

AMSANT Response to the Productivity Commission Issues Paper: The Social and Economic Benefits of Improving Mental Health

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Introduction

The Aboriginal Medical Services of the NT is the peak body for the community controlled Aboriginal primary health care (PHC) sector in the Northern Territory (NT). We have 25 members providing Aboriginal comprehensive primary health care across the NT from Darwin to the most remote regions. AMSANT has been established for 20 years and has a major policy and advocacy role at the NT and national levels.

The ACCHSs sector in the NT is comparatively more significant than in other jurisdictions, being the largest provider of Aboriginal primary health care services to Aboriginal people in the NT. Over half of all contacts (57%) in the Aboriginal PHC sector in the Northern Territory are provided by ACCHSs. Moreover, ACCHS deliver comprehensive primary health care that incorporates social and emotional wellbeing, mental health and AOD services, family support services and early childhood services, delivered by multidisciplinary teams within a holistic service model.

Within this submission we have responded directly to 5 of the issues listed under the scope of the inquiry, as they relate to Aboriginal people in the Northern Territory, with examples of domestic and international policies and experiences provided throughout as relevant.

In addition to this submission we would refer the Commission to AMSANT's submission to the 2018 Inquiry into *Accessibility and quality of mental health services in rural and remote areas*.

The effect of supporting mental health on economic and social participation, productivity and the economy: an Indigenous perspective

Aboriginal people experience a disproportionate morbidity and mortality burden from mental health and alcohol and other drug (AOD) problems. Nationally, 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). Tragically, from 2011-15, the Indigenous suicide rate was twice that of the non-Indigenous population (AHMAC 2017).

Many Aboriginal people in the NT are happy, engaged with their families and culture, and prepared to make a positive contribution to their communities. The physical and mental health of Aboriginal people have been maintained through beliefs, practices and ways of life that supported their social and emotional wellbeing across generations and thousands of years. Figure 1 below demonstrates the

distinct domains of connection that act together in the expression and experience of social and emotional wellbeing for Aboriginal people, their families and communities.

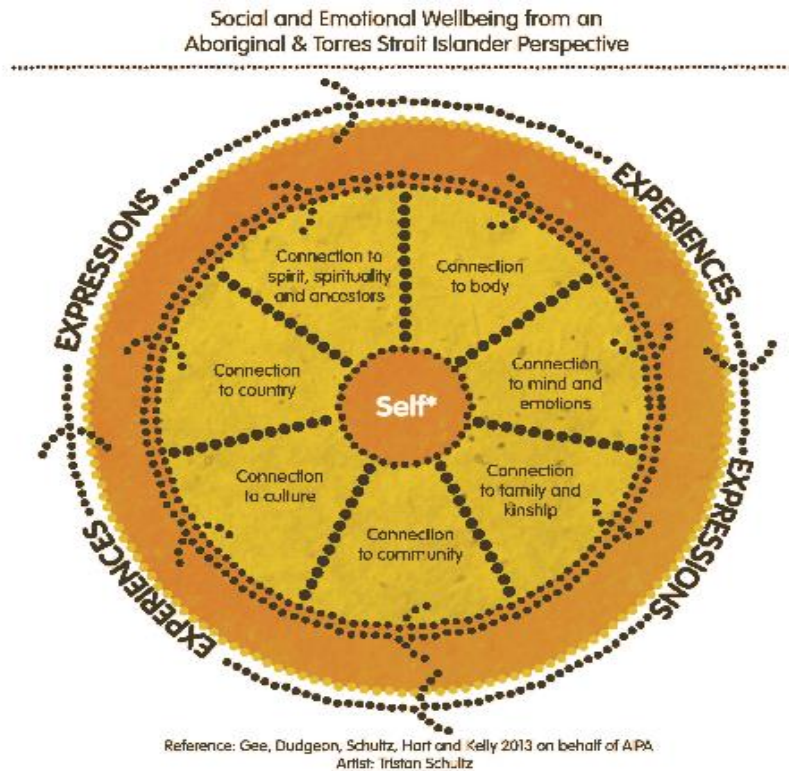


Figure 1. Social and Emotional Wellbeing from an Aboriginal and Torres Strait Islanders’ Perspective (from Chapter 4 Aboriginal and Torres Strait Islander social and emotional wellbeing, Working Together 2nd edition)

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 experiences of racism, have all contributed to profound feelings of loss and grief and exposure to unresolved trauma, which continues disadvantage, poor health and poor social outcomes for far too many Aboriginal people. This process has directly involved the disruption and severing of the many connections, illustrated in figure 1 above, which are at the heart of SEWB, health and mental health for Aboriginal people.

