Commissioner Stephen King
Presiding Commissioner
Productivity Commission Inquiry on Mental Health

Dear Commissioner

Thank you for the opportunity to provide a written submission to the Productivity Commission's Inquiry into the Australian Mental Health system. As a large regional provider of Aboriginal and Torres Strait Islander primary health care services, IUIH is pleased to provide the following observations to inform the Commission's deliberations. This submission elaborates on issues discussed with Commissioners on their visit to IUIH in November 2019. We look forward to continuing to discuss these issues at the Inquiry's Indigenous Consultation in February.

IUIH also respectfully offers the following comments on the Commission's interim report for consideration in developing the final report:

- Suggest replacing the term *Aboriginal and Torres Strait Islander communities* (which is used extensively throughout the document) with *Aboriginal and Torres Strait Islander people/populations.* The word *communities* often implies or is interpreted as meaning discrete Indigenous communities (where relatively few people live) and therefore inadvertently excludes the vast majority of Indigenous people who live outside these defined communities. We assume this is not the intent of the Commission.

- Page 25 – as well as racism and discrimination, access to health services by Aboriginal and Torres Strait Islander people in urban areas is also impeded by cost of the mainstream healthcare services and availability of transport, issues usually overcome by Aboriginal Community Controlled Health Service (ACCHS) service models.

- Page 28 - We refer to the following statements: *Aboriginal health practitioners and health workers comprise a relatively small proportion of the health workforce but play an important role in providing culturally capable care to Aboriginal and Torres Strait Islander people. There is a well-developed system of training for these workers, including in mental health. We are seeking more information on ways to expand their career opportunities, including scope for transition-to-practice arrangements for those wishing to move into more general mental health clinical or non-clinical roles.*

  In IUIH's view there are two main issues – (1) how Aboriginal Health Workers are utilised in the mainstream system – essentially where they carry the responsibility for rendering the service culturally capable but without a clinical or professional role outside of this; and (2) that becoming an Aboriginal Health Worker should not be seen as the only pathway for Aboriginal people wishing to work in mental health.

  Aboriginal Health Workers (AHWs) are often utilised differently in mainstream health services than in ACCHS. In mainstream services they are often culturally isolated and used in an engagement/transport capacity quite separate from the treating team, which usually remains inherently not culturally capable. In ACCHS they are more likely to be employed as valued members of Indigenous-led Multidisciplinary Care Teams where they provide advice, cultural mentorship and clinical support to non-Indigenous team members as well as facilitating access, fulfilling some clinical functions and providing direct wrap around care to the client. We agree with the Fifth National Mental Health and Suicide Prevention Plan which states, "*Aboriginal and Torres Strait Islander leadership in mental health services is fundamental to building culturally capable models of care. Governance, planning processes, systems and clinical pathways will be more effective if they include Aboriginal*

and Torres Strait Islander workers at key points in the consumer journey, such as assessment, admission, case conferencing, discharge planning and development of mental health care plans" (page 31). However, IUIH believes it is critical for all clinical services and programs to also operate within a robust, evidence-based clinical governance framework. A culturally capable service model must also be clinically effective. Therefore, IUIH believes the most effective models of mental health care for Aboriginal and Torres Strait Islander people will be clinical care that is strongly informed by Indigenous perspectives, both in the design and delivery of services.

IUIH also notes that while AHWs may be one important part of the workforce, this is often seen as the ONLY pathway or career options for Aboriginal people wanting to work in mental health. Resourcing the ongoing training and development of their Indigenous workforce must be a priority for public mainstream health services, providing the training is accompanied by real employment opportunities. A much heavier emphasis and effort should be directed into supporting career pathways for Aboriginal and Torres Strait Islander people through the breadth of disciplines needed i.e. social workers, mental health nurses, counsellors, psychologists, psychiatrists. IUIH provides training in Certificate IIIs for Aboriginal and Torres Strait Islander community members across a range of health disciplines. In particular, it focuses on providing opportunities to women returning to the workforce after rearing children and the long-term unemployed. In doing so, IUIH has identified that a key success factor has been the provision of significant mentoring and support while the student undertakes their studies. The importance of this (largely unfunded) pastoral care and support in achieving positive training and employment outcomes cannot be overstated.

- Page 33 – Post release care in particular is best undertaken by ACCHSs as their models of care integrate mental health into primary health care and they are well connected to community based social support services. This means that someone post-release is immediately connected to a range of mental health, general health and social support services, often available within the same organisation. However, government procurement processes for post-release care often favours mainstream mental health service providers even for custodial environments where Aboriginal and Torres Strait Islander people comprise a significant proportion of potential clients.

- IUIH notes the Commission's proposal that the current arrangement of commissioning mental health services through PHNs be replaced by the establishment of Regional Commissioning Agencies. IUIH supports the principle of regional commissioning, having advocated to the Australian Government that IUIH could take on the role of regional commissioner of Indigenous health services in SEQ. However, we ae concerned that for identifying need and commissioning mental health services for Indigenous Australians, such a body may have no more expertise or be any more efficient than PHNs. IUIH hopes the Commission will consider the role that regional ACCHSs could play in allocating mental health funding targeted to Indigenous Australians.

- Draft finding 2.1 (page 51) which reads: *Mental illness is the second largest contributor to years lived in ill-health, and almost half of all Australians will experience mental illness at some point in their life. Compared to other developed countries, the prevalence rate of mental illness in Australia is above the OECD average.* For completeness it would be pertinent to acknowledge that mental disorders are the largest contributor to the Indigenous burden of disease.

- Information Request 11.1 (page 65) which reads: *The Productivity Commission is seeking information from participants on any barriers impeding career progression for Aboriginal and Torres Strait Islander health workers, including barriers to the ability to move to broader health professions, such as mental health nursing.* Few gains will be made in this area until mainstream health services prioritise the upskilling of Indigenous staff as both a contribution to enhancing culturally capable healthcare AND a contribution to enhanced employment outcomes for Indigenous Australians which is both a government priority in its own right and a significant determinant of health outcomes for Indigenous people. Barriers impeding career progression for Aboriginal Health Workers include inadequate resourcing of training and jobs, financial support to those who

might be financially disadvantaged by taking time away from work to study, and provision of mentoring and support for people undergoing further studies/training. See also previous comments.

- Recommendation 16.4 (page 80) makes a strong statement that *State and Territory Governments should ensure Aboriginal and Torres Strait Islander people in correctional facilities have access to mental health supports and services that are culturally appropriate* [and that these services should be] *designed, developed and delivered by Aboriginal and Torres Strait Islander organisations where possible, trauma-informed, particularly when services are delivered to Aboriginal and Torres Strait Islander women, focused on practical application particularly for those on remand or short sentences who need the skills on release to reintegrate. State and Territory Governments should work with Aboriginal and Torres Strait Islander organisations to ensure Aboriginal and Torres Strait Islander people with mental illness are connected to culturally appropriate mental healthcare in the community upon release from correctional facilities.* IUIH strongly agrees, but would like to see a similarly strong statement regarding the development of community controlled community-based mental health services for Indigenous Australians.

- Recommendation 21.2 (page 97) states that COAG should develop a renewed *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* and associated *Implementation Plan* to guide suicide prevention activities in Indigenous communities. IUIH believes this recommendations would be strengthened by including the words *"develop and resource"* in relation to the renewed Strategy. Recommendation 21.2 also states that *Indigenous organisations should be the preferred providers of local suicide prevention activities for Aboriginal and Torres Strait Islander people.* IUIH contends that Indigenous organisations should be the preferred provider of primary mental health services, community-based specialist mental health services, suicide prevention and postvention services and post-custodial transition services for Aboriginal and Torres Strait Islander people with mental disorders.

- Recommendation 22.2 (Page 100) states that the Australian Government should expedite the development of an implementation plan for the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023. Again, there is no mention of resourcing. IUIH sees little value in the development of national plans and strategies that are not accompanied by a resourced implementation strategy, yet this often occurs. This recommendation could be significantly strengthened by including the words *"develop and resource"* in relation to the proposed implementation plan.

Finally, IUIH makes the following recommendations for the Commission's consideration:

Acknowledging:

- Mental disorders are the national leading contributor to the Indigenous burden of disease (19% of the total disease burden), with its contribution even greater in urban regions (25%)
- Commissioning for mental health services routinely applies a one-size-fits-all approach to mental health service provision despite the fact that evidence clearly shows that mental health needs are best supported in the context of holistic and culturally safe health care
- Current fragmented responsibilities across government agencies and mainstream commissioning arrangements are not conducive to community-led solutions for best practice care.

That the government commit to giving priority to:

- Commissioning Indigenous mental health services through regional ACCHSs
- Recognising ACCHSs as the preferred provider of Indigenous-specific community-based mental health and AOD services, suicide prevention initiatives and post-prison transition care services.
- Funding the establishment of Aboriginal community controlled and community-based specialist mental health services in Major Cities through partnership with the mainstream mental health service system
- Adding appropriate mental health Closing the Gap targets, supported by appropriate prevalence monitoring and adequate funding to address need.

Should you or Productivity Commission staff require any further information, please do not hesitate to contact Dr Carmel Nelson, Director of Clinical Quality and Innovation, at   OR Marianna Serghi, Strategic Policy Adviser at   .

Yours sincerely

Adrian Carson
Chief Executive Officer
31 January 2020

URBAN INDIGENOUS MENTAL HEALTH

A Submission to the Australian Productivity Commission Inquiry into the Australian Mental Health System

Institute for Urban Indigenous Health
January 2020
Adrian Carson, CEO

Contents

Please note: Throughout this document, the term *'mainstream''* is used to describe an organisation/practitioner that provides services to the general population (eg a private general practitioner, a hospital, a community mental health services) or a service or program that any eligible member of the Australian community may access. The term Indigenous-specific or targeted service are used to describe services that are funded and delivered specifically to Aboriginal and/or Torres Strait Islander people. A Community Controlled Health Service is a particular model of Indigenous-specific healthcare run by Indigenous non-government organisations.

About the IUIH Network

The Institute for Urban Indigenous Health Ltd (IUIH) was established in 2009 as a strategic response to the significant growth and geographic dispersal of Indigenous people within the South East Queensland (SEQ) region – where 38 percent of the State's and 11 percent of the nation's Indigenous population live. This region represents the largest and fastest growing Indigenous population in Australia, with current numbers of 84,229 (Markham and Biddle, 2017) projected to grow to 130,000 by 2031 (Biddle, 2013). Between the 2011 and 2016 Census counts, the Indigenous population of SEQ grew by 33%, compared to a national Indigenous population growth of 18% (Markham and Biddle, 2017).

