



AMSANT Submission to the Productivity Commission: Mental Health Draft Report

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PART 1 - THE CASE FOR MAJOR REFORM

The Commission's draft report is broad in scope, addressing mental health not only in terms of the health system, but also as it interacts with housing, education, the justice system and other key determinants. While the report makes some positive recommendations, AMSANT's submission attempts to interpret and ground the Commission's findings and recommendations within the context of Aboriginal health in the Northern Territory.

Aboriginal people in the Northern Territory experience a disproportionate morbidity and mortality burden from mental health and alcohol and other drug (AOD) problems. Mental health conditions are estimated to account for 12% of the life expectancy gap between Indigenous and non-Indigenous Australians, with suicide contributing another 6% and alcohol another 4% (Vos et al. 2007).

Many members of the Aboriginal community are happy, engaged with their families and culture, and prepared to make a positive contribution to their communities and to the NT as a whole. However, factors unique to the Aboriginal experience including the historical and ongoing process of colonisation that has seen loss of land, suppression of language and culture, forcible removal of children from families, and the experience of racism, all contribute to continuing disadvantage, poor health and poor social outcomes for a large portion of people. A significant result of this lived experience is the presence of intergenerational trauma within many Aboriginal communities, which further impacts on physical and mental health and wellbeing.

The 2014 report of the Mental Health Commission *Contributing Lives, Thriving Communities* made clear that Mental Health Services had failed Aboriginal people, noting higher rates of psychological distress, trauma, mental health conditions and suicide.

The Commission's report suggests that Governments need to make a choice as to how to tackle mental ill health in the long term. Our suggestion goes further than that. By healing intergenerational trauma, and dismantling systems that continue to oppress Aboriginal people, the burden of disease will decrease, and so will the demand on the "industry" that supports Aboriginal health. The long term aim is that our health status matches the wider community. This can only be achieved through self-determination.

Aboriginal organisations have long delivered services in the NT, and bring with them strong relationships with communities, understanding of community needs, cultural competence, and a permanent presence in Aboriginal communities. The Aboriginal Community Controlled Health Services (ACCHSs) sector, as the largest provider of primary health care to Aboriginal people in the NT, has been a primary driver of the impressive health gains for Aboriginal people in the NT over the last three decades.

PART 2 - REORIENTING HEALTH SERVICES TO CONSUMERS

Primary Mental Health Care

ACCHSs play a vital role in delivering comprehensive primary health care to Aboriginal people that incorporates holistic social and emotional wellbeing (SEWB) services with clinical mental health interventions. AMSANT was disappointed to see that this section of the report failed to directly acknowledge these services.

While recognition and support of the SEWB model embraced by ACCHSs is increasing, we still have some way to go. The result of this is unmet need in prevention and early intervention work for those at risk of and experiencing mental illness.

The National Mental Health Commission's 2014 Review of Mental Health Programmes and Services led to the recommendation that integrated mental health and SEWB teams should be established in all ACCHSs. Despite this, ACCHSs are still often forced to contest for service delivery contracts for mental health services. Often, these contracts are awarded to large mainstream NGOs who may have more capacity to present impressive grant applications but are often culturally inappropriate and lack relationships with the local community.

Recommendation 1: ACCHSs should be recognised as the preferred providers of mental health and SEWB services for Aboriginal and Torres Strait Islander people with adequate funding committed to fully realise the NMHC's recommendation.

Draft recommendation 5.9 of the draft report calls for the development of a system that can ensure all Australians have access to care that most suits their treatment needs (in line with the stepped care model) that is timely and culturally appropriate.

AMSANT is supportive of the stepped care approach to delivering mental health services, but notes that significant gaps currently exist in the NT at almost all levels of the continuum. In particular, there is an ongoing need for specialist children and adolescent services, and culturally appropriate care for Aboriginal people.

In spite of high levels of trauma and mental health issues among Aboriginal young people, it is deeply concerning that currently there are virtually no specialist child or adolescent psychiatry services available in remote areas of the NT.

Currently, children and adolescents in rural and remote areas who do meet the strict referral criteria for the Child and Adolescent Mental Health Service (e.g. depression, severe anxiety, post-

traumatic stress disorder), are managed by adult mental health teams, with CAMHS providing a secondary consultation/liaison service. Even when these outreach services were previously in place up to 2016, AMSANT's member services identified that they were often not culturally appropriate and did not work collaboratively with existing SEWB teams in community.

Recommendation 2: That culturally responsive specialist child and adolescent mental health services be provided in remote areas, as in reach within SEWB teams in ACCHSs where possible.

The implementation of an effective stepped care model in the NT will require an approach that supports strong Aboriginal governance and leadership, commissioning processes that prioritise culturally safe service delivery, as well as a more integrated approach to services and programs that acknowledges the significance of the social and cultural determinants in supporting strong mental health and wellbeing.

There also needs to be acknowledgment within the implementation of a stepped care model that people can transition from mild to severe mental illness very quickly so the system needs to be flexible to changing and emerging needs in people.

Achieving a stepped care model in the NT will not be possible without a strong and skilled workforce. Resources need to be given to ACCHSs to provide the stepped care model and a PD/education plan needs to be developed in partnership with a training provider/higher education body to provide a skilled workforce to help manage the rollout of the stepped care model in community (Refer to page 8 for more on Mental Health Workforce).

Draft recommendation 5.3 calls for headspace centres to match consumers with the right level of care by making funding conditional on centres meeting targets for referral of young people to low-intensity services.

The geographical reach of headspace is limited to the urban centres of Alice Springs, Darwin and Katherine in the Northern Territory, and services for young people in remote areas remain limited. This is reflected in the 2015 evaluation of headspace which found that nationally uptake by young people in remote areas, and from CALD backgrounds was very low (Hilferty et al. 2015).

We acknowledge the progress made by headspace national in recent years to establish an Indigenous national advisory group and Indigenous youth reference group. The employment of Indigenous advisors responsible for the development of Indigenous responsive services, as well as the development of a national Reconciliation Action Plan are also promising advances.

In spite of this, there remains a significant gap in services for Aboriginal young people living in remote areas and a major concern is the lack of psychiatry for young people out bush. AMSANT endorses extending headspace into the bush and especially remote Aboriginal Communities.