Identifying the extent and impacts of poor mental health among Aboriginal people must be founded on an understanding of this context and the reality that Aboriginal understandings and experiences of mental health and wellbeing are in many ways very different to that of mainstream society. Considering this, the Commission’s work through this Inquiry must reflect that ‘social and economic

participation' will be defined differently due to highly divergent social, cultural and economic realities in regional and remote Aboriginal communities.

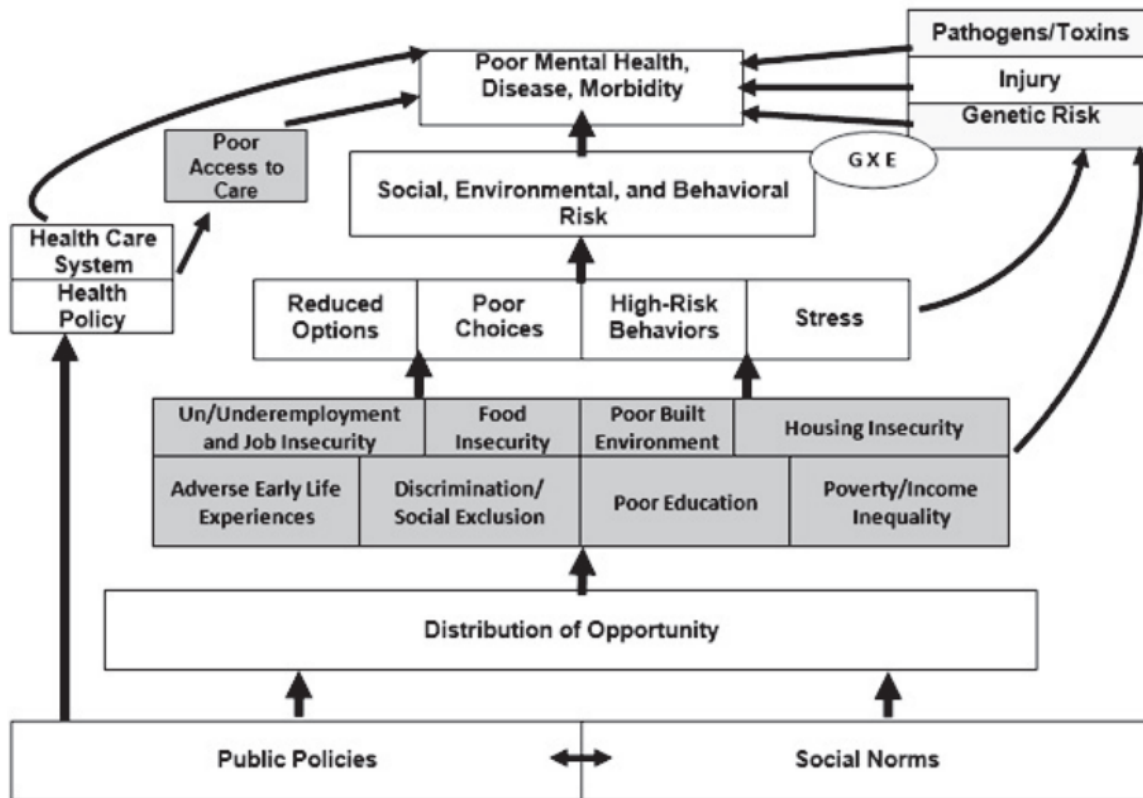
We note for example that the issues paper identifies levels of employment and absenteeism as key measures to be used to quantify the economic impacts of poor mental health. However the relevance of this measure must be questioned in the context of remote Aboriginal communities in the NT, where the scarcity of jobs means that half of the Aboriginal population in non-urban areas are not engaged in the labour force (NT Department of Treasury and Finance).

A 'one size fits all' approach that fails to respond to the unique experience of Aboriginal people should be avoided.

[How sectors beyond health can contribute to improved mental health: addressing the social determinants of health](#)

The issues paper notes that psychological distress is associated with unemployment, low income, low social capital and social support, as well as poor quality diet, fitness and physical illnesses. Social factors affect the risk for mental illnesses and substance use disorders, as well as health outcomes of persons with these disorders (Compton & Shim 2015; see Figure 2). These associations are reciprocal and circular in nature as deficiencies in the social determinants of health and in physical health are well known to impact on mental health and can in turn cause further impairment in social functioning, life circumstances and health. Social and environmental factors can influence genetic determinants through at least two mechanisms—gene-by-environment interactions and epigenetic modifications—to perpetuate psychological distress and poor health (Compton & Shim 2015).

