

The National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH), Indigenous Allied Health Australia (IAHA) and Australian Indigenous Psychologists Association (AIPA) Submission to the Productivity Commission's *Review of the Social and Economic Benefits of Improving Mental Health*.

Recommendations

Recommendation 1: The new Indigenous Productivity Commissioner role should report each year to Parliament (coincident with the PM's 'Closing the Gap Report') on Aboriginal and Torres Strait Islander health expenditure overall, including mental health expenditure, but considering both public and private expenditure and level of need, and as a specific input to closing the health and life expectancy gap

Recommendation 2: That Australian governments commit to gather, disaggregate, and publish Aboriginal and Torres Strait Islander mental health expenditure data across the mainstream and Indigenous-specific parts of the mental health system, with particular focus on primary mental health care, by 30 June 2020.

Recommendation 3: That Australian governments increase Aboriginal and Torres Strait Islander primary mental health expenditure to a quantum equivalent to 3 times per capita non-Indigenous spending starting in the 2020-21 financial year. Increased investment should by 30 June 2020 be used to cost and fund an implementation strategy for the 2017 *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing* within the *Fifth National Mental Health Plan* implementation process; and the development of a dedicated Indigenous suicide prevention strategy and fully funded implementation plan based on the 2013 *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*.

Recommendation 4: The Australian Government should ensure Aboriginal Community Controlled Health Services (ACCHSs) are positioned as preferred providers of mental health services in Aboriginal and Torres Strait Islander communities, and PHN funds for Aboriginal and Torres Strait Islander mental health and suicide prevention should be allocated to ACCHSs unless it can be clearly demonstrated that alternative arrangements can produce better results in terms of access to services and service outcomes.

Recommendation 5: By 30 June 2019, the Australian Government should retrospectively account for the approximate \$100 million Indigenous-specific mental health and suicide prevention expenditure allocated to Primary Health Networks since 2015. This includes:

- The quantum allocated per region
- How the quantum was allocated (processes)
- The services being funded by these funds and their locations
- The number of ACCHSs and Aboriginal and Torres Strait Islander organisations receiving funds, and the quantum, compared to mainstream providers
- The value for money (positive, measurable outcomes) being achieved through this expenditure.

Recommendation 6: By 30 June 2019, Aboriginal and Torres Strait Islander mental health and community leaders should co-design with the Australian Government a reporting framework that accounts for Indigenous specific mental health and suicide prevention expenditure allocated to Primary Health Networks on an annual basis. This includes:

- The quantum allocated per region
- How the quantum was allocated (processes)
- The services being funded by these funds and their locations
- The number of ACCHSs and Aboriginal and Torres Strait Islander organisations receiving funds, and the quantum, compared to mainstream providers
- The cultural safety of these services
- The value for money (positive, measurable outcomes) being achieved through this expenditure.

Recommendation 7: That the new Indigenous Productivity Commissioner, within the broader current inquiry, completes a cost-benefit analysis of increased investment in Aboriginal and Torres Strait Islander primary health care (to equity based on need) accounting for the costs associated with a range of social challenges associated with untreated Aboriginal and Torres Strait Islander mental health challenges, in addition to the additional costs to the mental health system.

Recommendation 8: That the new Indigenous Productivity Commissioner considers reinvestment opportunities in Indigenous-specific primary mental health care for the costs associated with a range of social challenges associated with untreated Aboriginal and Torres Strait Islander mental health challenges within the context of the current inquiry.

Introduction

The National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH), Indigenous Allied Health Australia (IAHA) and the Australian Indigenous Psychologists Association (AIPA) welcome the opportunity to provide a submission to the Productivity Commission's *Review of the Social and Economic Benefits of Improving Mental Health* in the Aboriginal and Torres Strait Islander population. Further information about our organisations can be found in an Appendix to this submission.

Aboriginal and Torres Strait Islander people experience health inequities across a range of health and wellbeing measures in the context of the effects of colonisation, intergenerational trauma, systemic and other forms of racism. Despite improvement in the life expectancy of Aboriginal and Torres Strait Islander people, the gap in life expectancy remains significant (8.6 years less for males; 7.8 less for females¹). Aboriginal and Torres Strait Islander people also experience higher rates of a number of health conditions.

The economic benefits of addressing the burden of mental health difficulties and inequity are varied and include increased economic participation and taxation revenue through ongoing and more stable employment through meaningful careers in health, savings through increased efficiencies and effective treatment in the health care system and enabling the direction of funding toward primary prevention and primary care from more expensive services such as tertiary and crisis services and/or constraining the need for further increases.

But when considering the social and economic costs of mental health difficulties in the Aboriginal and Torres Strait Islander population, a necessary starting point - prior to any consideration of social

and cost benefits from more efficient, or additional, expenditure, is existing health-system wide inequity in health expenditure.

Part 1: The overall picture

National Aboriginal and Torres Strait Islander Leadership in Mental Health

1. The fundamental inequity – Indigenous-specific primary health care spending

It is a basic principle of equity in the health system that funding follows need. As such, health expenditure on population groups with higher levels of health need should be proportionately higher. It is uncontroversial, for example, to spend more on the health of the elderly compared to that of young adults because of the former's often greater and more complex health needs. Comparing differences in populations' health status with differences in population per capita health expenditure can let us know how well this basic principle of equity in health expenditure is being observedⁱⁱ.

The Australian Institute of Health and Welfare (AIHW) estimates that the overall Aboriginal and Torres Strait Islander burden of disease is around 2.3 times greater than the non-Indigenous burden.ⁱⁱⁱ Using this as the basis for a broad needs index then, equitable health expenditure per Aboriginal and Torres Strait Islander person should be about 2.3 times spent per non-Indigenous person. That level of expenditure would be expected to reduce as improvements in health occur.

Australia's primary health care system is market-based: GPs and health professionals operate as sole traders, and/or general practices employ them in, and otherwise operate as, small businesses. In relation to this market, the Commonwealth takes the national lead in ensuring primary health care is accessible to all by:

- Subsidising customer costs (i.e. through the Medicare Benefits Schedule (MBS), supported by Pharmaceutical Benefits Schedule (PBS)).
- Addressing market failure including, of relevance to this submission, by funding Indigenous-specific primary health care services (IPHCOS) including Aboriginal Community Controlled Health Services (ACCHSs) – particularly in remote areas that find it harder to attract GPs, or in areas with income-poor populations.

Yet 2013-14 health expenditure levels (the latest data available) reported in the Commonwealth Government's 2017 *Aboriginal and Torres Strait Islander Health Performance Framework* show there are significant 'equity shortfalls' in Commonwealth primary health care expenditure – as summarised in Table 1 below. This indicates:

- Aboriginal and Torres Strait Islander people have significantly lower access to, or choose to use, the primary health care market – as indicated by lower MBS and PBS expenditure.
- The above is - to some degree - compensated for by the provision of 'community health services' (including IPHCOS and ACCHSs) with expenditure above general population level.
- But that despite the above, a significant primary health care equity gap remains.

