Expert advice on specific challenges for Aboriginal and Torres Strait Islander peoples’ mental health

FINAL REPORT

10 OCTOBER 2014
OUR VISION

To positively impact people’s lives by helping create better health services

OUR MISSION

To use our management consulting skills to provide expert advice and support to health funders, service providers and users.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>I</td>
</tr>
<tr>
<td>ABBREVIATIONS</td>
<td>I</td>
</tr>
<tr>
<td>EXECUTIVE SUMMARY</td>
<td>III</td>
</tr>
<tr>
<td>1 THE BRIEF</td>
<td>1</td>
</tr>
<tr>
<td>2 THE CONTEXT</td>
<td>3</td>
</tr>
<tr>
<td>3 REVIEW FINDINGS: THE PROBLEMS</td>
<td>6</td>
</tr>
<tr>
<td>4 THE SOLUTION: A NEW SERVICE DELIVERY MODEL</td>
<td>12</td>
</tr>
<tr>
<td>5 ASSESSMENT AGAINST REVIEW OBJECTIVES</td>
<td>18</td>
</tr>
</tbody>
</table>
ACKNOWLEDGEMENTS

The HMA team would like to acknowledge the support and guidance of the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group and the National Aboriginal and Torres Strait Islander Leadership in Mental Health. Both groups and their individual members provided timely and expert advice to ensure the review reflected their deep wisdom and experience, as well as helping the HMA team meet the tight project deadlines.
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
</tr>
<tr>
<td>ACCHO</td>
<td>Aboriginal Community Controlled Health Organisation*</td>
</tr>
<tr>
<td>ACCHS</td>
<td>Aboriginal Community Controlled Health Service*</td>
</tr>
<tr>
<td>AHW</td>
<td>Aboriginal Health Worker</td>
</tr>
<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
</tr>
<tr>
<td>AMS</td>
<td>Aboriginal Medical Service*</td>
</tr>
<tr>
<td>AMSANT</td>
<td>Aboriginal Medical Services Alliance Northern Territory</td>
</tr>
<tr>
<td>ATAPS</td>
<td>Access to the Allied Psychological Services</td>
</tr>
<tr>
<td>ATSIMHSPAG</td>
<td>Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group</td>
</tr>
<tr>
<td>BTH</td>
<td>Bringing Them Home</td>
</tr>
<tr>
<td>the Commission</td>
<td>National Mental Health Commission</td>
</tr>
<tr>
<td>DoH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>DSS</td>
<td>Department of Social Services</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>HMA</td>
<td>Healthcare Management Advisors</td>
</tr>
<tr>
<td>IAS</td>
<td>Indigenous Advancement Strategy</td>
</tr>
<tr>
<td>MBS</td>
<td>Medicare Benefits Schedule</td>
</tr>
<tr>
<td>MHNIP</td>
<td>Mental Health Nurse Incentive Programme</td>
</tr>
<tr>
<td>NACCHO</td>
<td>National Aboriginal Community Controlled Health Organisation</td>
</tr>
<tr>
<td>NATSILMH</td>
<td>National Aboriginal and Torres Strait Islander Leadership in Mental Health</td>
</tr>
<tr>
<td>NATSISS</td>
<td>National Aboriginal and Torres Strait Islander Social Survey</td>
</tr>
<tr>
<td>NEP</td>
<td>National Empowerment Project</td>
</tr>
<tr>
<td>NGO</td>
<td>Non government organisations</td>
</tr>
<tr>
<td>NHMRC</td>
<td>National Health and Medical Research Council</td>
</tr>
<tr>
<td>PBS</td>
<td>Pharmaceutical Benefits Scheme</td>
</tr>
<tr>
<td>PHaMS</td>
<td>Personal Help and Mentors</td>
</tr>
<tr>
<td>PIR</td>
<td>Partners in Recovery</td>
</tr>
<tr>
<td>PM&amp;C</td>
<td>The Department of Prime Minister and Cabinet</td>
</tr>
<tr>
<td>RACGP</td>
<td>Royal Australian College of General Practice</td>
</tr>
<tr>
<td>RCIDAC</td>
<td>Royal Commission into Deaths in Custody</td>
</tr>
<tr>
<td>SEWB</td>
<td>Social and emotional wellbeing</td>
</tr>
<tr>
<td>SSAMHS</td>
<td>Statewide Specialist Aboriginal Mental Health Service</td>
</tr>
<tr>
<td>TCCP</td>
<td>Targeted Community Care Programme</td>
</tr>
<tr>
<td>VACCHO</td>
<td>Victorian Aboriginal Community Controlled Health Organisation</td>
</tr>
</tbody>
</table>

*Note: see commentary on terminology on the next page*
Terminology

Throughout this report HMA’s use of the terms Aboriginal Community Health Service (ACCHS) and Aboriginal Medical Service (AMS) is guided by the terminology used by National Community Controlled Health Organisation (NACCHO) in its definitions page at http://www.naccho.org.au/about-us/. This notes that:

“An Aboriginal Medical Service (AMS) is a health service funded principally to provide services to Aboriginal and Torres Strait Islander individuals. An AMS is not necessarily community controlled. Therefore not all AMSs are eligible to be members of NACCHO and its affiliates. If an AMS is not community controlled it will be a government health service run by a State or Territory government.

These non-community controlled AMSs mainly exist in the Northern Territory and the northern part of Queensland.

An Aboriginal Community Controlled Health Service (ACCHS) is a primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it (through a locally elected Board of Management).”
EXECUTIVE SUMMARY

Scope
As part of the National Mental Health Commission’s overall review of mental health programmes, the Commission Secretariat engaged Healthcare Management Advisors (HMA) to:

“supply expert advice to the Commonwealth Government …to examine and consider specific challenges for Aboriginal and Torres Strait Islander people’s mental health including their social and emotional wellbeing, as well as suicide prevention.”

Process
The review commenced on 30 June 2014 and was completed in early October 2014. The project team reported to a Governance Committee that comprised: Professor Pat Dudgeon (National Mental Health Commissioner; Co-Chair, Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group (ATSIMHSPAG), Chair, National Aboriginal and Torres Strait Islander Leadership in Mental Health), Dr Tom Calma, AO (among other roles: Co-Chair, ATSIMHSPAG; and former Chair of the Aboriginal and Torres Strait Islander Suicide Prevention Advisory Group), and Ms Catherine Lourey, Acting Deputy CEO of the Commission.

Findings
The review found extensive evidence of significant levels of need for mental health services within the Aboriginal and Torres Strait Islander population.

The review identifies and documents many examples of good models of care and high quality services ‘on the ground’ seeking to address these needs. Yet, despite their best efforts, they are unable to deal with the extensive underlying demand.