For populations entrenched in socioeconomic disadvantage, such as that which is evident in Aboriginal peoples, the impact to individuals and communities on mental health, social and economic participation and productivity cannot be overemphasised. The care of these individuals not only consumes significant community resources but also diverts the productivity and resources within the family towards supportive roles. Suicide rates in Aboriginal youth alone attest to a significant mental health crisis the consequences of which perpetuate intergenerational trauma and social disadvantage in affected families.



^a G × E, gene-by-environment interaction

Figure 2. Conceptualising the social determinants of mental health (from Compton and Shim, 2015, p 420).

Socioeconomic context and position exert a powerful influence on the societal distribution of health conditions and mental disorders through the mechanisms of differential exposure, differential vulnerability and differential health care outcomes (Patel et al. 2010). Public policies and social norms, which mutually reinforce and strengthen one another, are the driving forces behind unequal distribution of opportunity and, in turn, many of the social determinants of mental health (Compton & Shim 2015). In order to improve a crisis that directly or indirectly affects all Australians, public policies and social norms need to build on the strengths and resilience of affected persons (particularly Aboriginal people) in close collaboration with them. Concerted and sustained policy and action by Government on the social determinants of health is crucial to enabling progress on mental health and a range of associated medical conditions.

AMSANT embraces a social and cultural determinants of health perspective which recognises that health and wellbeing are profoundly affected by interacting economic, social and cultural factors. The following outlines how control and self-determination, racism and discrimination, housing and

homelessness, and the overrepresentation of Aboriginal people in the justice system impact mental health and social and economic participation.

Community control and participation

The principles of community controlled primary health care, as set out by the National Aboriginal Health Strategy (1989), recognise that the degree of control and participation that individuals and their communities have over decisions affecting their life is integral to improving the health status of Aboriginal people.

Research reflects this, with a number of studies of Indigenous communities in Canada revealing a link between increased self-determination and community control and improved health and psychological wellbeing outcomes (Chandler and Lalonde 1998, Indian and Northern Affairs Canada 2009).

More recently, in an Australian context, a review found that programs that show promising results for Indigenous social and emotional wellbeing are those that encourage self-determination and community governance, reconnection and community life, and restoration and community resilience (Dudgeon et al. 2014).

Furthermore, 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).

Wherever possible these services should be provided by Aboriginal organisations, and where such capacity does not yet exist, these services should be provided in line with APO NT's NGO Partnership Principles (refer to attached document). APO NT's Principles have been developed to improve collaboration and coordination between service providers with the aim of strengthening and rebuilding an Aboriginal controlled development and service sector in the NT.

Racism and discrimination

It is widely understood that mental illness carries a certain amount of social stigma. The impact of this is magnified however for Aboriginal people, who are often subject to systemic racism and discrimination in their everyday lives.

Two recent studies from the NT made similar findings about Aboriginal people feeling stereotyped, judged, patronised and regarded with suspicion by non-Aboriginal people in their community. They also reported a significant lack of empathy for their life circumstances and felt they were 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 (Habibis et al. 2016 and Holmes and McRae Williams 2008).

The impacts of these kinds of attitudes on social and economic participation are manifold – affecting a person’s physical and mental health, increasing their need for supports, diminishing their capacity to engage in healthy and productive activities and simultaneously deterring people from some of the help-seeking behaviours they need in order to manage these experiences of discrimination.

For example, institutional discrimination has been shown to reduce the likelihood of Aboriginal people accessing essential services in areas such as the health system (AMA 2007) as well as the media, education, welfare and criminal justice systems and in the provision of public housing (Paradies et al. 2008).

Important in the context of employment, a recent survey on attitudes of non-Indigenous Australians (aged 25–44 years) towards Indigenous Australians found that 31% witnessed employment discrimination against Indigenous Australians and 9% admit they themselves discriminate in this context (Beyond Blue 2014). Another study examining self-reported racism among Indigenous people in Victoria found 42% of respondents experienced racism in employment settings (Ferdinand et al. 2012).

Overcrowded housing and homelessness

Adequate housing has long been recognised as a basic human right and an interrelated factor which impacts on the health, development and wellbeing of individuals and communities (Ware 2013). Access to stable and adequate housing ‘enables adults and children to engage in the wider community – socially, recreationally and economically, and can influence both their physical and mental health’ (AIHW 2011).