In sum, the Commonwealth's stewardship of primary health care (despite additional 'Closing the Gap' investment since 2009) is failing to ensure Aboriginal and Torres Strait Islander people receive equitable primary health care expenditure: in fact, only 61 per cent of what their additional need dictates. In other words, there is a 39 per cent primary health expenditure 'equity gap' to close.

This is what this submission identifies as the **fundamental inequity** in Aboriginal and Torres Strait Islander health expenditure overall: in relation to prevention-oriented primary health care services.

Table 1: 2013-14 Commonwealth expenditure on Aboriginal and Torres Strait Islander primary health care^{iv}

	Per capita expenditure: Indigenous	Per capita expenditure: Non-Indigenous	Equitable health expenditure per \$1 spent on a non-Indigenous person is:	Indigenous expenditure per \$1 spent on non-Indigenous person:	Actual spend as percentage of equitable spend is:
Commonwealth primary health care expenditure on medical services, including those paid for through the Medicare Benefits Schedule (MBS)	\$271	\$302	\$2.30	\$0.90	39% (Shortfall 61%)
Commonwealth Pharmaceutical Benefits Schedule (PBS) expenditure in the primary care sector	\$471	\$741		\$0.63	27% (Shortfall 73%)
Commonwealth expenditure on community health services	\$1114	\$312		\$3.60	157%
Total Commonwealth expenditure on primary health care (including the above)	\$3,496	\$2,451		\$1.42	61% (Shortfall 39%)

All data - Commonwealth Government's 2017 *Aboriginal and Torres Strait Islander Health Performance Framework*, p.191.

In addition, it should be noted that the above consideration does not include private (out of pocket) health expenditure including on health insurance. Among Aboriginal and Torres Strait Islander people in non-remote areas, in 2012-13, 20 per cent of adults had private health insurance, compared with 57 per cent of all adults (i.e. in the total population)^v.

In closing this section, the authors agree with the AMA's Indigenous Health Report Card 2018 that the long-standing failure of Australian governments to provide equitable levels of health funding is 'a primary example of a stubborn form of institutional racism that still challenges Aboriginal and Torres Strait Islander population health'^{vi} including mental health. They also support the Report Card's Recommendation 1 for the adoption of needs-based Aboriginal and Torres Strait Islander health expenditure targets based on at least 2.3 times per capita that of the non-Indigenous population.^{vii}

2. The distorting effect of the fundamental inequity on other spending

As a direct result of the underspend on primary health care, the following is reported:

- For Aboriginal and Torres Strait Islander peoples, expenditure on hospital-based health care is **six times higher** than expenditure on prevention-oriented general practitioner (GP) and other medical practitioner health care^{viii}. This compares with just twice as high for the non-Indigenous population^{ix}.
- The States and Territories, who shoulder the greater responsibility for hospitals and 'secondary' services, combined spend **roughly two health dollars per Aboriginal and Torres Strait Islander person for every dollar spent per non-Indigenous person**^x.

Aboriginal and Torres Strait Islander people are, receiving closer to equitable spending at the State and Territory level (about 87 per cent of equitable levels based on the 2.3 x needs index) in part because of a three-fold excess in avoidable hospital admissions. But **this comparatively higher ‘additional’ expenditure is, to a significant degree, required because of the fundamental inequity in primary health care spending.** For example, a 2014 ten-year study-report tracked health system use by 180 Aboriginal people with diabetes in remote Northern Territory communities. It reported that investing \$1 in medium-level primary care could save \$12.90 in hospitalisation costs for this cohort^{xi}. Or in other words, and reversing the logic, without that \$1 invested in primary health care, additional costs would inevitably accrue.

Indeed, expenditure on hospital and secondary services can serve to mask the **fundamental inequity** in the health system: in relation to primary health care. Our first recommendation is aimed at the Productivity Commission itself and is based on a recommendation in the AMA’s Indigenous Health Report Card 2018.

Recommendation 1: The new Indigenous Productivity Commissioner role should report each year to Parliament (coincident with the PM’s ‘Closing the Gap Report’) on Aboriginal and Torres Strait Islander health expenditure overall, including mental health expenditure, but considering both public and private expenditure and level of need, and as a specific input to closing the health and life expectancy gap.^{xii}

3. The mental health system

We began our submission with discussion about the health system overall because we believe the mental health system **precisely mirrors this situation.** Yet expenditure on Aboriginal and Torres Strait Islander mental health is, at the moment, almost impossible to quantify. In the absence of expenditure data, the signs and patterns associated with a significant underspend on Aboriginal and Torres Strait Islander primary mental health care point to a similar underspend in relation to Aboriginal and Torres Strait Islander primary mental health care.

(a) Assessing relative need

The abovementioned AIHW burden of disease study reported that in 2011 combined multiple chronic disease groups were the leading causes of the Aboriginal and Torres Strait Islander health gap. However, mental health and substance use disorders (which are considered a single disease group) represented 19 per cent of the Aboriginal and Torres Strait Islander burden; and 14 per cent of the health 'gap' with non-Indigenous people^{xiii}. This was the largest contribution of any single disease group to the Aboriginal and Torres Strait Islander burden of disease.

This picture is replicated within data from other sources. In the 2014-15 ABS Aboriginal and Torres Strait Islander social survey, for example, 29 per cent of respondents self-reported a diagnosed mental health condition: depression; anxiety; behavioural or emotional problems; and/or harmful use of, or dependence on drugs or alcohol over their lifetime^{xiv}.

Indeed, the AIHW burden of disease study estimates the Aboriginal and Torres Strait Islander burden of mental health and substance abuse disorders to be **2.4 times greater** than the non-Indigenous burden.^{xv} Within this estimate, the burden of alcohol disorders was **5 times greater**, intellectual disability **3.4 times greater**, conduct disorder **3.4 times greater** and schizophrenia **3.3 times greater**.^{xvi} But it should be noted that otherwise the overall 2.4 times greater rate estimate accounts for clinically identifiable conditions only, and **excludes psychological distress self-harm and suicidal behaviours**^{xvii}.

Note from the authors

In assessing relative Aboriginal and Torres Strait Islander mental health need, we would like to make clear that the majority of mental health difficulties – at least those that are excess to the rates reported in the non-Indigenous population - are considered by us to require, and to a significant degree are preventable with equitable access to primary mental health care. Because of the potential misuse and misunderstanding of data on mental health difficulties, and as an exercise of Indigenous data sovereignty, we request that any further reference to data quoted from this submission should include an explanation that the excess of Indigenous mental health difficulties are potentially preventable and require equitable access to primary health care.

Prevalence of these latter three mental health difficulties are discussed below:

- The 2012-13 ABS national Aboriginal and Torres Strait Islander health survey reported the proportion of Aboriginal and Torres Strait Islander adults assessed using the K-5 with high/very high levels of psychological distress in about 30 per cent of Aboriginal and Torres Strait Islander respondents: **2.7 times the rate** of their non-Indigenous peers^{xviii}.
- Over 2011-15, the Aboriginal and Torres Strait Islander suicide rate was **2.1 times the rate** of non-Indigenous people.^{xix}
- The AIHW burden of disease study further reported that suicide and self-harm contributed an additional (we calculate) **five per cent** or so to the Aboriginal and Torres Strait Islander burden of disease. (Our calculations are based on suicide and self-harm accounting for 30 percent of the 'injuries' category within the burden of disease study, which, in turn, total contributed 15 per cent to the overall disease burden^{xx}.)

