should be quarantined.
  - Funding allocated to implement the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and the National Strategic Framework for Aboriginal and Torres Strait Islander People’s Mental Health and Social and Emotional Wellbeing 2014–2019.
  - Wherever possible, existing expenditure should contribute to supporting Indigenous Primary Health Care Organisations (IPPCOs)/Aboriginal Community Controlled Health Services (ACCHS) Mental Health and Social and Emotional Wellbeing (SEWB) Teams and also specialist Aboriginal and Torres Strait Islander mental health services.
- Further attention is required by mainstream services to the mental health needs of Aboriginal and Torres Strait Islander people in custodial care. A justice reinvestment programme for detainees should be introduced as a cost-effective way to reduce the risk of reoffending and minimise future custodial care outlays. It also could be extended to more youth mental health services in Aboriginal and Torres Strait Islander communities.

2. Integrated Mental Health and SEWB Teams

- Require mental health and SEWB teams to be established in all government-funded IPPCOs and ACCHS, as part of renewed service agreements.
- Mental health services to be fully integrated within these services as a part of their existing comprehensive primary health care service package. This will enable the early detection and expanded treatment of mental health problems and some mental illness in relatively inexpensive community and primary health care settings. Such mental health and SEWB teams also could help support recovery in community settings.
- The integrated teams will provide access to:
  - medical care, including pharmacotherapies and preventive health care and health checks to promote, maintain and treat physical health
  - structured interventions using evidence-based therapy
  - 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.
- With links to:
  - community mental health
  - alcohol and other drugs services
  - primary health care
  - access to a psychiatrist
  - mainstream services.

Workforce requirements for introducing integrated teams can be informed by planning work undertaken by the Aboriginal Medical Services Alliance Northern Territory (AMSANT).
The integrated teams would implement models of care/clinical pathways for:

- community mental health—screening, treatment, support
- alcohol and other drugs
- chronic illness support
- SEWB promotion/community strengthening.

3. **Invigorate culturally responsive and accountable mainstream mental health services**

   - Provide incentives and place accountability requirements on mainstream services to improve their contribution to delivering better mental health outcomes for Aboriginal and Torres Strait Islander people, including strategies such as:
     - frameworks for policy approaches
     - quality and professional standards with organisations such as RACGP, Australian Practice Nurses Association and service accreditation standards agencies such as the Australian Commission on Quality and Safety in Health Care (ACSQHC)
     - targets and key performance indicators in funding agreements
     - partnership agreements being established at a local level between the leadership of mainstream services and the IPHCOs/ACCHS
     - clinical pathways development in partnership with local ACCHOs/AMS for mental health consumers, defining how the services will support them in their journey from primary care to acute care and the provision of ongoing care for people with a chronic mental illness
     - professional development programmes delivered to support mainstream staff develop cultural competencies.

4. **Sharpen role of dedicated Aboriginal and Torres Strait Islander services**

   - Refocus the role of dedicated Aboriginal and Torres Strait Islander services to support Aboriginal and Torres Strait Islander people’s journeys across the mental health system.

   Additional effort is needed to facilitate the journey of Aboriginal and Torres Strait Islander people into and through the specialist mental health service system, and in particular from primary mental health care settings into mainstream specialist mental health services and programmes.

   Each state and territory has a different infrastructure and mix of services, so the most appropriate responses will vary. Some jurisdictions could choose to establish specialist Aboriginal and Torres Strait Islander mental health services along the lines of the Western Australia Statewide Specialist Aboriginal Mental Health Service (SSAMHS) model.

   Irrespective of the precise approach, all Aboriginal and Torres Strait Islander people admitted to a specialist (mainstream) mental health service should be in the target group for this service and the following features/capabilities should be standard:

   - ensuring each referred/admitted person 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
   - maintaining links to family
   - facilitation of access to community support on return to community.
5. **Aboriginal and Torres Strait Islander mental health workforce development**

- Develop a National Aboriginal and Torres Strait Islander mental health workforce strategy to support the changes in service delivery proposed and enable all services (specialist and mainstream) to be more culturally responsive and better able to work with Aboriginal and Torres Strait Islander peoples.

Key components of the strategy should include:

- identifying current capacity and future workforce needs
- increasing 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
- increasing Aboriginal and Torres Strait Islander participation rates in tertiary courses and in the mental health workforce, involving health professional associations and education providers taking greater responsibility for increasing the level of Aboriginal and Torres Strait Islander students undertaking their courses and entering the profession. (The medical profession is demonstrating good practice in supporting the training and mentoring of Aboriginal and Torres Strait Islander medical students)
- developing specialist Aboriginal mental health courses such as the Djirruwang Programme through Charles Sturt University. This is a three year Bachelor of Health Science (Mental Health) degree and has curricula based on workplace learning, university learning, placement learning and development of mental health competencies.
Introduction

In 2013, the Commonwealth Government tasked the National Mental Health Commission (Commission) with conducting a national review of mental health programmes and services (the Review). The focus of the Review was on assessing the efficiency and effectiveness of programmes and services in supporting individuals experiencing mental ill-health and their families and other support people to lead a contributing life and to engage productively in the community. The final report was provided to the Commonwealth Government on 1 December 2014.

Aboriginal and Torres Strait Islander mental health outcomes are significantly worse than that of other Australians. In part because of this gap, the Review’s Terms of Reference required the Commission to look at the ‘specific challenges for Aboriginal and Torres Strait Islander people’.

Terms of Reference – 2014 National Review of Mental Health Programmes and Services

This Review will examine existing mental health services and programmes across the government, private and non-government sectors. The focus of the Review will be to assess the efficiency and effectiveness of programmes and services in supporting individuals experiencing mental ill-health and their families and other support people to lead a contributing life and to engage productively in the community.

Programmes and services may include those that have as a main objective:

- the prevention, early detection and treatment of mental illness
- the prevention of suicide
- mental health research, workforce development and training
- the reduction of the burden of disease caused by mental illness.

The Review will consider:

- The efficacy and cost-effectiveness of programmes, services and treatments.
- Duplication in current services and programmes.
- The role of factors relevant to the experience of a contributing life, such as employment, accommodation and social connectedness (without evaluating programs except where they have mental health as their principal focus).
- The appropriateness, effectiveness and efficiency of existing reporting requirements and regulation of programmes and services.
- Funding priorities in mental health and gaps in services and programmes, in the context of the current fiscal circumstances facing governments.
- Existing and alternative approaches to supporting and funding mental health care.
- Mental health research, workforce development and training.
- Specific challenges for regional, rural and remote Australia.
- **Specific challenges for Aboriginal and Torres Strait Islander people.**
- Transparency and accountability for outcomes of investment.
The gap between the mental health of Aboriginal and Torres Strait Islander peoples and other Australians

**Psychological Distress:** In 2012–13, 30 per cent of respondents to the *Australian Aboriginal and Torres Strait Islander Health Survey* over 18 years of age reported high or very high psychological distress levels in the four weeks before the survey interview. That is nearly three times the non-Indigenous rate. In 2004-05, high and very high psychological distress levels were reported by 27 per cent of respondents, suggesting an increase in Aboriginal and Torres Strait Islander psychological distress rates over the past decade.

**Trauma:** Trauma is a complex phenomenon, has many symptoms and is difficult to measure in a population. Post-Traumatic Stress Disorder (PTSD) is one manifestation of trauma. A 2008 study of Aboriginal and Torres Strait Islander prisoners in Queensland reported 12.1 per cent of males and 32.3 per cent of females with PTSD.

**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. Rates of psychiatric disability (including conditions such as schizophrenia) are double that of non-Indigenous people.

**Suicide:** The overall Aboriginal and Torres Strait Islander suicide rate was twice the non-Indigenous rate between 2001 and 2010. Approximately 100 Aboriginal and Torres Strait Islander deaths by suicide per year took place over that decade. In 2012, 117 suicides were reported.

Healthcare Management Australia (HMA) was commissioned to undertake the Aboriginal and Torres Strait Islander elements of the Review for the Commission. This included reviewing the submissions received from Aboriginal and Torres Strait Islander people and organisations. HMA undertook their work with the oversight of a governance committee that included Commissioner Professor Pat Dudgeon and Professor Tom Calma AO.

Commissioner Dudgeon and Prof. Calma are also Co-chairs of the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group (ATSIMHSPAG), that advises the Minister for Health, Minister for Indigenous Affairs and Assistant Health Minister on Aboriginal and Torres Strait Islander mental health, social and emotional wellbeing and suicide prevention. ATSIMHSPAG and the National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH) also advised HMA at key junctures of the review process.

HMA’s report can be found on the Commission’s website.

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1Based 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.
Recommendations

Recommendations 5 and 18 of the report are the Review’s main responses to the challenges faced by Aboriginal and Torres Strait Islander peoples.

Recommendation 5 advocates making Aboriginal and Torres Strait Islander mental health a priority and agreeing an additional COAG Closing the Gap target specifically for mental health. Specifically, the Commission calls on COAG to establish a coordinated process for developing a dedicated, national Aboriginal and Torres Strait Islander mental health plan. Recommendation 5 is intended to supplement the National Mental Health and Suicide Prevention Plan called for under Recommendation 2 in the Review.

The call for a dedicated Aboriginal and Torres Strait islander mental health plan reflects a long-standing position of the Commission. Indeed, it first recommended such a dedicated plan in its inaugural 2012 National Report Card on Mental Health and Suicide Prevention (Recommendation 5). Such a plan is needed to close the mental health gap with other Australians. It should take into account the unique historical and social determinants of these mental health conditions. Such a plan should also be culturally appropriate, and recognise the connections between poorer mental health outcomes and the entrenched poverty and discrimination faced by Aboriginal and Torres Strait Islander peoples.

A dedicated mental health plan would aim to close mental health service gaps for Aboriginal and Torres Strait Islander peoples by providing much needed social and emotional wellbeing teams in Indigenous Primary Health Care Organisations, as stated in the Review Recommendation 18. This would ensure general population mental health services are accessible to, and able to work effectively with, Aboriginal and/or Torres Strait Islander people. The required increase in mental health services also requires the training of an Aboriginal and Torres Strait Islander mental health workforce, and ensuring general population mental health service workers and professionals are able to provide a culturally appropriate service.

Suicide among Aboriginal and Torres Strait Islander peoples is reported at over twice the rate of other Australians with youth suicide and suicide clusters in certain communities being of great concern. Hence, the Review acknowledges that Aboriginal and Torres Strait Islander peoples should be a priority group for national suicide prevention efforts.