This is not helped by major difficulties with current mainstream and targeted interventions at the programme level. This reflects problems with

• How individual programmes are designed
• How the programme ‘silos’ interact (or don’t) and the impact this has on clients
• Poor quality linkage of patients across system components, particularly between the primary mental health components (mainly funded by the Commonwealth) and specialist clinical services components (mainly delivered by the States and Territories).

The review found that the current package of programmes is ineffective at the macro level because of these structural problems.

Compounding these problems are limitations in the policy implementation environment including poor data collection on service usage by Aboriginal and Torres Strait Islander people and the need to endorse key policy frameworks.

Solution
Government should support introduction of an Enhancing Mental Health and SEWB Reform Strategy to more appropriately target Aboriginal and Torres Strait Islander mental health funding. This should have ‘five pillars’ to support the transformation process:

(1) Integrated Mental Health and SEWB Teams operating in all ACCHSs/ AMSs
(2) Culturally responsive mainstream services, including specialist mental health services and general practice, that are accountable for how they deliver better mental health outcomes for Aboriginal and Torres Strait Islander people
(3) Linking and supporting patients in specialist clinical services to facilitate the patient journey for Aboriginal and Torres Strait Islander peoples across the service system within each jurisdiction.
(4) National Aboriginal and Torres Strait Islander workforce development programme.

(5) Increased funding under a proposed COAG ‘Closing the Gap’ mental health funding stream and establishing mental health as a priority within the COAG Closing the Gap Framework.

The preliminary estimate of funding the programme is $323m, once fully operational. These costs could be partially offset by reinvesting funds from mainstream programs where there is evidence that have been ineffective in supporting the needs of Aboriginal and Torres Strait Islander people.
1 THE BRIEF

SCOPE

As part of the National Mental Health Commission’s overall review of mental health services and programmes, the Commission Secretariat engaged HMA to

“supply expert advice to the Commonwealth Government ...to examine and consider specific challenges for Aboriginal and Torres Strait Islander people’s mental health including their social and emotional wellbeing, as well as suicide prevention.”

The project terms of reference mirrored specifications for the broader review. In summary HMA was requested to:

1. Examine and consider the ‘top five issues’ currently affecting the mental health of Aboriginal and Torres Strait Islander people.
2. Provide advice that aligns with the seven heads of consideration given to the Commission:
   - leadership and good governance,
   - promoting a productive population,
   - developing strong markets,
   - infrastructure requirements,
   - smart use of technology,
   - developing a skilled workforce, and
   - promoting research.
3. Advise on appropriate ways of translating models into implementation, including how funding can be more appropriately targeted.

PROCESS

The review commenced on 30 June 2014 and was completed in early October 2014. The project team reported to a Governance Committee that comprised: Professor Pat Dudgeon (National Mental Health Commissioner; Co-Chair, Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group (ATSIMHSPAG), Chair, National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH), Dr Tom Calma, AO (among other roles: Co-Chair, ATSIMHSPAG; and former Chair of the Aboriginal and Torres Strait Islander Suicide Prevention Advisory Group), and Ms Catherine Lourey, Acting Deputy CEO of the Commission.

The review methodology involved desk top analysis of documentation, discussions with members of ATSIMHSPAG and NATSILMH, and interviews with eight subject matter experts identified by the advisory groups. The project consultation processes were narrow, limited by the need for signed confidentiality agreements and the tight project timelines. Nevertheless, HMA felt comfortable that the ready access to ATSIMHSPAG and NATSILMH, and their nominated experts, ensured the review analysis and project findings were informed by specialist knowledge.

HMA analysed the key themes emerging from the previous stages and presented this material to meetings of ATSIMHSPAG and NATSILMH, and their nominated experts, ensured the review analysis and project findings were informed by specialist knowledge.

The National Aboriginal Community Controlled Health Organisation (NACCHO) was given further additional opportunity to comment on the draft report before finalisation.

REPORT STRUCTURE

The remainder of the final report has the following structure:

- Chapter 2, The Context gives a brief overview of significant facts about the sector relevant to the review findings
- Chapter 3, The Problems describes the main findings of the review
THE BRIEF

• Chapter 4, The Solution responds to the third term of reference – translating models into implementation. It presents a vision for a new service delivery model to address the problems found by the review.

• Chapter 5, Assessment Against the Review Objectives gives specific responses to the other review terms of reference: the ‘top five’ issues and the seven ‘heads of consideration’.

Accompanying the final report is a background paper that presents additional detail to support the review findings. This includes discussion of models that work well, descriptions of good practice, and details of programme expenditure.
2  THE CONTEXT

DEMOGRAPHICS

The Australian Bureau of Statistics (ABS) estimated that in June 2011 there were 670,000 Aboriginal and Torres Strait Islander people in Australia. This represented 3% of the total population.

CURRENT SERVICE SYSTEM STRUCTURE

There are four main categories of mental health service accessed by Aboriginal and Torres Strait Islander people seeking support for their illness. Three of these service categories are the same as for non-Indigenous Australians:

- mainstream primary care, including general practice and community health (see further comments below on the importance of this service category)
- specialist clinical mental health services, and
- specialist non-clinical mental support services.

The fourth sector specifically targets the primary health care needs of Aboriginal and Torres Strait Islander people: health care organisations funded by the Commonwealth to specifically address their primary health care needs. In 2012-13 there were 260 of these organisations. The range of services they provide varies by agency but can comprise:

- primary health: these services, particularly those with general practitioners (GPs), are usually the first health service visited by a patient with a health concern, including a mental health problem.
- social and emotional wellbeing (SEWB) counselling services: these services provide counselling support for Aboriginal and Torres Strait Islander people. Programme guidelines require services to prioritise clients in the following order:
  - people from the first generation of the Stolen Generations who were directly impacted by forcible child removals,
  - members of families and communities from which children were removed, and
  - second, third, fourth and subsequent generations
- Link Up: provide Stolen Generation family tracing, reunions and counselling
- Substance use services: provide drug and alcohol rehabilitation services.

Information on the extent of mental health service provision within ACCHO’s primary health programmes is limited. Reporting to the Department of Health (DoH) is at an aggregate level and DoH does not have access to patient level data. As a consequence, it is not possible to identify the total number of unique patients receiving mental health-related services or the number of episodes of care received across the above service types. DoH is making some progress to enhance reporting through its OCHREStreams initiative, an on-line reporting environment for government funded community health services. This requires ongoing investment effort.

Of the 260 Commonwealth funded health care organisations, around two thirds (67% or 175) identify as Aboriginal Community Controlled Health Services (ACCHSs) with community-based boards of governance. The other forms of governance comprise:

- other non-government organisations - 38 services (14.6%)
- government agencies – 47 services (18.1%).