Taking all the above into account, we **conservatively** estimate that the total burden of mental health difficulties to be about **3 times greater** in the Aboriginal and Torres Strait Islander population, when compared to the non-Indigenous. This estimate is also used hereon as the basis of a broad Aboriginal and Torres Strait Islander mental health needs index.

(b) Assessing mental health expenditure against relative need

The AIHW also estimate the national recurrent expenditure on total population mental health-related services to be around \$9.1 billion in 2016-17: about \$375 per person^{xxi}. Of this:

- State and Territory governments provided about two thirds of expenditure: \$5.6 billion. Community mental health care services expenditure totalled \$2.1 billion. Costs of public acute hospitals with a specialist psychiatric unit or ward amounted to \$2 billion; and costs of public psychiatric hospitals \$0.6 billion.
- The Australian Government provided about one third of expenditure - \$3 billion. In 2017-18, this included \$1.2 billion / \$49 per person, on MBS-subsidised mental health-specific services; and \$534 million/ \$22 per person on PBS subsidised mental health-related prescriptions.
- Private health insurance funds provided \$508 million.

Publicly available health expenditure data collections are not disaggregated to capture Aboriginal and Torres Strait Islander expenditure. For example, the National Mental Health Commission (NMHC) in its 2015 Review of Mental Health Services and Programmes was not able to identify Aboriginal and Torres Strait Islander expenditure within mainstream mental health services.^{xxii} This has serious implications. How can policy makers and Aboriginal and Torres Strait Islander mental health leaders work effectively in such an information vacuum? This leads to our second recommendation.

Recommendation 2: That Australian governments commit to gather, disaggregate, and publish Aboriginal and Torres Strait Islander mental health expenditure data across the mainstream and Indigenous-specific parts of the mental health system, with particular focus on primary mental health care, by 30 June 2020.

Outside of the mainstream, the NMHC in its 2015 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. The NMHC observed at the time: *there are minimal funds for prevention and early intervention services.*^{xxiii} Overall, the NMHC Review emphasised the need to rebalance the mental health system towards relatively inexpensive mental health promotion and prevention and away from expensive services^{xxiv} – a key message of this submission.

In response to the NMHC Review, \$85 million in additional Indigenous-specific mental health expenditure was announced over 2016/17 – 2018/19. However, in contrast to the NMHC recommendations, this went to the Primary Health Networks to distribute rather than supporting the ACCHSs,^{xxv} a matter we shall return to below. A further \$89 million has been provided until 2021-22 but also being channelled through PHNs.^{xxvi}

Further, \$5.6 million per year was allocated to PHNs over 2017-2021 for the delivery of culturally appropriate suicide prevention services specifically for Aboriginal and Torres Strait Islander people, in addition to about \$3 million each to the two Indigenous specific (of 12) PHN suicide prevention trial sites in Darwin and the Kimberly.

While the above is of course welcome, it has not necessarily resulted in equity in mental health spending, and particularly primary mental health spending. Referring again to the 3 times needs ratio we estimated above, about \$1125 primary mental health spending per Aboriginal and Torres Strait Islander person per year would be expected in an equitable situation.

As is stands, even without the ability to calculate dollar differences in expenditure, the pattern of mental health service usage by Aboriginal and Torres Strait Islander people provides strong evidence for the need for additional expenditure on Indigenous primary mental health care, as set out in

Table 3 below - populated with data from the AIHW's *Aboriginal and Torres Strait Islander Health Performance Framework 2017*.

Table 3: Estimating Aboriginal and Torres Strait Islander primary mental health care shortfall according to need on available data

		Indigenous usage expectation based on 3 needs ratio	
Per cent of population accessing MBS subsidised mental health care	10% of Indigenous population 9% of the non-Indigenous population	Around 3 times greater non-Indigenous usage - 27% of the Indigenous population -	37% (Shortfall 63%)
GPs managing mental health problems for Indigenous people	Managed at 1.2 times the rate of non-Indigenous people	Should be 3 times greater	40% (Shortfall 60%)

Further, and as might be expected, the usage of hospitals and specialised mental health care services is significantly higher as set out in Table 4.

Table 4: Estimating Indigenous over-use of hospitals and specialised mental health care according to selected available data

State and Territory community mental health services	Attending at 4 times the rate of non-Indigenous people	Expectation: Should be 3 times the non-indigenous rate	133% over expectation
Separation rates for specialised mental health care without psychiatric treatment	Occurring at 3 time the non-Indigenous rate		At expectation
As above, with psychiatric treatment	Occurring at 3.3 time the non-Indigenous rate		110% over expectation
Specialist homelessness services clients with mental health issues	Indigenous clients reported to have such issues at 6 times the rate of non-indigenous clients		200% over expectation

Further, rates of suicide and self-harm are known to further increase with persons living in rural and remote Australia. The recent *Senate Inquiry into the accessibility and quality of mental health services in rural and remote Australia* reported that Australians living in rural and remote communities are less likely to seek mental health treatment than persons living in urban areas.

Recommendation 3: That Australian governments increase Aboriginal and Torres Strait Islander primary mental health expenditure to a quantum equivalent to 3 times per capita non-Indigenous spending starting in the 2020-21 financial year. Increased investment should by 30 June 2020 be used to cost and fund an implementation strategy for the 2017 *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing* within the *Fifth National Mental Health Plan* implementation process; and the development of a dedicated Indigenous suicide prevention strategy and fully funded implementation plan based on the 2013 *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*.

(c) *The role of Indigenous Primary Health Care Services including Aboriginal Community Controlled Health Services*

As per the broader primary health system 'market', the Commonwealth funds primary mental health services in areas of market failure. For Aboriginal and Torres Strait Islander communities, most of the 200 or so Commonwealth-funded Indigenous primary health care organisations, including ACCHSs, provide care in relation to social and emotional wellbeing and mental health issues with funding provided through the Department of Health. Further, and - within that total - 100 or so also receive funding from the Department of the Prime Minister and Cabinet through its Social and Emotional Wellbeing Program. According to the Budget Paper for 2018-19, the Department's Outcome 2, Program 2.3 (Safety and Wellbeing) received \$281m in 2018-19^{xxvii}. Within this sum is included expenditure on the Social and Emotional Wellbeing Program, although how much of this is for the Social and Emotional Wellbeing Program does not appear to be publicly available.

Yet despite the above, significant mental health service gaps are reported by these Commonwealth-funded services, and most significantly in relation to mental health service capacity. In 2015-16, about half of these services reported such a gap – effectively, unmet need in Aboriginal and Torres Strait Islander communities^{xxviii}.