Addressing the mental health needs of young people in the bush remains a complex issue and responses should be developed in partnership with the communities requesting services. AMSANT has been made aware of a large research project in the Kimberly that is working at adapting the headspace model for Indigenous communities, and is particularly focused on fostering partnership.

Similarly, headspace Alice Springs, run by the Central Australian Aboriginal Congress (CAAC), report that headspace national have tried to organically foster development of the service in partnership with the organisation. In line with recommendation 1 of this submission it is AMSANT's position that ACCHSs should be considered the preferred provider wherever headspace services are being delivered to young Aboriginal people.

In order to support engagement with young Aboriginal people, CAAC have sought external funding to employ an Aboriginal Advisor, however there is no certainty for this funding beyond June. Ideally, funding should be available through headspace national for this position to continue in addition to a position for an Aboriginal youth engagement officer.

Recommendation 3: That dedicated funding be allocated for headspace to employ Aboriginal advisors and engagement officers where services are being delivered to a high population of Aboriginal young people.

Supported Online Treatment

Many ACCHSs throughout rural and remote NT have significant experience using various examples of telehealth technology to enhance the accessibility and effectiveness of health services in rural and remote regions. One service has routinely accessed specialist psychiatrist and clinical psychologist consultations for clients with complex mental health issues using videoconferencing and teleconferencing facilities. Videoconferencing and teleconferencing is also used to network and train the workforce working in these services, providing meaningful opportunities for professional development and support.

Draft recommendation 6.1 calls for the integration and expansion of supported online treatment for people living with mental ill-health with mild to moderate symptoms.

Online treatment options should be reviewed for cultural appropriateness and applicability to the NT context. There are a lot of things that have been developed based on evidence but it's unclear

whether they have been rolled out within Aboriginal community contexts and/or evaluated for their effectiveness. We should be using what has already been developed and tested for effectiveness before creating new resources.

AMSANT is in support of enhancing opportunities for telehealth but not at the expense of the further development of the local workforce. It is also critical that providers using telehealth have a strong cultural orientation which should be undertaken on country and that telehealth should supplement and expand visiting services rather than replace those visiting services. Working on site and being mentored and supported by local Aboriginal workforce is critical to the visiting provider being able to provide culturally safe effective services.

Available and appropriately resourced interpreters are also essential to making online treatment culturally safe, however they are essentially unavailable in remote which is fundamentally inequitable

Regions without access to high quality fast internet continue to be prevented from benefiting from these kinds of opportunities. Ensuring that the NBN is provided in all rural and remote regions of Australia would enhance accessibility and effectiveness through enabling these opportunities.

Towards Integrated Care

The Indigenous model of SEWB is a holistic and integrated model that brings together mental health and AOD treatment into primary health care. SEWB services are designed to support individuals, families and communities in all aspects of life that strengthen wellbeing. This requires multidisciplinary, culturally and trauma-informed teams with expertise across these various aspects of wellbeing for Aboriginal communities.

For Aboriginal communities continuity of care should centre around ACCHSs as the link between governmental health services, NGOs, community centres, outreach programs and the local Aboriginal population. This requires dedicated funding to be able to provide wrap around care through effective case management and care coordination.

A successful approach to integrated care for clients with complex social, emotional and physical health needs in the NT is currently being employed in Katherine. The Community Based Case Management approach was commenced in 2018 through a partnership with multiple local agencies to better support the needs of socially vulnerable people frequently attending the Katherine Hospital ED. Interim findings from a prospective cohort study indicate the program has reduced ED presentations by approximately 23% and increased access to primary care by 90% (Quilty et al 2019).

The success of the program would not be possible if it were not for funding provided to the Katherine based ACCHS Wurli Wurlinjang Health Service (WWHS) to establish a dedicated case management team which works alongside their SEWB unit. This program is reaching the most vulnerable and disadvantaged in the community.

Recommendation 4: That dedicated funding be allocated for community-led mental health and wellbeing programs that facilitate regional service integration, case management and care coordination in Aboriginal communities.

Draft recommendation 10.3 calls for the development of Single Care Plans for consumers with moderate to severe mental illness who are receiving services across multiple clinical providers.

Improving integration through care planning has the capacity to support a more coordinated and multidisciplinary healthcare approach to complex social and emotional needs, addiction, justice, family, homelessness, physical and mental health.

At the same time, our services take the privacy of their patients' information seriously. Aboriginal people are acutely aware of the way that health information and data can be misused and intensify stigma and discrimination. Information relating to a patients' mental illness is highly sensitive and particular care needs to be taken before sharing information to ensure consent protocols, governance and usage of data are robust and clear.

We note that a number of AMSANT's member services are part of the Health Care Homes (HCH) trial, providing coordinated care for patients with chronic illness, including those with mental illness. Additionally, the NT ACCHSs sector is a committed user of My Health Record and particularly recognise its importance for transient client populations.

We would encourage the Commission to recommend building upon and improving these existing care planning and information sharing mechanisms wherever possible.

Draft recommendation 10.4 suggests all people with severe and persistent mental illness who require care coordination services due to their complex health and social needs should be receiving them. Governments should set a national benchmark for all commissioning authorities, to ensure such services are available and any gaps are addressed.

As noted in the Commission's report, funding is provided through Primary Health Networks (PHNs) nationally for the Integrated Team Care (ITC) program, supporting Aboriginal and Torres Strait Islander people with chronic disease, which can include mental illness. A number of AMSANT's member services receiving funding for care coordinators under this program, however there is not enough funding to ensure every eligible person in the NT can access a care coordinator.

Additionally, care coordinators are stretched with such high patient numbers that a diagnosis of mental illness alone in the absence of another chronic disease diagnosis, or even with another

well managed chronic disease, wouldn't be sufficient for acceptance on to the program in many places. While AMSANT has provided training and support to some of our member services' care coordinators to better understand the needs of their clients with mental health conditions, their ability to provide effective support for this cohort remains limited.

AMSANT broadly supports the idea of specialist mental health care coordination, however there must be flexibility in how such a program would be implemented. For some clinics this may be best provided through a specialist mental health care coordination workforce, and for others it may be better to invest in training and upskilling the existing mental health workforce in care coordination.

Mental Health Workforce

AMSANT believes that services which are governed, designed, delivered and staffed by a local Aboriginal workforce are more accessible and effective for Aboriginal people. SEWB programs within ACCHSs are well placed to grow and develop local Aboriginal mental health and SEWB workforces, as well as support the non-Aboriginal workforce to work in accordance with culturally informed and trauma informed principles.