The Northern Territory has by far the highest rates of homelessness and overcrowding in Australia – 731 people per 10,000 people in the 2011 Census compared to a national average of 49 per 10,000 (ABS 2012). The definition of homelessness captured by these statistics includes those living in an

inadequate dwelling and those living in severely crowded houses. According to 2011 Census data, 85% of homeless people in the Northern Territory were in severely crowded dwellings, 91% of those dwellings were in very remote locations and 98% of those living in severely overcrowded houses were Indigenous (Ibid.). 60% of houses in very remote communities were overcrowded, which is approximately twice the rate of overcrowding than comparable jurisdictions (WA, SA and Qld) (Ibid.).

This worsening housing reality in many Aboriginal communities is interrelated with mental health in many ways – increasing urban drift from overcrowded and under-resourced communities, further contributes to rates of homelessness as well as disconnection from country, family and culture, and increases associated mental and emotional ill-health.

Similarly, recovery from mental illness is unlikely whilst people are suffering from homelessness, with provision of safe secure housing being an essential first step in recovery (Micah Projects 2016; Bodor et al 2011). This accords with the experience of clinicians within our services, who find that 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 likely to be an aggravating factor in physical and mental illness in many situations, having been identified within the general population as a contributor to high rates of domestic violence (Bailie and Wayte 2006). 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).

Current approaches to housing largely view the social and cultural context of Aboriginal communities as a barrier or problem to be overcome or circumvented, rather than working with Aboriginal communities in a way that respects cultural values and draws strength from Aboriginal knowledge systems and practices. The fabric of Aboriginal traditional land tenure has been altered and substantially replaced with a western model of private property. This model has been imposed on a group which traditionally have a much more communal understanding of space and place (Bailie and Wayte 2006).

AMSANT strongly supports the need for housing services for Aboriginal people to be provided by properly resourced Aboriginal controlled organisations. Governed by local Aboriginal people,

community controlled organisations incorporate a greater understanding of local circumstances and needs, and are therefore well-placed to approach housing design and construction in ways that fit with local ways of living. Furthermore, building the capacity of local Aboriginal organisations to conduct repairs and maintenance works can lead to more prompt resolution of housing issues – including repairs to essential health hardware (food storage, water and sewerage) – while simultaneously increasing local employment opportunities.

Overrepresentation of Aboriginal young people in justice and child protection systems

The 2014 Review of the Northern Territory Youth Detention System reported that many young people in the youth justice system come from homes where poverty, alcohol abuse, violence and dysfunctional relationships are the norm (Vita, 2015). Responding to the offending behaviour of young people in a way that addresses these underlying factors, rather than punishing and re-traumatising them, will lead to improved health and wellbeing and a greater capacity to positively contribute to society throughout their lives.

Census data from June 2017 reveals that among the 964 young people in detention on an average night in Australia, 53% were Aboriginal or Torres Strait Islander and 64% has not been sentenced. In the Northern Territory, these rates were as high as 95% for Aboriginal or Torres Strait Islander children, with 70% unsentenced.

Traumatic experience impacts the developing brain, causing a person to stay activated in their fear response, believing themselves to be in perpetual danger and causing symptoms such as isolation, aggression, lack of empathy and impulsive behaviour (Perry, 2008). Often children in the youth justice system may appear to be violent, aggressive, oppositional, unreachable or disturbed, however, underlying these behaviours is the grief of a child who has had to live through traumatic experiences, resulting in feelings of powerlessness, anxiousness, and depression (Dierkhising et al. 2013).

For these reasons, having a youth justice system that incorporates punishment as a form of behavioural management will only perpetuate the child's belief that their world is unsafe, and further compound and escalate complex and violent behaviours. If the emotional and psychological wounds do not get appropriately addressed then there is risk of a lifelong pattern of anger, aggression, self-destructive behaviours, academic and employment failures, and rejection, conflict, and isolation in every key relationship. This cycle of trauma and violence can continue across generations (U.S. Department of Justice, 2012).

Rather, a youth justice system that is trauma informed and sits within a social emotional wellbeing (SEWB) framework would be a positive way forward in redirecting youth away from the justice system, supporting social and emotional health and aiding in community re-entry.

The incorporation of the SEWB framework into programs such as behaviour management, diversion, reintegration back into community, and operational procedures provides a conceptual context that helps programs and procedures to define and communicate what they do and why they do it. At the same time it provides the context within which every staff member can continually examine his or her own accountability.