The authors believe a goal of Primary Health Network-commissioning processes (i.e. that utilise the abovementioned additional Indigenous specific mental health and suicide prevention funding provided since 2015) or, indeed, any other PHN-fund allocation process, should be to support Commonwealth-funded Indigenous primary health care organisations, and particularly ACCHSs, to meet these gaps and ensure these services can meet the additional mental health needs in Aboriginal and Torres Strait Islander communities.

By this, the authors support the placement of ACCHSs, in particular, as the **preferred providers** of mental health, suicide prevention and related area services to Aboriginal and Torres Strait Islander communities, wherever it is in the best interest of the Aboriginal and Torres Strait Islander community to do so. This is because ACCHSs provide a more accessible service by being based in Aboriginal and Torres Strait Islander communities and providing a culturally safe service environment and a culturally competent service experience. In contrast, most other services tend to lack these community/ cultural connections that are essential for promoting access to services.

A fundamental public policy principle is the need to maximise the return on investment of public funds - including in relation to mental health services. Yet, competitive tendering processes often utilised by PHNs to maximise the return on investment of public funds only work effectively in the idealised functioning 'health markets' which simply don't exist for Aboriginal and Torres Strait Islander mental health services in many parts of Australia. This leads to further instances of market failure and a shift in patient demand toward services such as ACCHS services, which are often underfunded or not funded at all. But even in Aboriginal and Torres Strait Islander communities where competitive tendering processes are possible, competitive tendering will not necessarily maximise the return on investment of public funds. Instead, they will tend to favour organisations that have the best tender application writing skills even though ACCHSs are likely to provide significantly better return on investment by ensuring better access to a range of treatments, and more sustainable outcomes.^{xxix}

Funds to improve Aboriginal and Torres Strait Islander mental health and wellbeing and reduce suicide rates are limited. There certainly isn't enough funding to support organisations, which will struggle to be as accessible as ACCHSs, or produce equivalent outcomes to ACCHSs for Aboriginal and Torres Strait Islander communities (i.e. will not maximise return on investment). In these circumstances, the well-established procedure of 'preferred provider' should be adopted including by selected tender processes over competitive tendering. By this, ACCHSs should be positioned as preferred providers, and PHN funds for mental health and suicide prevention should be allocated to

ACCHSs unless it can be clearly demonstrated that alternative arrangements can produce better results in terms of access to services and service outcomes.

Recommendation 4: The Australian Government should ensure Aboriginal Community Controlled Health Services (ACCHSs) are positioned as preferred providers of mental health services in Aboriginal and Torres Strait Islander communities, and PHN funds for Aboriginal and Torres Strait Islander mental health and suicide prevention should be allocated to ACCHSs unless it can be clearly demonstrated that alternative arrangements can produce better results in terms of access to services and service outcomes.

The authors are also strongly concerned with the accountability of PHNs to the Aboriginal and Torres Strait Islander communities they serve and more broadly, and particularly so in relation to Aboriginal and Torres Strait Islander mental health and suicide prevention. There are 31 PHNs across the country. If the \$196 million allocated to them towards Aboriginal and Torres Strait Islander mental health and suicide prevention since 2015 (as discussed above) is averaged out, that means that each PHN has received \$6.32 million. But we are not clear how this money has been spent, on which organisations, by what processes and with what results. Further, PHN approaches to commissioning or otherwise establishing mental health services in rural and remote areas vary significantly throughout the networks. This leads to our next two recommendations.

Recommendation 5: By 30 June 2019, the Australian Government should retrospectively account for the approximate \$100 million Indigenous-specific mental health and suicide prevention expenditure allocated to Primary Health Networks since 2015. This includes:

- The quantum allocated per region
- How the quantum was allocated (processes)
- The services being funded by these funds and their locations
- The number of ACCHSs and Aboriginal and Torres Strait Islander organisations receiving funds, and the quantum, compared to mainstream providers
- The value for money (positive, measurable outcomes) being achieved through this expenditure.

Recommendation 6: From 30 June 2019, Aboriginal and Torres Strait Islander mental health and community leaders should co-design with the Australian Government a reporting framework that accounts for Indigenous specific mental health and suicide prevention expenditure allocated to Primary Health Networks on an annual basis. This includes:

- The quantum allocated per region
- How the quantum was allocated (processes)
- The services being funded by these funds and their locations
- The number of ACCHSs and Aboriginal and Torres Strait Islander organisations receiving funds, and the quantum, compared to mainstream providers
- The cultural safety of these services
- The value for money (positive, measurable outcomes) being achieved through this expenditure.

(d) The social and economic costs of not acting

Table 5 below summarises a decade's worth of selected social and cost analyses in relation to mental health issues in the mainstream population and in Aboriginal and Torres Strait Islander communities. Although the figures provided are indicative only **and require further analysis**, based on these we estimate that potentially each year in Australia around \$2 billion is being spent addressing Aboriginal and Torres Strait Islander social and other challenges associated with mental health issues, rather than being invested in primary mental health care.

In other words, **it is possible that up to an equivalent of 21 per cent of total population Australian government expenditure on mental health (9.1 billion)** is spent dealing with the aftermath of mental health difficulties in the Aboriginal and Torres Strait Islander population rather than on Indigenous specific primary mental health care. While we caution use of these figures without qualification, we suggest that our preliminary analysis provides a strong rationale for further analysis and that significant consideration to be given to reinvestment opportunities, particularly justice reinvestment opportunities, in Indigenous primary mental health care by the Productivity Commission in this inquiry.

Recommendation 7: That the new Indigenous Productivity Commissioner, within the broader current inquiry, completes a cost-benefit analysis of increased investment in Aboriginal and Torres Strait Islander primary health care (to equity based on need) accounting for the costs associated with a range of social challenges associated with untreated Aboriginal and Torres Strait Islander mental health challenges, in addition to the additional costs to the mental health system.

Recommendation 8: That the new Indigenous Productivity Commissioner considers reinvestment opportunities in Indigenous-specific primary mental health care for the costs associated with a range of social challenges associated with untreated Aboriginal and Torres Strait Islander mental health challenges within the context of the current inquiry.

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Table 5 – Summary of selected social and economic costs associated with mental health difficulties with estimates of the potential for reinvestment