ACCHSs are in a unique position to support and develop both an Aboriginal and a non-Aboriginal 'mental health'/SEWB workforce that will enhance the accessibility and effectiveness of SEWB services for Aboriginal communities. It is critical that Aboriginal people working in this area have access to culturally appropriate training from entry level to postgraduate training, with funding for traineeships, scholarships and mentoring schemes. Entry level training needs to be available within communities and all training must be culturally safe and have strong Aboriginal input.

Recommendation 5: That the Commission's final report recommends increased support for ACCHSs to continue to grow and develop local Aboriginal mental health and SEWB workforces, including through traineeships, scholarships and mentoring schemes.

Draft recommendation 11.1 indicates that the forthcoming update of the National Mental Health Workforce Strategy should align health workforce skills, availability and location with the need for mental health services.

This National Strategy must also include specific planning relating to the development of the Indigenous mental health and SEWB workforce.

Information request 11.1 seeks information about 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.

There is currently a declining number of AHWs and barriers which prevent people from enrolling or completing their AHW training. These barriers include the need to move away from home for long periods of time in order to study.

A SEWB forum hosted by AMSANT in 2019 bringing together workers from ACCHSs and NT Government clinics across the NT identified the need for more access to pathways for Traineeships. Traineeships were seen as an under-utilised method of recruiting a local workforce that already possesses essential local cultural and social knowledge. Traineeships can provide a career pathway to gaining specific qualifications whilst gaining on the job experience in a primary health care setting. Traineeships should also work in conjunction with a mentoring program.

Draft recommendation 11.7 The Australian, State and Territory Governments should make working in rural and remote areas a more attractive option for health professionals by reducing professional isolation, increasing opportunities for professional development, and improving the scope to take leave.

A review of health workforce turnover in remote NT Department of Health clinics between 2013-15 revealed annual turnover rates of 148% for remote area nurses, and very low stability rates, with only 20% of nurses and AHPs still working at the same remote clinic 12 months after commencing and half having left within 4 months (Wakerman et al 2019).

These are very concerning results, and are likely contributing to sub-optimal continuity of care, compromised health outcomes and poorer levels of staff safety. Wakerman et al (2019) goes on to estimate that if staff turnover in remote NTG clinics were halved, the potential savings to the NTG health system in PHC, travel and hospital costs would be approximately A\$32 million p.a., some 29% of the total NTG remote clinic expenditure in 2015.

While AMSANT supports some of the recommendations put forward by the Commission to attract and retain more health professionals to work in remote areas, we believe it overlooks reforms to the broader health system that are fundamental to supporting an effective and stable workforce. Some of these include:

- Ensuring adequate funding to services for the level of need in their community;
- Prioritising community participation and employment of locals;
- Adequate infrastructure including fit-for-purpose clinics, staff housing, transport and information technology;
- Ensuring a good 'fit' between individual staff and the community (especially with regard to cultural skills); and
- Optimising coordination and management of services that empower staff and create positive practice environments.

Investing in training support and development to build a local workforce will be far more sustainable in the long term than simply making it more appealing for health professionals to come and work in rural and remote areas for short periods of time.

PART 3 - REORIENTING SURROUNDING SERVICES TO PEOPLE

Psychosocial supports

As a peak body AMSANT plays a role in advocacy and support of our member services to understand the NDIS and to assist ACCHSs to determine whether it is viable for them to become providers. However, this work is currently done without any direct funding and therefore our capacity to provide the level of support to member services that they need is restricted.

While a small number of AMSANT's member services are now providing NDIS services, particularly as coordinators of support, others have decided that the scheme's individualised, market-base model does not align with their delivery of culturally appropriate, comprehensive primary health care and/or it is not economically viable for them to engage with the scheme at this stage. Services who are NDIS providers find the scheme arduous and at times culturally unsafe but are working with it as they understand that they are best placed to do so and if they do not engage, people with significant mental illness will miss out on essential services.

Moreover, the reality in many remote Aboriginal communities is that basic needs relating to the social determinants of health - housing, food security, safety etc. - are not being met. Filling these basic needs will continue to be a higher priority for some NDIS clients than accessing specific disability supports and poor living conditions will make effective delivery of disability support services more expensive and complex.

NDIS data reveals that only 56% of individuals in the NT with established plans are currently accessing services under their plan. It also shows that 76% of NDIS participants in the NT require support coordination for their plans, compared with 25% nationally.

The ACCHSs sector already provides comprehensive PHC to almost two thirds of Aboriginal people in the NT. In many areas, particularly in small remote communities, they are the main service provider with strong existing relationships in community and are already supporting people in their community with disability and mental ill-health.

There are concerns that the NDIS' competitive market based model will undermine these vital services by bringing in external NGOs and the private sector who may be motivated primarily by financial gain, rather than improved health and wellbeing outcomes, and do not have relationships with the community or local health service.

Despite these concerns, we note some positive progress has been made with the extension of the Remote Community Connectors Program into the NT. We are hopeful that this program will provide an opportunity for increased local employment through ACCHSs to promote understanding and awareness of the NDIS and increase the number and quality of care plans.

Draft recommendation 12.2 calls for a guarantee for continued access to psychosocial support so that anyone who requires it is able to access it, including former participants of Australian Government-funded psychosocial support.

AMSANT supports this recommendation and notes that data reported by the NDIS in June 2019 indicates 43% of applicants who have applied for psychosocial supports under the NDIS in the NT that were formerly receiving these same supports have been knocked back.

While transition and continuity of support funding are being provided through the PHNs for individuals who are deemed ineligible, or are still waiting on plan approval, this has only been committed for the next 1-2 years depending on funding type. Funding certainty must be provided beyond this.

We also note evidence reported by Community Mental Health Australia and University of Sydney in 2019 which suggests a high proportion of people previously receiving psychosocial supports, including some with very severe mental illness, are choosing not to apply at all for services transitioning to the NDIS. Reasons given for this include:

- Clients are fearful of the application process;
- Clients' mental health is too poor or too unstable;
- Clients are dealing with more urgent priorities (e.g., housing insecurity);
- Clients don't trust government related agencies;
- Clients don't accept/identify as having a 'disability';
- Inability to obtain the evidence required by the NDIA due to transience and limited contact with services (Hancock 2019).