As the peak body of a regional network of member Aboriginal and Torres Strait Islander Community Controlled Health Services (ACCHSs) in SEQ, the IUIH was created by its Members to drive the development and implementation of transformational change to the way health care services were delivered for urban Indigenous Australians in the region.

The IUIH is now the largest ACCHS in Australia, with an annual budget of more than $85 million. With over 550 staff, around half of whom identify as Aboriginal and/or Torres Strait Islander, IUIH is now the largest employer of Indigenous people in SEQ.

The IUIH Network, including its member ACCHSs – ATSICHS Brisbane, Yulu-Burri-Ba, Kambu, and Kalwun Development Corporation – collectively operate 20 community controlled primary health care clinics across SEQ (see Figure 1) and has a combined annual budget of over $130 million and more than 1,170 staff, including 620 Indigeneous employees.

FIGURE 1: IUIH NETWORK CLINICS, SEQ 2020

The IUIH System of Care

In SEQ, IUIH has pioneered a new regional and systematised model – a regional health 'ecosystem' - which is underpinned by groundbreaking innovation to the way services are delivered. From a starting point that focussed on putting control of health back in community's hands, the '*IUIH System of Care*' has delivered unprecedented improvements in health access and outcomes, validated through research, and which the IUIH now advocates as having significant applicability to progress the closing the gap agenda in other regions (both urban and remote). For example, since the establishment of the IUIH, these improvements include an increase in regular client numbers from 8,000 in 2009 to 35,000 in 2018-19), and an increase in annual Health Assessments (from 550 in 2009 to 23,500 in 2018-19).

The IUIH understood the complexity and fragmented nature of the health system in SEQ and that the <u>solution to exponentially increase access to comprehensive care lay firstly in the integration of the health system at a regional level, in order to ensure integrated care at the local level.</u> The focus was on integrating a fragmented health system and disparate funding programs (Indigenous-specific and mainstream) to support a coherent regional strategy which spanned the care continuum and life course. In this way, the *IUIH System of Care* is characterised by a highly systematic approach to the delivery of accessible, efficient and comprehensive health care by ACCHSs within a regional framework.

The point of difference of this radically new approach is that it isn't just about implementing a 'model of care' at the local clinic, but rather embedding frontline clinical care into a broader **regional 'ecosystem'.** This ecosystem promotes integration at, and between, every level of the IUIH Network operations:

I.   *Health Systems level*:
     The IUIH as an integrator for regionally-led reforms around strategic planning, service development, business modelling, funding/investment, IT, data, clinical and corporate governance, CQI, workforce development (including student placements), cross-sector connectivity, research;

II. *Clinic-level*:
     Universal (no-cost), consistent and evidence-based 'single point of care' for clients at each of the 20 site locations, supplemented by locally accessible but regionally managed programs delivered 'on-site' such as allied health, mental health, dental, Specialist, '*IUIH Connect'* (interface with tertiary system), care-coordination, aged care, justice, family well-being, and child protection; and

III. *Community level*:
     Utilising preventative health/social marketing campaigns such as *Deadly Choices* to engage the community and empower behavioural change ('generating a demand for change'), in addition to addressing social determinants of health.

The architecture of this ecosystem is based on the premise of providing a completely integrated and seamless client experience. The client's worry about access to services is <u>our</u> worry, not theirs, with the conversation about integrated care starting and ending with the client.

Achieving this in practice has, however, proved to be particularly challenging. This is the case both within the primary health care system itself; between the primary, secondary and tertiary systems; as well between the health and other systems (education, aged care, disability, justice etc.).

The IUIH has taken an approach to reshape and create a new regional system, rather than to continually find a 'work-around' to the discordant elements. The later approach can often result in additional cost and effort in supporting complex referral networks, diminution of care quality, time delays etc.

Accordingly, the *IUIH System of Care* which has emerged is now characterised by arguably one of the most comprehensive range of service offerings available for clients.

At the front end, community and school engagement strategies such as *Deadly Choices*, Deadly Sistas, MomenTIM [1] and Tackling Indigenous Smoking programs have proved highly successful both in terms of health promotion campaigns, as well as being the interlockers to facilitate access to the health system.

In terms of clinical care, in addition to the GP/Nurse/Aboriginal Health Worker core team, a full suite of disciplines is readily available to the client, including:

- IUIH Allied/Specialist Health regional workforce[2] – inclusive of physiotherapy, occupational therapy, podiatry, exercise physiology, dietetics, diabetes education, psychology, counselling, social work, audiology, speech pathology, child/maternal nursing, paediatrics;
- Dental – 21 dental chairs operate across 9 clinics; and
- Optometry.

Complementary chronic disease self-management programs such as the *Work It Out* provide fitness, rehabilitation and health literacy programs.

Recognising the vital contribution that education, employment, physical environment and social inclusion have on health outcomes, a priority strategic direction going forward for the IUIH is to deliver a broader range of social health programs (including early childhood education, family well-being, justice, child protection, aged care, disability). This will ensure integration of primary care with the social determinants of health, which are estimated to contribute 31% to the health gap.

To date, these expanded social health initiatives have included:

- Aged Care – Home Support programs; a national trial to provide an integrated health/aged care experience for elders, including interfacing the My Aged Care and Patient Information Record Systems
- Deadly Kindies
- Legal Services – IUIH was recognised as a Community Legal Centre (CLC) in 2018, employing lawyers to work alongside clinicians in a unique model of Health/Justice Partnership
- Prison Transition Care
- Disability Services and
- Child Safety and Family Wellbeing.

The value-add of this regional ecosystem (*System of Care*) is that it has sufficient strength, scope and resources to be impactful in addressing, and in some cases replacing, the systemic barriers and fragmentation which have been serious inhibitors to improving access and outcomes.

As a regional integrator of this *System of Care*, IUIH has been able to implement enabling strategies which, at the regional level, are delivering dramatic reforms to the health system in SEQ in terms of improved effectiveness and efficiency:

- *Financial sustainability*: Through its regional business development role, the IUIH has led the design of a more sustainable financial architecture across the network, including optimisation of non-grant revenue streams. This has enabled it to spearhead the rapid clinic expansion across SEQ and re-invest in services not otherwise grant funded or accessible for a client population with complex needs and a limited disposable income

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[1] MomenTIM is a mental health engagement strategy targeting 12-25-year-old males. Deadly Sistas provides similar engagement for young females

[2] The IUIH Regional Allied Health/Specialist team includes 90 + staff. An active workforce development strategy supporting both this team and the broader IUIH workforce has seen a record 388 students from 21 disciplines undertake placements in the IUIH network during 2016-17.

- *Harnessing efficiencies through regionally scaled solutions*: The capacity of the IUIH to leverage economies of scale through region-wide funds pooling, the creation of its own service ecosystem and enhanced purchasing power has delivered significant savings which are reinvested to support additional services and programs. Examples include:
  - the IUIH has established a large regional allied health and specialist workforce[3] 'pool' funded from multiple funding sources, centrally based, and regionally servicing SEQ through an outreach model to all 20 clinics. This has allowed unprecedented cost-effective and universal (free) client access to a comprehensive range of disciplines, otherwise not possible if managed independently by individual ACCHSs. It has also ensured consistent quality and cultural competency and reduced the number of resources otherwise required to interface IUIH clients with other providers
  - through the establishment of a regional logistics hub/warehouse, the IUIH has implemented an integrated supply-chain solution for all Network members and clinics, including the storage and distribution of clinical supplies/consumables and equipment. Bulk purchasing, capability for competitive price procurement and a fully automated stock inventory system are delivering significant cost savings and economies of scale (to be reinvested in supporting additional services)
  - the prorating of a portion of Queensland Health's mainstream dental program to the IUIH has led to increased integration and efficiency, where dental services can be delivered within IUIH clinics as part of a holistic system of client care

- *Driving quality improvement:* As the regional 'backbone' organisation, the IUIH plays a key role in leading the development of shared measurement systems, targets and trajectories as part of a monitoring and evaluation framework. The capacity of the IUIH to leverage concentrated expertise to provide regional ICT, CQI, data analytics and clinical governance services for its SEQ network members has delivered standardised systems and consistent quality improvement outcomes. This has supported embedding the *System of Care* throughout the network and ensured systematised accountability frameworks to monitor and benchmark National Key Performance Indicators (nKPIs), care cycle and Medicare targets. Combined, these enablers have produced nationally best practice results and demonstrated validated progress in closing the gap at a faster rate in SEQ.

While the construct and operation of this IUIH regional ecosystem are driving change, these changes have not always been matched by complementary and enabling government funding, program and policy parameters. Barriers of duplication, red tape and involvement of middlemen persist. Further, the government doesn't always understand the inter-dependencies within the created eco-system (which now include a complex mix of Indigenous-specific and non-Indigenous programs). These inter-dependencies have driven improved efficiency and effectiveness, but at the same time pose increased challenges and complexity for the existing funding arrangements to accommodate. The challenge for government, and the imperative for further systems reform (refer below), is to understand that integration of care is dependent on the integration of systems at the regional level.

For example, the IUIH is subcontracted to implement the Commonwealth Department of Health's Integrated Team Care -ITC (formerly CCSS) program on behalf of four PHNs[4]. This requires the IUIH to negotiate a separate contract with each PHN (four separate contracts in total). The IUIH's experience confirmed in a 2016 evaluation of the IUIH administered CCSS program (Pekarsky et al, 2016), is that channelling these funds through PHNs has *not* been administratively efficient, but rather has added cost and complexity to program implementation. The evaluation found that: *"the only substantive source of inefficiency was in relation to the margin retained by the Primary Health Network (PHNs) … (and) allocative efficiency would be improved if these funds were allocated to IUIH CCSS instead of retained as margins ….."* It was estimated that these PHN retained funds equated to an amount of $232,469 per annum, which could have provided care

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[3] 90 staff across 12 disciplines
[4] The IUIH Network covers Brisbane North, Brisbane South, Gold Coast and part of West Moreton Darling Downs PHNs

for an additional 33 clients per month. It was also estimated by the evaluators that the additional administrative costs to the IUIH in having to manage four separate contracts with the PHNs were in the order of $75,000 annually to manage. Further demonstrating the benefits of a regionally scaled solution, the evaluation identified that the estimated annual savings realised by the IUIH's regional model of bulk purchasing CCSS respiratory equipment and footwear were $178,395 and $164,305 respectively.