A focus of the Review is on a national response to suicide. To that end, as noted, Recommendation 2 proposes a National Mental Health and Suicide Prevention Plan. Further, Strategic Direction 7 proposes an ambitious national target to reduce suicide and suicide attempts by 50 per cent over the next decade; and Recommendation 19 proposes establishing 12 regions across Australia as the first wave for nationwide introduction of sustainable, comprehensive, whole-of-community approaches to suicide prevention. This national response embraces Aboriginal and Torres Strait Islander peoples and communities. Under Recommendation 19, for example, the Commission would expect that Aboriginal and Torres Strait Islander suicide would be a significant issue in a high proportion of the 12 regions chosen.
The Review also intends that this national approach be supplemented by dedicated responses to Aboriginal and Torres Strait Islander suicide, supporting local and cultural strengths to be recognised in planning and implementation. Indeed, the evidence demonstrates that just as there are unique contributors to suicide in this population group, so dedicated responses which account for these determinants as well as cultural differences are essential. The Review makes this clear in its support for a properly funded implementation of the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy under Recommendation 5. Further, the Review highlights the need for culturally appropriate suicide prevention and postvention services including those that support access to culturally competent suicide prevention workers in Chapter 6 of Volume 2 of its report.

Other recommendations directly relevant to Aboriginal and Torres Strait Islander peoples include:

- **Recommendation 1**: ‘Agree the Commonwealth’s role in mental health is through national leadership and regional integration, including integrated primary and mental health care’. This is a key part of Strategic Direction 1 that aims to ‘set clear roles and accountabilities’ among the Commonwealth, States and Territories for mental health service delivery’, including for Aboriginal and Torres Strait Islander peoples. In particular, the Review recommends that the Commonwealth should ‘take overall responsibility for Aboriginal and Torres Strait Islander primary mental health care through its funding of Indigenous Primary Health Care Organisations (including Aboriginal Community Controlled Health Services); through Primary and Mental Health Networks; through MBS-subsidised mental health services provided by general practitioners, and through the PBS’. Another element of this recommendation is balancing Commonwealth leadership with regional-level planning and service integration around the needs of individuals, their families and communities. This includes Aboriginal and Torres Strait Islander individuals, families and communities within any given region.

- **Recommendation 7**: ‘Reallocate a minimum of $1 billion in Commonwealth acute hospital funding in the forward estimates over the five years from 2017–18 into more community-based psychosocial, primary and community mental health services. As noted, such as: ‘redirection of funds... is required to support the systemic changes to Aboriginal and Torres Strait Islander mental health services and programmes proposed in this Review’. The Review, however cautions, that ‘[s]uch redirection should be managed so as not to have a disproportionate or unfair impact on Aboriginal and Torres Strait Islander people already experiencing mental illness—recognising that in the short term Aboriginal and Torres Strait Islander people will continue to rely more heavily on hospital services for the treatment of mental health conditions than other Australians: that is, until increased levels of primary health care have been in place long enough to take effect’.

- **Recommendation 8**: ‘Extend the scope of Primary Health Networks (renamed Primary and Mental Health Networks) as the key regional architecture for equitable planning and purchasing of mental health programmes, services and integrated care pathways. This includes requiring Primary and Mental Health Networks ‘to be responsible and accountable within their jurisdictions for improved Aboriginal and Torres Strait Islander mental health outcomes’.

- **Recommendation 9**: ‘Bundle-up programmes and boost the role and capacity of NGOs and other service providers to provide more comprehensive, integrated and higher-level mental health services and support for people, their families and supporters.’ This includes ensuring contracts for the delivery of bundled up programmes ‘include
specific accountabilities for better mental health outcomes for Aboriginal and Torres Strait Islander people and development of partnerships with Indigenous primary health care organisations including Aboriginal Community Controlled Health Services’.

- **Recommendation 10**: ‘Improve service equity for rural and remote communities through place-based models of care’. This is relevant because approximately one in four Aboriginal and Torres Strait Islander people live in remote and very remote areas. The recommendation includes a mapping exercise undertaken by Primary and Mental Health Networks along with Local Health Networks designed to support the development of social and emotional wellbeing and mental health teams under Recommendation 18, and regional mental health and suicide prevention strategies to support regional level planning and service delivery under Recommendation 1.

- **Recommendation 12**: ‘Strengthen the central role of GPs in mental health care through incentives for use of evidence-based practice guidelines, changes to the Medicare Benefits Schedule, and staged implementation of Medical Homes for Mental Health’. This is relevant because significant numbers of Aboriginal and Torres Strait Islander people, particularly those unable to access Indigenous Primary Health Care Organisations (including Aboriginal Community Controlled Health Services) are reliant on GPs for primary mental health care, and the ability of GPs to provide a culturally competent service is critical to how the mental health system responds to greater Aboriginal and Torres Strait Islander mental health needs.

- **Recommendation 16**: ‘Identify, develop and implement a national framework to support families and communities in the prevention of trauma from maltreatment during infancy and early childhood, and to support those impacted by childhood trauma’. This includes funding studies on the social and other costs of such trauma in (among others) Aboriginal and Torres Strait Islander communities, and on the prevalence of mental health conditions among child sexual abuse survivors including by connecting such studies to the Footprints in Time—Longitudinal Study of Indigenous Children.

- **Recommendation 20**: ‘Improve research capacity and impact by doubling the share of existing and future allocations of research funding for mental health over the next five years, with a priority on supporting on supporting strategic research that responds to policy directions and community needs.’ This includes applied research in the area of Aboriginal and Torres Strait Islander mental health to understand better what interventions work as a research priority.

There is a strong Aboriginal and Torres Strait Islander presence in many of the Review’s recommendations, and these should be read as a whole to grasp the overarching picture for how better Aboriginal and Torres Strait Islander mental health and suicide prevention outcomes will be achieved through the reforms it proposes.

Finally, throughout the Review is underscored the need for Australian governments to support and partner with Aboriginal and Torres Strait Islander mental health leaders and experts to initiate and help implement the reforms needed to close the mental health gap and reduce suicide among Aboriginal and Torres Strait Islander peoples.
Relevant strategic directions and recommendations

**Strategic Direction 2**

Agree and implement national targets and local organisational performance measures

*What success looks like*

- Agreement on national targets and transparency about progress in achieving them over time.
- Agreement on a new Closing the Gap Target on Mental Health.
- Agreement on state, territory and regional KPIs, tied to ongoing funding.
- Aboriginal and Torres Strait Islander mental health is recognised as a national priority supported by a dedicated national Aboriginal and Torres Strait Islander mental health plan.
- NGOs and others receiving government funding have measurable performance targets, with achievement of targets tied to ongoing funding.
- Increased transparency and accountability for results and outcomes.
- A person with a lived experience to tell their story once, not many times: a shared case record and a single care plan links providers into a person-centred approach.
- There is “no wrong door” into mental health and related services.

**Recommendation 5:**

Make Aboriginal and Torres Strait Islander mental health a national priority and agree an additional COAG Closing the Gap target specifically for mental health

*How this will be achieved*

1. Establish a credible Aboriginal and Torres Strait Islander mental health, social and emotional wellbeing, suicide prevention, and alcohol and other drug use prevention leadership and stakeholder partnership mechanism.

2. Working with the above body, COAG:
   - agrees that Aboriginal and Torres Strait Islander mental health and closing the mental health gap is a national priority within the Closing the Gap Framework
   - develops and agrees a mental health specific target for Closing the Gap
   - establishes a coordinated process for developing a dedicated, national Aboriginal and Torres Strait Islander mental health plan
   - identifies medium and long-term savings to be made from closing the mental health gap (i.e. from lower imprisonment rates, better physical health, increasing employment and reducing unnecessary hospitalisation for mental health conditions)
   - identifies medium and long-term savings to be made from decisively shifting its approach to Aboriginal and Torres Strait Islander mental health, suicide and alcohol and other drug use to promotion, prevention and early detection
   - develops a reinvestment-based funding strategy for closing the mental health gap over the next decade, based on the above two assessments, that includes the additional services proposed in Recommendation 18
   - agrees to a national approach to closing the mental health gap that is included in the *National Indigenous Reform Agreement*. 

**Issues:**

- Dedicated national Aboriginal and Torres Strait Islander mental health planning and service and programme design is needed because general population mental health policy, service and programme design may not be appropriate for Aboriginal and Torres Strait Islander people.

- This is because of (a) the greater burden of mental health problems and mental illness among Indigenous Australians, (b) the cultural and experiential differences between Aboriginal and Torres Strait Islander people and non-Indigenous people that underpin the ‘mental health gap’ and (c) the need for tailored services that work within the SEWB context and take into account cultural differences.

- The *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2014–19* provides the basis for such planning and service and programme development. This should be developed and implemented along 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 People’ Drug Strategy* (under development).

- A coordinated implementation process for all four is not only necessary to close the mental health gap, but such a process will avoid duplication and be more efficient.

- Programme success also requires improved support for Aboriginal and Torres Strait Islander families, and culturally competent services available to communities.

- Public and regular reporting on progress is required to ensure accountability and performance evaluation against targets.

**Strategic Direction 6**

**Expand dedicated mental health and social and emotional wellbeing teams for Aboriginal and Torres Strait Islander people**

**What success looks like**

- Access is improved to:
  - Mental health and social and emotional wellbeing teams in Indigenous Primary Health Care Organisations (including Aboriginal Community Controlled Health Services).
  - Aboriginal and Torres Strait Islander specialist mental health services.

- General population mental health services are accountable for better Aboriginal and Torres Strait Islander mental health outcomes.
**Recommendation 18:**

Establish mental health and social and emotional wellbeing teams in Indigenous Primary Health Care Organisations (including Aboriginal Community Controlled Health Services), linked to Aboriginal and Torres Strait Islander specialist mental health services.

**How this will be achieved**

4. Start with the context provided by the implementation of Recommendation 5: the establishment of Aboriginal and Torres Strait Islander mental health as a national priority, the establishment of a credible leadership body and dedicated national planning to improve Aboriginal and Torres Strait Islander mental health outcomes and close the mental health gap.

5. Each IPHCO/ACCHS to have an integrated mental health and SEWB team providing links to: community mental health, alcohol and other drugs; primary health care, access to a psychiatrist and links to mainstream services.

6. Work with the states and territories on services and systems required to be put in place to facilitate the transition of Aboriginal and Torres Strait Islander people into and through the specialist mental health service system, and in particular from primary mental health care settings into mainstream specialist mental health services and programmes.

7. Ensure through contractual performance requirements that general population mental health services are accountable for better Aboriginal and Torres Strait Islander mental health outcomes.

8. Train and employ the Aboriginal and Torres Strait Islander workforce needed to close the Aboriginal and Torres Strait Islander mental health gap.

**Issues:**

- Mental ill-health is so prevalent and such a high priority among Aboriginal and Torres Strait Islander people that it needs to be integrated as a core part of a holistic approach to care and support.