This further emphasises the need for funding of positions within locally based Aboriginal organisations, through programs like the Remote Community Connectors, to support clients through these barriers to access.

Recommendation 6: AMSANT supports draft recommendation 12.2 and further recommends that funding for Remote Community Connectors positions, based in local Aboriginal organisations, be expanded to support people through the NDIS application process for psychosocial supports.

It is clear that there will continue to be a need for funding of psychosocial supports outside of the NDIS for participants deemed ineligible. Currently these services are primarily provided by mainstream NGOs in the NT. As noted previously in this submission these organisations frequently lack cultural knowledge, local relationships and employ fewer local Aboriginal people.

Given that ACCHSs are already providing non-clinical community based support for individuals with severe mental illness in their communities through their SEWB workforce, we believe that

psychosocial support funding for Aboriginal communities would be well placed within these same services. This would reduce duplication, improve integration and increase the cultural safety of service provision.

Recommendation 7: That ACCHSs be recognised as preferred providers of psychosocial supports to Aboriginal people that continue to be funded outside of the NDIS.

Draft recommendation 12.3 calls on the NDIA to continue to improve its approach to people with psychosocial disability.

It is AMSANT's experience that many aspects of the Aboriginal health sector are not suited to the introduction of greater competition and user choice under a market-based system such as the NDIS. Reasons for this include:

- The particular model of community controlled governance which is an expression of self-determination exercised by Aboriginal communities and underpins the demonstrated effectiveness of service provision by community controlled organisations.
- The remote locations within which our services operate lack sufficient economies of scale to support the viable provision of the full range of health and human services necessary for the NDIS, let alone multiple, competitive providers of services.

Additionally, the personalised, market-driven NDIS requires patients and families to have high health literacy and capacity to navigate a complex system and negotiate with a large bureaucracy to obtain the best outcome from the scheme. Research suggests this type of scheme can widen existing inequalities if these structural issues are not addressed (Malbon et al 2019). There is strong evidence that this is happening in the NT.

As such, it is AMSANT's position that the NDIA should be looking to options for funds pooling and centralised, needs-based planning for NDIS services in Aboriginal communities, including psychosocial supports, in order to address market failures.

Recommendation 8: That draft recommendation 12.3 include specific direction for the NDIA to consider options for funds pooling and collaborative, needs-based planning for the delivery NDIS services, including psychosocial supports, in Aboriginal communities.

Income support

Returning to work or engaging with the workforce for the first time for an Aboriginal person can be complicated particularly if they have been suffering from mental illness. They need to be supported to engage in training to orient them to work and be supported in any ongoing training

to develop their career pathways. This will not only help them to be able to look after themselves, but assist in increasing wellness.

Training programs for basic living skills would support this transition, such as what to do with your pay and how to look after the money you earn. As the person recovers from mental illness, they should be enrolled in further financial management programs to create a financial buffer should they suffer any future relapses and have a support network around them to assist in their times of need. It would be preferable if these services were provided by Aboriginal organisations in a way which builds capacity of individuals and communities.

AMSANT has repeatedly expressed concerns about Australia's increasingly punitive welfare policies. Expansion of the cashless debit welfare card, onerous work for the dole requirements and drug testing requirements are placing more pressure on individuals to change their behaviour through compliance mechanisms, with limited focus on addressing the structural disadvantage that drives access to welfare in the first instance.

When people are subjected to highly onerous compliance and quarantining mechanisms their sense of empowerment and control over their life circumstances are undermined, and health and wellbeing are impacted. In remote Aboriginal communities we are seeing an increasing number of people disengaging entirely from welfare receipt as a result. This contributes to food insecurity, stress and conflict within families and further erodes mental health and wellbeing.

Draft recommendation 14.1 suggests that assessment tools for jobactive and Disability Employment Services participants should be reviewed to ensure they are relevant to job seekers with mental illness.

AMSANT supports this recommendation and strongly encourages the Commission to call for the same review of mechanisms under Community Development Program (CDP), the remote equivalent to job active, for assessing capacity to participate and causes of non-compliance.

Recommendation 9: That draft recommendation 14.1 include the review of assessment processes under the Community Development Program (CDP) to establish capacity to participate and causes of non-compliance.

While review of assessment processes is required in relation to the current CDP program, AMSANT's view is that the CDP program is fundamentally flawed and requires comprehensive reform in order to prevent the significant harms that the program is causing to individuals and families, including those experiencing mental illness, trauma and stress, and to ensure the program contributes to positive outcomes.

The Aboriginal Peak Organisations NT (APO NT) alliance, of which AMSANT is a member, has developed an alternative model to the current CDP, the Fair Work and Strong Communities Remote Development and Employment Scheme¹.

The scheme includes the establishment of a pool of local jobs bid for by local Aboriginal organisations, and community-led arrangements and compliance for those unable to access a job. This would require the assessment of participants carried out through the local community-based provider to identify those who have disabling or chronic health and mental health conditions or immediate issues to deal with that prevent job searching, and ensure an appropriate response.

This would include ensuring engagement requirements are appropriate to the level of capacity of a person, and that there is the provision of support to stabilise immediate adverse circumstances and access appropriate services or where necessary to exit from the program to a disability or other form of income support. Importantly, the scheme would enable the kinds of supports and training referred to above to support recovery and transition to work.

Recommendation 10: That the Commission recommend the Community Development Program (CDP) be reformed in line with APO NT's Fair Work and Strong Communities Remote Development and Employment Scheme.

Housing and Homelessness

AMSANT supports a public health, community-wide approach to improving housing. Research demonstrates that recovery from mental illness is unlikely whilst people are suffering from homelessness and that provision of safe secure housing is an essential first step in recovery (Micah Projects 2016; Bodor et al 2011).

This accords with the clinical experience of clinicians in SEWB/AOD services within Aboriginal primary health care. Patients who are homeless, living in adverse circumstances, and/or who are not having other basic needs met – including income, housing, and basic family support – will be less likely to benefit from counselling unless these issues are dealt with. Indeed, many clients may largely recover with cultural, practical and psychosocial support.

The social stress associated with overcrowding is also likely to be an aggravating factor in physical and mental illness in many situations, particularly when rates of overcrowding in remote communities in the NT is at endemic levels. Certainly, the social stress associated with overcrowding has been identified within the general population as a contributor to high rates of domestic violence (Bailie and Wayte 2006).