Effectiveness of current programs and initiatives: A culturally responsive approach

There is an urgent need for better coordination and integration of mental health services in the NT, within a more stable policy setting that encompasses greater community control and engagement. Equally there is a real need for meaningful job creation for Aboriginal people throughout the NT, particularly in remote areas where job markets are thin or non-existent.

Key to achieving both of these aims is a considered approach to workforce development. Recent research has demonstrated that longstanding problems with health workforce supply and turnover in remote Aboriginal communities in the NT threaten the effectiveness of primary care delivery and the effort to overcome the substantial gaps in health outcomes for this population (Zhao et al 2017). However, the realities of workforce turnover in the NT extend well beyond the health sector, reinforcing the need to 'grow our own' through locally relevant education and training.

Here we discuss a number of programs and initiatives that we believe are able to facilitate better delivery of mental health services, increased employment, as well as overall improved mental health in Aboriginal communities.

Social and Emotional Wellbeing (SEWB) and Culturally Responsive Trauma Informed Care (CRTIC)

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.

AMSANT strongly supports the use of a SEWB framework in understanding and addressing complex health, mental health and substance abuse issues within Aboriginal communities. Such a framework encompasses domains of connection to culture, body, mind and emotions, land, family and kinship, spirituality and community (Gee et al. 2014). Understanding the implications of disruption and connection in relation to these domains is central to developing the capacity of staff, services and organisations to create a culturally informed environment in which healing and wellbeing can be nurtured.

Additionally enhancing skill capacity in the workforce by providing awareness training of the impacts of trauma and developing preventative strategies that is embedded within the organisation has shown significant positive impact on staff as well as improved client health outcomes (Browne et al. 2016).

In keeping with this Indigenous model of SEWB, AMSANT believes that integrating SEWB, mental health and AOD services, which work toward preventing and addressing these issues, into primary health care services is the most cost-effective approach to the delivery of mental health services in NT. To achieve this, SEWB programs require funding for multidisciplinary, culturally and trauma informed teams with expertise across these various aspects of wellbeing for Aboriginal communities. SEWB services are designed to support individuals, families and communities in all aspects of life that strengthen wellbeing.

A review conducted for the Closing the Gap Clearinghouse, found that the programs that show promising results for Indigenous social and emotional wellbeing are those that encourage self-determination and community governance, reconnection and community life, and restoration and community resilience (Dudgeon et al. 2014). The defining features of ACCHSs guarantee these components are central within SEWB, mental health and AOD programs based within these Services.

The National Mental Health Commission's 2015 Review of Mental Health Programmes and Services led to the recommendation that integrated mental health and SEWB teams should be established in all ACCHSs. The Commission concluded that mainstream mental health services had largely failed Aboriginal communities.

Cultural Industries

Emerging research is beginning to demonstrate the significant potential of many cultural industries in simultaneously cultivating the protective factors and domains of connection that support good social

and emotional wellbeing, whilst also providing opportunities for economic productivity and income generation, particularly in rural and remote areas. We briefly discuss some of these here.

Land management & caring for country

Programs and enterprises based around natural resource management, carbon farming and caring for country are particularly significant for regional and remote Aboriginal communities, providing both an economic base and improved health and wellbeing outcomes. The development of these industries will also be crucial in enhancing the capacity of NT communities to adapt and respond to the impacts of climate change.

Ranger groups provide a formalised structure for the transfer of traditional knowledge from old to young, as well as being a vehicle for land and sea conservation and the training and employment of Aboriginal people living in remote areas. A recent study that engaged rangers working with the Central Land Council (CLC) identified strong associations between ranger participation and two wellbeing outcomes: very high life satisfaction, and high family wellbeing. These outcomes persisted after individual adjustment for key sociodemographic and health factors (Jones et al. 2018).

There are currently some 35 Northern Territory Indigenous ranger groups funded through the federal government's Working on Country and Indigenous Protected Area programs. While funding from the Commonwealth has been committed to continue existing programs, we note that long-term and increased government funding for these programs is essential to their sustainability and should be recommended by the Commission through this inquiry in light of their demonstrated ability to improve wellbeing and increase employment.

Bush foods & medicines

Opportunities exist to explore and preserve Indigenous knowledge of traditional medicinal plants and their use while also developing sustainable Indigenous-led agribusinesses. Similarly, Australia's bush food industry is growing, however a recent survey of the industry found that only 1% of the industry's produce and dollar value is generated by Indigenous people (Mitchell & Becker 2019).