- Mental health services need to be expanded and fully integrated within IPHCOs and ACCHS as a part of their existing comprehensive primary health care service package. The integrated teams will provide access to:
  - medical care, including pharmacotherapies and preventive health care and health checks to promote, maintain and treat physical health
  - structured interventions using evidence-based therapy
  - social and cultural support, including access to housing, support with issues of cultural identity and support from local Aboriginal people via AHWs and Aboriginal mental health workers.

- An effective approach will require strong links and partnerships between the Commonwealth, states and territories. This will be particularly important for those who require specialist services and therefore require easily navigable pathways through the system.

- While approaches will vary according to local circumstance, for all Aboriginal and Torres Strait Islander people admitted to a specialist (mainstream) mental health service 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 link to family
- facilitation of patient access to community support on return to community.

- The delivery of primary mental health services to Aboriginal and Torres Strait Islander people outside of IPHCO/ACCHS settings and mainstream specialist mental health services and programs needs to be culturally competent and culturally safe. In the development of the National Mental Health and Suicide Prevention Plan, governments 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:
  - Development of quality and professional standards with organisations such as RACGP, Australian Practice Nurses Association and the Australian Psychological Society.
  - 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.
  - Ensure professional development programmes are being delivered to support mainstream staff develop cultural competencies.

- Planning between the Commonwealth, states and territories, and at regional and local levels, needs to identify the future demand for services and the workforce required to meet that demand.
  - Opportunities need to be identified 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 should set a target for the numbers of Aboriginal and Torres Strait Islander students undertaking mental health and related training and entering the mental health professions and workforce. Progress should be benchmarked and reported against standards developed by professional associations and education providers.
  - Scholarship and traineeship programmes should specify a special weighting for Aboriginal and Torres Strait Islanders to enter into the mental health workforce.
  - Relevant professional associations and education providers develop specialist Aboriginal and Torres Strait Islander mental health courses based on models of good practice such as the Djirruwang Programme (UNSW) and roll them out nationwide.
## Other relevant strategic directions and recommendations

Note: this table references Volume 1, Report of the National Review of Mental Health Programmes and Services

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<td>Set clear roles and accountabilities to shape a person-centred mental health system</td>
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<tr>
<td><strong>What success looks like</strong></td>
<td>Australian governments agree responsibilities for Aboriginal and Torres Strait Islander mental health and are held accountable for improved outcomes.</td>
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| **Rec 1**        | • Agree the Commonwealth’s role in mental health is through national leadership and regional integration, including integrated primary and mental health care. How this will be achieved:  
  • The Commonwealth to confirm its primary roles in mental health as being in national leadership of those things where a national approach is efficient and effective, and in enabling regional integration around the needs of people, their families and communities. This includes:  
    o leading national mental health policy direction (...)  
    o supporting better mental wellbeing through its other national roles in areas such as communications, standards, guidelines, research, and payment of benefits to individuals (including through MBS and PBS), and employment, education, and social services  
    o ensuring that Aboriginal and Torres Strait Islander people are benefitting in an equitable manner (including with reference to their greater mental health needs) through MBS-subsidised mental health care, including that provided by GPs, and by access to PBS-subsidised mental health medications  
    o providing pooled funding to promote regional integration of services around the needs of individuals, their families and communities through primary and mental health networks.  
  Issues:  
  • Clarifying Commonwealth and state and territory roles is important to the efficient delivery and planning of mental health programmes and investment (…)  
  • In its national leadership role, the Commonwealth should: (…)  
    o take overall responsibility for Aboriginal and Torres Strait Islander primary mental health care through its funding of Indigenous Primary Health Care Organisations (including Aboriginal Community-Controlled Health Services); through Primary and Mental Health Networks; through MBS-subsidised mental health services provided by general practitioners, and through the PBS.  
  • (...) Regional integrators will be required to consult and plan locally, and have the opportunity to drive improvements and efficiencies in service delivery, including fewer silos, greater integration (including with physical health programmes) and a person-centred, whole-of-person approach.  
  • (...) Involving Aboriginal and Torres Strait Islander communities as partners in these activities will be critical to their success.  
  • The states and territories should be responsible for the delivery of the Aboriginal and Torres Strait Islander specialist mental health services proposed in this Review. A model of great promise for these services is the Western Australian Statewide Specialist Aboriginal Mental Health Services (SSAMHS). These work within the State mental health system but were | 54-58  |
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| Rec 2   | **Develop, agree and implement a National Mental Health and Suicide Prevention Plan with states and territories, in collaboration with people with lived experience, their families and support people.** How this will be achieved:  
- The Commonwealth to lead development of a new National Mental Health and Suicide Prevention Plan, based on the directions identified in this report.  
- Overarching principles and objectives to include:  
  - targets and indicators for mental health outcomes including Aboriginal and Torres Strait Islander mental health outcomes  
  - roles and responsibilities for achieving better Aboriginal and Torres Strait Islander mental health outcomes, including responsibilities for the additional services proposed in this Review  
  - Aboriginal and Torres Strait Islander mental health outcomes to be monitored to support accountability across the federal system.  
  - The plan to set out the preconditions for hospital funding related to mental health supports. In return for ongoing Commonwealth funding for mental health services provided through the acute hospital system, the plan should require: long-term reductions in Aboriginal and Torres Strait Islander peoples’ use of hospitals for preventable mental health conditions, with savings redirected to Aboriginal and Torres Strait Islander primary mental health care. Issues:  
  - Aboriginal and Torres Strait Islander mental health and suicide prevention needs dedicated planning and additional resources if better mental health outcomes are to be achieved. |
| Rec 3   | **Urgently clarify the eligibility criteria for access to the National Disability Insurance Scheme (NDIS) for people with disability arising from mental illness and ensure the provision of current funding allows for a significant Tier 2 system of community supports.** Issues:  
- Aboriginal and Torres Strait Islander people with qualifying mental health conditions need to be able to access the NDIS in an equitable fashion. This means ensuring providers are able to work in a culturally competent manner. |
<p>| Strategic Direction 2 | Agree and implement national targets and local organisational performance measures (includes Recommendation 5 - extracted above)                                                                                                                                                                                                                                                                  |
| What success looks like | Aboriginal and Torres Strait Islander mental health is recognised as a national priority supported by a dedicated national Aboriginal and Torres Strait Islander mental health plan.                                                                                                                                                                                                                                      |</p>
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<td><strong>Rec 6</strong></td>
<td>Tie receipt of ongoing Commonwealth funding for government, NGO and privately provided services to demonstrated performance, and use of a single care plan and eHealth record for those with complex needs. How this will be achieved: • Consult with peak consumer and carer bodies, including Aboriginal and Torres Strait Islander bodies and the National Aboriginal Community-Controlled Health Organisation, to seek engagement and buy-in on the approach to use of a single care plan.</td>
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<td><strong>Strategic Direction 3</strong></td>
<td><strong>Shift funding priorities from hospitals and income support to community and primary health care services</strong></td>
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<td><strong>Rec 7</strong></td>
<td>Reallocate a minimum of $1 billion in Commonwealth acute hospital funding in the forward estimates over the five years from 2017–18 into more community-based psychosocial, primary and community mental health services. How this will be achieved: • A redirection of funds also is required to support the systemic changes to Aboriginal and Torres Strait Islander mental health services and programmes proposed in this Review. Such redirection should be managed so as not to have a disproportionate or unfair impact on Aboriginal and Torres Strait Islander people already experiencing mental illness – recognising that in the short term Aboriginal and Torres Strait Islander people will continue to rely more heavily on hospital services for the treatment of mental health conditions than other Australians: that is, until increased levels of primary health care have been in place long enough to take effect.</td>
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<td><strong>Rec 8</strong></td>
<td>Extend the scope of Primary Health Networks (renamed Primary and Mental Health Networks) as the key regional architecture for equitable planning and purchasing of mental health programmes, services and integrated care pathways. How this will be achieved: • Require PMHNs to be responsible and accountable within their jurisdictions for improved Aboriginal and Torres Strait Islander mental health outcomes. Issues: • Treatment rates for mental illness is a measurable indicator on the proportion of the population accessing primary mental health care programs, disaggregated by program stream and including identification of Aboriginal and Torres Strait Islander access. To be meaningful, the indicator should include hospital attendance information (given that in many rural and remote areas people go to hospital to see a GP rather than private practice) as well as ATAPS and MHNIP activity as being alternatives to MBS-subsidised items. This approach also needs to include local benchmarking of access.</td>
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<td><strong>Rec 9</strong></td>
<td>Bundle-up programmes and boost the role and capacity of NGOs and other service providers to provide more comprehensive, integrated and higher-level mental health services and support for people, their families and supporters. How will this be achieved: • Agree to establish a smaller number of larger regional programmes, to be</td>
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managed regionally by Primary and Mental Health Networks.

- Determine which programmes should be managed at a regional level, and the number of bundled programmes which should be created.
  - While one option is a single programme, this may not be the best approach to achieve government policy directions.
  - Another option is for programmes focused on individuals such as PHaMs and Day to Day Living to be bundled into one programme, while programmes focused on clinical services such as ATAPS and Mental Health Services in Rural and Remote Areas (MHSRRA) could go into another. (...)

- Ensure contracts include specific accountabilities for better mental health outcomes for Aboriginal and Torres Strait Islander people and development of partnerships with Indigenous primary health care organisations including Aboriginal Community Controlled Health Services.

**Rec 10**

**Improve service equity for rural and remote communities through place-based models of care**

How this will be achieved:

- Primary and Mental Health Networks, in partnership with Local Health Networks, should conduct comprehensive mapping of mental health services, programmes and supports available in regional, rural and remote areas through Commonwealth, state and territory and local governments, private and not-for-profit sectors.

- As appropriate, this mapping exercise also should be used to support the development of mental health and social and emotional wellbeing teams operating in rural and remote Indigenous Primary Health Care Organisations (including Aboriginal Community-Controlled Health Services) and specialist mental health services.

Issues:

- About one in four Aboriginal and Torres Strait Islander people live in remote and very remote areas. This recommendation should be closely developed with the overall systemic approach to improving Aboriginal and Torres Strait Islander mental health proposed in this Review.

**Strategic Direction 4**

**Empower and support self-care and implement a new model of stepped care across Australia**

**Rec 12**

**Strengthen the central role of GPs in mental health care through incentives for use of evidence-based practice guidelines, changes to the Medicare Benefits Schedule, and staged implementation of Medical Homes for Mental Health.**

How this is to be achieved:

- **MBS Health Assessment items**: Promote mental health and social and emotional wellbeing assessments as a part of the MBS-subsidised health checks for Aboriginal and Torres Strait Islander children, adults and over-55s.