¹ Details of the scheme can be found at <http://www.amsant.org.au/apont/remote-employment/>.

Evidence from the NT reflects this with a study of the experiences of Aboriginal people living rough in Darwin, finding that the most common reason people left home communities was to escape family problems, particularly involving violence, which were often exacerbated by a lack of housing (Holmes and McRae-Williams 2008).

ACCHSs in urban areas are funded on the basis of their regular client population size. However, they also do important and resource intensive work with at risk and mobile populations despite the fact that they are not specifically funded to provide this support.

Providing integrated comprehensive culturally safe services in combination with much better funded emergency and permanent housing is likely to reduce expenses in other areas such as secondary and tertiary hospital care, the justice system, and child protection. This is evidenced by a study conducted in Katherine which found that homelessness was the most significant predictive factor for Emergency Department attendance (Quilty et al. 2016).

The AOD team at Darwin-based Danila Dilba Health Service (DDHS) works in partnership with Darwin City Council's Safer City Program to engage with homeless people who are affected by alcohol or other drug problems, offering brief interventions about the effects of substance misuse and linking people to services that support their immediate needs.

In 2018 DDHS also began a regular weekly breakfast outside the Darwin Clinic that now draws about 70 homeless people and provides an opportunity to engage clients in conversations about their health and wellbeing, and encourage further support if necessary.

Draft recommendation 15.1 advocates for housing services to increase their capacity to prevent people with mental illness from experiencing housing issues or losing their home

There is a very high level of unmet demand for homelessness services in the NT with 45.3% of those seeking support unable to be assisted in 2016-17, twice as high as unmet requests nationally (23%) (AIHW 2018a). One of the flow on effects of this is that many people are missing out on the tenancy support they require.

The NT remains one of the least affordable private housing markets in the country in which to rent a property. Additionally, regional and remote townships of the Northern Territory have historically low supply and high demand markets, and for those eligible for public housing, the waitlist is 6-8 years for a number of locations across the Territory.

AMSANT supports the sentiment of this recommendation, but notes that in the context of the NT this will require significant additional funding for housing services to close the gap in unmet demand for people struggling to maintain their tenancies, as well as significant additional investment in infrastructure to meet the chronic housing shortfall.

Draft recommendation 15.2 calls on State and Territory Governments to commit to a nationally consistent formal policy of no exits into homelessness for people with mental illness who are discharged from institutional care, including hospitals and prisons

AMSANT strongly supports this recommendation but reiterates that achieving this in the NT will require significant additional investment. In 2016 the NT's homelessness rate was 10 times higher than the national average. 81% of the homeless population were living in 'severely' crowded dwellings, while 48 per 10,000 persons were living in improvised dwellings, tents or sleeping out (ABS 2018).

Improving discharge processes and supporting people to move back to their home communities after leaving hospital or prison will require considered and timely planning in collaboration with locally based ACCHSs and Aboriginal housing organisations.

Justice system

Aboriginal and Torres Strait Islander people comprised 84% of the adult prisoner population in the NT as at June 30, 2017. This was the largest proportion of any state or territory, compared to the national average of 27%. (ABS 2017). Similar overrepresentation is seen in youth detention, with 95% of young people in detention identifying as Aboriginal or Torres Strait Islander in 2016-17 (AIHW 2018b).

Furthermore, research has demonstrated that Indigenous people with mental health and cognitive disabilities are significantly more likely to have experienced earlier and more contact with the criminal justice system and to have greater levels of multiple disadvantage than non-Indigenous people (Baldry et al 2016).

It follows therefore that any actions in the NT to improve the mental health of people in contact with the justice system, or prevent this contact in the first place, should be done in partnership with, or under the governance of, Aboriginal people and organisations.

We would specifically like to note for the Commission the high number of young people coming into contact with the youth justice system who have cognitive disability, including FASD. While no prevalence studies have been done in the NT, a 2018 study of young people in the Banksia Hill Detention Centre in WA found 89% had at least one domain of severe neurodevelopmental impairment, and 36% were diagnosed with FASD (Bower et al 2018).

In the absence of early and appropriate diagnosis, intervention and support in the community, young people with mental and cognitive disability, in particular those from more disadvantaged backgrounds, are being systematically criminalised. Too often these young people become entrenched in the system and continue on to adult prisons, which are normalised as places of management and control for people with severe disability and mental illness.

Draft recommendation 16.2 National mental health service standards should apply to mental healthcare service provision in correctional facilities to the same level as that upheld in the community.

While AMSANT support draft recommendation 16.2 its realisation in the Northern Territory would require a significant increase in investment, staffing as well as major structural reforms.

A recent review of NT Forensic Mental Health services found “The Northern Territory is a long way from a contemporary system design for its forensic services” and noted the immediate need to increase the resource base and staffing, with particular need identified in Central Australia (McGrath 2019).

Recommendations from this review specific to Aboriginal clients include:

- Increasing the availability of community based mental health supports, in collaboration and partnership with ACCHS to allow relevant Part IIA clients to return to their community and/or country.
- Ensuring appropriate access to Aboriginal mental health workers with forensic skills in the forensic teams.
- Incorporate into clinical services planning a specific set of responses for women and girls in the criminal and youth justice systems, including work to ensure the specific needs of Aboriginal and Torres Strait Islander women are met.

We note that Complex Behavioural Unit (CBU) at the Darwin Correctional centre, which is used to manage individuals on Part IIA orders (not guilty by reason of mental impairment) remains under the authority of NT Corrections. This is inconsistent with national and international best practice, and the aforementioned review recommends that that operational authority be transitioned to NT Health.

AMSANT is unaware of NT Government progress in implementing these recommendations.

Draft recommendation 16.4 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. They should also 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.

In the Northern Territory the North Australian Aboriginal Justice Agency (NAAJA) throughcare program provides coordinated case management support to adults and young people, beginning when they first go into prison and continuing until they are living a safe and fulfilling life back out in the community. The Program currently runs in Darwin and Alice Springs.

While this program has seen positive results for many clients in reducing in recidivism, it is AMSANT’s understanding that the team faces significant issues finding supported accommodation for people post-release. Many people cannot access parole or receive suspended sentences due to this lack of supported accommodation and so are by default placed in prison. The subsequent disconnection from family and country that results from time in prison leads to diminished wellbeing and exacerbates existing mental health issues.