The challenges to bring coherence and efficiency to service delivery are exacerbated when applied across all the multiple funding arrangements. To support the IUIH effort, 55 different program contracts are required across 15 different agencies - all requiring specific contractual obligations and with their particular program constraints. The recent machinery of government changes has not assisted. For example, the portfolio de-coupling of substance use, social and emotional well-being and suicide prevention funding from the Department of Health to the Department of the Prime Minister and Cabinet is not consistent with an integrated and holistic approach to health and wellbeing. As noted above, the subsequent and additional appropriation of Indigenous-specific mental health, substance use and suicide prevention funding to PHNs only contributes to further fragmentation.

IUIH contends that there are multivarious examples of best practice which it can share through supported knowledge translation with other regions. It is also recommending that there be opportunities for the IUIH and others to trial transformational Indigenous-led regional funding and decision-making models – calibrated to each context – which is considered essential to further accelerate the improvements required to meaningfully progress the CTG Refresh agenda in SEQ and nationally.

Against the two COAG Close the Gap (CTG) health targets (life expectancy and child mortality), the IUIH is demonstrating national best practice improvements. For example, in contrast to national trends where the life expectancy gap is still widening, validated research that the Health Adjusted Life Expectancy (HALE) gap in SEQ is closing at a rate faster than predicted trajectories represents a national-first achievement and a major policy and service delivery breakthrough.

In addition, a significant contribution is being made in relation to meeting CTG employment targets, with a substantial increase in Indigenous employment across the IUIH Network. This reflects the interdependencies of health and employment and the benefits of a highly integrated regional model.
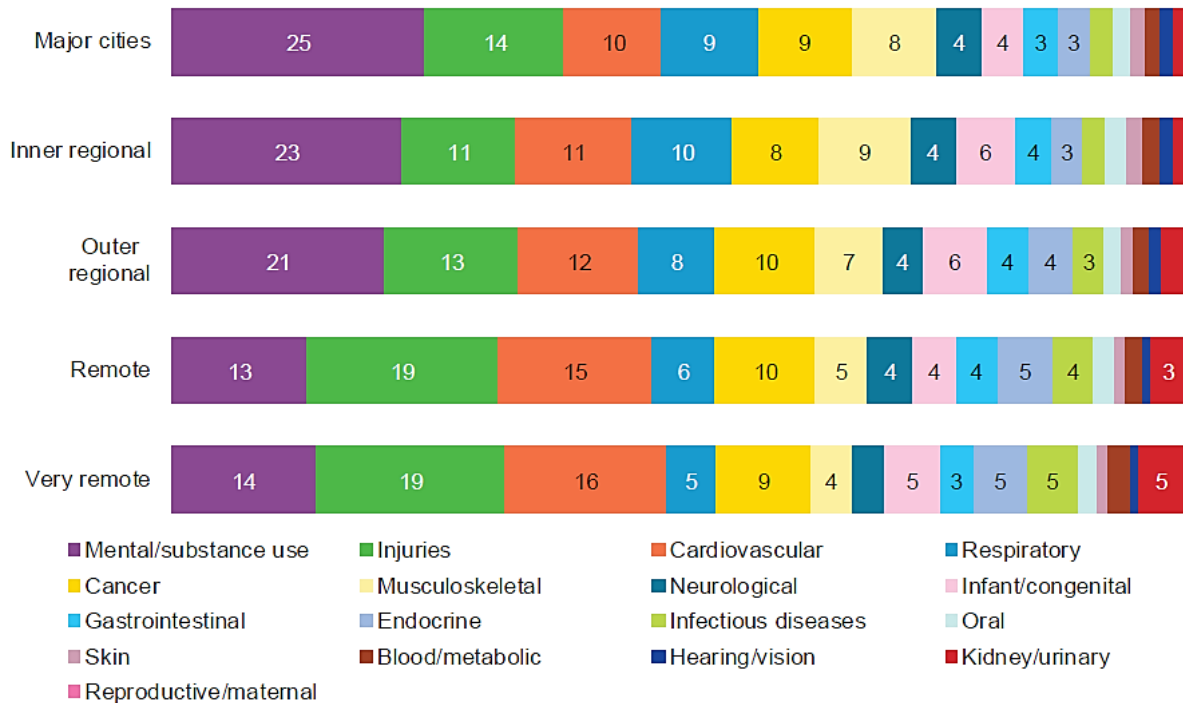
IUIH's Mental Health Services

- *The leading contributors to the burden of disease and injury amongst Queensland's Indigenous population varies by remoteness. Mental disorders contributed 28.8% to the Indigenous burden of disease in Queensland's Major Cities, 21.19% in Regional areas and 9.1% in Remote/Very Remote areas. In SEQ, mental disorders are the largest contributor to the Indigenous burden of disease, whereas cardiovascular disease is the leading contributor in Remote/Very Remote areas (QH, 2017).*

- *Suicide rates amongst Indigenous Queenslanders are more than double those of Queensland's non-Indigenous population and is listed as the second leading cause of death amongst Indigenous males (ABS, 2017)*

- *In Queensland, rates of juvenile detention and adult incarceration are 23.6 times and 10.6 times the non-Indigenous rates respectively (QH, 2016).*

Nationally, mental and substance use disorders were responsible for 19% of the total disease burden and 14% of the health gap experienced by Indigenous Australians in 2011, making it the disease group contributing most to the burden of disease and injury and the second largest contributor to the gap in total burden. It was also the leading cause of non-fatal burden, accounting for more than one-third (39%) of all YLD (AIHW, 2016). When looking at remoteness categories, mental disorders make up an even higher contribution to the Indigenous burden in urban

areas compared to remote areas. For example, <u>in Major Cities, mental disorders contribute to 25% of the total disease burden</u> (DALY)[5], almost double that in remote areas. Refer Figure 2.

FIGURE 2. Causes (%) of total Indigenous burden of disease (DALY), by disease group, remoteness, Indigenous Australians, 2011 (Source: AIHW Burden of Disease Report, 2016a)

Note: Per cent labels are not shown for disease groups contributing less than 3% of burden.

Source: This figure is based on data in a supplementary table available online—Table S12.2.4.

The IUIH Network delivers a range of mental health and substance misuse services specifically tailored for Aboriginal and Torres Strait Islander people. These include culturally and clinically capable individual and group therapy services, psychosocial support, prison transition, family wellbeing services, support services for homeless people within the CBD area, and social support services specifically targeted to Aboriginal and Torres Strait Islander people in South East Queensland. At IUIH, we refer to this collection of mental health and substance misuse services as Social Health Services.

Within Social Health IUIH employs psychologists, social workers, peer support workers known as Family Wellbeing Workers, health workers with mental health and AOD qualifications and a psychiatric registrar. These services are fully integrated into a comprehensive primary health care model which means that anyone receiving IUIH's Social Health services is exposed to and can access (depending on their specific needs) the full range of GP, allied health, dental and other services available through the IUIH Network of 21 clinics across the region. To our knowledge, no other organisation in South East Queensland (including Hospital and Health Services) is currently equipped to deliver such a comprehensive and integrated model of culturally capable primary mental health care.

IUIH places a strong emphasis on improving mental health outcomes for our Indigenous populations and believe we are well-placed to effectively deliver targeted Social Health services that are coordinated, culturally appropriate, Indigenous-led and integrated into primary health care. Our strong links with more than 70 local Indigenous and mainstream government and community providers of psychosocial support means that we can

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[5] Note that in SEQ, mental disorders contribute to up to 30% of the Indigenous disease burden

provide wrap-around care as well as strong clinical care. Our workforce of Community Liaison Officers assist in identifying and supporting community members not otherwise connected to our clinics, including some of the most marginalised and disconnected families. In addition, our workforce development programs provide training opportunities for those affected by mental health and substance use problems to gain qualifications and employment, thereby contributing to both health and employment outcome targets.

IUIH has long been concerned that the existing reliance on general population (mainstream) community-based mental health services, particularly in urban areas, does not adequately address the needs of Aboriginal and Torres Strait Islander people. IUIH believes strongly that the community controlled health sector has a strong role to play in leading provision of Indigenous community-based specialised mental health and AOD services, psychosocial support services and post-prison transition services, well beyond the Social and Emotional Wellbeing programs currently funded by the Australian Government. IUIH therefore strongly encourages the commission to re-think the commissioning and delivery of mental health services for Aboriginal and Torres Strait Islander people. In particular, IUIH urges the Commission to consider the benefits of establishing Aboriginal community controlled and community-based specialized mental health services, particularly in Major Cities (populations of more than 100,000 people).
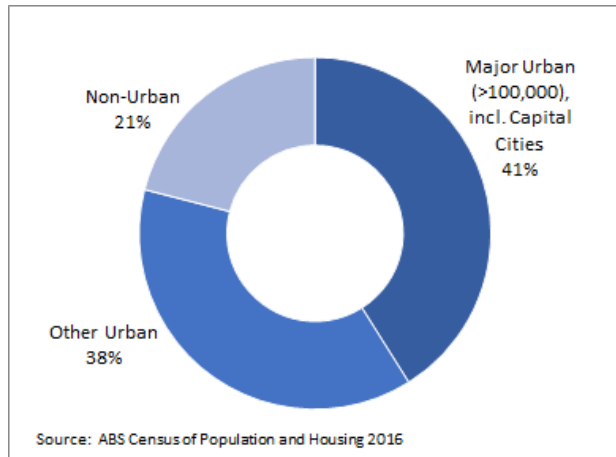
Urban Indigenous Populations

- *Nationally, 79% of Indigenous Australians live in urban areas with the largest cohort (41%) living in Major Cities (populations over 100,000 people) (ABS, 2016). The fastest growing Indigenous populations are in Major Cities.*

- *Nationally, 73% of the total Indigenous burden of disease and 74% of the total health gap is in urban areas (AIHW, 2016a)*

- *There is a 10.9 year life expectancy gap for Indigenous Queenslanders in urban areas. The Health-Adjusted Life Expectancy (HALE) gap is 1.5 times greater in SEQ (11.6 years) than in remote areas of Queensland (7.6 years). (QH, 2017)*

The Indigenous policy debate has often relied on a false dichotomy between remote/urban communities, where the argument is about who is in most need (Brand et al, 2016). To date, this has influenced government funding and program responses to the national CTG campaign, often resulting in an elevated emphasis on remote service delivery initiatives. There is, however, the need for a more nuanced approach if we are to better understand how to progress closing the gap in disadvantage for all Indigenous Australians.