- **Staged implementation of Mental Health Medical Homes**: Pool existing funding from programmes supporting people who experience serious mental illness and develop new funding and administrative approaches in a number of PMHNs, including at least one with regional, rural and remote communities to keep people out of hospital and functioning capably within the community.
Work with the dedicated Aboriginal and Torres Strait Islander specialist services to ensure patient transitions across services.  

Issues:

- Aboriginal and Torres Strait Islander people, particularly those unable to access Indigenous Primary Health Care Organisations (including Aboriginal Community-Controlled Health Services) generally are reliant on GPs for primary mental health care. Evidence suggests that this is the case for approximately 50 per cent of the Aboriginal and Torres Strait Islander population. As such, the ability of GPs to provide a culturally competent service is critical to how the mental health system responds to greater Aboriginal and Torres Strait Islander mental health needs.
- MBS-subsidised GP health assessments are a potentially useful tool for screening and detecting high or very high levels of psychological distress among Aboriginal and Torres Strait patients and for then connecting them to programmes like ATAPS or Better Access for treatment, or otherwise ongoing referral.
- Bundled payments could be provided where practices (including general practices and Aboriginal Community-Controlled Health Services) take on proactive management of eligible enrolled patients to develop a care plan, engage a multi-disciplinary team, actively manage health care to prevent hospitalisations and care for people in the community.

Rec 13 Enhance access to the Better Access programme for those who need it most through changed eligibility and payment arrangements and a more equitable geographical distribution of psychological services.

How this will be achieved:

- Consider ways to ensure Aboriginal and Torres Strait Islander people access Better Access, including by providing culturally competent professional services through the programme.

Strategic Direction 5 Promote the wellbeing and mental health of the Australian community, beginning with a healthy start to life.

What success looks like

- Significant reductions are achieved in the rates of suicide and suicide attempts among young Aboriginal and Torres Strait Islander people.
- Drastic reductions occur in the rate of detention among Aboriginal and Torres Strait Islander people aged 10–17 years.

Rec 15 Build resilience and targeted interventions for families with children, both collectively and with those with emerging behavioural issues, distress and mental health difficulties.

How this will be achieved:

- Identify as a national priority for primary and mental health networks the mental health and wellbeing of children, adolescents and young adults, including Aboriginal and Torres Strait Islander people.
- At the 2011 Census, individuals under 15 years of age comprised 35.9 per cent of the total Aboriginal and Torres Strait Islander population, compared with 18.3 per cent of the non-Indigenous population. Families are pivotal to the wellbeing of Aboriginal and Torres Strait Islander children. Aboriginal and Torres Strait Islander families can be structured differently to non-Indigenous families, with child rearing managed more collectively. These differences must be accounted for in responses to support families and...
Aboriginal and Torres Strait Islander child mental health. The youth justice example below, based on AIHW data, provides an illustration:

**Focus on young Aboriginal and Torres Strait Islander people in detention**

On any given night, nearly half of those aged 10-17 years in juvenile detention will be Aboriginal and Torres Strait Islander young people. Over the four-year period (June quarter 2009 to June quarter 2013) the level of Aboriginal and Torres Strait Islander overrepresentation among young people in detention increased from 25 to 28 times the non-Indigenous rate. The impact of incarceration at an individual, family and community level is significant. For those entering custody for the first time, this in itself can be traumatic. Being in custody removes young people from their family and puts them into an environment that does not support them achieving the age-appropriate developmental tasks needed for early adulthood. Those recurrently incarcerated risk institutionalisation. The early involvement of young people in the criminal justice system also puts them at much higher risk of further involvement as adults.

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<td>Aboriginal and Torres Strait Islander child mental health. The youth justice example below, based on AIHW data, provides an illustration: <strong>Focus on young Aboriginal and Torres Strait Islander people in detention</strong></td>
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<td><strong>On any given night, nearly half of those aged 10-17 years in juvenile detention will be Aboriginal and Torres Strait Islander young people. Over the four-year period (June quarter 2009 to June quarter 2013) the level of Aboriginal and Torres Strait Islander overrepresentation among young people in detention increased from 25 to 28 times the non-Indigenous rate. The impact of incarceration at an individual, family and community level is significant. For those entering custody for the first time, this in itself can be traumatic. Being in custody removes young people from their family and puts them into an environment that does not support them achieving the age-appropriate developmental tasks needed for early adulthood. Those recurrently incarcerated risk institutionalisation. The early involvement of young people in the criminal justice system also puts them at much higher risk of further involvement as adults.</strong></td>
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<th>Strategic Direction 6</th>
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<td>Strategic Direction 7</td>
<td>Reduce suicides and suicide attempts by 50 per cent over the next decade</td>
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<td>Rec 19</td>
<td>Establish 12 regions across Australia as the first wave for nationwide introduction of sustainable, comprehensive, whole-of-community approaches to suicide prevention.</td>
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How this will be achieved:

- Use funds from within the National Suicide Prevention Programme and the Taking Action to Tackle Suicide (TaTs) Programme for funding regional initiatives as the first stage in implementing an evidence-based comprehensive whole-of-system approach to suicide prevention.
- Work with state and territory governments, people with lived experience and other key stakeholders in the development of a National Suicide Prevention Framework which is based on Australian and international evidence of what works.
- Invite business cases consistent with the framework from regional partnerships, possibly based on Regional Development Australia regions, on co-created models of suicide prevention.
- Use Commonwealth funding as incentive funds to leverage local contributions: encourage models which demonstrate buy-in from local communities through inclusion of contributions (either in dollars or in kind) from partners, including local councils, business, clubs and community organisations.
- Progressively roll the model out across Australia over five years.

Issues:

- Suicide rates are particularly high among Aboriginal and Torres Strait Islander people. Nationally there were 21.4 suicides per 100 000 Aboriginal and Torres Strait Islander people, more than double the rate of 10.3 for other Australians. Aboriginal and Torres Strait Islander people report stressful events at 1.4 times the rate of non-Indigenous people.
- The consortia would need to include those who come into direct contact
with vulnerable people; e.g. health, police and ambulance services and Aboriginal and Torres Strait Islander services, as well as PMHNs and LHNs (or equivalent).

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<td>Build workforce and research capacity to support systems change</td>
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<td>Rec 20</td>
<td>Improve research capacity and impact by doubling the share of existing and future allocations of research funding for mental health over the next five years, with a priority on supporting strategic research that responds to policy directions and community needs. &lt;br&gt;• (...) The strategy should: &lt;br&gt;• Include applied research in the area of Aboriginal and Torres Strait Islander mental health to understand better what interventions work as a research priority.</td>
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<td>Rec 21</td>
<td>Improve supply, productivity and access for mental health nurses and the mental health peer workforce. &lt;br&gt;How this will be achieved: &lt;br&gt;• Promote the uptake of the programme by Indigenous Primary Health Care Organisations including Aboriginal Community Controlled Health Services, including opportunities for MHNIP-funded nurses to be a part of the proposed mental health and social and emotional wellbeing teams. &lt;br&gt;• Grow the Aboriginal and Torres Strait Islander workforce in social and emotional wellbeing: set a target of growing the workforce at least proportionate to their three per cent presence in the population.</td>
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<td>Rec 22</td>
<td>Improve education and training of the mental health and associated workforce to deploy evidence-based treatment. &lt;br&gt;How this will be achieved: &lt;br&gt;• Improve knowledge and capability of the primary health sector in identification, management and referral of people with mental illness, as well as mental health literacy and cultural competency. This should target all GPs, practice nurses, allied health professionals, Aboriginal health workers, nurse practitioners, peer support workers, paramedics and personal carers.</td>
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<td>Rec 23</td>
<td>Require evidence-based approaches on mental health and wellbeing to be adopted in early childhood worker and teacher training and continuing professional development. &lt;br&gt;• Integrate and coordinate existing programmes with school communities to better target school aged children and families on a regional basis, and to get better outcomes from existing programme investments (such as KidsMatter and MindMatters) across communities. This includes with Aboriginal and Torres Strait Islander children. &lt;br&gt;Issues: &lt;br&gt;• The impact of trauma on Aboriginal and Torres Strait Islander children and their families is a major determinant of mental health conditions in the Aboriginal and Torres Strait Islander adult population. However, services often fail to detect this trauma.</td>
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Extract from Chapter 4, Volume 2 – Aboriginal and Torres Strait Islander people’s mental health

This chapter addresses the urgent and evident need to deliver better outcomes for Aboriginal and Torres Strait Islander peoples to improve their social and emotional wellbeing.
Aboriginal and Torres Strait Islander Health and Wellbeing

- The **LIFE EXPECTANCY** for Aboriginal and Torres Strait Islander people is still around **10 YEARS LOWER** than for other Australians.
- Aboriginal and Torres Strait Islander adults are **2.7 TIMES MORE LIKELY TO HAVE HIGH/VERY HIGH DISTRESS LEVELS**, compared with their non-Indigenous counterparts.
- Of all Aboriginal and Torres Strait Islander people aged 15 years and over, **38.1% HAD EXPERIENCED AT LEAST THREE ‘LIFE’ STRESSORS** in the previous 12 months. For example, death of a family member, serious illness, or inability to get to work.
- In 2012, **27 PER CENT OF THE ADULT PRISON POPULATION** were Indigenous.
- From 2001–2010, **SUICIDE RATES** amongst the Aboriginal and Torres Strait Islander population were around **TWICE AS HIGH** as they were amongst the non-Indigenous population.

In 2012–13 Aboriginal and Torres Strait Islander people reported that they did not go to a counsellor despite reporting the need to see one because...

- Too busy (for reasons such as work or family responsibilities): **34.0%**
- Decided not to seek care: **31.7%**
- Dislikes the service or professional (or feeling afraid or embarrassed): **26.6%**
- Felt it would be inadequate: **18.0%**
- Too long to wait—or the service was not available at the time: **12.3%**
- Does not trust the counsellor: **11.8%**
- Problems with transport or distance: **10.4%**
- Other: **17.2%**

This chapter considers the challenges for Aboriginal and Torres Strait Islander peoples’ mental health. It documents the mental health gap which underlines the necessity for COAG and the Commonwealth to commit to include, under Closing the Gap, an indicator for mental health and prepare a national Aboriginal and Torres Strait Islander peoples’ mental health plan. This would be developed in consultation with Aboriginal and Torres Strait Islander people and national advisory committees.

**What is happening now**

Around three per cent of the Australian population (approximately 670,000 people) identify as being of Aboriginal or Torres Strait Islander origin (2011 Census) and they fare badly on most high-level outcome indicators such as life expectancy, mortality, educational attainment and other measures of wellbeing.