Source	Social costs/ challenges associated with mental health difficulties	Connection to mental health	Economic costs	Indicative potential expenditure available for reinvestment if mental health is addressed prior to becoming associated with a social challenge
Imprisonment 2013 - Senate Legal and Constitutional Affairs References Committee report, Value of a justice reinvestment approach to criminal justice in Australia, released in June 2013 ^{xxx}	At 30 June 2018, just under 12,000 Indigenous prisoners; 28 per cent of the total population. ^{xxxi} Median expected sentence time was 1.3 years. ^{xxxii}	A 2008 survey in Queensland found 72.8 per cent of male and 86 percent of female Indigenous prisoners had suffered from at least one mental health condition in the preceding 12 months. Further, 12.1 per cent of males and 32.3 per cent of females with had PTSD. A 2009 survey of NSW prisoners reported that 54.9 per cent of Indigenous men and 63.3 per cent of women reported an association between drug use and their offence.	About \$100,000 per annum ^{xxxiii} . \$624 per day for juvenile detention detainee (\$227,760 per annum)	Based on 12,000 prisoners serving 1.3 years - around \$1.2 billion per annum. Assuming 50 per cent are in prison due to untreated mental health difficulties results in a potential \$500-600 million cost association.
Employment/ productivity National Mental Health Commission's 2015 Review of Mental Health Services and Programs	Among the 27 per cent of the 26 per cent of the Indigenous people 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. ^{xxxiv}		A 2010 report estimated that psychological distress produces a \$5.9 billion reduction in Australian employee productivity per annum ^{xxxv} .	\$177 million (Indigenous population at 3 per cent.)
Physical health impacts 2014 'Reeve Study' ^{xxxvi}	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'.		The total annual cost of type 2 diabetes in Australia was estimated at \$14.6 billion in 2013. ^{xxxvii}	Significant additional costs to the health system - Indigenous people 3 x more likely to have diabetes.
AOD Collins DJ, Lapsley Study, 2008 ^{xxxviii}	A range of social problems and situational trauma is associated with AOD use. 14 per cent of Indigenous men were drinking an average of more than five standard drinks per day in 2011–12; 8.1 per cent were drinking more than seven standard drinks per day ^{xxxix}	AOD abuse and addiction is both associated with mental health difficulties and trauma, and addiction is a mental health difficulty in its own right	\$55.2 billion for the whole population	\$1.6 billion p.a. (Indigenous population at 3 per cent.)
KPMG – Economic cost of suicide in Australia 2013 ^{xl}	in 2017, 165 Indigenous persons died as a result of suicide	Depression is significantly associated with suicide	About \$650,000 in direct and indirect costs per death (KPMG)	\$107 million p.a.
Total				About 2 billion p.a.

Part 2: Investing in Workforce development

Indigenous Allied Health Australia and Australian Indigenous Psychologists Association

Developing the Aboriginal and Torres Strait Islander mental health workforce, across professions including psychology, counselling, social work, psychiatry, occupational therapy and others, including emerging and peer workforces, is essential to improving mental health and social and emotional wellbeing outcomes for Aboriginal and Torres Strait Islander peoples. Increasing Aboriginal and Torres Strait Islander employment across the entire mental health and social and emotional wellbeing workforce is therefore recognised as a key strategy within the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Wellbeing 2017-2023^{xii} and should be a priority focus for the additional investment (and reinvestment) of mental health dollars available.

Outcome 1.1 of the Social and Emotional Wellbeing and Mental Health Framework identifies “*career pathways by reducing barriers and pathways to education and training including training for emerging professional workforces accredited workers, paraprofessionals and established professionals and professions*” as a key strategy for the development of an effective and empowered mental health and social and emotional wellbeing workforce. It is important, therefore, to consider both the existing Aboriginal and Torres Strait Islander mental health workforce and areas of need.

Aboriginal and Torres Strait Islander people represented 2.8 per cent of the population in the 2016 Census^{xiii}. Despite this, the Aboriginal and Torres Strait Islander health workforce remains under-represented accounting for approximately 1 per cent of the total health workforce and less than 0.5 per cent for most allied health professions. According to data in the National Health Workforce Data set, the total number of occupational therapists and psychologists registered in 2016 were 15,928 and 25,219 respectively. Of those registered, 64 occupational therapists and 175 psychologists identified as ‘Australia Born Indigenous’, accounting for 0.4 per cent and 0.69 per cent of the total respective workforces.^{xliii}

Based on these 2016 figures, a further 393 occupational therapists and 547 psychologists would be required for the workforce to be representative of the 2.8 per cent of the Australian population who identified as Aboriginal and/or Torres Strait Islander in the 2016 census. Taking in to account that the estimated total burden of mental health difficulties as being about 3 times greater in the Aboriginal and Torres Strait Islander population, a **further threefold increase** would be required for the workforce to be representative of need.

As a self-regulated profession data for the Aboriginal and Torres Strait Islander social work workforce is available only from the Australian Bureau of Statistics Census data. In 2016, the most recent census for which this data available, 706 social workers identified as Aboriginal and/or Torres Strait Islander accounting for 3.2 per cent of the social worker workforce. While Aboriginal and Torres Strait Islander social workers are comparatively well represented in the workforce, they remain below the workforce required based on need due to the increased burden of mental health difficulties. With increasing future demand for social work services identified, and strong employment growth predicted for the sector, it is important that recruitment and retention of the Aboriginal and Torres Strait Islander social work workforce is a key driver of future growth.

While there is no workforce for direct comparison with Aboriginal Mental Health Workers, it is notable that access to culturally safe mental health supports is a significant feature within a range of mental health and social emotional wellbeing policy strategies, including the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2017-2023*. The Aboriginal and Torres Strait Islander mental health workforce is uniquely

placed to provide culturally safe and responsive, trauma-informed and patient centred care in line with Indigenous worldviews on what constitutes good health. To date, approximately 270 Aboriginal and Torres Strait Islander people have graduated through Djirruwang Program at Charles Sturt University. This university-run and accredited degree produces graduates with crucial skills in areas of high demand yet most employers, including most state governments and the NDIS (through its service funding mechanisms), do not recognise or enable the use of this workforce. Expansion - and systems to enable the appropriate utilisation - of this emerging workforce will be significant in supporting established professions to improve access to quality care.

It is important to note that access to health care services is not only determined by proximity, but also the appropriateness and acceptability of services to Aboriginal and Torres Strait Islander people to access them. This was identified in the recent Inquest into the 13 Deaths of Children and Young Persons in the Kimberley Region^{xliv} which stated:

“The considerable services already being provided to the region are not enough. They are still being provided from the perspective of mainstream services, that are adapted in an endeavour to fit into a culturally relevant paradigm.”

Increasing the accessibility and cultural safety of health services improves patient outcomes through earlier and more frequent contact, greater opportunity for preventative and early interventional care, stronger relationships between patients and the health service/health workforce and improved continuity of care. Continuity of care is vital to improving care outcomes. In mental health, continuity of provider can reduce the need for patients to retell and revisit trauma(s), removing a potential access barrier and improving mental health and wellbeing^{xlv}. Preventative and ‘upstream’ services in primary care, of which the mental and allied health workforce is a key component, are demonstrated to improve outcomes and are cost effective, particularly when compared with the cost of services provided in the hospital setting. Likewise, the peer workforce has been shown to help promote principles of recovery, contribute to better health outcomes and reduce the rate of hospital admissions for service users. Utilisation of the peer workforce can therefore have similar effectiveness in increasing social and economic participation of individuals with mental health difficulties and reduce the burden on tertiary health care.^{xlvi}

While increasing the Aboriginal and Torres Strait Islander mental health workforce is a key strategy toward improving the cultural responsiveness of the health care system, it requires complementary action from mainstream health services and professionals. We support the current work of the Australian Health Practitioner Regulation Agency (AHPRA) to recognise the requirement for cultural safety within professional standards and accreditation and encourage further development of a more culturally safe system, as endorsed by health ministers under COAG. Provision of culturally safe and responsive care provides opportunity to improve access to services, experience and subsequently health and wellbeing outcomes. Equally, culturally safe environments to study, train and work will better support the health, wellbeing, recruitment and retention of the Aboriginal and Torres Strait Islander health workforce and thereby be reinforcing.