It is true that remote Indigenous populations experience greater rates of disadvantage relative to urban Indigenous populations, against a majority of health and social indicators. However, due to the sheer size of the urban Indigenous population, it is important to recognise that the greatest numbers of disadvantaged Indigenous Australians (79%) live in cities and urban settings outside of remote communities. This is compounded by the very rapid Indigenous population growth in urban areas compared to remote areas. The consequence is that, alarmingly, the majority of the burden of disease (73%) and Indigenous health gap (74%) is in urban areas (AIHW, 2016a). There remains a 10.9-year Life Expectancy gap for urban Indigenous Australians (ABS, 2013).

The policy and funding implications of this are clear. If both the Government and the community do not give priority to, and invest in, these sizeable and fast-growing urban communities, efforts to close the gap will fail, and the gap will only widen (Brand et al, 2016). Given the continuing greater relative disadvantage of Indigenous Australians living in urban areas (compared to non-Indigenous people in urban areas), a policy position which assumes that access to mainstream services alone is sufficient to address the health needs of the urban Indigenous population is not supported by the evidence.   Proximity to health services has not translated into health equity.

FIGURE 3. Indigenous population, by urban, non-urban, Census count, Australia, 2016

Source: ABS Census of Population and Housing 2016

TABLE 1. Indigenous population, by Section of State, Census count, Australia 2016

	Urban Areas	Non- Urban Areas	Total
	%	%	No.
New South Wales	85.5	14.1	216 176
Victoria	86.8	12.6	47 788
Queensland	81.2	18.4	186 482
South Australia	80.7	18.5	34 184
Western Australia	72.6	26.6	75 978
Tasmania	72.3	27.5	23 572
Northern Territory	50.0	48.8	58 248
Australian Capital Territory	99.3	0.3	6 508
Australia	79.0	20.4	649 171

Source: ABS Census of Population and Housing, 2016

Nationally, the urban Indigenous population is growing faster than the numbers in remote areas and far outpaces the overall non-Indigenous urban population growth. This is one of the most striking demographic changes since Indigenous populations were first counted. For example, from 2011, the changes in the percentage of distribution of the Indigenous count for Major Cities increased by 2.6%. Conversely, there has been a decline in the percentage growth for Outer Regional (-1.5%), Remote (-1.0%) and Very Remote (-1.9%) areas (Markham and Biddle, 2017). Refer Table 2).

Significantly, the Indigenous population increased by the greatest amount are the Indigenous Regions[6] of Brisbane (17,467; 33% growth), the New South Wales Central and North Coast (17,456; 33% growth), and Sydney – Wollongong (13,842; 27% growth). Almost half (49%) the growth of the national Indigenous population occurred in just these three Regions.

TABLE 2. Indigenous and non-Indigenous population count distributions by geographical remoteness, 2016 (Source: Markham and Biddle, 2017

Remoteness	Indigenous population count	Percentage of Indigenous count	Change in percentage of Indigenous count, 2011–16	Non-Indigenous population count	Percentage of non-Indigenous count	Change in percentage of non-Indigenous count, 2011–16
Major cities	235 527	36.8	2.6	15 409 691	72.3	1.3
Inner regional	154 087	24.1	1.7	3 858 090	18.1	−0.5
Outer regional	130 976	20.5	−1.5	1 738 227	8.2	−0.6
Remote	40 689	6.4	−1.0	224 485	1.1	−0.1
Very remote	79 041	12.3	−1.9	90 897	0.4	−0.1

Note: Not stated population excluded. Calculated on the basis of 2011 remoteness boundaries, using an area-based 2016 to 2011 Statistical Area 1–level concordance.

[6] Indigenous Regions are part of the Indigenous Structure of the Australian Statistical Geography Standard used by the ABS. There are 37 Indigenous Regions in Australia (largely reflecting previous ATSIC boundaries).

At the other end of the spectrum, several remote Indigenous Regions experienced a decline in the number of people counted as Indigenous in the 2016 Census. Figure 4 maps all Indigenous Regions, reflecting the absolute growth/decline from 2011 to 2016.

FIGURE 4. Change (from 2011) in the number of Indigenous people counted in the 2016 Census, by Indigenous Region (Source: Markham and Biddle, 2017)

Burden of disease

It is important to note that while remote Indigenous populations generally experience greater rates of disadvantage relative to urban Indigenous populations, the bulk of the total national burden of disease (73%) [7] for Indigenous people is in non-remote areas (AIHW, 2016). The burden of disease is measured in Disability Adjusted Life Years (DALYs). Table 3 refers. This is also reflected in the Queensland context, where 76% of the total Indigenous burden of disease in Queensland is in urban areas (Queensland Health, 2017).

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[7] Measured in total number of Disability Adjusted Life Years (DALYs), which equals YLL (Years Life Lost) plus YLD (Years Lived with Disability). Note: Urban areas include: Major City, Inner Regional and Outer Regional.

TABLE 3. Number and proportion of population and total burden (DALY), by remoteness, Indigenous Australians, 2011 (Source: AIHW Burden of Disease Report, 2016a)
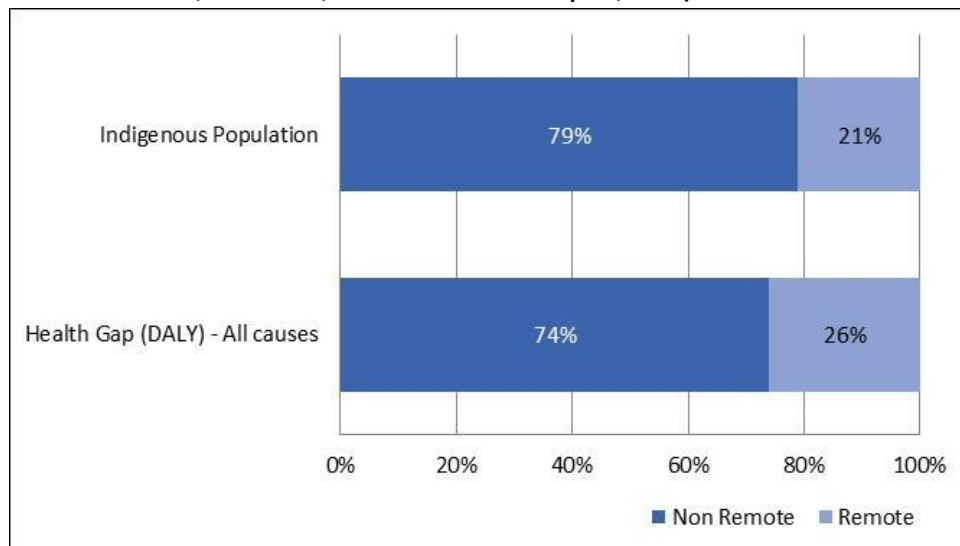
	Major cities	Inner regional	Outer regional	Remote	Very remote	Total[a]
Indigenous population (no.)	233,146	147,683	146,129	51,275	91,648	669,881
Indigenous population %	34.8	22.0	21.8	7.7	13.7	100.0
DALY no.	56,512	34,037	40,491	19,284	29,418	179,743
DALY %	31.4	18.9	22.5	10.7	16.4	100.0
YLD no.	31,855	19,302	19,585	7,682	10,996	89,420
YLD %	35.6	21.6	21.9	8.6	12.3	100.0
YLL no.	24,657	14,735	20,907	11,602	18,423	90,324
YLL %	27.3	16.3	23.1	12.8	20.4	100.0

(a)   Totals exclude records with unknown/missing remoteness classification.

Note: The numbers may not add to total for all columns due to rounding.
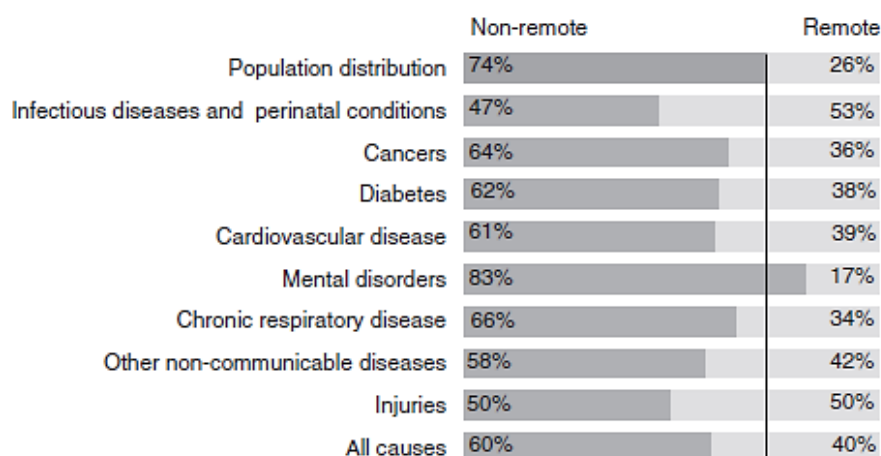
The latest AIHW Burden of Disease Report (AIHW, 2016a) confirms earlier work by Vos et al (2009) which demonstrated that, for all disease causes, the majority of the DALY health gap was in non-remote areas. In the VOS et al study (based on 2003 data), 60% of the DALY health gap was in non-remote areas, also accounting for the bulk of the gap in chronic respiratory disorders (66%), cancers (64%), diabetes (62%), and cardiovascular disease (61%), and overrepresented in mental disorders (83%). In the latest AIHW Report (AIHW, 2016a), based on 2011 data, the percentage of the Indigenous DALY health gap in non-remote areas has increased to 74%, in line with an increased Indigenous population in non-remote areas as noted earlier. Figures 5 and 6 refer.