“Enterprises based on local bush produce offer not only alternative pathways to Arid Zone economic development, but they also rely on land management practices that are conducive to socio-cultural and environmental sustainability and health.” (White, 2012)

White (2012) identifies a number of key factors that need to be considered in the development of an Arid Zone bush produce industry that is socio-culturally just and beneficial to local Aboriginal livelihoods and well-being. These factors include ensuring local engagement and agency in knowledge

protection and management and the need for an innovative national policy approach, recognising that diverse culture-based hybrid economies are the “real” economy in remote Australia.

Art, music & dance

AMSANT recognises the important role that ceremony, music, dance and art has in healing trauma and improving mental health and wellbeing. Perry highlights that exposure to these practices promotes renewal in the neurobiology of the brain where it has been effected by trauma, as well as influencing healthy brain development for children (Perry 2006).

These kinds of protective, healing practices and knowledges have existed within Aboriginal communities for thousands of years and should be valued, supported and further developed to support the improved mental health of all Aboriginal people in the NT. Art centres and enterprises are vital to creating an income for some of the poorest and most disadvantaged individuals and families. These may include the elderly, people living with a disability or in poor health, or equally those who have disengaged from social support systems due to onerous compliance regimes. Disengagement is becoming increasingly common for remote job seekers under the CDP program (Jobs Australia 2016; Fowkes 2019)

The evidence for the economic and social benefits of arts programs is now well established. An evaluation of the Tjanpi Desert Weavers’ project of Central Australia found that in addition to the economic outcomes produced from selling weavings, there is also evidence of social, cultural, spiritual, creative, psychological, and physical benefits (Thompson 2014). Additionally, an evaluation of cultural industries in the Kimberly found 97% of respondents agreed very strongly that artistic activities such as painting, music, dance and writing can provide jobs and incomes for young people in their community (Throsby and Petetskaya 2016).

Importantly, a Closing the Gap Clearinghouse report on arts programs identifies ‘what works’ in successful arts programs including: linking arts programs with other services such as health, using local languages and linking programs to culture, involving the community in the planning and implementation of programs, and stable funding and staffing (Ware 2014).

AMSANT strongly supports consistent investment in a wide range of community-led arts programs in recognition of their role as healing practices, and the opportunities they present for economic development and income generation.

Current investment in mental health: A more equitable approach

There is a very high burden of mental health, SEWB and AOD issues throughout Aboriginal communities in the NT and the current funding and provision of mental health services is not currently commensurate with need. Funding of mental health and SEWB programs should be determined through an equitable needs based approach, overseen by jurisdictional forums, such as the NT Aboriginal Health Forum within the NT.

The redirection of Commonwealth funding for mental health to Primary Health Networks (PHNs) has led to duplication and inefficiencies. Growth and support of SEWB programs within ACCHSs would be better supported if all Aboriginal-specific funding for mental health/AOD and SEWB was directed through the Commonwealth Department of Health and went directly to ACCHSs with input and advice on equitable distribution through the jurisdictional forums.

A significant proportion of new funding for mental health and AOD services for Aboriginal people continues to be allocated via competitive tendering processes rather than being directed towards Aboriginal primary health care providers. We know that competitive grants funding does not work for Aboriginal service delivery. In fact, it is our experience that increased competition usually leads to suboptimal outcomes by undermining the effectiveness of individual services, reducing service integration and increasing fragmentation, and weakening existing relationships and knowledge.

Recognising both the impact of control as a determinant of health, and the benefits inherent to investing in community controlled organisations, there must be a systematic focus on increasing investment of mental health funding to Aboriginal controlled services wherever possible.

Measuring and reporting the outcomes of mental health policy

AMSANT acknowledges current overarching national policies in the area of Indigenous mental health, including the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023, and the Fifth National Mental Health and Suicide Prevention Plan. In light of the unique circumstances and needs of different jurisdictions and communities, we advocate for localised and regionalised approaches to be supported within these national frameworks.

We note that there are currently no national KPIs to measure SEWB. Given the centrality of this concept to the way that the ACCHSs sector responds to mental ill health, we feel that there is a need for the development of holistic, qualitative measures that are able to capture and evaluate the impacts of SEWB interventions for Aboriginal people.

As stated above, AMSANT does not support the funnelling of mental health funds through PHNs. However, so long as this is the case and ACCHSs continue to be asked to comply with onerous reporting requirements, PHNs have a responsibility to share their data on funding allocation outcomes with the sector to ensure greater transparency and accountability to Aboriginal communities.

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