The recently released sixth report in the Overcoming Indigenous Disadvantage (OID) series measures the wellbeing of Aboriginal and Torres Strait Islander Australians. The report highlights that outcomes have worsened in some areas:

- For the period 2008–2012, the rate of deaths from suicide for Aboriginal and Torres Strait Islander Australians was twice the rate for non-Indigenous Australians.
- Suicide rates were highest for Aboriginal and Torres Strait Islander people aged 25–34 years (39.9 deaths per 100,000 population), around three times the rate for non-Indigenous Australians of the same age. There was no difference in rates between Aboriginal and Torres Strait Islander and non-Indigenous people aged 45 years and over.
- From 2004–05 to 2012–13, the hospitalisation rate for intentional self-harm increased for Aboriginal and Torres Strait Islander Australians by 48.1 per cent, while the rate for other Australians remained relatively stable. The rate for Aboriginal and Torres Strait Islander Australians increased from 1.7 to 2.7 times the rate for other Australians.
- The adult imprisonment rate increased 57 per cent between 2000 and 2013. Juvenile detention rates increased sharply between 2000–01 and 2007–08 and have fluctuated since at around 24 times the rate for non-Indigenous youth.

The OID report also presents a picture on related indicators where no change—that is, no improvement—has occurred.

- On education standards, there was virtually no change in the proportions of students achieving minimum standards for reading, writing and numeracy from 2008 to 2013.
- There remained relatively high rates of family and community violence, with no improvement between 2002 and 2008.
- There was little change in alcohol and substance use and harm over time.
- Relatively high rates of disability and chronic disease have not improved.

On some indicators, such as life expectancy and child mortality, there has been progress in Closing the Gap. Educational attainment and employment indicators have improved, but remain well behind those of non-Indigenous people.
The Review commissioned research and consultation and sought advice on the needs of Aboriginal and Torres Strait Islander peoples and the current state of play in the system. The consultants worked closely with the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory group to the Commonwealth and with the National Aboriginal and Torres Strait Islander Leadership in Mental Health group that advises the mental health commissions of Australia. They also consulted subject matter experts and key stakeholders, conducted a literature review, stakeholder interviews and a review of Aboriginal and Torres Strait Islander-related submissions.

Highlights of that report showed:

- There is a significant mental health gap between Aboriginal and Torres Strait Islander peoples and non-Indigenous people—with higher rates of psychological distress, hospitalisation for mental illnesses and deaths from intentional self-harm reported.\(^3\)
- Stressful life events are experienced at high rates. In the 2012–13 Australian Aboriginal and Torres Strait Islander Health Survey, (AATSIHS) 73 per cent of respondents aged 15 years and over reported that they, their family or friends had experienced one or more stressful life events in the previous year.\(^5\) That is 1.4 times the rate of non-Indigenous people. Stressful life events can include serious illness and accidents, the death of a family member or close friend, divorce or separation and not being able to get a job.\(^6\) Stressful life events and psychological distress are linked: experiencing between 1.9 and 2.6 overlapping stressful life events is associated with mild or moderate psychological distress, and between 3.2 and 3.6 events is associated with high or very high psychological distress.\(^7\)
- Psychological distress levels are rising. In 2012–13, 30 per cent of respondents to the Australian Aboriginal and Torres Strait Islander Health Survey over 18 years of age reported high or very high psychological distress levels in the four weeks before the survey interview.\(^5\) That is nearly three times the non-Indigenous rate. In 2004–05, high and very high psychological distress levels were reported by 27 per cent of respondents, suggesting an increase in Aboriginal and Torres Strait Islander psychological distress rates over the past decade.\(^5\)

But despite having greater need, Aboriginal and Torres Strait Islander people experience lower access to needed mental health services. Among the 27 per cent of those adults who reported high/very high levels of psychological distress in the National Aboriginal and Torres Strait Islander Social Survey (NATSIS) 2008, 38 per cent were unable to work or carry out their normal activities for significant periods of time because of their feelings.

In part this is because of the way general population services and programmes are designed. In particular, they do not work within a broader context of social and emotional wellbeing as understood by Aboriginal and Torres Strait Islander people, often referred to as cultural competence.

Further, such services do not ensure a connected transition through the mental health system for Aboriginal and Torres Strait Islander peoples and, in particular, between the primary mental health components (mainly funded by the Commonwealth) and specialist clinical services components (mainly delivered by the states and territories).

A lack of focus on 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.
Aboriginal and Torres Strait Islander people are proportionally over-represented in mental health-related hospitalisations, with specialised psychiatric care accounting for 4.9 per cent of these hospitalisations in 2012–13. They had a hospitalisation rate that was over double that of non-Indigenous people (12.7 and 6.3 per 1,000 population respectively).4

Current national approaches to addressing these gaps and poor outcomes

The National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes contributed approximately $1.6 billion over four years, which included, among other health measures, the Indigenous Chronic Disease Package. The cost savings in addressing mental health, as part of an overall approach to chronic disease, are yet to be quantified here. The agreement expired in June 2013.

The COAG Roadmap for National Mental Health Reform 2012–22 committed to ‘Improve the mental health and social and emotional wellbeing (SEWB) of all Australians.’9 This was recognition, at the highest level of governments, that the concept of SEWB underpinned any pathway to improving outcomes for Indigenous people. The SEWB concept acknowledges the importance of employment, housing and education to wellbeing.10 It committed governments to taking a whole-of-government approach at Commonwealth and state and territory levels.

At the time of writing, there are a number of unimplemented or unreleased strategic responses to Aboriginal and Torres Strait Islander mental health and related issues.

- The unimplemented National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2013 was released in May 2013 and has $17.8 million pledged against it.
- In July 2014 the Australian Government announced a review and implementation strategy for the Aboriginal and Torres Strait Islander Health Plan 2013–2023, in partnership with Aboriginal and Torres Strait Islander health leadership bodies. While the review phase is under way, implementation is yet to begin. The plan is not focused on mental health, although it does propose some action in relation to it.
- A National Aboriginal and Torres Strait Islander People’s Drug Strategy is in development.

Perhaps the most important strategic response is the National Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing Framework (the Framework) that is currently in development.

This unusual conjunction of unimplemented and overlapping strategic responses provides a unique opportunity to develop a dedicated, overarching national Aboriginal and Torres Strait Islander mental health plan based on the Framework, but that maintains the priority focuses of the individual strategies.

This would allow for a coordinated implementation of all four strategic responses and would maximise efficiencies. It also could support the Indigenous Advancement Strategy (as referred to below) and the COAG Closing the Gap targets and framework.

The draft National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2014–19 identified key action areas at system level. These were further prioritised as the ‘top five’ issues by the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group (ATSIMHSPAG).

These top five issues were articulated as follows:

- strategies to promote the healing and wellbeing of communities, families and individuals
• promoting mental health and social and emotional wellbeing across the life course, with a focus on younger age groups
• prevention strategies to detect and manage risks to mental health
• clinical and culturally appropriate treatment of mental health problems and mental illnesses
• promoting the social and emotional wellbeing of those with ongoing and severe mental illnesses to assist with recovery and relapse prevention.

Other national frameworks and plans, which are either endorsed or in the process of early implementation, are:

• The Indigenous Advancement Strategy (IAS) streamlined more than 150 individual programmes and activities into five broad based programmes to make it easier for organisations delivering important services in communities. The total Indigenous specific funding through the Prime Minister and Cabinet portfolio is $8.5 billion.
• The Indigenous component of the National Suicide Prevention Strategy (NSPS). Commonwealth initiatives for suicide prevention totalled $68.8 million in 2012–13. Expert advisers engaged by the Commission found in their analysis that around 12.7 per cent of this allocation ($8.7 million) targeted the needs of Aboriginal and Torres Strait Islander people.

Key findings

We found that the high rates of mental health problems reported among Aboriginal and Torres Strait Islander peoples encompass a range of other challenges and disadvantage. This includes higher rates of chronic disease, unemployment, family breakdown, alcohol and other drugs abuse, smoking, and high rates of imprisonment and crime victimisation.

Further, the burden of mental health problems and mental illness is far greater than existing services and programmes can realistically address. The current suite of services and programmes is neither cost-effective nor efficient at the macro, or system, level because of problems at service and programme level.

This is partly due to the design of individual services and programmes. In particular, they do not work within a broader context of social and emotional wellbeing (SEWB) as understood by Aboriginal and Torres Strait Islander people and that requires consideration, not only of the mental health of individuals, but of their broader wellbeing and that of their families, communities and cultures.

Coordination and collaboration—how services and programmes work together— is lacking. There is no connected journey through the mental health system for Aboriginal and Torres Strait Islander peoples and, in particular, between the primary mental health components (mainly funded by the Commonwealth) and specialist clinical services (mainly delivered by the states and territories).

Compounding the above problems, the Review identified significant limitations with policy implementation and monitoring. Dedicated, national Aboriginal and Torres Strait Islander mental health planning and service and programme design is needed because mainstream mental health policy, service and programme design is, in general, not appropriate for Aboriginal and Torres Strait Islander people. The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2014–2019 provides the basis for such planning and service and programme development.
The Review findings are presented below in five areas, reflecting where action is required:

- social and emotional wellbeing
- underlying disadvantage which has direct connection to the mental health status of Aboriginal and Torres Strait Islander people
- mainstream services capability and accountability for service delivery to Aboriginal and Torres Strait Islander people
- effectiveness of dedicated services and programmes for Aboriginal and Torres Strait Islander people
- limitations with policy implementation and monitoring.

Social and emotional wellbeing

Social and emotional wellbeing (SEWB) is critical to Aboriginal and Torres Strait Islander mental health service and programme delivery.

For Aboriginal and Torres Strait Islander people, as for non-Indigenous people, the SEWB concept acknowledges the importance of employment, housing and education to wellbeing. Additionally, it takes into account:

- the unique historical events and present day social determinants faced by Aboriginal and Torres Strait Islander people
- cultural differences, in particular the unique structures and belief systems underpinning family, community, culture and cultural practice, relationships to country and spirituality (including ancestors).

It is a ‘whole-of-life’ perspective on wellbeing that includes mental health, but is not limited to it, or equivalent to it. However, for Aboriginal and Torres Strait Islander peoples’ mental health, SEWB is critically important for two reasons.

First, as a source of resilience. Resilience is important because Aboriginal and Torres Strait Islander peoples experience adverse childhood events 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. For Aboriginal and Torres Strait Islander people, mental health promotion and a good deal of prevention is about strengthening SEWB to provide the resilience needed to cope with the unique and greater rates of stressful life events they face.

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

Underlying disadvantage and co-morbidities influencing mental health status

Mental health problems and mental illness are connected to other forms of Aboriginal and Torres Strait Islander disadvantage. There are high costs associated with these.

Chronic disease

Much of the current national focus around Aboriginal and Torres Strait Islander disadvantage is drawn to the impacts of chronic disease.
Research over the past decade suggests a chain of causation may be present between mental health conditions (in particular, serious psychological distress) and chronic disease. The 2014 ‘Reeve Study’ correlated data from the 2004–05 ABS National Aboriginal and Torres Strait Islander Health Survey and the 2004–05 ABS National Health Survey\textsuperscript{12} to make some significant findings as to what was required to close the diabetes gap.