Of the 175 ACCHSs, 145 were staffed with a GP and therefore able to provide primary mental health medical services.

Use of ACCHSs is extensive. AIHW’s On-Line Services Report found that 314,000 Aboriginal and Torres Strait Islander clients used these services in 2012-13.

1 Note: AIHW uses the term Aboriginal Controlled Health Organisation. See the comment on terminology in on p. iii.
representing around half (47%) of the estimated total Aboriginal and Torres Strait Islander population of 670,000.

USE OF MAINSTREAM MENTAL HEALTH SERVICES BY ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

A significant proportion of Aboriginal and Torres Strait Islander people (around half) do not use an ACCH for their primary health care. It can be surmised that this is for two possible reasons:

- there is no ACCH in their immediate geographic area, and/or
- they prefer to use a mainstream service.

The mainstream primary medical health care system, including its primary mental health care capacity, is therefore an important source of services for many Aboriginal and Torres Strait Islander people. However, there is only limited information available about the characteristics of this client group within the primary health system, potentially amounting to almost half of the total Aboriginal and Torres Strait Islander population. This includes in relation to their MBS and PBS use for mental health and related goods and services.

Aboriginal and Torres Strait Islander people have an ongoing need to access specialist mental health services funded and operated by state and territory public health services. These include acute inpatient mental health care, community residential care, and newly emerging sub-acute mental health services (for step-up and step-down support from inpatient care).

MENTAL HEALTH COMPARED TO SOCIAL AND EMOTIONAL WELLBEING

The concept of social and emotional wellbeing (SEWB) is central to critiquing the operations of service delivery for Aboriginal and Torres Strait Islander people. This is a broader perception than mental health. A succinct summary contrasting the concepts is the following:

The concept of mental health comes more from an illness or clinical perspective and its focus is more on the individual and their level of functioning in their environment. The social and emotional wellbeing concept is broader than this and recognises the importance of connection to land, culture, spirituality, ancestry, family and community, and how these affect the individual. Social and emotional wellbeing problems cover a broad range of problems that can result from unresolved grief and loss, trauma and abuse, domestic violence, removal from family, substance misuse, family breakdown, cultural dislocation, racism and discrimination and social disadvantage.

A conceptual model of SEWB described by Gee, Dudgeon, Schulz, Hart and Kelly is shown below (see Figure 2.1). It emphasises:

- the importance of having regard to the historical, political and cultural determinants that have negatively impacted on the mental health of Aboriginal and Torres Strait Islander peoples,
- that the concept of ‘self’ used in the model is grounded within a perspective that views the self as inseparable from, and embedded within, family, kinship and community, and
- the importance of strengthening people’s connection to body, mind and emotions, family and kin, community, culture, country and spirit, spirituality and ancestors in order to support their mental health and overall wellbeing.

SEWB is particularly important as a support of mental health and a source of resilience against adversity. Supporting and strengthening SEWB is important to preventative responses to mental health problems in Aboriginal and Torres Strait Islander communities.
THE CONTEXT

Figure 2.1: The Concept of Social and Emotional Wellbeing.

3 REVIEW FINDINGS: THE PROBLEMS

OVERALL DESCRIPTION OF THE PROBLEMS

The review found extensive evidence of **significant levels of need** for mental health services within the Aboriginal and Torres Strait Islander population.

The review identifies and documents many examples of good models of care and high quality services ‘on the ground’ seeking to address these needs. These are delivered by dedicated clinicians and support workers with the back-up of committed management and boards.

However, despite their best efforts, they are unable to deal with the extensive underlying demand. The *AIHW Online Service Report, 2012-13* stated that in 56.6% of ACCHOs there was a gap in services for mental health/social and emotional wellbeing.\(^5\)

This is not helped by major difficulties with both mainstream and targeted interventions at the programme level. This reflects problems with

- how individual programmes are designed
- how the programme ‘silos’ interact (or don’t) and the impact this has on clients, and
- poor quality linkage of patients across system components, particularly between the primary mental health components (mainly funded by the Commonwealth) and specialist clinical services components (mainly delivered by the States and Territories).

The review found that the **current package of programmes is ineffective** at the macro level because of these structural problems.

Compounding these problems are **limitations in the policy implementation environment**.

Each of these broad categories of problem is examined in more detail below.

A CRISIS OF NEED

Information on the underlying mental health needs of Aboriginal and Torres Strait Islander people is confronting; on most comparable measures their needs are significantly higher than those of other Australians.

Data from a range of sources including the ABS and the Australian Institute of Health and Welfare (AIHW) shows:

Prevalence

- in 2008 nearly one third (31%) of Aboriginal and Torres Strait Islander adults had *high or very high* levels of psychological distress, more than twice the rate for Other Australians.\(^6\)

Incidence

- suicide rates of Aboriginal and Torres Strait Islander people vary by jurisdiction. Statistics for the combined jurisdictions of NSW, Queensland, South Australia, Western Australia and the Northern Territory over the period 2001-2010 show that there were **21.4 suicides per 100,000 Aboriginal and Torres Strait Islander people**, more than double the rate for Other Australians with a rate of 10.3 per 100,000 people
  - The suicide rates for Aboriginal and Torres Strait Islander people were higher in some jurisdictions, for example: 30.8 per 100,000 people in the NT, 26.7 per 100,000 people in South Australia, and 26.2 per 100,000 people in Western Australia.
- **Aboriginal and Torres Strait Islander people report stressful events at 1.4 times the rate of non-Indigenous people.** Stressful events can include serious illness,
REVIEWS FINDINGS: THE PROBLEMS

serious accident, mental illness, serious disability, death of a family member or close friend, divorce or separation, not able to get a job, involuntary loss of job, alcohol or drug-related problem, gambling problems, witness to violence, abuse or violent crime, and trouble with the police.7

Service Usage

• **depression**: admission to hospital for Aboriginal and Torres Strait Islander men with severe mood and neurotic disorders was 1.2 times the rate of other Australians8

• **personality disorders**: Aboriginal and Torres Strait Islander men were admitted to hospital with personality disorders at 1.8 times the expected rate for their proportion of the Australian population (3%). Unexpectedly, the equivalent admission rate for Aboriginal and Torres Strait Islander women was 0.8 times the expected rate.9

The greater levels of need described above are reflected in higher per capita levels of expenditure on acute inpatient care, the most expensive part of mental health treatment. The ratio of Aboriginal and Torres Strait Islander per capita expenditure in 2010-11 compared with Other Australians was:

- 2.68 to 1 for all mental health and behavioural disorder hospital separations ($336:$125 per capita)
- 1.65 to 1 for anxiety and depression hospital separations ($53: $32 per capita)
- 3.97 to 1 for alcohol dependence and other harmful use ($37:89 per capita), and
- 2.58 to 1 for self-inflicted injuries, an indicator of attempted suicide ($19:7 per capita).10

These statistics all relate to Aboriginal and Torres Strait Islander people experiencing mental illness. The impacts of disease are likely to have ‘knock-on’ affects to other family members and the communities where they live but there is no national level data on these multiplier effects. The review found no categorical evidence of whether these measures are trending up or down. The normative view of experts consulted in the review is that nationally the trends are getting worse (see Evidence Box 1).