FIGURE 5. Distribution of health gap (measured in DALYs), all causes, by remoteness, Indigenous Australians, 2011 (Source: ABS Census 2016; and AIHW, Burden of Disease Report, 2016)

FIGURE 6. Distribution of Health Gap (measured in DALYs) by remoteness and cause, Indigenous Australians, 2003 (Source: Vos et al, 2009)

	Non-remote	Remote
Population distribution	74%	26%
Infectious diseases and perinatal conditions	47%	53%
Cancers	64%	36%
Diabetes	62%	38%
Cardiovascular disease	61%	39%
Mental disorders	83%	17%
Chronic respiratory disease	66%	34%
Other non-communicable diseases	58%	42%
Injuries	50%	50%
All causes	60%	40%

The Life Expectancy gap is one of the current CTG targets (closing the life expectancy gap by 2031). The Prime Minister's 2019 CTG Report highlighted that this target is not on track to be met (Commonwealth of Australia, 2019). The latest ABS data[8] for Life Expectancy highlights the shows that urban Indigenous Australians are just as disadvantaged as non-urban Indigenous Australians (refer Table 4):

- There is little difference in life expectancy for Indigenous Australians in both urban and non-urban areas;
- The average (across male and female) Life Expectancy gap between Indigenous and non-Indigenous Australians in urban areas (10.9) is actually slightly higher than between Indigenous and non-Indigenous in non-urban areas (10.7).

TABLE 4. Life expectancy at birth, by sex, and remoteness areas (2010-2102). (Source: ABS, 2013)

Remoteness areas	Indigenous		Non-Indigenous		Difference (years)	
	Males	Females	Males	Females	Males	Females
Major cities and inner regional combined	68.0	73.1	79.9	83.0	11.9	9.9
Outer regional, remote and very remote combined	67.3	72.3	78.5	82.5	11.2	10.2

HALE is a preferred measure to Life Expectancy because HALE extends the concept of life expectancy by also considering the time spent living with disease and injury. It reflects the length of time an individual can, on average, expect to live in full health. This provides a better understanding of whether people are spending more years in good health or more years living with illness. The IUIH contends that reducing premature mortality is not enough if people are going to live longer but in states of ill health and disability and encourages COAG to consider replacing the current Life Expectancy target with a HALE target. At present the crude measure of life expectancy does not highlight or provide capacity for targeted measurement of the significant disease burden and health gap which Indigenous Australians are experiencing through disease and ill health (2.3 that of non-Indigenous Australians). The non-fatal component of the Indigenous burden of disease, for example, represents approximately half (47.1%) of the total disease burden. For particular diseases, it is of course much higher. Mental disorders, hearing and dental conditions are examples of conditions that are not being systematically measured under current close the gap targets because of their low contribution to mortality. Yet the impact of these conditions can be quality of life, education and employment outcomes.

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[8] Latest data references 2010-2012. Next Life Expectancy data will be released by the ABS in November 2018.

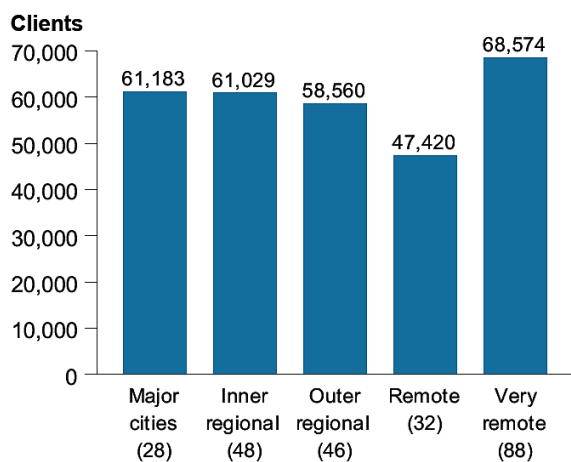## Urban Indigenous access to health services

- *Only 26% of the Indigenous population resident in a major city is accessing an ACCHS, compared to 97% in remote areas, and 46% nationally (across all remoteness categories) (AIHW, 2017)*

- *There are 174,000 Indigenous Australians in major cities who are not currently accessing comprehensive primary health care in a culturally appropriate ACCHS setting (AIHW, 2017).*

- *The 2014-15 Aboriginal and Torres Strait Islander Social Survey also reported that Indigenous people with a mental disorder were more likely to have experienced problems accessing health services (23%) than were people with other long-term health condtions (13%) or no long-term health condition (10%)*

- *Indigenous people have lower than expected access to mental health services and professionals. In 2012-13, the most common CTG service deficits reported by ACCHSs related to mental health and SEWB services (Department of Health, 2017a).*

- *Per capita Commonwealth Department of Health Indigenous health expenditure is significantly less in urban areas thn in remote areas (AIHW, 2017). Per-person Commonwealth Department of Health grant funding allocated to ACCHSs in remote areas is 3.7 times that allocated to ACCHSs in major cities.*

The inadequacy of mainstream services and inequitable access lie at the heart of Indigenous health disadvantage (Brand et al, 2016b). In particular, access to culturally appropriate and comprehensive primary health care in urban environments is challenging for urban Indigenous Australians. These challenges can be further understood through looking at:

- the availability of and access to ACCHSs;
- the broader barriers to mainstream health access in an urban setting;
- the broader urban experience; and
- social and economic determinants.

Ready access to comprehensive and culturally safe health care from an ACCHS is considered best practice in terms of optimising the health benefits for clients, including to close the gap in health disadvantage. The burden of disease data presented above has highlighted that reliance on access to mainstream services is not resulting in better health outcomes for urban Indigenous people. The AIHW (2017a) reports the number of regular Indigenous clients accessing ACCHSs in 2015 was 274,848. The spread of this client population by remoteness category is reflected in Figure 7.
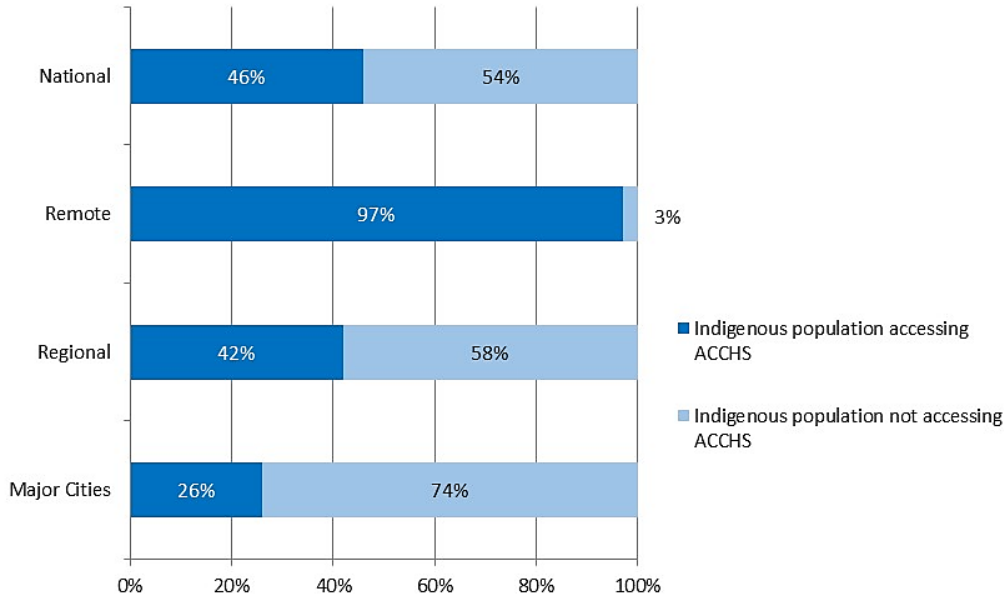
FIGURE 7. Regular Indigenous clients accessing ACCHSs by remoteness, Australia, 2015 (Source: AIHW National Key Performance Indicators Report, 2017a)

Note: Number of organisations is in brackets.

Compared to ACCHSs in remote areas reaching 97% of their potential Indigenous population, ACCHSs in major cities are only reaching 26% of Indigenous people living in major cities. This means that <u>there are over 174,000 Indigenous Australians in major cities who are not currently accessing comprehensive primary health care in a culturally appropriate ACCHS setting</u>. This represents 27% of the entire Australian Indigenous population. Refer Figure 8.

FIGURE 8. Regular Indigenous clients accessing ACCHSs as a percentage of population, by remoteness, Australia, 2015 (Source: AIHW National Key Indicators Report, 2017a)

When looking at the distribution of the 138 ACCHSs[9] across Australia, a similar picture emerges in relation to the relative lack of ACCHSs in urban areas relative to the Indigenous population. While there is a need for an additional number of ACCHSs in remote settings (due to population dispersal etc.), there nevertheless is a significant lack of current ACCHS capacity to support the urban Indigenous population. Refer Table 5.

TABLE 5. Distribution of ACCHSs compared to Indigenous population, by remoteness, Australia, 2015

	Indig Pop	% Pop	No. of ACCHS	% of ACCHS	Rate of ACCHS per 1000 (Indig Pop)
Major city	235,527	37%	16	12%	0.07
Inner Regional	154,087	24%	34	25%	0.22
Outer regional	130,976	20%	36	26%	0.28
Remote	40,689	6%	20	14%	0.50
Very Remote	79,041	12%	32	23%	0.41
Total	**640,320**	**100%**	**138**	**100%**	**0.22**
Source: AIHW National nKPI Report, 2017; ABS 2016 Census					

The AIHW (2015) has undertaken some spatial analysis of service gaps and identified 40 SA2 areas where there was no Indigenous-specific primary health care service within one hours drive and with poor access to GP services in general. Many of these areas are in Remote and Very remote areas of Queensland and Western Australia. The total Indigenous population of these identified gap areas was 24,240 with 20 of the identified sites having an Indigenous population fewer than 600 people.
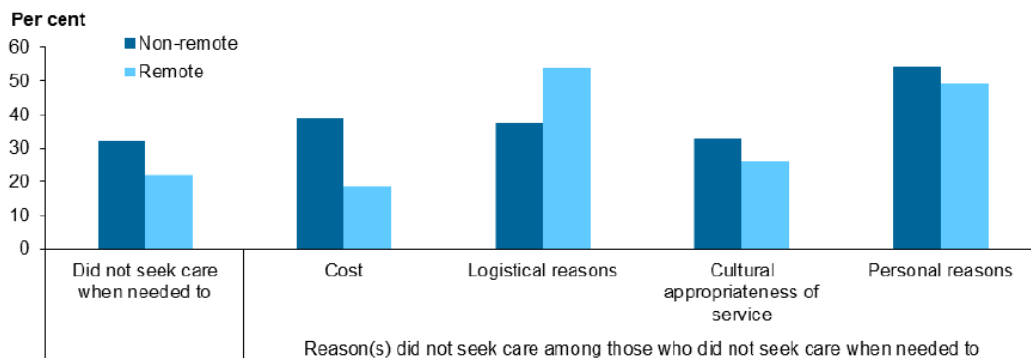
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[9] This data does not take into account any satellite or outreach locations

The National Aboriginal Community Controlled Health Organisation (NACCHO 2018) made reference to this report in its 2018 Pre-Budget submission, recommending the establishment of 10 new ACCHSs in the AIHW identified gap areas where the Indigenous population was greater than 600. The NACCHO also highlighted, however, that policies and funding appropriations which are not impacting on the greatest number of Indigenous people and burden of disease will not deliver progress to close the gap (NACCHO, 2018). In this context, it has advocated for funding for expanded satellite clinics in areas of high population and need.