Among other findings, it found an association between people who self-reported diabetes and those who reported the forced removal of relatives. It described the finding as ‘consistent with emerging evidence that serious psychological stress contributes to a range of health problems and may be involved in the development of risk factors for metabolic syndrome, including raised blood glucose’.\textsuperscript{12}

Regardless of the causal link, mental health conditions must be considered as significant co-morbidities with chronic disease that can prevent the effective treatment of chronic disease and are associated with increased exposure to risk factors for chronic disease.\textsuperscript{13}

**Employment**

Among the 27 per cent of Aboriginal and Torres Strait Islander adults who reported high and very high levels of psychological distress in 2008, 38 per cent were unable to work or carry out their normal activities for significant periods of time because of their feelings.\textsuperscript{14}

These findings are echoed by studies in the general population. In particular, a 2013 review by the Mental Health Commission of NSW cited the evidence for the costs and impacts on the economy and productivity due to mental ill-health. This reported that high psychological distress increases work absenteeism and decreases employee performance at work by 6.1 per cent, resulting in a net productivity loss of 6.7 per cent.\textsuperscript{15} A 2010 report estimated that psychological distress produces a $5.9 billion reduction in Australian employee productivity per annum.\textsuperscript{15} This is further explored in Chapter 3. This is in addition to the billions of dollars spent annually on mental health services and programmes, including those on Aboriginal and Torres Strait Islander peoples.

**Alcohol and other drugs**

High alcohol consumption and at-risk drinking can have harmful short and long-term effects on a person’s physical, social and mental health and safety.\textsuperscript{16} Conversely, alcohol and other drug use can lead to mental health problems and mental illness.

Of great concern is what could be referred to as ‘daily binge drinking’. The COAG Reform Council 2012 report on Closing the Gap targets reported that approximately 14 per cent of Aboriginal and Torres Strait Islander men and 12.7 per cent of non-Indigenous men aged 15 and over were drinking an average of more than five standard drinks per day in 2011–12.\textsuperscript{17} A significantly larger proportion of Aboriginal and Torres Strait Islander men (8.1 per cent) than non-Indigenous men (6.1 per cent) were drinking more than seven standard drinks per day.\textsuperscript{17}

While figures for Aboriginal and Torres Strait Islander peoples are not available, in 2004–05 the annual economic cost of alcohol and illicit drug misuse to Australian society was estimated at $55.2 billion.\textsuperscript{18} Leading researchers Collins and Lapsley found that alcohol misuse cost society $15.3 billion and illicit drugs cost $8.2 billion, while alcohol and illicit drugs acting together accounted for a further $1.1 billion.\textsuperscript{18} If the costs to Aboriginal and Torres Strait Islander peoples are roughly calculated by use of a 2.5 per cent population measure (as estimated in the 2006 Census) the costs would amount to $675 million.
Alcohol and other drugs measures and services

The Central Australian Aboriginal Congress, in its Review submission, provided evidence that alcohol supply reduction measures were particularly cost-effective in the primary and secondary prevention of mental illness. In particular, in Alice Springs:

- there has been a ten per cent decrease in alcohol consumption, which has prevented a large number of hospital admissions, including admissions for assault
- as a result, children are less exposed to the type of violence and trauma, which the Californian Adverse Early Childhood study has demonstrated leads to the development of mental illness, especially depression in later life.

Significant gaps were identified in the availability of drug and alcohol services, including detoxification and rehabilitation facilities, treatment programmes and services to support clients with dual diagnoses. This was particularly so in rural and remote communities.

There was strong support for integrating drug and alcohol services alongside primary mental health and social and emotional wellbeing services to support comprehensive primary health services delivered within Aboriginal Community Controlled Health Services.

High rates of imprisonment

Twenty seven per cent of the adult prison population is Indigenous—drawn from just three per cent of the overall population. Of particular concern is the significant over representation of Aboriginal and Torres Strait Islander youth within juvenile detention centres, where they represent 54.7 per cent of juvenile detainees (approximately 460 people). Further, Aboriginal and Torres Strait Islander young people aged ten to 17 years were 28 times more likely to be in detention than non-Indigenous people that age, and 16 times more likely to be under community-based supervision in 2012–13.

As noted in the Commission’s 2012 Report Card, a 2008 survey in Queensland found most male (72.8 per cent) and female (86.1 per cent) Aboriginal and Torres Strait Islander prisoners had suffered from at least one mental health condition in the preceding 12 months, and 12.1 per cent of males and 32.3 per cent of females with post-traumatic stress disorder (PTSD). In turn, mental health conditions are associated with high incarceration rates. A 2009 survey of NSW prisoners reported that 54.9 per cent of Aboriginal men and 63.3 per cent of Aboriginal women reported an association between drug use and their offence. In the same sample group, 44.5 per cent of men and 51.9 per cent of women self-reported they had been assessed or treated for an emotional or mental health conditions.

In a recent Senate Legal and Constitutional Affairs References Committee report, Value of a justice reinvestment approach to criminal justice in Australia, released in June 2013, the economic costs of imprisonment were estimated at:

- $226 per day for an adult prisoner ($82,490 per annum)
- $624 per day for juvenile detention detainee ($227,760 per annum)
- $77 per day for community custody ($28,105 per annum).
Further attention is required by mainstream services to the mental health needs of Aboriginal and Torres Strait Islander people in custodial care. A justice reinvestment programme for these detainees should be introduced to reduce the risk of reoffending and minimise future custodial care outlays. Such a programme is an excellent example of an “invest to save” approach. Reducing recidivism is good for people and for taxpayers. It could also be extended to more youth mental health services in Aboriginal and Torres Strait Islander communities.

**Mainstream services capability and accountability**

There are four broad categories of service accessed by Aboriginal and Torres Strait Islander people seeking support for their mental health. These are:

- community-based Indigenous Primary Health Care Organisations (IPHCOs) and Aboriginal Community Controlled Health Services (ACCHS), largely funded by the Commonwealth
- mainstream general practice and primary health care services
- specialist clinical mental health services
- specialist non-clinical mental support services.

It is not possible to identify what proportion of the approximately $9.6 billion spent by the Commonwealth on the above mental health programmes and services in 2012–13 (in addition to state and territory contributions) is reaching Aboriginal and Torres Strait Islander people.

The principal organisational types favoured for Commonwealth funding under the mainstream mental health programme design rules are:

- individual clinicians (e.g. MBS for psychologists)
- Medicare Locals (e.g. the Access to Allied Psychological Services programme)
- a combination of Medicare Locals or non-government organisations (e.g. Partners in Recovery and Personal Helpers and Mentors programme).

Several of these programmes cannot routinely or accurately advise what proportion of Aboriginal and Torres Strait Islander people use their services, despite the high level of need of this population group. For example, the level of use of MBS psychology services by Aboriginal and Torres Strait Islander people is not known.

However, it is clear that the greater levels of need described above are reflected in higher per capita levels of expenditure on acute inpatient care, the most expensive part of mental health treatment.
headspace

One area where there is some clarity around service usage is in relation to headspace services. Youth mental health services and programmes are of great importance to Aboriginal and Torres Strait Islander people, with 64 per cent of the population under 30 years of age. Data provided by headspace shows that approximately seven per cent of all headspace-serviced clients for the period June to December 2013 identified as Aboriginal and Torres Strait Islander. The following description is an abridged excerpt from the headspace website (2014):

Yarn Safe

For this project, headspace worked with a group of Aboriginal and Torres Strait Islander young people from across Australia and the Indigenous-specific advertising agency, Gilimbaa, to develop this campaign.

The campaign's aims are to increase the awareness of headspace as a place for Aboriginal and Torres Strait Islander young people to seek information, help and support. Common themes emerged from the workshop, including:

- The lives of Aboriginal and Torres Strait Islander youth and the issues they are facing are many and varied, complicated and serious.
- Mental health issues are having dramatic and devastating effects on communities across the country, from cities to remote areas.

There is shame around asking for help.

There is stigma around the language used in mental health.

Key themes emerged around critical areas related to health and wellbeing:

- identity
- culture
- relationships
- responsibility
- stress and pressure
- alcohol and other drugs
- family
- racism
- community

The ratio of Aboriginal and Torres Strait Islander per capita hospital expenditure in 2010–11 compared with other Australians was:

- 2.68 to 1 for all mental health and behavioural disorder hospitalisations ($336 per capita Aboriginal and Torres Strait Islander people; $125 per capita non-Indigenous)
- 1.65 to 1 for anxiety and depression hospitalisations ($53: $32)
- 3.97 to 1 for alcohol dependence and other harmful use ($37: $9)
- 2.58 to 1 for self-inflicted injuries, an indicator of attempted suicide ($19:$7).
Aboriginal and Torres Strait Islander people will have an ongoing need to access specialist mental health services funded and operated by state and territory public health services. As such, the application of the ‘one-size-fits-all’ approach should be avoided as it is wasteful use of resources and unable to meet the needs of Aboriginal and Torres Strait Islander people.

In particular, there is a need for more training in delivering culturally competent and culturally safe services. This training needs to include clinicians in general practice, other primary health care settings and specialist mental health services. Training should be extended to workforce categories that support the care of Aboriginal and Torres Strait Islander people, including medical clinic receptionists, hospital admission staff, orderlies and pharmacy staff.

An important issue identified in submissions to the Review and in commissioned research was how mainstream services and programmes work together to ensure a connected journey through the mental health system for Aboriginal and Torres Strait Islander peoples. In particular, coordination between the primary mental health components (mainly funded by the Commonwealth) and specialist clinical services components (mainly delivered by the states and territories) was lacking.

Effectiveness of dedicated services and programmes

In contrast to mainstream mental health services, the Review was able to identify Commonwealth mental health and related grants that were specifically targeted to Aboriginal and Torres Strait Islander people to a value of $123.1 million in 2012–13. In addition to some smaller programmes, the main recipients of these funds are as follows:

- the Social and Emotional Wellbeing (SEWB) Programme delivered by Indigenous Primary Health Care Organisations
- the Access to Allied Psychological Services (ATAPS) programme.

Social and Emotional Wellbeing Programme delivered by Indigenous Primary Health Care Organisations (IPHCOS)

There are 260 Indigenous Primary Health Care Organisations (IPHCOS) funded by the Commonwealth to provide health services in the community for Aboriginal and Torres Strait Islander people and the majority are Aboriginal Community Controlled Health Services. These deliver primary health and mental health services, particularly those with GPs. As in the wider community, GPs are usually the first health service visited by a person with a health concern, including a mental health issue.