Evidence Box 1

During consultations for the review Winthrop Professor Helen Milroy, a specialist in Aboriginal and Child psychiatry observed:

“A harmed child equals a harmed adult….. Investment in early childhood mental health care will provide the best ‘bang for the buck’. There should be lots of support to mothers during early infancy and readiness for school should be monitored…..

…….The way Aboriginal kids are being brought up is increasingly abnormal. Their parents are suffering from chronic health problems at a young age. Elders are not providing the buffer that they used to – because they are dying. This cycle is getting worse.”

CURRENT PROGRAMMES: DESIGN FLAWS

The review found a range of problems with the design of both mainstream and targeted programmes.

Design Flaw #1: Targeted Programmes Focus on Treatment, not Promotion and Prevention

Resource allocation is skewed towards treatment. There are minimal funds for prevention and early intervention services. The review identified $123.1m of Commonwealth grants that were specifically targeted to Aboriginal and Torres Strait Islander mental health in 2012-13. Of this amount, 78.3% ($96.5m) is allocated to just two treatment programmes located within the Department of the Prime Minister and Cabinet (PM&C):

- $40.1m for SEWB Counselling and related programmes (Link-up and counselling workforce support), and
- $56.4m for substance use (drug and alcohol programmes)

There were no targeted programme allocations for early intervention services relating to children or youth. There was a small allocation ($0.650m) for SEWB promotion.
Some early intervention and prevention resources are allocated at an organisation level from the pool of primary health care funding distributed by DoH. But this is unlikely to be extensive. Most primary health care resources are directed towards the management of Aboriginal and Torres Strait Islander chronic disease.

It will not be possible to reduce this expenditure on treatment in the short-term; it will take years for the impact of investing more resources in prevention and early intervention services to reduce underlying demand for treatment services. Nevertheless, the current approach to mental health resource allocation for Aboriginal and Torres Strait Islander people needs a change in emphasis.

**Design Flaw#2: Mainstream Commonwealth Programmes Apply a ‘One Size Fits All’ Approach**

The review found the Commonwealth approach to mainstream programme design is often not effective from an Aboriginal and Torres Strait Islander perspective. There should be more attention to directing mainstream programme funds through ACCHSs. The use of ACCHSs is an effective mechanism for getting services to Aboriginal and Torres Strait Islander people (see Evidence Box 2).

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

1. Individual clinicians (e.g. MBS for psychologists),
2. Medicare Locals (e.g. Access to Allied Psychological Services (ATAPS))
3. A combination of Medicare Locals or non-government organisations (e.g. Partners in Recovery (PIR) and Personal Helpers and Mentors (PHaMS)).

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

The ATAPs Tier 2 programme (to enable Aboriginal and Torres Strait Islander people to access culturally competent mental health professionals and suicide prevention...
services) shows that an initiative located within mainstream services – even one that seeks to address the lack of access by Aboriginal and Torres Strait Islander people – is likely to have only limited success if it is not promoted effectively. ATAPS Tier 2 was a response to the lack of take-up of ATAPs Tier 1 funded services by Aboriginal and Torres Strait Islander people. Yet the ATAPS Tier 2 programme has been relatively underused and HMA heard anecdotal evidence of a lack of awareness about the programme in some communities. During 2012-13 there were just 2,097 users under the Tier 2 component, a low take-up rate given the high levels of underlying need identified above.

The review concluded mainstream programmes should give more attention to how ACCHs can be positively favoured to get a larger share of the mainstream grants, reflecting the high level of need of the population they serve. An alternative funding approach would be to redirect a needs-based proportion of all mainstream mental health programme resources into a funding pool for Aboriginal and Torres Strait Islander primary mental health. This pool would then be allocated to ACCHs using population-based resource allocation formulae incorporating relative needs indices.

### Design Flaw #3: Inefficient Resource Allocation

Funding allocations to ACCHs are often inefficient; small parcels of funding make it difficult for service providers to have a real, sustainable impact. There are also problems with integration of services on the ground.

Although the SEWB Counselling Programme is the primary counselling service for Aboriginal and Torres Strait Islander people using an ACCHs, the current resource distribution is small and inequitably distributed. The $18.6m allocated for SEWB Counselling Program in 2012-13 went to 116 grant recipients. This represents an average SEWB counselling grant of $160,000. The AIHW 2014 On-line Services Report found that in the 198 SEWB reporting services, there were an average of just 1.8 counsellors per SEWB service.\(^3\)

The allocation of these $18.9m was also inequitable across jurisdictions (see Table 3.1).

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>No of Grants</th>
<th>Total Grants</th>
<th>Average Grant</th>
<th>Grant per Capita, by Jurisdiction</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT</td>
<td>3</td>
<td>635,418</td>
<td>211,806</td>
<td>103.15</td>
</tr>
<tr>
<td>SA</td>
<td>13</td>
<td>1,833,874</td>
<td>141,067</td>
<td>49.02</td>
</tr>
<tr>
<td>NT</td>
<td>9</td>
<td>2,835,531</td>
<td>315,059</td>
<td>41.18</td>
</tr>
<tr>
<td>VIC</td>
<td>20</td>
<td>1,944,593</td>
<td>97,230</td>
<td>41.08</td>
</tr>
<tr>
<td>WA</td>
<td>18</td>
<td>2,932,083</td>
<td>162,894</td>
<td>33.22</td>
</tr>
<tr>
<td>NSW</td>
<td>27</td>
<td>4,499,615</td>
<td>166,652</td>
<td>21.58</td>
</tr>
<tr>
<td>TAS</td>
<td>3</td>
<td>485,303</td>
<td>161,768</td>
<td>20.08</td>
</tr>
<tr>
<td>QLD</td>
<td>23</td>
<td>3,372,792</td>
<td>146,643</td>
<td>17.85</td>
</tr>
<tr>
<td>TOTAL</td>
<td>116</td>
<td>18,539,209</td>
<td>159,821</td>
<td>27.69</td>
</tr>
</tbody>
</table>

Because of these limitations, the SEWB Counselling Programme is a poorly resourced base for the development of comprehensive primary mental health services for ACCHs. A full suite of Aboriginal and Torres Strait Islander healing and culturally appropriate SEWB and mental health promotion, prevention, early intervention, treatment and recovery services is needed to support the needs of local communities. A significant injection of funds is required to have a real impact.