Given the burden of disease and significant health gaps and lack of access in urban areas as outlined in this paper, and the success of IUIH's regional service system, the IUIH contends that the establishment of satellite clinics in identified gap areas is critical if progress to closing the gap is to be achieved.

Compounding the lack of sufficient ACCHS clinics to provide adequate accessibility for urban Indigenous Australians, are the additional barriers they face in accessing alternate mainstream services. The 2012/13 National Aboriginal and Torres Strait Islander Health Survey as reported in the Aboriginal and Torres Strait Islander Health Performance Framework 2017 (AHMAC, 2017; AIHW, 2018) identified that Indigenous Australians living in non-remote areas were more likely to report not seeking care when needed compared to those living in remote areas (32% compared to 22%). This differential was experienced across all healthcare types, including GPs, dentists, counsellors, hospitals and other health professionals. Reasons for not seeking care included cost, cultural appropriateness wait times and lack of transport (refer Figure 9).

FIGURE 9. Proportion of Indigenous Australians who did not access health services when needed, and why, by remoteness, 2020-13 (Source: AIHW, 2018)

Many Indigenous people continue to experience high levels of exclusion, victimisation, discrimination and racism at personal, societal and institutional levels. Racism continues to have a significant impact on Aboriginal and Torres Strait Islander people's decisions about when and why they seek health services and their acceptance of and adherence to treatment.

In the recent *My Life My Lead* consultation report to refresh the Implementation Plan of the National Aboriginal and Torres Strait Islander Health Plan 2013-2023, it was acknowledged that systemic racism and a lack of cultural capability, cultural safety and cultural security remained barriers to health system access. It was further acknowledged that racism makes people sick and that constructive action to address its causes and effects will have significant positive impacts on health and broader life outcomes (Department of Health, 2017b).

In the 2014–15 Aboriginal and Torres Strait Islander Social Survey (as reported in AHMAC, 2017), one-third (33%) of Aboriginal and Torres Strait Islander people aged 15 years and over felt that they had been treated unfairly at least once in the previous 12 months, because they were of Aboriginal or Torres Strait Islander origin. Indigenous people in non-

remote areas were more likely than those in remote areas to feel that they had been treated unfairly in the last 12 months (35% compared with 28%). Indigenous people in non-remote areas further reported that in the last 12 months their GP or specialist did not always show them respect (15%), listen carefully to them (20%) or spend enough time with them (21%) (AHMAC, 2017). This is likely due to the fact that in remote areas models of care (even those delivered by mainstream organisations) are more likely to be tailored towards Indigenous people unlike urban areas, where Indigenous Australians are more likely to comprise a small minority of a mainstream service's client base.

The additional challenges faced by urban Indigenous people through unfair treatment, and related barriers to access, are not assisted in the context of a policy framework which relies on a mainstream response to meeting need.

The Urban Experience

Urban Indigenous people experience considerable health disadvantage relative to their non-Aboriginal counterparts and may experience particular challenges relating to dislocation, racism and disempowerment (Eades et al, 2010).

Brand et al (2016a) argue that the paradox of urbanisation is that, despite the positive opportunities which urban areas may present, Indigenous people in urban areas face particular and additional challenges, including limited access to services, discrimination, generalised language loss and cultural identity deterioration, as well as poor health and low socioeconomic outcomes.

Brand et al (2016a) further report that there are trends of both isolation and segregation in urban Indigenous communities. In some cases, Indigenous enclaves exist in urban centres. In others, Indigenous communities are less geographically distinguishable, and identifying their needs is challenged by 'Indigenous invisibility'. To the outsider, the perceived lack of homogeneity, coupled with a geographical dispersion of Indigenous populations, reinforces the idea of Indigenous invisibility and ignores the strong family and kinship ties that characterise Indigenous communities in urban areas.

In relation to housing, the Indigenous population in urban areas often has a greater disadvantage in terms of affordability and habitability. Urban Indigenous people are often priced out of the market, and more likely to live on the urban fringe, impacting on mobility and access to services. The distribution of the urban Indigenous population in these high population density outer suburban areas perpetuates social disadvantage. The urban fringe is characteristically disadvantaged in terms of social and physical infrastructure, 'transport poverty', social exclusion and lower rates of labour force participation.

Indigenous experience of urbanisation has sometimes been described as an experience of loss. Many Indigenous groups experience the loss of relationship to communities of origin, resulting in the break of transmission of culture, language and history. While strong cultural resilience and resurgence are evident in some urban Indigenous populations, stress and other mental health issues are significantly more prevalent in urban populations (as discussed above) and present an ongoing additional barrier to accessing services, including health care.
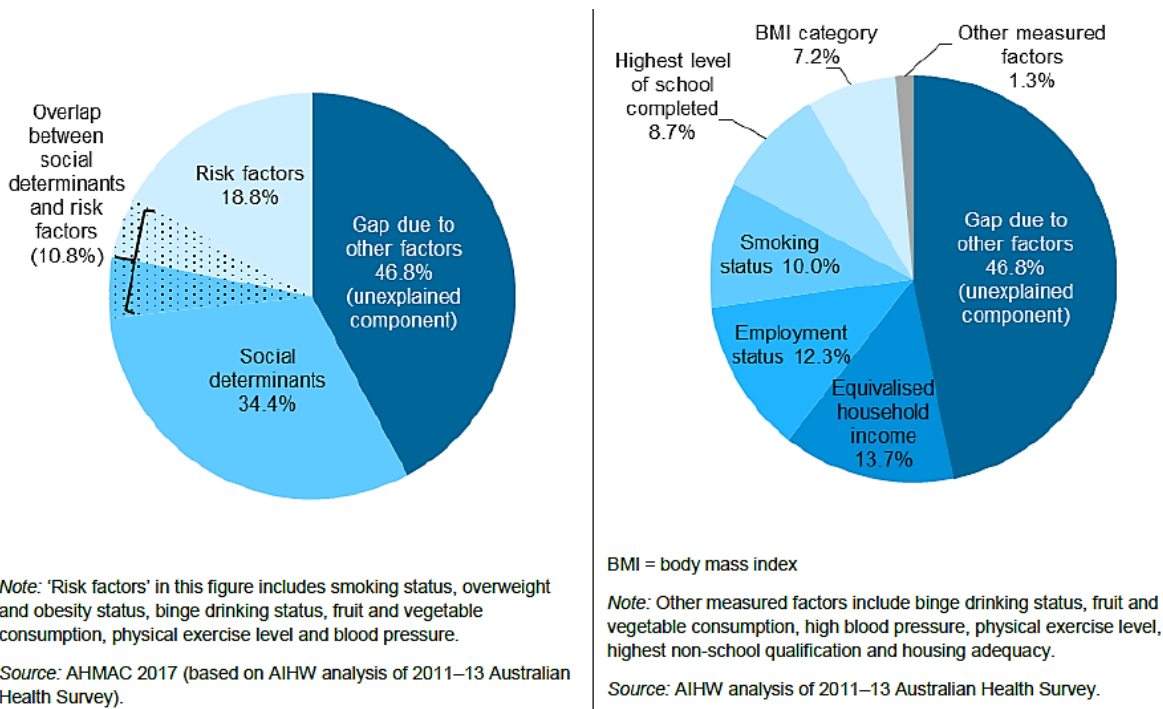
Social and Economic Determinants

In recent years, the importance of social and economic factors in determining health outcomes has been increasingly recognised. An AIHW analysis of the 2011–13 Australian Health Survey has found that selected social and economic determinants, such as education, employment status, overcrowding and household income, accounted for around one-third (34%) of the gap in health outcomes between Indigenous and non-Indigenous adults aged 15 to 64. In contrast, health risk factors, including smoking, obesity, alcohol use and diet, accounted for only 19% of the health gap (AIHW 2018).

The AIHW analysis (2018) further reported that the individual variable making the largest contribution to the explained component of the health gap was household income. This variable contributed almost 14% of the overall health gap (and around 26% of the explained component of the health gap). Other significant variables were employment status and

school education, which on their own, explained another 12.3% and 8.7%, respectively, of the overall health gap. Refer Figure 10.

FIGURE 10. Proportion of the health gap between Indigenous and non-Indigenous Australians explained by differences in social determinants and risk factors. (Source: AIHW, 2018)

Note: 'Risk factors' in this figure includes smoking status, overweight and obesity status, binge drinking status, fruit and vegetable consumption, physical exercise level and blood pressure.

Source: AHMAC 2017 (based on AIHW analysis of 2011–13 Australian Health Survey).

BMI = body mass index

Note: Other measured factors include binge drinking status, fruit and vegetable consumption, high blood pressure, physical exercise level, highest non-school qualification and housing adequacy.

Source: AIHW analysis of 2011–13 Australian Health Survey.

One way to understand the contributions of income, employment and education to the health gap in terms of the population distribution of Indigenous Australians, is to use the ABS Index of Relative Socio-Economic Advantage and Disadvantage (IRSAD)[10]. The IRSAD is a continuum of disadvantage to advantage for specified geographic areas. It is based on variables relating to a range of factors, such as income, employment, education, occupation, internet connection, housing, family structure, marital status and disability. Using ABS 2016 data ranked by the IRSAD at the SA2 level, a case study of the major urban area of SEQ revealed that 20% of the urban Indigenous population lived in the most disadvantaged decile (bottom 10%) and almost half (49%) lived in the four bottom deciles[11]. This profile clearly demonstrates the significant socio-economic disadvantage persisting for urban Indigenous Australians and the negative impact this has on health outcomes.