The vast majority of individuals on Part IIA orders held in custody in the NT are Aboriginal. However, the 2019 review of forensic mental health services revealed limited use of interpreters, cultural interventions that map to a client's own community, a dearth of Aboriginal mental health workers and very little community based mental health support in remote communities.

A number of AMSANT's member services are currently providing services to support their clients in contact with the Justice System. In Katherine, WWHS runs the StrongBala Justice program for men, providing holistic health and wellbeing care as well as diversionary measures, tools and messages to reduce recidivism, domestic violence and substance abuse.

Darwin-based DDHS supports youth in the Don Dale Youth Detention Centre through the youth social support program. DDHS acts as an independent advocate to Centre management (and the NT Government) on issues such as living conditions and treatment of detainees, and works closely with the young people through educational programs and support activities. An important part of the program is to prepare young people for release, working with them to identify goals and develop a personal plan.

Similarly, CAAC delivers case management and psychological services in the Alice Springs Youth Detention Centre, and has recently received funding under the Back on Track program to work with Aboriginal children and young people aged 8-17 (as well as their families) who are at risk of engagement, or re-engagement, with the youth justice system. A child focused psychologist, two social workers, an Aboriginal youth worker and an Aboriginal family support worker have been engaged to undertake this work.

Recommendation 11: Increased support for Aboriginal organisations to provide community-based throughcare and integrated social and health programs to support transition from prison and detention back into the community.

Draft recommendation 16.5 All State and Territory Governments should develop disability justice strategies to ensure the rights of people with mental illness are protected and promoted in their interactions with the justice system.

AMSANT supports this recommendation and would like to note the work of a number of our member services in establishing health justice partnerships to bridge this disability/justice divide.

In Tennant Creek, a Memorandum of Understanding (MOU) has been negotiated and agreed to between Anyinginyi Health Aboriginal Corporation and the Central Australian Women's Legal Service (CAWLS) for CAWLS to provide an in-house specialised domestic unit where Women have both legal and non-legal needs addressed. This unit allows easy and culturally appropriate access for Aboriginal women seeking advice.

In Nhulunbuy, NAAJA and Miwatj Health Aboriginal Corporation are piloting a partnership in Nhulunbuy, with a social worker employed by Miwatj to make referrals to NAAJA and drive the partnership.

PART 4 - EARLY INTERVENTION AND PREVENTION

Interventions in early childhood

There is now overwhelming evidence that factors in pregnancy and early childhood have a profound influence on adult outcomes, including mental health issues (Center on the Developing Child at Harvard University 2010). Long term, intervening early to improved childhood environments through targeted early childhood and family support programs will lessen an individual's vulnerability to mental illness.

AMSANT believes that regional ACCHSs should be resourced to implement evidence-based family support programs that target at risk families and provide education about child development and prevention/detection of child abuse as part of a comprehensive suite of primary health care services.

We refer the Commission to the document Progress and Possibilities, developed by the NT Aboriginal Health Forum (NTAHF) which sets out a core services model for Aboriginal Primary Health Care in the NT.

As noted under section 2 of this submission, it is a significant concern to AMSANT and its members that currently there are virtually no specialist child or adolescent psychiatry services available in remote areas of the NT.

Draft recommendation 17.1 calls for Governments to take coordinated action to achieve universal screening for perinatal mental illness.

AMSANT has concerns about the universal implementation of this recommendation without available follow up services. There is little use in screening women for perinatal depression where limited services are available, as is the case in many remote areas of the NT, and/or services are not culturally appropriate, in fact it can be considered unethical to do so.

We also note that there is a need to make use of appropriate perinatal screening tools for Aboriginal mothers to detect depression and other mental health concerns. Projects are currently underway to develop appropriate tools.

One such tool developed in WA, is known as the Kimberly Mums Mood Scale and another project 'Healing the Past by Nurturing the Future' is currently underway to co-design perinatal awareness, recognition, assessment and support strategies for Aboriginal and Torres Strait Islander parents who have experienced complex trauma.

Draft recommendation 17.2 calls for the expansion of early childhood health checks, such that they assess social and emotional development before they enter preschool.

Data from the Australian Early Development Census (AEDC) demonstrate that children in the NT are more than twice as likely to be considered developmentally vulnerable on two or more

domains as the rest of the country (23% compared to 11%). In some remote Aboriginal communities, more than 50% of children were found to be vulnerable on two or more domains at school entry (AEDC 2018).

Children with developmental delay and intellectual impairment are at an increased risk for future mental health problems as compared with normally developing children (Eapen 2014). This added complexity compounds the psychosocial trajectory and can lead to family distress, poor community participation, unemployment and involvement with the criminal justice system.

AMSANT notes that ASQ-TRAK, a developmental screening tool adapted for Aboriginal children, is well suited to the purpose of screening children in Aboriginal communities. Early screening and assessment can provide the opportunity to intervene early and change the trajectory of a young person's life.

Despite this, we note that for some of our services in remote areas an inability to access treatment and support for children with developmental delay or intellectual impairment has created an ethical disincentive to conduct these kinds of assessments or provide a diagnosis. Without appropriate infrastructure, a skilled workforce or adequate funding for support services, a diagnosis may be more stigmatising than useful.

However, funding available through the NDIS' Early Childhood Early Intervention stream provides a potential opportunity to address issues of early childhood development and disability in remote Aboriginal communities. As mentioned above, however, we believe this funding will not be most effectively utilised under an individualised market-based mechanism, and instead should be pooled and allocated through a collaborative needs-based planning process with ACCHSs as the preferred provider.

Draft recommendation 17.2 further indicates the need for all early childhood education and care services to have access to support and advice from qualified mental health professionals, and training programs for early childhood educators and teachers should include specific learning on children's social and emotional development.

In 2008 Council of Australian Government's (COAG) committed to providing high quality pre-schooling to all children for fifteen hours a week, delivered by early childhood teachers with at least four years of training. This is still yet to be delivered consistently across all Aboriginal communities in the NT, although access to early education has improved since this time.

AMSANT supports training for early childhood educators and teachers in social and emotional development, including Aboriginal understandings of SEWB and culture. However, more needs to be done to ensure all children have equal access and sustained exposure to early education, as well as intensive and targeted support where required.