Despite the limitations in the base allocation of counselling resources for ACCHs, other mainstream programmes have not enhanced the base when allocating their own funds (see Evidence Box 3).

---

Table 3.1: Average SEWB Counselling Grant Per Capita, by Jurisdiction, 2012-13
Evidence Box 3

A submission to the Commission observed:

“Multiple funding streams have lead to multiple service providers in many Aboriginal communities that do not integrate the care they provide with other elements of the health system. This has lead to fragmented care and patients not being treated as whole patients. An example in [town X] has been the PHaMS program which was given to Mission Australia without consideration of integrating its service within the [ACCHS] Social and Emotional Wellbeing Service. … PHaMS, Better Access to Psychologists and Mental Health Services in Rural and Remote Australia has lead to isolated psychologists and other mental health workers employed by a myriad of organisations not integrated into primary health and duplicating existing effort while requiring the expertise of local Aboriginal health services to access clients.”

The application of the ‘one size fits all’ approach can result in expensive unit costs of delivery. For example, analysis of ATAP’s Tier 2 Indigenous component statistics showed:

- the average cost of a ‘mainstream’ session was around $170
- the average cost of a Tier 2 Indigenous programme session was $483, 260% higher.

Allocation of resources to address mental health needs of Aboriginal and Torres Strait Islander people are welcome but they should be effectively applied. It would be more efficient to allocate these funds into a resource funding pool for Aboriginal and Torres Strait Islander primary mental health delivered by ACCHOs.

Design Flaw #4: Lack of Cultural Responsiveness

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

This training should support broader measures to increase cultural safety, including employment of Aboriginal and Torres Strait Islander doctors, nursing, allied health professional and/or health care workers, respecting gender-based cultural values and practices in clinical approaches (i.e., men’s business and women’s business), having access to interpreter services, and recognising cultural conceptions of health and wellness in clinical practice.

LIMITATIONS IN THE POLICY IMPLEMENTATION ENVIRONMENT

Problems in the policy implementation environment are hindering the speed at which change is implemented.

Strategic Frameworks

The draft National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2014-2019 is being developed and is still to be signed off by Australian health ministers. Likewise, a new Aboriginal and Torres Strait Islander Peoples’ Drug Strategy is in development. The National Aboriginal and Torres Strait Islander Suicide Prevention Strategy needs to be implemented by the Australian Government. Complementing these, the National Aboriginal and Torres Strait Islander Health Plan 2013-23 contains some mental health and social and emotional wellbeing content but also remains to be implemented.

All these strategies should be operationalised as soon as possible and resourcing allocated to support their implementation in a coordinated fashion. In particular the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2014-2019 provides an opportunity to develop the first dedicated plan of action to improve the mental health of Aboriginal and Torres Strait Islander peoples.
3 REVIEW FINDINGS: THE PROBLEMS

Split of Programme Responsibilities

Recent changes to machinery of government arrangements have further fractured ministerial responsibility for Aboriginal and Torres Strait Islander mental health and SEWB programmes at a Commonwealth level. There are now three portfolios that have responsibility for these areas: DoH, the Department of Social Services (DSS) and PM&C.

An integrating mechanism is needed to ensure these portfolios are working to a common goal. The Commission should have a role in monitoring implementation of these arrangements.

Statistics on Programme Use and Outcomes

There is an urgent need to increase the knowledge about use of both mainstream and targeted programmes by Aboriginal and Torres Strait Islander people. Government and the community need to know if the investment of resources they are making is having any impact.
4  THE SOLUTION: A NEW SERVICE DELIVERY MODEL

THE REQUIREMENT

None of the problems highlighted in this review are new. The flaws in programme design, gaps in service delivery and growing evidence of unmet need have been discussed within the sector for years. Some of the problems discussed in this report were first placed in the public spotlight by the 1991 report of the Royal Commission into Aboriginal Deaths in Custody.

The terms of reference state that the review should propose how funding can be more appropriately targeted. This chapter presents that approach.

OVERVIEW OF APPROACH

Realising generational change to the mental health and SEWB of Aboriginal and Torres Islander people requires a new, coordinated investment. This will take five to ten years to implement and requires extensive planning in the short-term, and probably many more years before the results start to be reflected in health outcome measures.

Extensive implementation planning is required in the immediate short-term. The proposed *Enhancing Mental Health and SEWB Reform Strategy* has five pillars to support the transformation process:

1. **Integrated Mental Health and SEWB Teams in all ACCHs and AMSs**

2. **Culturally responsive mainstream services**, including specialist mental health services and general practice that are accountable for how they deliver better mental health outcomes for Aboriginal and Torres Strait Islander people.

3. **Linking and Supporting Patients in Specialist Clinical services** to facilitate the patient journey for Aboriginal and Torres Strait Islander people across the service system within each jurisdiction. This could involve models like WA’s Specialist Aboriginal Mental Health Service team (SSAMHS) but may need to be adapted to other jurisdictions.

4. **National Aboriginal and Torres Strait Islander workforce development programme** to increase the numbers of Aboriginal and Torres Strait Islander in the delivery and clinical leadership of culturally responsive mental health services in ACCHOs, AMSs and mainstream mental health services.

5. **Increased funding under a proposed COAG ‘Closing the Gap’ mental health funding stream and establishing mental health as a priority within the COAG Closing the Gap Framework.**

The relationship of the five pillars to SEWB is shown in Figure 4.1 (see next page).

In addition to strengthening mental health and SEWB services to ensure Aboriginal and Torres Strait Islander people are able to lead contributing lives it is important ACCHS and AMSs, together with mainstream mental health services, work with governments and community organisations to improve access to secure housing, education and employment and strengthen social inclusion. These are the key social determinants that need to be addressed to support Aboriginal and Torres Strait Islander people with a mental illness to lead a contributing life.

The strategies within each of the five pillars need to be aligned and integrated to ensure they support the strengthening of Aboriginal and Torres Strait Islander mental health and SEWB. This should be supported by the implementation of the *National Aboriginal and Suicide Prevention Strategy* and the development of a dedicated Aboriginal and Torres Strait Islander mental health plan through implementation of the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2014-2019* and related strategies.
A description of each of the reform pillars shown in Figure 4.1 is provided below.