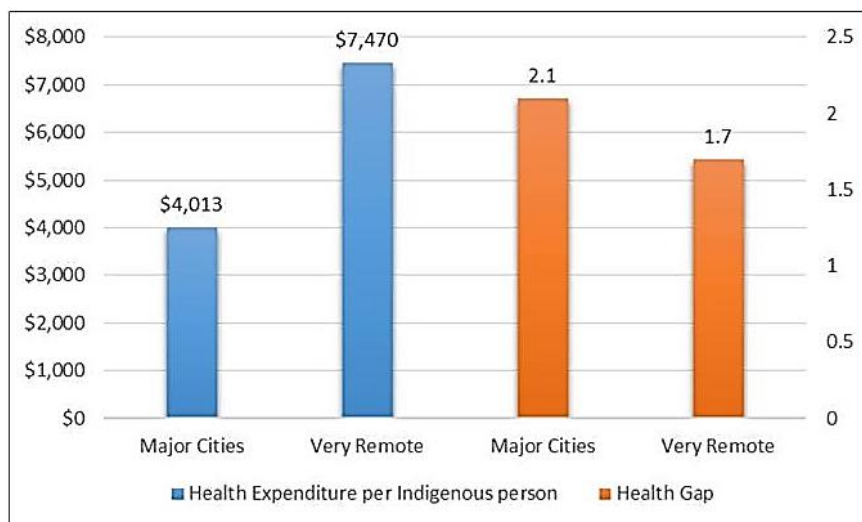## Urban Indigenous Health Expenditure

The Aboriginal and Torres Strait Islander Health Performance Report (AIHW, 2017) details health expenditure data for services and programs accessed by Indigenous people. On a per person basis, average health expenditure for Aboriginal and Torres Strait Islander people in 2013–14 was estimated to be $8,515, which was $1.38 for every $1.00 spent per non-Indigenous Australian (AHMAC, 2017). This rate of expenditure (1.38 times more expenditure for Indigenous people) contrasts with the health gap (which is still 2.3 times worse for Indigenous people). There has been strong advocacy by the NACCHO and the community controlled sector to increase health expenditure to match the health disparity.

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[10] The IRSAD is one of four indices which form part of the ABS Socio-economic Indexes for Areas (SEIFA), which ranks areas in Australia according to relative socio-economic advantage and disadvantage.
[11] Discussed further in Section 5.2

The Health Performance Framework Report further details national expenditure for a subset of main health programs[12]. In 2013–14, Indigenous health expenditures for these programs were an estimated $4,386 per person overall, $7,470 per person in remote/very remote areas, $4,033 per person in outer/ inner regional areas and $4,013 per person in major cities (refer Figure 11). This corroborates the IUIH's contention that the under-funding of ACCHSs in many urban locations is significantly impeding access to comprehensive primary health care for urban Indigenous people.
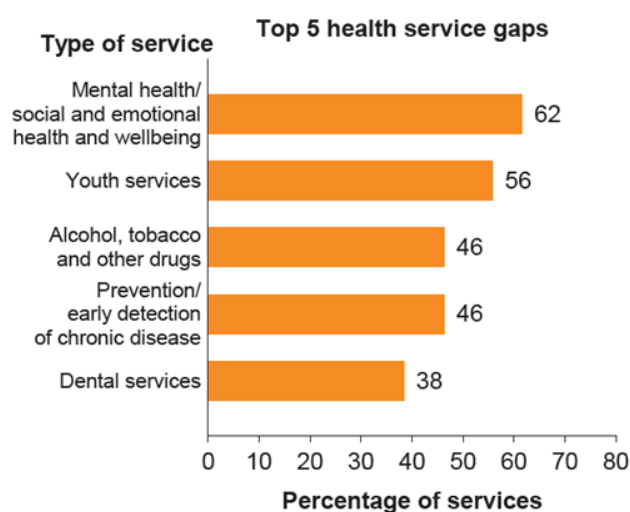
FIGURE 11. Health expenditure per person on selected health services (2013-14) referenced to health gap (2011), by remoteness, Indigenous Australians. (Source: AHMAC, 2017)

Indigenous access to mental health services

Indigenous people have lower than expected access to mental health services and professionals. In 2012–2013, the most common Closing the Gap service deficits reported by ACCHSs related to mental health and social and emotional wellbeing services (Department of Health, 2017a). Refer Figure 12.

FIGURE 12. Top 5 service gaps identified by ACCHS. (Source: AIHW, Healthy Futures 2016b)

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[12] Includes public and private hospital admissions, MBS, PBS, DOH Grant funding to ACCHSs

Most Aboriginal and Torres Strait Islander people want to be able to access services where the best possible mental health and social and emotional wellbeing strategies are integrated into a culturally capable model of health care. This approach needs an appropriate balance of clinical and culturally informed mental health system responses, including access to traditional and cultural healing.

Aboriginal and Torres Strait Islander people embrace a holistic concept of health, which inextricably links mental and physical health within a broader concept of social and emotional wellbeing. A whole-of-life view, social and emotional wellbeing recognises the interconnectedness of physical wellbeing with spiritual and cultural factors, especially a fundamental connection to the land, community and traditions, as vital to maintaining a person's wellbeing (Department of Health, 2017a).

Mental health service access challenges were again highlighted in the recent *My Life My Lead* consultations undertaken by the Commonwealth Department of Health (2017). The consultation report reiterated the importance of culturally valid understandings in shaping the provision of services and guiding the assessment, care and management of mental disorders for Indigenous people. The report identified inpatient and specialist services as often the least culturally safe for Indigenous people accessing mental health care. Fear of accessing inpatient services is often compounded by people having a lack of support due to dislocation from family and country.

The impact of intergenerational trauma and social and economic disadvantage at individual, family and community levels also continues to challenge the mental and physical health and wellbeing of Aboriginal and Torres Strait Islander people, who can present to mental health services with a complex and interrelated mix of problems. Indeed, IUIH contends that a significant proportion of mental health and well-being issues impacting Aboriginal and Torres Strait Islander people will be at least in large part alleviated if not resolved by addressing their determinants/drivers. Improving cultural and social connection, reducing financial stress, building esteem and purpose through education and employment, enacting rights through direct access to legal services are essential prerequisites for good mental health and well-being services.

To meet these needs in the culturally and holistic way described, Aboriginal and Torres Strait Islander leadership, including ACCHSs, must have an integral role in the design and delivery of an appropriately responsive mental health and well-being service system for Indigenous Australians. Indeed, large regional ACCHSs such as IUIH can, and are, supporting families to access programs and services which address these determinants of mental health either through direct provision of programs or by walking with families being referred to other providers.

Unfortunately, the current mental health funding framework is not conducive to best supporting this principle. Where mental health, social and emotional well-being and substance use funding should be given to directly to ACCHSs to ensure that comprehensive and integrated care models can be efficiently delivered, an entirely inefficient and fragmented program arrangement is in place. Following the previous machinery of government changes, mental health, social and emotional well-being, suicide prevention and substance use responsibilities and funding are now split between the Department of Health and the Department of the Prime Minister and Cabinet. Further, specific mental health appropriations for Indigenous people is directed through Primary Health Networks (PHNs) to commission, which adds an inefficient additional layer of administration at best, and at worst, the risk of additional service fragmentation through PHN 'market driven' procurement practices. The administrative inefficiency of this fragmentation impacts heavily on funded organisations through the impost of an extreme burden of reporting. For example, even coming from one department, there may be multiple streams with different labels that require separate reporting, often by provider, or by service-specific type. While an ACCHS, such as IUIH, will make significant effort to cobble together various sources of funding in order to deliver an integrated and seamless service for clients, the effort needed to dis-integrate data to meet often unhelpful / uninformative reporting requirements, really is a serious issues that taxes stretched resources that could otherwise be spent attending to clients.

Aboriginal and Torres Strait Islander people in urban areas would benefit greatly from the establishment of Indigenous-led, community controlled specialised mental health services. The state-run Statewide Specialist Aboriginal Mental Health Service (SSAMHS) operating in Perth and the Kimberley is an Indigenous-led, but not community controlled, model of mental health service provision, which utilises partnerships with mainstream general practice. Although a preferred

model would be one where an ACCHS manages the service, utilising partnerships with state-run mainstream mental health services and private specialists, the SSAMHS model provides valuable insight into replicating a targeted Indigenous mental health services in other major cities.

Recommendation: Addressing Indigenous Mental Health Needs to Close the Gap

Acknowledging:

− Mental disorders are the national leading contributor to the Indigenous burden of disease (19% of the total disease burden), with its contribution even greater in urban regions (25%)
− Commissioning for mental health services routinely applies a one-size-fits-all approach to mental health service provision despite the fact that evidence clearly shows that mental health needs are best supported in the context of holistic and culturally safe health care
− Current fragmented responsibilities across government agencies and mainstream commissioning arrangements are not conducive to community-led solutions for best practice care.

That the government commit to giving priority to:

− Consolidating Indigenous mental health, suicide prevention, social and emotional wellbeing and substance use funding back under the Commonwealth Department of Health to support preferred service delivery through ACCHSs and more effective partnerships with the mainstream service sector
− Commissioning Indigenous mental health services through regional ACCHSs
− Recognising ACCHSs as the preferred provider of Indigenous-specific community-based mental health and AOD services, suicide prevention initiatives and post-prison transition care services.
− Funding the establishment of Aboriginal community controlled and community-based specialist mental health services in Major Cities through partnership with the mainstream mental health service system
− Adding appropriate mental health Closing the Gap targets, supported by appropriate prevalence monitoring and adequate funding to address need.

Indigenous access to the National Disability Insurance Scheme

The IUIH's strategic priority to deliver a broader range of social health programs includes a focus on the NDIS rollout to ensure that the design and implementation of this scheme supports Indigenous people having culturally appropriate access to services – particularly in relation to the SEQ region.

The NDIS represents a complex and disruptive change to the long-established Commonwealth-State/Territory responsibilities for disability services. Importantly, the NDIS has been designed to transfer choice and control to disabled persons for customising and personalising their annual Service Plans to reflect their own goals. This radically changes the traditional relationships with disability service providers who previously managed block-funded grants.

The potential for this model to support more tailored and empowered decision making regarding care arrangements for Indigenous clients, is, however at risk.

The IUIH has significant concerns regarding:
• The NDIS investment strategy
• The NDIS engagement strategy

NDIS investment strategy

The National Disability Insurance Authority (NDIA) has allocated what it calls *Service Area Participant Volumes* on a regional basis. However, because these participant numbers do not reference or set targets for Indigenous people, there

is a serious risk that the needs of the most disabled and disadvantaged cohort of the NDIS client population will not be adequately met.

Indigenous people have higher rates of disability compared to non-Indigenous people in every age cohort. When applying these rates to the IUIH Network footprint, it is estimated that there are at least 4,225 Indigenous people[13] with profound or severe disability in SEQ (ABS, 2016).