Draft recommendation 17.2 also notes that State and Territory Governments should expand the provision of parent education programs through child and family health centres.

AMSANT supports this recommendation and notes the success of the Australian Nurse Family Partnership Program (ANFPP) being delivered through a number of ACCHSs in the NT along with a similar program (MESCH). Study results from a retrospective and prospective cohort study has suggested that the modified Nurse Family Partnership program delivered by CAAC may have reduced child protection system involvement in a highly vulnerable population, especially in younger or first-time mothers (Segal et al. 2018). It is worth noting that the main way that this program was modified from the original was through employing Aboriginal workers.

It is AMSANT's position that parenting programs should be funded in all ACCHSs as part of a comprehensive suite of primary health care services supporting children and families.

Interventions in school education

Schools are an important contributor to the early identification of, and response to the mental ill health and wellbeing of our young people. However, we would caution against an overreliance on an already overloaded education system to improve health outcomes. Schools must be appropriately resourced to implement any new measures, and in many cases it may be more appropriate to establish partnerships and collaborations between education and health sectors for the provision of more specialised advice and intervention to young people.

In order to improve outcomes for school aged children with mental health in the NT there should also be a recognition of the division for urban and remote schools. Many of the Commission's recommendations will likely be unrealistic for full implementation in every remote Aboriginal community. More innovative approaches may be required to effectively use limited resources but also respond to the specific needs of a given community.

APS ratios that suggest there should be 1 psychologist for every 500 children should be reviewed for remote areas. Again, it is unrealistic to apply a one size fits all approach to schools in major cities and remote communities. This also does not take into account the high levels of trauma experienced in many communities.

Draft Recommendation 17.3 calls for the COAG Education Council to develop a national strategic policy on social and emotional learning in the Australian education system.

While AMSANT is supportive of the implementation of social and emotional learning programs in schools, we note that many of these policies and programs already exist at the jurisdictional level, but continue to lack resourcing for implementation. For example, in the NT a social and emotional learning curriculum has recently been developed, but there has been little support, training or supervision for teachers to integrate this into their practice in a meaningful way.

We would suggest that investment may be better targeted at implementation and strengthening of these existing policies, rather than the development of a new national policy, which may not be able to effectively capture regional priorities and needs.

Draft Recommendation 17.3 indicates that ongoing learning on child social and emotional development and wellbeing should form part of PD requirements for all teachers, including the SEWB of Aboriginal children.

AMSANT supports this recommendation and notes that training relating to the SEWB of Aboriginal children in schools needs to be created and run by indigenous health professionals working in collaboration with local schools and governments to address the specific needs of the local area.

Draft recommendation 17.5 suggests all schools should employ a wellbeing leader, to oversee wellbeing policies, coordinate with service providers and assist teachers and students to access supports.

AMSANT supports the intent of draft recommendation 17.5, but would support the role of the wellbeing leader to go beyond engagement at school itself and should include outreach into the community. This person should be part of a team and have the opportunity for debriefing.

We would further recommend flexible implementation of the role. Smaller communities, for example, may require one wellbeing teacher who travels between schools within a region. In these places it may be more useful to employ locally based liaison officers to work with the “wellbeing leader”, and link families with community-based support.

Collaboration and partnerships between health and education will be required to provide more specialist intervention and care. For example, the dental program currently operates in tandem with the school term to provide children access to dentists. A program staffed by a wellbeing team could also be on a roster and work with the already employed wellbeing officers present in schools. This initiative combined with evidenced based wellbeing programs could enhance the early detection, treatment/relapse prevention of mental ill-health in schools.

A similar model could also operate in remote areas where school attendance is poor. Local ACCHSs could work alongside childcare centres and/or preschools to engage with at risk children and families and continue to support the attendance of the child at primary and later stages of school.

Social participation and inclusion

It is widely understood that mental illness carries with it social stigma. The impact of this is magnified however for the vast majority of Aboriginal people, who experience systemic racism and discrimination in their everyday lives.

A recent study exploring Aboriginal understandings and experiences of race and race relations engaged with Aboriginal people living in, or regularly visiting Darwin. The study identified that respondents felt stereotyped, judged and patronised when engaging with non-Aboriginal people, and felt that this group displayed ignorance about Aboriginal culture as well as an active evasion and denial of the historic treatment of Aboriginal people (Habibis et al. 2016).

Incidence of discrimination are certainly evident within the healthcare system where institutional racism can influence detection or diagnosis of illness. The Royal Commission into Aboriginal Deaths in Custody noted that many Aboriginal men with a forensic history are diagnosed as having personality disorders and their depression is missed (GPPHCNT 2007).

A study examining the views and experiences of Aboriginal people living rough in Darwin found a significant lack of empathy for the life circumstances of the people studied. Aboriginal people in public places were usually regarded with suspicion by mainstream society and perceived to be: irresponsible, choosing a morally corrupt lifestyle, a source of contagion, neglectful of their children, and engaging in unhealthy social behaviours including alcohol abuse (Holmes and McRae-Williams 2008).

The impacts of this kind of discrimination can be understood to exacerbate existing mental health issues as well as severely limit the ability of this group of people to access health and social services.

Draft recommendation 20.1 proposes that the National Mental Health Commission develop and drive the implementation of a national stigma reduction strategy that focuses on the experiences of people with mental illness that is poorly understood in the community.

Recommendation 12: That the development of any national stigma reduction strategy specifically recognise the significant level of discrimination and social isolation experienced by Aboriginal people in our community and identify actions to address this.

Draft recommendation 20.3 call for the Australian Government to evaluate best practices for partnerships between traditional healers and mainstream mental health services for Aboriginal and Torres Strait Islander people. This evaluation should incorporate the knowledge and views of Aboriginal and Torres Strait Islander people and seek to improve the evidence about how a partnership between traditional healers and mainstream mental healthcare can most effectively support Aboriginal and Torres Strait Islander people with mental illness and facilitate their recovery in their community

AMSANT suggests that this recommendation should go further to recommend the role that community-led healing programs more generally can play in addressing ongoing trauma and isolation. Also the need to recognise a wider variety of mental health treatment options including creative/art/narrative therapy which are more aligned with indigenous models of healing.