**INTEGRATED MENTAL HEALTH AND SEWB TEAMS**

**Rationale:** Mental health services should be fully integrated within ACCHSs and AMSs as comprehensive primary health care services, and not exist as ‘siloed’ services. It then becomes more possible to treat the needs of the ‘whole person’ as per the holistic concept of health and mental health that underpins the ACCHS/AMS service model. The integrated teams will provide access to:

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

**What’s proposed:** Each ACCHS and AMS will have an integrated Mental Health and SEWB team providing links to:

- community mental health
- alcohol and other drugs
- primary health care
- access to a psychiatrist
- links to mainstream services

**Workforce requirements** for the model are informed by planning work undertaken by the Aboriginal Medical Services Alliance Northern Territory (AMSANT). The adapted model proposes workforce groupings to population catchments in multiples of 1,500 people with the core for each team comprising:

- 1 psychologist
- 2 specialist Mental Health Nurses and/or Aboriginal Mental Health Worker
- 2 counsellors (CBT trained)
- 4 community mental health support workers, including traditional Aboriginal healers and peer support workers
- 1 psychiatrist (per 10,000 people)

The integrated teams would implement models of care/clinical pathways for:

- community mental health – screening, treatment, support
- alcohol and other drugs
- chronic illness support
THE SOLUTION: A NEW SERVICE DELIVERY MODEL

- SEWB promotion / community strengthening.

**Evidence base for approach:** AMSANT planning. The model is partially implemented in some AMSANT affiliates such as Congress (Alice Springs) and Danila Dilba Health Service (Darwin)

**Indicative cost:** $210m per annum (net of current SEWB Counselling services, which would be rolled into the new teams)

**Initial steps prior to implementation:** develop a detailed model at the ACCHS/regional level of operational costs. This would require:
- mapping of the current workforce infrastructure across ACCHS/AMSs
- workforce gap analysis – comparing current infrastructure with the proposed model
- estimate actual operational costs
- estimate new workforce requirements by ACCHS/AMS.

**CULTURALLY RESPONSIVE MAINSTREAM SERVICES**

**Rationale:** Aboriginal and Torres Strait Islander people are reliant on mainstream general practice and specialist public mental health services for much of their mental health care. These services have been demonstrated to be unresponsive to the cultural needs of Aboriginal and Torres Strait Islander people.

**What’s proposed:** Aboriginal and Torres Strait Islander mental health is the business of every part of the mental health system. It is ‘every body’s business’. As such, every jurisdiction should consider ways to hold mainstream service providers accountable for improved outcomes for Aboriginal and Torres Strait Islander mental health, which may include:
- Legislative, and/or policy approaches
- Development of quality and professional standards with organisations such as RACGP, Practice Nurses Association and AGPAL
- Setting targets and key performance indicators in funding agreements as a way of holding mainstream service providers accountable for the development of culturally responsive services. Key indicators could be set in relation to:
  - Partnership agreements being established at a local level between the leadership of mainstream services and the ACCHS/AMS
  - Requirements to develop Aboriginal mental health service plans and/or professional development strategies
  - Developing clinical pathways in partnership with the local ACCHS/AMS for mental health patients defining how the services will support patients in their journey from primary care to acute care and the provision of ongoing care for people with a chronic mental illness
- Ensure professional development programmes are being delivered to support mainstream staff develop cultural competencies.

**Evidence base for approach:** learnings from the Victorian Government’s *Koolin Balit strategic directions for Aboriginal health 2012–2022* developed in conjunction with the Victorian Aboriginal and Community Controlled Health Organisations (VACCHO). One of the strategy enablers is *cultural responsiveness* of mainstream services. Initiatives have been implemented to make services more culturally responsive (e.g. training, accreditation processes, pilots for improved participation by Aboriginal people in cardiac rehabilitation, paediatrics, emergency, and cancer care). This work can guide the development of the broader national strategy.

**Indicative cost:** $10m per annum

**Initial steps prior to implementation:** develop an implementation strategy that will require:
- map current cultural competence and safety resources available to support staff in public health services (mental health specific and generic, including general practice), by jurisdiction
- development of templates for:
  - partnership agreements
  - targets
  - cultural competence and safety standards
  - clinical pathways
- set jurisdictional targets.
Further attention is required by mainstream services to the mental health needs of Aboriginal and Torres Strait Islander people in custodial care. Of particular concern is the significant over-representation of Aboriginal and Torres Strait Islander youth within juvenile detention centres, where they represent 54.7 per cent of juvenile detainees (around 460 people). A justice reinvestment programme for these detainees should be introduced to reduce the risk of reoffending and minimise future custodial care outlays ($23m per annum).

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

**LINKING AND SUPPORTING PATIENTS IN SPECIALIST CLINICAL SERVICES**

**Rationale:** Additional services should be put in place to facilitate the journey of Aboriginal and Torres Strait Islander people into and through the specialist mental health service system.

**What’s proposed:** Each state and territory has a different infrastructure and mix of services, so the most appropriate response will vary. Some jurisdictions could choose to establish specialist Aboriginal and Torres Strait Islander mental health services along the lines of the Western Australian Statewide Specialist Aboriginal Mental Health Service (SSAMHS) model. This model may need to be adapted to the specific service delivery structures of other jurisdictions. Irrespective of the precise approach, the implementation model should have the following features:

- **Target group:** All Aboriginal and Torres Strait Islander people admitted to a specialist (mainstream) mental health service.
- **Process:**
  - Ensure each referred/admitted patient is linked from the ACCHs/AMSs to the mainstream service and back again on discharge.
  - Cultural support during admission.
  - Access to traditional healers and healing services.
  - Maintain link to family.
  - Facilitate access to community support on return to community.

**Evidence base for approach:** The SSAMHS model implemented in Western Australia under the National Partnership Agreement in Closing the Gap in Indigenous Health Outcomes. An evaluation of the services has recently been completed but is yet to be released. Anecdotal reports suggest the services are significantly more successful than mainstream services in meeting the needs of Aboriginal and Torres Strait Islander peoples in WA.

**Indicative cost:** $50m per annum.

**Initial steps prior to implementation:** Assess the implications of a rollout at jurisdiction level, based on:

- Findings from the WA SSAMHS evaluation
- Develop a cost model template to assess resource and funding requirements at an individual jurisdiction level.

**NATIONAL ABORIGINAL AND TORRES STRAIT ISLANDER WORKFORCE DEVELOPMENT PROGRAMME**

**Rationale:** Implementation of integrated Mental Health and SEWB teams will require significant expansion of an appropriately skilled workforce in ACCHs/AMSs and mainstream health services.

**What’s proposed:** Each jurisdiction needs to develop a workforce strategy that examines current capacity and identifies future workforce needs with a view to growing a strong and sustainable Aboriginal and Torres Strait Islander mental health workforce in both mainstream services and ACCHs/AMSs.
THE SOLUTION: A NEW SERVICE DELIVERY MODEL

Key components of the strategy should include:

- **identify current capacity and identify future workforce needs.** Little has been done to date in this area, although NSW Health has a policy directive under its NSW Aboriginal Mental Health and Wellbeing Policy requiring at least one Aboriginal and Torres Strait Islander mental health worker to be employed per 1,000 Aboriginal and Torres Strait Islander people in the catchment area.