Achieving an increase in the Aboriginal and Torres Strait Islander mental health workforce requires career pathway development, local solutions and appropriate resourcing. Effective models for workforce development exist, however these often remain at the margin of the health and education systems. For example, Indigenous Allied Health Australia (IAHA), working in partnership with Aboriginal Medical Services Alliance Northern Territory (AMSANT), have developed an innovative project to increase the number of young Aboriginal and Torres Strait Islander people completing Year 12 and entering the health workforce. This model works collaboratively across health disciplines and organisational structures such as health, education, training and employment

to improve and increase high school retention to Year 12 and to promote future career opportunities in health and has shown great promise.

Localised workforce development and pathways are also important to addressing distribution issues and the increasing demand for services. The Victorian Allied Health Workforce Research Program^{xlvii} noted that demand for social workers is *“predicted to continue to rise with the ageing population, and increasing policy focus on family violence, disability and mental health support. Future areas of high demand include family violence, aged care, disability, mental health, child protection, and Indigenous mental health. There are existing service gaps in these areas and also in rural areas.”* Development of local health workforce solutions, as opposed to continued reliance of visiting health services and health workers, may increase the efficiency of health expenditure in several ways including:

- reduction in administration costs associated with the co-ordination of visiting services;
- reduction in administration costs associated with recruitment and training to replace higher staff turnover associated with locum staffing or longer-term recruitment of professionals from outside the local region; and
- reduced reliance on financial incentivisation to encourage professionals to move from metropolitan and major regional centres to more remote locations.

In addition to efficiencies within existing expenditure, developing local health workforce solutions should bolster economic prosperity within communities and regions. In addition to generating taxation, employment of local staff increases the likelihood of money staying within and being spent in the region, thereby increasing other non-health economic opportunities and supporting increased local services and infrastructure.^{xlviii} The health gains associated with improving local conditions – addressing some of the social determinants of health – will compliment improved access to appropriate health services, as it has been estimated that 34.4 per cent of the health gap is attributable to social determinants.^{xlix}

The Research Program also suggested little evidence that there was a shortage of psychologists; rather, there is a lack of appropriately funded and graded positions within the community to meet the needs of clients. These distribution issues may be further evidenced by 2011 data from NSW, indicating that people from disadvantaged and rural and remote areas were more likely to be treated through medication only, and less likely to receive a mix of services and medications or services only.^l Other evidence, produced by the Australian Commission on Safety and Quality in Health Care, has demonstrated a markedly disproportionate use of mental health related medications in rural and remote areas where there is also a shortage of allied health professionals (please refer to the Australian Health Atlas). Consideration of health care funding and career progression, particularly within the public system, is needed to improve retention rates within the public system and, therefore, increase the availability of these services. Retention of mental health staff within systems and locations is also essential for continuity of care and service uptake, reducing the need for patients to provide detailed histories and retell and relive trauma(s) on multiple occasions, which may otherwise discourage service use.

In addition to the expense, evidence also suggests that the ‘fly-in fly-out’ model of provision of health services may in fact inhibit the develop of local health service infrastructure in regions or areas with enough capacity and demand to support economically viable services.^{li} Establishing models of localised health service delivery can improve access through improved proximity and consistency of service availability, particularly in areas with seasonal fluctuations in accessibility, for example due to flooding and road conditions. Supporting more appropriate distribution of the existing and future workforce where adequate numbers exist, and increasing the uptake of available

services, contribute to increased efficiencies or resourcing, including maximising the effectiveness of the tertiary education system.

The Workforce Development Program, under the *Fifth National Mental Health and Suicide Prevention Plan*^{lii}, includes strategies to attract and retain mental health workers in rural and regional areas. This may include enhanced career pathways and incentives to encourage psychiatrists, psychologists, Aboriginal mental health workers to relocate from urban practice. Such initiatives should include all mental health workers, including peer workers, mental health nurses, occupational therapists and social workers, acknowledging the important role of these professions in mental health and wellbeing care. It is important that consideration is given to how this workforce and model of care can be enhanced through utilisation of traditional healing alongside the biomedical model of treatment.

In addition to the substantial and much needed gains in addressing health and wellbeing inequities, economic benefits arising as a result of increasing the Aboriginal and Torres Strait Islander health workforce include increased economic participation and a reduced burden of ill-health. Australia have an aging population demographic, often will multiple and complex health needs, resulting in increasing demands on the health budget to be supported by - and funded through - a limited workforce and taxation base. The Aboriginal and Torres Strait Islander population in Australia is growing and is – in contrast - younger demographically than the non-Indigenous population, with more than half (53%) of Aboriginal and Torres Strait Islander people under the age of 25 in 2016.^{liii} Improvements in mental health and social and emotional wellbeing among Aboriginal and Torres Strait Islander people are therefore likely to have increased long-term social participation benefits and a substantial reduction in YLD and DALY's over the life course. The benefits to increasing the Aboriginal and Torres Strait Islander health workforce are likely to be reinforcing, with meaningful employment demonstrated to be a protective factor for individual mental health.^{liv} With the health workforce already the largest area of employment in Australia, and health care and social assistance predicted to grow by another 250,300 jobs over the five years to May 2023^{lv}, health workforce development addresses a significant area of need and provides individuals with sustainable and long-term employment opportunities.

Approaches to addressing the mental health and social and emotional need to be holistic and designed around Aboriginal and Torres Strait Islander perspectives of health, for example the definition of Aboriginal and Torres Strait Islander health from the 1989 National Aboriginal Health Survey below:

“not just the physical wellbeing of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total well-being of their Community. It is a whole-of-life view and includes the cyclical concept of life-death-life. Health care services should strive to achieve the state where every individual is able to achieve their full potential as a human being and this bring about the total well-being of their community.”^{lvi}

This is essential for several reasons including addressing the relationship (co-morbidities) between physical and mental health and appropriate recognition of the relationship between individual mental health and the wellbeing of communities. A social and cultural determinants approach to health, which considers the needs of individuals and communities across health and non-health portfolios including income support, education, employment, housing and the justice system is needed. Investment in the needs of Aboriginal and Torres Strait Islander people should be viewed as being cost-effective and directed through Aboriginal and Torres Strait Islander led and community-

controlled services to increase the effectiveness and efficiency of allocated resources. The need for Aboriginal and Torres Strait Islander leadership is widely recognised, including in the Fifth National Mental Health and Suicide Prevention Plan^{lvii} which requires governments to:

“Improve Aboriginal and Torres Strait Islander access to, and experience with, mental health and wellbeing services in collaboration with ACCHSs and other service providers by: recognising and promoting the importance of Aboriginal and Torres Strait Islander leadership and supporting implementation of the Gayaa Dhuwi (Proud Spirit) Declaration”.