The IPHCOS also deliver what was known until recently as the Social and Emotional Wellbeing Programme. This comprises:

- **Link Up Services** – These provide family tracing, reunions and counselling for members of the Stolen Generations ($12.7 million in 2012–13 for 20 grants). Link Up services aim to work closely with SEWB counselling services and other organisations to assist clients to reunite with their families, culture and community, and restore their social and emotional wellbeing wherever possible. Link Up services are either stand-alone organisations or are positioned within a larger organisation such as ACCHOs.
- **SEWB Counselling Services** – These were previously funded as Link Up counsellors, Bringing Them Home counsellors and mental health workers ($18.6 million in 2012–13 for 116 grants). These services provide counselling support for Aboriginal and Torres Strait Islander peoples, prioritising members of the Stolen Generations. Priority is given in the following order:
  - people from the first generation who were directly impacted
– members of families and communities from which children were removed
– second, third, fourth and subsequent generations. These services are under stress because of the limited availability of other services to respond to the SEWB and mental health needs of Aboriginal and Torres Strait Islander people. Thus, in 2012–13, the programme provided support to 17,700 clients. But of these, almost half (47 per cent) were other than first, second, third, fourth or subsequent members of the Stolen Generations.

- **Additional programme activity** – This includes: Workforce Support Units that support the SEWB workforce, including counsellors, Link Up caseworkers and substance use workers ($5.2 million in 2012–13 for 11 grants); Support for the National Sorry Day Committee and the National Stolen Generations Alliance; and funding for National coordination and support, which provides a range of projects to support SEWB services ($3.6 million in 2012–13 for 16 grants).

Funding provided for SEWB stolen generations counselling in 2012–13 is summarised in Table 4.1.

<table>
<thead>
<tr>
<th>Programme Component</th>
<th>Number of Services</th>
<th>Realised Demand (2012–13)</th>
<th>Recurrent Funding 2012–13 ($m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEWB Counselling</td>
<td>116 grant recipients</td>
<td>17,725 clients</td>
<td>18.539</td>
</tr>
<tr>
<td>Workforce Support Units</td>
<td>11 grant recipients</td>
<td>Not applicable</td>
<td>5.218</td>
</tr>
<tr>
<td>Link up services</td>
<td>20 grant recipients</td>
<td>Not available</td>
<td>12.672</td>
</tr>
</tbody>
</table>

Sources: PM&C grant allocations spreadsheets, AIHW On-line Services Report, 2014, p.76.

The Review was impressed with the model for a SEWB team provided by the Aboriginal Medical Services Alliance Northern Territory (AMSANT), which underpins our support for wider uptake of the SEWB team model.

**Access to Allied Psychological Services (ATAPS) programme**

The ATAPS programme targets people diagnosed with a mild to moderate mental health disorder who may not have their needs met through MBS-subsidised services.

Under the original programme, consumers, including Aboriginal and Torres Strait Islander people, were eligible for 12 allied health sessions per calendar year, with the option for a further six sessions on review by the referring GP. It primarily supports treatment of high prevalence mental health disorders such as anxiety and depression.

Between July 2003 and June 2010 the ATAPS programme was not targeted to meet the needs of Aboriginal and Torres Strait Islander peoples. In this period, 115 General Practice Networks delivering ATAPS programmes generated 6,745 GP Mental Health Treatment Plans for Aboriginal and Torres Strait Islander people. This is an average of 863 GP Mental Health Care Plans generated for Aboriginal and Torres Strait Islander people each year over the life of the ATAPS programme.

While welcome, the first ATAPS was not functioning at a level to meet the needs of Aboriginal and Torres Strait Islander peoples. The 2012–13 AATSIHS reported that up to 30 per cent of respondents had high to very high psychological distress. The number of places falls far short of the potential number of Aboriginal and Torres Strait Islander people requiring assistance.
In the 2010–11 Budget, ATAPS was substantially increased, in part to ensure that it performed better in relation to meeting Aboriginal and Torres Strait Islander mental health needs. A two tier scheme was introduced for ATAPS, with Aboriginal and Torres Strait Islander specific components. These include components for:

- **Culturally competent mental health services.** This is designed to deliver culturally appropriate mental health services to Aboriginal and Torres Strait Islander people. Cultural competence training is provided by the Australian Indigenous Psychologists Association as a part of this component of the programme.

- **Culturally competent suicide prevention services.** For these services, exceptions are made to the standard ATAPS eligibility requirements with the objective that a person at risk of suicide should be able to access allied mental health services rapidly. A person does not need a completed Mental Health Treatment Plan, for example, as they do for other ATAPS programmes. There is no limit to the number of consultations a person at risk of suicide can have in any one year (although a typical intervention period is expected to last two months). Allied mental health service providers are required to have completed training in providing culturally acceptable suicide prevention counselling to Aboriginal and Torres Strait Islander peoples to qualify as providers for these services.  

The ATAPS Tier 2 Aboriginal and Torres Strait Islander components offer the following benefits.

- The approach was developed in partnership by the Department of Health and Ageing and its (then) Aboriginal and Torres Strait Islander Mental Health Advisory Group.
- There are dedicated funds for services for Aboriginal and Torres Strait Islander people within the overall programme which reflect both population size and relative need.
- It built on partnerships, captured in formal agreements, between what were Medicare Locals (now moving to Primary Health Networks) and ACCHS. In particular, these agreements address the vital issue of service accessibility and standards. Further, they recognise the greater accessibility and better health outcomes associated with ACCHS.

About $36.5 million has been specifically allocated under ATAPS Tier 2 over five years from 2011–12, to provide mental health and suicide prevention services to Aboriginal and Torres Strait Islander people.

A recent analysis by the University of Melbourne found low service uptake by Aboriginal and Torres Strait Islander people (2,097 clients in 2012–13) and suggested an average session cost of an ATAPS Tier 2 Aboriginal and Torres Strait Islander service of $483, compared to the average Tier 1 (overall population) cost of $170.  

Comparisons should be made with caution. Certainly, the high costs of establishing such ATAPS Tier 2 services (including the cultural competence training of practitioners) must be taken into account and, conversely, the relatively low uptake of the ATAPS Tier 2 programme by Aboriginal and Torres Strait Islander people may be one explanation for the high per session cost.

Further, low uptake of ATAPS Tier 2 programme may be due to poor promotion among Aboriginal and Torres Strait Islander communities. Despite this, the model of service is seen as having great potential by Aboriginal and Torres Strait Islander experts consulted by the Review team, particularly for the fact that it sets out to provide culturally competent services.
Other programmes

- **Suicide prevention services.** Commonwealth initiatives for suicide prevention totalled $68.8 million in 2012–13. Around 12.7 per cent of this allocation ($8.7 million) targeted the needs of Aboriginal and Torres Strait Islander peoples in addition to the mental health funds discussed previously.\(^25\)

- **Mental Health Services in Rural and Remote Areas (MHSRRA) programme.** This provides funding for mental health professionals in more than 200 rural and remote communities across Australia that would otherwise have little or no access to MBS-subsidised mental health services. Two ACCHSs are funded under the MHSRRA programme: Wuchopperen Health Service, located in Cairns, and Nganampa Health Council, located in far northeast South Australia. In 2012–13, Wuchopperen received approximately $640,000 and Nganampa received approximately $375,000 (both GST exclusive).\(^28\)

- **The Mental Health Nurse Incentive Programme (MHNIP).** This was introduced in 2007 to provide support to people with severe mental disorders during periods of significant disability. The programme provides non-MBS incentive payments to eligible organisations such as community-based general practices and private psychiatrist practices, which engage mental health nurses to assist in the provision of coordinated clinical care for people with severe mental disorders. Three IPHCOs currently participate in MHNIP.

Using dedicated Aboriginal and Torres Strait Islander services in a strategic way

The Review identified $123.1 million of Commonwealth grants that were specifically targeted to Aboriginal and Torres Strait Islander mental health in 2012–13, including $56.4 million for substance abuse programmes. There are minimal funds for prevention and early intervention services. Overall, the Review has emphasised the need to rebalance the mental health system towards relatively inexpensive mental health promotion and prevention and away from expensive services. For Aboriginal and Torres Strait Islander people the involvement of Indigenous organisations to ensure culturally sensitive and capable delivery is essential. These are best delivered by IPHCOs and ACCHS.

Greater consideration needs to be given to how IPHCOs and ACCHS can be positioned in relation to mainstream programmes (both public sector and NGO grants), reflecting the high level of need of the population they serve. The use of Aboriginal controlled community based organisations is an effective mechanism for getting services to Aboriginal and Torres Strait Islander people.

An additional funding approach would be to build on what is being proposed in the Review and identify a proportion of all mainstream mental health programme funds as a specific funding pool for Aboriginal and Torres Strait Islander primary mental health. This pool would then be allocated to ACCHS using population based resource allocation formulae incorporating relative needs indices and allocated and delivered through a regionally based model.

Limitations with policy implementation and monitoring

Mainstream mental health policy, service and programmes in general have not been designed with sufficient consideration of the needs of Aboriginal and Torres Strait Islander people in mind. This is due partly to the greater burden of mental health problems and mental illness among them, and also to the cultural and experiential differences that underpin the ‘mental health gap’. The need for tailored services that work within the SEWB context and take into account cultural differences is well established.
The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2014–19 provides the basis for such planning and service and programme development. This should be developed and implemented along 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. A coordinated implementation process for all four is not only necessary to close the mental health gap, but such a process will avoid duplication and be more efficient.

There also are significant limitations in monitoring the effectiveness of services and programmes in reducing mental health problems and mental illness among Aboriginal and Torres Strait Islander people. The quality of data remains limited and poor. This means services and programmes cannot be held to account for better Aboriginal and Torres Strait Islander mental health outcomes.

Where to from here – implications for reform

Our commissioned research highlighted that broad action was required in seven domains.

- Leadership and good governance
- Promoting productivity and participation
- Developing a strong market
- Infrastructure support
- Smart use of technology
- Innovative workforce
- Research

Leadership and good governance

The accountability of leadership for the delivery of quality mental health services to Aboriginal and Torres Strait Islander people, and the development of appropriate targets and indicators, needs consideration at three levels of governance: community providers, mainstream services and policy implementation.

- Services in the community – Indigenous led organisations (IPHCOs/ACCHOs) to be encouraged and accountable for the continuing development of mental health and social and emotional wellbeing services in their communities, broadly through existing funding and renewed services agreements with government, taking into account services outside health (the regional model).
- Mainstream mental health services – In general, accountability for the quality of care they deliver to Aboriginal and Torres Strait Islander people and for improved mental health outcomes through agreements and performance reporting at regional level. There should be additional obligations placed on NGOs and other mainstream organisations funded to provide mental health services to report on their levels of engagement with Aboriginal and Torres Strait Islander people and communities and the cultural responsiveness of the services.
• Policy, programme design and implementation – the Commonwealth Aboriginal and Torres Strait Islander led ministerial advisory group Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group (ATSIMHSPAG) provides a platform for ongoing advice to the Australian Government on Aboriginal and Torres Strait Islander programmes and services.