- **strengthen Aboriginal and Torres Strait Islander health workers to attain advanced qualifications** by strengthening educational pathways from the Vocational Education Training sector to the University sector.

- **strengthen Aboriginal and Torres Strait Islander participation rates in tertiary courses and in the mental health workforce.** This will involve health professional associations and education providers taking greater responsibility for increasing the level of Aboriginal and Torres Strait Islander students undertaking their courses and entering the profession. The medical profession is currently demonstrating good practice in supporting the training and mentoring of Aboriginal and Torres Strait Islanders medical students. Similar attention is required in all health workforce categories, including nursing and relevant allied health disciplines. Progress should be benchmarked against standards developed by colleges and other professional associations.

- **development of specialist Aboriginal mental health courses** based on Djirruwang Programme (Charles Sturt University). This three year Bachelor of Health Science (Mental Health) degree has a curricula based on: workplace learning, university learning, placement learning and development of mental health competencies.

**Evidence base for approach:** *Medical profession approach* to increasing numbers of Aboriginal and Torres Strait Islander doctors and the *Djirruwang Programme.*

**Indicative cost:** $30m per annum.

**IMPLEMENTATION ISSUES**

The range of activities envisaged under the Enhancing Mental Health and SEWB Reform Strategy will require extensive planning over the next 12 to 18 months prior to commencing implementation. This will require assessment of what funding from mainstream programmes could be diverted into the new programme to offset costs. This must be subject to the outcome of individual programme reviews but HMA envisages this could include elements of ATAPS, MHNIP, PIRS, PHAMS, headspace, and mainstream suicide prevention programmes.

Administrative arrangements must be introduced to monitor implementation of the Reform Strategy and ensure accountability of government departments and jurisdictions for progress. Options for monitoring include:

- a specific term of reference for the National Mental Health Commission
- a new independent position.

The monitoring process should look at linkages to other reform initiatives including broader health reform and the Indigenous Advancement Strategy.

**FUNDING IN THE INTERIM: WHAT SHOULD HAPPEN**

Given the size of the mental health gap, there must be no cuts to funding of any programme that specifically targets the needs of Aboriginal and Torres Strait Islander people. Further, there should be an assumption that - until an evidence base is in place to say otherwise – having any programme or service in place is better than having none.

The review suggests progressing along the following lines:

- **suicide prevention spending commitments, including to the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy should be quarantined**
- wherever possible, existing expenditure should contribute to supporting expanded ACCHSs and SEWB services and also specialist Aboriginal and Torres Strait Islander mental health services (i.e. support pillars 1 and 2 of the Reform Strategy).
- **Government should consider the adoption of a standardised approach to setting macro level funding targets for mental health programme for Aboriginal and Torres Strait Islander people, with the following elements**
  - any new initiative for mental health should automatically quarantine an agreed target allocation to be directed to Aboriginal and Torres Strait Islander mental
health, irrespective of the programme type involved (e.g. primary mental health, specialist non-clinical services, Commonwealth/State cost shared programmes).

– agreement on how best to deliver the service type in an Aboriginal and Torres Strait Islander context should only be determined after consultation with relevant stakeholders, including NACCHO.

– the target funding level should be set based on epidemiological modelling but nominally should be around 6% of mainstream service funding (reflecting that Aboriginal and Torres Strait Islander peoples comprise about 3% of the total population but have about double the mental health needs.)

• funding effort would partially shift from treatment towards a greater focus on promotion and prevention. The shift should occur gradually – over ten plus years. It is not the intention of the review to cut funding to treatment if it is currently needed.

• funding should be increased in order to implement the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2014-2019. Funding could be channelled from the Indigenous Advancement Strategy particularly the “Culture and Capability” and “Safety and Wellbeing” streams to support this process.
5 ASSESSMENT AGAINST REVIEW OBJECTIVES

In accord with the terms of reference, this chapter presents the ‘top five issues’ and discusses findings in response to the seven heads of consideration: leadership and good governance, promoting a productive population, developing strong markets, infrastructure requirements, smart use of technology, developing a skilled workforce, and promoting research.

TOP FIVE ISSUES

The first term of reference requested the identification of the ‘top five issues’ currently affecting the mental health of Aboriginal and Torres Strait Islander peoples with respect to planning, delivery and outcomes of Commonwealth, state and territory, and non-government mental health programmes.

Guided by ATSIMHSPAG, the review finds that the top five issues aligned closely with key action areas framed at a system level that are identified in the draft National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2014-19:

1. The need for strategies to promote the healing and wellbeing of communities, families and individuals
2. Effective promotion of mental health and social and emotional wellbeing across the life course with a focus on younger age groups
3. The need for prevention strategies to detect and manage risks to mental health
4. The need for clinical and culturally appropriate treatment of mental health problems and mental illnesses
5. The need to promote the social and emotional wellbeing of those with ongoing and severe mental illnesses to assist with recovery and relapse prevention.

SEVEN HEADS OF CONSIDERATION

Leadership and good governance

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

The review found that ACCHS/AMSs should be accountable for the continuing development of mental health and social and emotional wellbeing services in their communities broadly through existing funding and services agreements with government. However, these agreements should be expanded and streamlined to include the delivery of services and programmes that are the responsibility of DoH, DSS and PM&C.

There must be additional obligations placed on NGOs and other mainstream organisations funded to provide mental health services to report on their levels of engagement with Aboriginal and Torres Strait Islander people and communities and the cultural responsiveness of the services.

Mainstream mental health services should be accountable for the quality of care they deliver to Aboriginal and Torres Strait Islander people and for improved mental health outcomes through performance reporting at the jurisdiction level.

ATSIMHSPAG provides a platform for ongoing guidance and advice to the Australian Government on Aboriginal and Torres Strait Islander mental health, social and emotional wellbeing and suicide prevention services.
Promoting productivity and participation

Promoting Aboriginal and Torres Strait Islander health and mental health workforce participation could be a major element of the Indigenous Advancement Strategy (IAS) with its focus on employment.

The 2011 Census results show that health services (including, but not limited to, ACCHSs) employ 14.6 percent of employed Aboriginal and Torres Strait Islander people. Health services are thus the single biggest source of employment, and employment in this ‘industry’ has expanded by almost 4,000 places since 2006.16

Developing a strong market

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

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

Recommendations of the review seek to address the lack of competition and consumer choice for mental health services needed by:

• using ACCHSs and AMSs as the building block for future primary mental health service development (this addresses the market limitations by acknowledging the limited market and building on the local level infrastructure that does exist)
• emphasising the need for mainstream services to improve their cultural responsiveness to the needs of Aboriginal and Torres Strait Islander people.