Empowering community self-determination also increases agency and recognises the inherent strengths and capabilities that exist within communities. Evidence suggests that increased self-determination and agency at the individual and community level is protective of mental health and aids recovery for those with mental ill-health.

“Our communities and cultures are sources of identity, values and practices that can help protect against suicide. Such strengths provide the foundation for a mix of short, medium, and longer-term action in the face of increasing Indigenous child and youth suicide deaths, and that is required to turn this tragic situation around.”

Professor Pat Dudgeon^{lviii}

This approach is consistent with governments commitment to work in closer partnership with Aboriginal and Torres Strait Islander people as detailed in the December 2018 Council of Australian Governments (COAG) Communique which stated that *“COAG recognises that in order to effect real change, governments must work collaboratively and in genuine, formal partnership with Aboriginal and Torres Strait Islander peoples as they are the essential agents of change.”*^{lix} This public commitment has led to the recently announced Partnership Agreement on Closing the Gap. While this is promising, ongoing commitment to genuine partnership with Aboriginal and Torres Strait Islander people, communities and organisations is essential and should be foundational to work on improving mental health and social and emotional wellbeing.

END

Appendix – About the authors

- NATSILMH was established in November 2013 to provide a leadership platform for Indigenous mental health leaders working mainly in the National, Queensland, New South Wales and Western Australian mental health commissions. All of NATSILMH's individual members are Indigenous with organisational members including NACHHO, the Aboriginal and Torres Strait Islander Healing Foundation, IAHA and AIPA. As a collective, NATSILMH has expertise in mental health, social and emotional wellbeing and suicide prevention. It also has great strength in mental health workforce issues.

The proactive 2015 development and launch of the *Gayaa Dhuwi (Proud Spirit) Declaration* is NATSILMH's signature achievement to date. After extensive lobbying, a watershed moment for NATSILMH was the recognition of the *Gayaa Dhuwi (Proud Spirit) Declaration* in the *Fifth National Mental Health and Suicide Prevention Plan* (Fifth Plan) as providing: *a platform for governments to work collaboratively to achieve the highest attainable standard of mental health and suicide prevention outcomes for Aboriginal and Torres Strait Islander peoples*. NATSILMH helped develop the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Social and Emotional Wellbeing and Mental Health 2017 - 2023* and continue to advocate for a fully funded implementation plan to be developed within the Fifth Plan implementation process.

- IAHA is a national not for profit, member-based organisation building and supporting the growth and practice of Aboriginal and Torres Strait Islander allied health graduates and students. Since its establishment in 2009, IAHA has grown significantly in terms of profile and membership, with members working in allied health, mental health, social work, social welfare, psychology, counselling, oral health, dentistry, dietetics, occupational therapy, exercise science, exercise physiology, physiotherapy, public health, nutrition, radiography/radiation therapy, pharmacy, paramedics, speech pathology, audiology, optometry, chiropractic, podiatry and osteopathy.

IAHA is a leader in Aboriginal and Torres Strait Islander health and social and emotional wellbeing, including as an organisational member of the NATSILMH. IAHA is represented on a range of significant national, Aboriginal and Torres Strait Islander led campaigns, forums and committees including the Close the Gap Steering Committee and the National Health Leadership Forum. More information on IAHA, including our approach to sustainable workforce development can be found in our 2017-18 Annual Report and Workforce Development Strategy (2018-2020).

- AIPA is the national body representing Aboriginal and Torres Strait Islander psychologists in Australia. AIPA was established in 2009. AIPA is committed to improving the social and emotional well-being and mental health of Aboriginal and Torres Strait Islander peoples by leading the change required to deliver equitable, accessible, sustainable, timely and culturally competent psychological care which respects and promotes their cultural integrity. Furthermore, AIPA is committed to supporting and formally representing the views of Aboriginal and Torres Strait Islander psychologists and students, supporting Indigenous psychologists through undergraduate and post graduate courses, working toward achieving equity within the profession and developing and delivering professional development activities which aim to increase the cultural competence of the mental health workforce, service delivery and the mental health system overall. There are currently 90 members of AIPA and this is expected to grow exponentially in the next few years.