Promoting productivity and participation

Promoting Aboriginal and Torres Strait Islander workforce participation is guided by the new Indigenous Advancement Strategy (IAS). The 2011 Census results show that health services (including, but not limited to, mental health services) currently employ 14.6 per cent of employed Aboriginal and Torres Strait Islander people. Health services are thus the single biggest ‘industry’ source of employment, which has expanded by almost 4,000 places since 2006.

Health services, including ACCHS, also provide pathways to employment for community members through internships and ‘in-house’ training. This reduces welfare dependency and connects individuals, families and communities to the wider economy. Flow-on benefits include the enabling of healthy norms and routines for community members and their families. Investment in ACCHS has a multiplier effect in communities beyond the critical improvements in health they deliver.

Developing a strong market

The market for the delivery of mental health services to Aboriginal and Torres Strait Islander people has features of market failure. It lacks competition for a range of reasons related to geography, the specialist nature of some services, and a strong user preference by a significant proportion of the population to access community controlled service providers.

In this situation it is important for the Commonwealth Government to have a clear view of its intentions and expected outcomes from the investment of resources that seek to redress the market failure (including funding, regulatory frameworks and programme interventions). Mechanisms must be put in place to monitor the effectiveness of those interventions (because there is limited competition to moderate outcomes).

Infrastructure support

There is a strong consensus among Aboriginal and Torres Strait Islander mental health experts consulted through the Review that IPHCOs/ACCHS provide value for money and a foundation for good practice for developing primary mental health services.
Case Study: Statewide Specialist Aboriginal Mental Health Service

The Western Australia Statewide Specialist Aboriginal Mental Health Service (SSAMHS) is attached to mainstream specialist mental health services. The service works with IPHCOs and ACCHS to not only ensure that their patients journey smoothly across the mental health system according to their needs, but also that they receive cultural support, including access to traditional healers and the support of their families and community. In recovery, the service helps connect people to community services and programs. Again, the focus is on the needs of the ‘whole person’ in a SEWB context.

An evaluation of the services has recently been completed but is yet to be released. Anecdotal reports suggest the services are significantly more successful than mainstream services in meeting the needs of Aboriginal and Torres Strait Islander peoples in WA.

Further uptake of the approach will be subject to consideration of the WA SSAMHS evaluation and developing a costing model to assess resource and funding requirements at jurisdictional level and/or regional levels.

Indigenous organisations (ACCHOs and AMS) have the potential to be the building block for future primary mental health service development. This addresses the market limitations by acknowledging the scope of the existing market and emphasising the need for mainstream services to improve their cultural responsiveness to the needs of Aboriginal and Torres Strait Islander people. The Western Australia Statewide Specialist Aboriginal Mental Health Service is a good example.

Smart use of technology

Smart technology will provide opportunities to strengthen the mental health service system to Aboriginal and Torres Strait Islander communities, but at present the use of innovative technology is limited. Examples of new clinical tools under development with a specific Indigenous emphasis include:

- the e-mental health portal
- *R U Appy*, a mobile application focused on supporting clients to strengthen SEWB
- *iBobbly*, a mobile application focused on supporting clients experiencing suicidal ideation.

Opportunities exist to promote coordinated care for Aboriginal and Torres Strait Islander people through greater use of information in electronic health records. Stakeholders interviewed during the Review saw potential for technology to enable connections to be maintained with family when Aboriginal and Torres Strait Islander people travel from a remote community to metropolitan or regional areas for acute mental health treatment.

Technology also has potential as a tool to enable family input into processes for care planning and discharge planning.

It is important that any overall strategy continues to support the development of a range of culturally appropriate electronic tools to improve access to care, and to support clinicians’ work in culturally appropriate ways with clients.
Innovative workforce

Significant work is needed to develop the mental health workforce supporting the SEWB and mental health needs of Aboriginal and Torres Strait Islander people. In particular, there is a need for a skilled Aboriginal workforce within the mental health system.\textsuperscript{30}

Workforce development in this area should address the five professions that contribute significantly to the mental health workforce: mental health nursing, occupational therapy, psychiatry, psychology and social work. There is no comprehensive data on the proportion of the professional groups listed above with an Indigenous background. Anecdotally, the levels are low.

‘I think it [lack of cultural awareness] stops you from having a really meaningful conversation that really matters.’

\textit{Participant in Centre of Research Excellence in Suicide Prevention interview Care After a Suicide Attempt Project (NMHC, unpublished, 2014)}

From an undergraduate training perspective, some progress has occurred in medicine, where Aboriginal enrolments have reached 2.5 per cent of the student population. Similar levels have not been achieved in other health undergraduate courses.\textsuperscript{30}

Workforce development plans should include the following strategies.

- Identify current capacity and identify future workforce needs. We understand little has been done to date in this area, although under the \textit{NSW Mental Health and Wellbeing Policy}, NSW Health required at least one Aboriginal mental health worker to be employed per 1,000 Indigenous people in the catchment area.
- Strengthen 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.
- Strengthen Aboriginal and Torres Strait Islander participation rates in tertiary courses and in the mental health workforce. This will involve health professional associations and education providers taking greater responsibility for increasing the level of Aboriginal and Torres Strait Islander students undertaking their courses and entering the profession. The medical profession is demonstrating good practice in supporting the training and mentoring of Aboriginal and Torres Strait Islander medical students. The Djirruwang Program through Charles Sturt University is considered a programme of merit supporting increased participation of Aboriginal and Torres Strait Islander people as mental health practitioners in mainstream mental health services.

Research

Only a minimal amount of Aboriginal and Torres Strait Islander-specific research in mental health has been undertaken to date. Much of this is documented in \textit{Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice}, published by the Commonwealth in June 2014.

While the knowledge and experience of clinicians has an important role to play in strengthening services, greater effort is required to undertake applied research projects and facilitate partnerships between service delivery organisations and research institutions.
Support was expressed in submissions to the Review for strength-focused research aimed at identifying effective approaches for:

- building SEWB and resilience
- interventions across the life stages
- protective and risk factors in responding to Aboriginal and Torres Strait Islander suicide
- interventions for particular population groups, including people who have borderline personality disorders
- interventions to assist high needs families where one or both parents have mental illness, and healing interventions.

It is important that Aboriginal and Torres Strait Islander experts and stakeholders lead in the above research.

The Commission acknowledges that these actions need to be funded from within existing resources and therefore their timing will be subject to realisation of whole-of-system efficiencies. The Commission considers that the mental health of Aboriginal and Torres Strait Islander people should be considered the first priority for investment when efficiencies and savings are realised.
Extract from Chapter 11, Volume 2 – Implementation of a better mental health system

This chapter outlines the steps for implementation to set the foundation for long-term change to improve outcomes for people and productivity of the system. The following table outlines areas for action from the mid-to-long-term (three to ten year) policy directions. These priorities were informed through the Review’s consultation process and by commissioned advice.
### Years 3–5: Set the foundation for long-term change

**Policy priority:** Evaluate progress with establishing mental health and social and emotional wellbeing teams.

**Implementation steps:**

*Working with the National Aboriginal Community Controlled Health Organisation and other stakeholders:*

- After a year’s operation, establish the optimal service model for mental health and social and emotional wellbeing teams.
- Audit existing delivery by teams and identify gaps.
- Identify workforce needs (both supply and training needs).

**Policy priority:** Dedicated Aboriginal and Torres Strait Islander services support Aboriginal and Torres Strait Islander individuals’ journeys across the mental health system.

**Implementation steps:**

*Working with leaders and stakeholders in Aboriginal and Torres Strait Islander mental health, social and emotional wellbeing, suicide prevention, and alcohol and other drug use prevention:*

- Support state and territory governments to facilitate the journey of Aboriginal and Torres Strait Islander people into and through the specialist mental health service system, and in particular from primary mental health care settings into mainstream specialist mental health services and programmes.
- State and territory governments assess the evaluation of the Western Australian Statewide Specialist Aboriginal Mental Health Service model for potential adaptation to their jurisdictions.

### Years 5–10: A vision for change

**Policy priority:** General population mental health, suicide prevention, and alcohol and other drug use prevention professionals (including general practitioners) are culturally competent and services are culturally safe. Such professionals and services are accountable for better Aboriginal and Torres Strait Islander mental health, suicide prevention, and alcohol and other drug use prevention outcomes and closing the mental health gap.

**Implementation steps:**

*Working with leaders and stakeholders in Aboriginal and Torres Strait Islander mental health, social and emotional wellbeing, suicide prevention, and alcohol and other drug use prevention:*

- All relevant professional associations agree pathways to ensure their membership has undertaken cultural competence training within five to 10 years.
- Relevant professional associations and education providers ensure that all graduates have undertaken cultural competence training within five to 10 years.
- Australian governments, through collaborative COAG processes, develop Aboriginal
Years 5–10: A vision for change

and Torres Strait Islander cultural safety standards for all general population mental health services and programmes, including those provided by NGOs.

- Progress in the above is benchmarked against standards developed by professional associations and education providers.
- Australian governments, through collaborative COAG processes, develop service and programme accountability mechanisms to ensure they play their part in closing the mental health gap. These could include area targets and assessments of equitable resource allocation against agreed levels.

**Policy priority:** Train and employ the Aboriginal and Torres Strait Islander workforce needed to close the Aboriginal and Torres Strait Islander mental health gap.

**Implementation steps:**

*Working with leaders and stakeholders in Aboriginal and Torres Strait Islander mental health, social and emotional wellbeing, suicide prevention, and alcohol and other drug use prevention:*

- Australian governments, through collaborative COAG processes, identify minimum mental health, social and emotional wellbeing, suicide prevention, and alcohol and other drug use prevention personnel requirements per population catchment area.
- Australian governments, through collaborative COAG processes, strengthen 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.

**Policy priority:** A sound evidence base for Aboriginal and Torres Strait Islander mental health, social and emotional wellbeing, suicide prevention, and alcohol and other drug use prevention services and programmes.

**Implementation steps:**

*Working with leaders and stakeholders in Aboriginal and Torres Strait Islander mental health, social and emotional wellbeing, suicide prevention, and alcohol and other drug use prevention:*

- Australian governments, through collaborative COAG processes, designate a national body, with Aboriginal and Torres Strait Islander leadership, to establish best practice in Aboriginal and Torres Strait Islander mental health, social and emotional wellbeing, suicide prevention, and alcohol and other drug use prevention services and programmes.
References