Infrastructure support

There is a strong consensus amongst Aboriginal and Torres Strait Islander experts consulted through the review that ACCHSs provide value for money and a foundation for good practice for developing primary mental health services. A recent paper prepared for NACCHO noted that Aboriginal and Torres Strait Islander people have preferences for:

• “…ACCHOs over mainstream primary health care services”, and
• “…‘own culture’, ‘own system’, ‘own community control’. ”17

Some stakeholders attribute improved health outcomes to attendance at ACCHSs, arguing that the more familiar sociocultural surroundings and model of care features (e.g. use of Aboriginal Health Workers to triage service access and undertake treatment follow-up; access to clinic transport services) contribute to attendance and service use.

This view suggests that cultural comfort results in increased patient satisfaction, promoting adherence and compliance with treatment regimens.

Smart use of technology

Smart technology will provide opportunities to strengthen the mental health service system to Aboriginal and Torres Strait Islander communities, but at present the use of innovative technology is limited.

Examples of new clinical tools under development with a specific Indigenous emphasis include:

• the E-mental health portal
• R U Appy, a mobile application focussed on supporting clients to strengthen SEWB
• Ibobbbly, a mobile application focussed on supporting clients experiencing suicidal ideation.

Opportunities exist to promote coordinated care for Aboriginal and Torres Strait Islander people through greater use of information in electronic health records. Stakeholders interviewed during the project saw potential for technology to enable maintenance of connections with family when Aboriginal and Torres Strait Islander people travel from a remote community to metropolitan or regional areas to receive...
acute mental health treatment. Technology also has potential as a tool to enable family input into care planning and discharge planning processes.

It is important government continues to support the development of a range of culturally appropriate electronic tools to improve access to care and support clinicians to work in culturally appropriate ways with clients. Clinicians need workforce development programmes to equip them in the smart use of new technology.

**Innovative workforce**

A significant investment is needed to develop the mental health workforce supporting the SEWB and mental health needs of Aboriginal and Torres Strait Islander people. There is a need for a skilled Aboriginal workforce within the mental health system. Workforce development in this area should address the five professions that contribute significantly to the mental health workforce: mental health nursing, occupational therapy, psychiatry, psychology and social work. There is little available data on the proportion of the professional groups listed above with an Indigenous background. Otherwise, anecdotally, the levels are low.

From an undergraduate training perspective, some progress has occurred in medicine, where Aboriginal and Torres Strait Islander enrolments have reached 2.5% of the student population. Similar levels have not been achieved in other health undergraduate courses.

There is a need to develop workforce development plans to:

1. **Identify current capacity and identify future workforce needs.** We understand little has been done to date in this area, although NSW Health has a policy directive under its NSW Mental Health and Wellbeing Policy requiring at least one Aboriginal mental health worker to be employed per 1,000 Indigenous people in the catchment area.

2. **Strengthen opportunities for Aboriginal and Torres Strait Islander health workers to attain advanced qualifications** by strengthening educational pathways from the Vocational Education Training sector to the university sector, and

3. **Strengthen Aboriginal and Torres Strait Islander participation rates in tertiary courses and in the mental health workforce.** This will involve health professional associations and education providers taking greater responsibility for increasing the level of Aboriginal and Torres Strait Islander students undertaking their courses and entering the profession. The medical profession is currently demonstrating good practice in supporting the training and mentoring of Aboriginal and Torres Strait Islanders medical students. The Djirruwang Programme is considered a programme of merit supporting increased participation of Aboriginal and Torres Strait Islander people as mental health practitioners in mainstream mental health services.

**World leading research**

Little Aboriginal and Torres Strait Islander specific research in mental health has been undertaken to date. Much of the research that has been undertaken is documented in *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* published by Commonwealth in June 2014.

Stakeholder submissions and expert advisors to the review:

- emphasised the need to strengthen the current mental health service system given the high prevalence of mental illness amongst Aboriginal and Torres Strait Islander people
- were supportive of a national discussion being lead by NATSILMH and the National Mental Health Commission, and supported by ATSIMSPAG, to develop new models of care based on effective interventions.

Whilst the practice wisdom of clinicians has an important role to play in strengthening services, greater investment will be required in undertaking applied research projects and facilitating partnerships between service delivery organisations and research institutions.

Stakeholders expressed a strong interest in strengthening programme evaluation and research capacity with a view to building the evidence base on effective interventions. Support was expressed in submissions to the Commission for a strengths-focused research to identify effective:
ASSESSMENT AGAINST REVIEW OBJECTIVES

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

To strengthen the evidence base there is a need for:

- funding systems to focus on strengthening health outcomes
- investment in resources and professional development programmes to strengthen evaluation and research capacity of health professions
- future health information systems to have the capacity to record information about the type of therapy being provided, the number of sessions provided and health outcomes using appropriate health outcome measures such as AUDIT C, K5, K10 and SOFAS
- incentives that encourage ACCHSSs and research institutions to form partnerships on applied research projects.
APPENDIX A  REFERENCES

1 These comprise funding for primary health care (DoH and DSS), substance use services (PM&C), and SEWB counselling (PM&C) or Link-up services (PM&C).
2 AIHW, Aboriginal and Torres Strait Islander health organisations, On-line Services Report—key results, 2012-13, p.46.
3 Referred to in ibid., p.14.
5 AIHW, op.cit., p.43.
6 AIHW, The health and welfare of Australia’s Aboriginal and Torres Strait Islander peoples: an overview, Canberra, 2011, p.38.
9 Pink, B., et. al., op.cit.
10 AIHW, Expenditure on health for Aboriginal and Torres Strait Islander people, 2010-11, Health and Welfare Expenditure Series No.49. Canberra, 2013, p.17,p.19.
11 Personal communication with HMA, 13 August 2014.
14 Average cost of a ‘mainstream’ session [HMA ATAPs Tier 1 data, 2013 study for DoHA] = $158 [2010/11 data] or around circa $170 in 2012/13 prices; Tier 2 Indigenous funding allocated to Medicare Locals: $3,949 m; recorded Indigenous Tier 2, 2012-13 service users: 2,097, resulting in an estimated average Indigenous Tier 2 cost per user of $1,883. Average number of sessions per Indigenous Tier 2 user was 3.9 session= $482.82 per session ($1,833/3.9 sessions).
18 Brideson, T., et.al., The Djirrawa Program: Cultural Affirmation for Effective Mental Health, in Dudgeon, P. et.al., Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice, op.cit., p. 523.
19 Ibid.,p.530.