For example, we would refer the Commission to the work of Gan'na Healing, incorporating modern psychological treatments with traditional healing to run trauma-informed workshops, bush camps and healing circles for Aboriginal people. Lukas Williams' work with Aboriginal men

through healing circles in Hermannsburg, NT has been particularly effective in creating a safe space for men to talk about the trauma that often underlies violent behaviour.

Recommendation 13: That draft recommendation 20.3 also include support for community-led healing programs to address ongoing trauma and isolation in Aboriginal communities

The Report goes on to acknowledge: “The limited control that Aboriginal and Torres Strait Islander people have, and feel that they have, over the circumstances in which they live is seen by them as limiting both their social and emotional wellbeing and their own ability to do anything about it”.

In 2017 at the National Constitutional Convention, after months of consultation around the nation, Aboriginal and Torres Strait Islander leaders came together and produced the Uluru Statement from the Heart, setting out an invitation to non-indigenous Australians to join with them in a process of truth-telling and political recognition of our First Nations people.

We would like to see a further recommendation in the Commission’s report that acknowledges the importance of constitutional recognition and truth-telling in improving the SEWB of Aboriginal people; as well as the importance of supporting and growing the community controlled sector more generally.

Recommendation 14: That the final report of the Commission include a recommendation for the Commonwealth Government to fully support and implement the Uluru Statement from the Heart.

Suicide Prevention

From 2011-15, the Indigenous suicide rate was twice that of the non-Indigenous population (AHMAC 2017). Australia’s history of colonisation and the consequent past and present experiences of trauma and intergenerational trauma are understood to underlie some of the most complex health and mental health issues within our communities. High rates of suicide can be understood as one tragic symptom of many of these complex issues.

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

Draft recommendation 21.1 calls for Australian, State and Territory Governments to offer effective aftercare to anyone who presents to a hospital, GP or other government service following a suicide attempt.

AMSANT supports this recommendation and notes important ongoing discussions in the NT to improve information sharing about suicide attempts between government and community service providers. However, we have some concern about the use of the term aftercare as it is an essentially meaningless term. Some will require long term therapeutic and cultural support, others may require a lower level of intervention but after care downplays the importance of this service. This communication is central to effectively responding to people who attempt.

AMSANT suggests that ACCHSs should be resourced to provide this care as it is likely to be more culturally safe, effective and holistic if provided by an Aboriginal organisation (noting that some Aboriginal people may choose to go to mainstream services).

Draft recommendation 21.1 states that the COAG Health Council 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.

AMSANT support this recommendation and note the need to further build the evidence base around what works in suicide prevention in Aboriginal communities through effective evaluation of programs. Research and evaluation relating to Indigenous suicide prevention should build on the work of Pat Dudgeon et al (2016).

Draft recommendation 21.1 further advises that Indigenous organisations should be the preferred providers of local suicide prevention activities for Aboriginal people. For all organisations providing programs or activities into Indigenous communities, the requirements of performance monitoring, reporting and evaluation should be adapted to ensure they are appropriate and reflective of the cultural context.

AMSANT strongly support draft recommendation 21.1. In 'Recent developments in suicide prevention among the Indigenous peoples of Australia', Dudgeon and Holland (2018) note that one of the quality indicators of suicide prevention services is culturally safe services and that: 'These are optimally provided by Aboriginal Community Controlled Health Organisations that are based in communities' (p. 168).

They also identify 'Cultural competent practitioners' and 'Trauma-informed services' as quality indicators and again, SEWB programs within Aboriginal Community Controlled Health Organisations are well placed to support both of these areas.

PART 5 - PULLING TOGETHER THE REFORMS

Federal roles and responsibilities

Information request 23.1 asks for consideration for the Renovate and Rebuild models for the architecture of the future mental health system.

Renovate Model

AMSANT is not supportive of the renovate model. While relaxing restrictions on PHNs would provide some improvements to the current system we do not support activity-based funding or diverting activity to hospital based care.

Rebuild model

AMSANT has experienced some success with funds pooling in the past, when coupled with a clear and common set of needs-based, regional priorities. However, the effectiveness of this kind of arrangement would require strong Aboriginal governance. As such we would recommend that RCAs be mandated to establish Aboriginal and Torres Strait Islander reference groups with decision-making powers. Additionally, workers on the ground, in each region, would still be essential to ensure local priorities are fed up into an RCA and avoid centralisation.

Similarly the distribution of funds between State/Territory Governments on a weighted per-capita basis must take into account the true cost of service delivery in very remote areas, and effectively quantify the significant levels of trauma, physical and mental ill health experienced in some of our communities.

While there are some advantages to funds pooling AMSANT is concerned that the rebuild model could see direct funding from the Commonwealth to ACCHS filtered through the Regional Commissioning Agencies and put out to tender.

It is AMSANT's experience that Aboriginal Comprehensive Primary Health care is not suited to these kinds of competitive tender processes. The reasons for this are complex, addressing issues encompassing the location, demographics and aspirations of Aboriginal communities; the features of ACCHSs and the particular requirements of delivering comprehensive primary health care to Aboriginal people including the need for culturally competent service delivery and Aboriginal leadership; and the effectiveness of the quality assurance and continuous quality improvement (CQI) framework that Aboriginal CPHC operates within.

In recent years we have seen Aboriginal AOD and SEWB funding transferred from the Department of Health to DPM&C and put to open tender under the Indigenous Advancement Strategy (IAS). Before this change there had already been the introduction of an increasing number of non-Indigenous not-for-profit providers competing and in some instances taking service funding from ACCHSs (and other Aboriginal service providers).

The IAS increased the number of ACCHSs' programs previously funded through siloed, ongoing grants that have been opened to competitive tendering. The increasing take-over of service funding by NGOs has led to perverse and negative outcomes including fragmentation and duplication of service delivery and lack of coordination.

Recommendation 15: That Aboriginal specific mental health, SEWB and Suicide prevention be directly funded from the Commonwealth Indigenous Health Division to ACCHSs

Instead of blanket implementation of the rebuild model as has been proposed by the Commission, we would like to see SEWB funding currently sitting with the NIAA returned to the Indigenous health division. Then all Aboriginal specific mental health, SEWB and Suicide prevention should be directly funded from the Commonwealth Indigenous Health Division.

Further, we would like to see a policy imperative that all Indigenous suicide prevention funding that is currently going to mainstream organisations be redirected to Aboriginal organisations within the next 5 years.

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