The high proportional levels of these estimated NDIS participant volumes are consistent with the Indigenous demographic profiles already detailed in this paper, where SEQ has the largest and fastest growing Indigenous population in Australia. In addition, the current NDIS numbers are expected to exponentially increase in line with the projected rapid Indigenous population growth to 2031.

It is imperative that investment and resource allocation methodologies are in place and ensure equitable NDIS access by this large and high-need urban Indigenous population in SEQ.

The IUIH recommends the implementation of a targeted investment strategy which incorporates mandatory Indigenous number or percentage targets commensurate with the estimated Indigenous NDIS participant rate and level of need.

NDIS Engagement Strategy

The NDIS Engagement Strategy (NDIA 2017) includes the principle of a 'community by community' approach:

> *"Underpinning effective engagement is the recognition that the NDIA's community by community approach will involve building community capability and capacity to develop local solutions and a deliberate focus on options to grow the number of Indigenous registered providers of support".*

Notwithstanding this principle, the NDIA Engagement Strategy, confusingly, also places an equal emphasis on mainstream services which it argues are as important as support and services delivered by specialist disability services. This is advocated despite an acknowledgment that the NDIS runs a risk of creating access barriers to Indigenous people with disabilities, as has occurred in the implementation of previous mainstream disability service initiatives.

This ambivalent mainstreaming strategy is similar to that discussed earlier in relation to health programs for urban Indigenous people, and clearly at odds with best practice community-controlled service responses. The Indigenous engagement and participation strategies outlined in the current NDIS framework has not been developed on evidence-based policies which would ensure that the NDIS, along with all other service areas, must have Indigenous-led arrangements to ensure culturally appropriate access and holistic support is provided for Indigenous clients.

Representations have been made by the IUIH to the NDIA to address these concerns and seek engagement in, and co-design of, NDIS implementation. Suggested design enhancements have included:

- Redress of the functional and siloed constraints inherent in the current NDIS model, including in relation to Local Area Coordination (LAC) services, Early Childhood Early Intervention (ECEI) services, Registered Providers of Supports (RPoS) and Integration Linkage and Coordination (ILC) services;
- Acknowledgement that Indigenous community-controlled organisations are best placed to engage with Indigenous clients to navigate these barriers – and specifically to generate functional impact Access Request Forms, develop client service plans for the next 12 months ('Plan Build"), and submit these to the NDIA Planner; and
- Reconstruction of the NDIS model to allow active engagement by Indigenous organisations in the above process, including contracting Indigenous organisation on a preferred provider basis to undertake these functions.

In response, the NDIA has acknowledged that the mainstream NDIS system architecture is flawed and has funded IUIH to conduct a Pilot of National Significance in SEQ. This pilot completely departs from the current mainstream approach and includes replacing LACs with IUIH Indigenous staff who support Indigenous clients in all aspects of the NDIS eligibility

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[13] This is most likely an undercount

application and plan building processes. IUIH welcomes the NDIA's willingness to consider alternative approaches to enhance access by Indigenous Australians to the NDIS, noting the following recommendation of the recent Tune Report review of the NDIS ACT 2013 (Tune, 2019):

> ***Recommendation 10:*** *The NDIA develops a comprehensive national outreach strategy for*
> *engaging with people with disability who are unaware of, or are reluctant to seek support*
> *from the NDIS, with a dedicated focus on Aboriginal and Torres Strait Islander peoples,*
> *culturally and linguistically diverse communities, and people with psychosocial disability.*

NDIS Disability Profile, SEQ

NDIA actuaries have provided data on the primary disability types experienced by Aboriginal and Torres Strait Islander NDIS participants with an approved NDIS Plan. In SEQ, these are, in order of ranking:

- 29.5% of Participants have "autism";
- 20% have "Intellectual disability";
- 8.7% have "Pyschosocial Disability";
- 5.6% have "Cerebral Palsy";
- 5.5% have "Other Physical"; and
- 5.3% have "Other Neurological" as their primary disability.

These 6 types account for almost 75% of all Participant primary disabilities.

IUIH has long recognised the importance of embedding perinatal psychology (and other allied health such as paediatric occupational therapy) services into its early childhood health and education services, including in its Birthing in Our Community and Mums and Bubs Program.

References

ABS 2013 (Australian Bureau of Statistics). 2013 Life expectancy at birth of Aboriginal and Torres Strait Islander Australians. (Cat No. 3302.0.55.003), Canberra, Australia: Author. Retrieved from http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/A80BD411719A0DEECA257C230011C6D8?opendocument

ABS 2016 (Australian Bureau of Statistics). 2016. National Aboriginal and Torres Strait Islander Social Survey, 2014-15, cat no 4714.0, ABS, Canberra. Retrieved from http://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

ABS 2017 (Australian Bureau of Statistics). 2017. Census of Population and Housing: Reflecting Australia - Stories from the Census, Aboriginal and Torres Strait Islander Population 2016, cat no 2071.0, ABS, Canberra. Retrieved from http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2071.0~2016~Main%20Features~Aboriginal%20and%20Torres%20Strait%20Islander%20Population%20Article~12

ABS 2018a (Australian Bureau of Statistics). 2018. Census of Population and Housing: Socio-Economic Indexes for Areas (SEIFA), 2016, cat no 2033.0.55.001, ABS, Canberra. Retrieved from http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/2033.0.55.001Main+Features12016?OpenDocument

Australian Bureau of Statistics, *3303.0 – Causes of Death, Australia, 2017*, released at 11.30am, 20/09/2018, ABS Canberra. Retrieved from https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2017~Main%20Features~Intentional%20self-harm%20in%20Aboriginal%20and%20Torres%20Strait%20Islander%20people~10

AIHW 2015 (Australian Institute of Health and Welfare). 2015. Spatial variation in Aboriginal and Torres Strait Islander people's access to primary health care. Cat. no. IHW 155. Canberra: AIHW. 2015.

AIHW 2016a (Australian Institute of Health and Welfare). 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

AIHW 2016b (Australian Institute of Health and Welfare). 2016. Healthy Futures—Aboriginal Community Controlled Health Services: Report Card 2016. Cat. no. IHW 171. Canberra: AIHW.

AIHW 2017a (Australian Institute of Health and Welfare). 2017. National Key Performance Indicators for Aboriginal and Torres Strait Islander primary health care: results from June 2016. National key performance indicators for Aboriginal and Torres Strait Islander primary health care series no. 4. Cat. no. IHW 177. Canberra: AIHW.

AIHW 2018 (Australian Institute of Health and Welfare). 2018. Closing the Gap targets: 2017 analysis of progress and key drivers of change. Cat. no. IHW 193. Canberra: AIHW.

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

Biddle N. 2013. Census Papers (2011): Population Projections. Census Paper No.14. Centre for Aboriginal Economic Policy Research, Australian National University, 2013, Canberra

Brand E, Bond C, Shannon C. 2016a. Indigenous in the City: urban Indigenous populations in local and global contexts. (University of Queensland Poche Centre for Indigenous Health). Retrieved from https://poche.centre.uq.edu.au/publications/uq-poche-monograph-series

Brand E, Bond C, Shannon C. 2016b. Community Control: The changing landscape of Indigenous health (University of Queensland Poche Centre for Indigenous Health). Retrieved from https://poche.centre.uq.edu.au/publications/uq-poche-monograph-series

Commonwealth of Australia 2019. Department of the Prime Minister and Cabinet, *Closing the Gap Prime Minister's Report 2019*.

Department of Health 2017a. Fifth National Mental Health and Suicide Prevention Plan, Implementation Plan. Department of Health. Canberra.

Department of Health 2017b. My Life My Lead - Opportunities for strengthening approaches to the social determinants and cultural determinants of Indigenous health: Report on the national consultations. December 2017

Eades S J, Taylor B, Bailey S, Williamson A B, Craig J C & Redman R. 2010. The health of urban Aboriginal people: insufficient data to close the gap. Medical Journal of Australia, 193(9), 521-524.

Markham F, Biddle N. 2017. Indigenous Population Change in the 2016 Census. 2016 Census Paper No.1. Centre for Aboriginal Economic Policy Research, Australian National University, Canberra.

NACCHO (National Aboriginal Community Controlled Health Organisation). (2018). Pre-budget Submission, Canberra, 2018. Retrieved from https://nacchocommunique.com/category/budget-2018/

NDIA 2017 (National Disability Insurance Authority). 2017. National Disability Insurance Scheme Aboriginal and Torres Strait Islander Engagement Strategy. Retrieved from https://www.ndis.gov.au/Aboriginal-and-Torres-Strait-Islander-Strategy

Queensland Health 2016. *Aboriginal and Torres Strait Islander Mental Health Strategy 2016-2021*, Queensland Health, Brisbane.

Queensland Health 2017. *The burden of disease and injury in Queensland's Aboriginal and Torres Strait Islander people 2017 (reference year 2011) Main report*, Queensland Health, Brisbane – Final Report, June 2016.

Pekarsky, B et al. 2016. *Evaluation of the IUIH CSSS Program – Final Report, June 2016*. Wardliparingga Aboriginal Research Unit, South Australia Health and Medical Research Institute, Adelaide 2016 (unpublished report for the Institute for Urban Indigenous Health).

Tune, D. 2019. Review of the national disability insurance scheme act 2013 – Removing red tape and implementing the NDIS Participant Service Guarantee, December 2019.

Vos T, Barker B, Begg S, Stanley L, & Lopez A D. 2009. Burden of disease and injury in Aboriginal and people. 3rd edn. East Melbourne, Vic: RACGP, 2018.Torres Strait Islander Peoples: The Indigenous health gap. International Journal of Epidemiology, 38(2), 470-477. Doi: 10.1093/ije/dyn240

The terms Aboriginal and Torres Strait Islander and Indigenous are used interchangeably in this document with respect.

Institute for Urban Indigenous Health Ltd

ACN 140 019 290

22 Cox Road Windsor QLD 4030

www.iuih.org.au

Phone: + 61 7 3828 3600

Email: reception@iuih.org.au

Fax: + 61 7 3252 9851

The Aboriginal and Torres Strait Islander Community Health Service (ATSICHS) Brisbane

The Kambu Aboriginal and Torres Strait Islander Corporation for Health (Kambu)

Yulu-Burri-Ba
The Yulu-Burri-Ba Aboriginal Corporation for Community Health

The Kalwun Development Corporation.

Moreton Aboriginal and Torres Strait Islander Community Health Service