- ⁱ Department of Prime Minister and Cabinet, 2019, Closing the Gap Report 2019
- ⁱⁱ AIHW, ATSIHPF, p191.
- ⁱⁱⁱ Australian Institute of Health and Welfare 2016. Australian Burden of Disease Study: Impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011. Australian Burden of Disease Study series no. 6. Cat. no. BOD 7. Canberra: AIHW, p.viii.
- ^{iv} All figures in Table 1 from Australian Health Ministers' Advisory Council 2017. *Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report*, AHMAC, Canberra, p.192.
- ^v Australian Institute of Health and Welfare 2015. The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2015. Cat. no. IHW 147. Canberra: AIHW, p.150.
- ^{vi} Australian Medical Association 2018. Rebuilding the Closing the Gap Health Strategy: Including a Review of the 2016 and 2017 AMA Indigenous Health Report Card Recommendations. Available online at: https://ama.com.au/system/tdf/documents/2018%20AMA%20Report%20Card%20on%20Indigenous%20Health_1.pdf?file=1&type=node&id=49617
- ^{vii} As above
- ^{viii} Australian Health Ministers' Advisory Council 2017. *Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report*, AHMAC, Canberra, pp.191-2.
- ^{ix} As above.
- ^x As above.
- ^{xi} Thomas, S., Zhao, Y., Guthridge, S.L. *et al.* 2014. 'The cost-effectiveness of primary care for Indigenous Australians with diabetes living in remote Northern Territory communities', *Med J Aust* 2014; 200 (11): 658-662. doi: 10.5694/mja13.11316
- ^{xii} See fn.8. Australian Medical Association 2018.
- ^{xiii} Australian Institute of Health and Welfare 2016. Australian Burden of Disease Study: Impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011. Australian Burden of Disease Study series no. 6. Cat. no. BOD 7. Canberra: AIHW, p.148.
- ^{xiv} Australian Bureau of Statistics 2016, National Aboriginal and Torres Strait Islander Social Survey, 2014-15. ABS cat no. 4714.0. Published online: [https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4714.0~2014-15~Feature%20Article~Aboriginal%20and%20Torres%20Strait%20Islander%20people%20with%20a%20mental%20health%20condition%20\(Feature%20Article\)~10](https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4714.0~2014-15~Feature%20Article~Aboriginal%20and%20Torres%20Strait%20Islander%20people%20with%20a%20mental%20health%20condition%20(Feature%20Article)~10)
- ^{xv} See fn.15. Australian Institute of Health and Welfare 2016.
- ^{xvi} As above
- ^{xvii} As above, p.144.
- ^{xviii} As above, fn.10. Australian Health Ministers' Advisory Council 2017.
- ^{xix} As above, p.43.
- ^{xx} As above, fn.19. Australian Institute of Health and Welfare 2016.
- ^{xxi} Australian Institute of Health and Welfare 2018, 'Expenditure on mental health services' Chapter in *Mental Health Services in Australia*. Published online: <https://www.aihw.gov.au/getmedia/a188ec24-8542-48a7-8d8f-c20842200b5a/Expenditure-on-mental-health-services-2016-17.pdf.aspx>
- ^{xxii} National Mental Health Commission, 2014: Specific Challenges for Aboriginal and Torres Strait Islander People: A Summary of the National Review of Mental Health Programmes and Services. Sydney
- ^{xxiii} As above.
- ^{xxiv} As above. As above, fn.10. Australian Health Ministers' Advisory Council 2017, p.167.
- ^{xxv} As above. As above, fn.10. Australian Health Ministers' Advisory Council 2017, p.167.
- ^{xxvi} Hunt, G (Minister for Health) 2019, \$1.45 billion to strengthen mental health services and support job security (Media release). Available online: <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2019-hunt008.htm>
- ^{xxvii} Commonwealth of Australia 2018, Budget 2018-19, Portfolio Budget Statements 2018-19, Budget Related Paper No 1.14, Prime Minister and Cabinet Portfolio. Available online: https://www.apf.gov.au/Parliamentary_Business/Senate.../.../health509.pdf
- ^{xxviii} Australian Institute of Health and Welfare 2017. Aboriginal and Torres Strait Islander health organisations: Online Services Report—key results 2015–16. Aboriginal and Torres Strait Islander health services report no. 8. Cat. no. IHW 180. Canberra: AIHW.
- ^{xxix} Panaretto K, Wenitong M, Button S and Ring I, 'Aboriginal community controlled health services: leading the way in primary care' (2014) 200(11) *Medical Journal of Australia*, 200 (11) 649; Thompson SC, Haynes E, Shahid S, Woods JA, Katzenellengogen, Teng T-H, Davidson PM and Boxall A, 'Effectiveness of primary health care for Aboriginal Australians'. Unpublished literature review commissioned by the Australian Government Department of Health, 2013 as cited in Mackey, P, Boxall, A-M, Partel K (2014) 'The relative effectiveness of Aboriginal Community Controlled Health Services compared with mainstream health service', *Deeble Institute Evidence Brief*, No 12.
- ^{xxx} The Senate - Legal and Constitutional Affairs References Committee. Value of a justice reinvestment approach to criminal justice in Australia Canberra: Commonwealth of Australia, 2013
- ^{xxxi} Australian Bureau of Statistics 2018, Aboriginal and Torres Strait Islander Prisoner Characteristics Prisoners in Australia, 2018. ABS cat. no. 4517.0 Published online: <https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4517.0~2018~Main%20Features~Aboriginal%20and%20Torres%20Strait%20Islander%20prisoner%20characteristics%20~13>
- ^{xxxii} As above, webpage 'Sentenced Prisoners'. Available online : <https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4517.0~2018~Main%20Features~Sentenced%20prisoners~18>
- ^{xxxiii} Bushnell A., 2017. Australia's Criminal Justice Costs: An International Comparison. Melbourne: Institute of Public Affairs. Available online: <https://ipa.org.au/wp-content/uploads/2017/08/IPA-Report-Australian-Criminal-Justice-Costs-An-International-Comparison.pdf>
- ^{xxxiv} Australian Bureau of Statistics. The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples. Cat. no. 4704.0. Canberra: ABS, 2010.
- ^{xxxv} Doran CM. The costs and benefits of interventions in the area of mental health: a rapid review. Sydney: Check rapid review brokered by the Sax Institute for the Mental Health Commission of NSW, 2013.
- ^{xxxvi} Reeve R, Church J, Haas M, Bradford W, Viney R. Factors that drive the gap in diabetes rates between Aboriginal and non-Aboriginal people in non-remote NSW. *Australian and New Zealand Journal of Public Health* 2014; 38(5): 459-66.
- ^{xxxvii} <https://static.diabetesaustralia.com.au/s/fileassets/diabetes-australia/e549bdb8-0f80-46f8-b827-35cb4f1b6cd2.pdf>
- ^{xxxviii} Collins DJ, Lapsley HM. The costs of tobacco, alcohol & illicit drug abuse to Aust. society in 2004–05 Summary. Canberra: Department of Health and Ageing, 2008.

-
- ^{xxxix} COAG Reform Council. Indigenous Reform 2012–13: Five years of performance. Sydney: CRC, 2014.
- ^{xl} Collins DJ, Lapsley HM. The costs of tobacco, alcohol & illicit drug abuse to Aust. society in 2004–05 Summary. Canberra: Department of Health and Ageing, 2008.
- ^{xli} Commonwealth of Australia 2017. National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing. Canberra: Department of the Prime Minister and Cabinet.
- ^{xlii} Australian Bureau of Statistics, 2071.0 - Census of Population and Housing: Reflecting Australia - Stories from the Census, 2016
- ^{xliii} Department of Health, National Health Workforce Dataset (NHWDS)
- ^{xliv} Inquest into the 13 Deaths of Children and Young Persons in the Kimberley Region
<https://www.coronerscourt.wa.gov.au/files/inquest-2019/13-Children-and-Young-Persons-in-the-Kimberley-Region-Finding.pdf>
- ^{xlvi} Report Accessibility and quality of mental health services in rural and remote Australia, 4 December 2018, Commonwealth of Australia, ISBN 978-1-76010-860-1
- ^{xlvii} Health Workforce Australia, 2014, Mental Health Peer Workforce Study
- ^{xlviii} Allied Health Workforce Research Program, Department of Health & Human Services, State Government of Victoria
<https://www2.health.vic.gov.au/health-workforce/allied-health-workforce/allied-health-research>
- ^{xlix} Morris, R. (2012) Scoping Study: Impact of Fly-in Fly-out/Drive-in Drive-out Work Practices on Local Government, Australian Centre of Excellence for Local Government, University of Technology, Sydney.
- ^l Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW
- ^{li} Mental Health Commission of New South Wales, 2016, Data Snapshot - Access to mental health services for people living in NSW, 2011
- ^{lii} Carey et al. BMC Health Services Research (2018) 18:476 <https://doi.org/10.1186/s12913-018-3269-5>
- ^{liii} Department of Health, 2017, The Fifth National Mental Health and Suicide Prevention Plan
- ^{liiii} Australian Bureau of Statistics, 2071.0 - Census of Population and Housing: Reflecting Australia - Stories from the Census, 2016
- ^{liv} Modini, M., Joyce, S., Mykletun, A., Christensen, H., Bryant, R. A., Mitchell, P. B., & Harvey, S. B. (2016). The mental health benefits of employment: Results of a systematic meta-review. *Australasian Psychiatry*, 24(4), 331–336. <https://doi.org/10.1177/1039856215618523>
- ^{lv} Department of Jobs and Small Business, 2018, 2018 Employment Projections - for the five years to May 2023
- ^{lvi} National Aboriginal Health Strategy, 1989
- ^{lvii} Department of Health, 2017, The Fifth National Mental Health and Suicide Prevention Plan
- ^{lviii} Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention, 25 March 2019, Media Release - Indigenous Leaders Call Australian Governments to Action on Indigenous Child and Youth Suicide
- ^{lix} Council of Australian Governments, 12 December 2018, COAG Statement on the Closing the Gap Refresh