



PRE-BUDGET SUBMISSION 2019-20

NACCHO is the national peak body representing 145 ACCHOs across the country on Aboriginal health and wellbeing issues. In 1997, the Federal Government funded NACCHO to establish a Secretariat in Canberra, greatly increasing the capacity of Aboriginal peoples involved in ACCHOs to participate in national health policy development. Our members provide about three million episodes of care per year for about 350,000 people. In very remote areas, our services provide about one million episodes of care in a twelve-month period. Collectively, we employ about 6,000 staff (56 per cent whom are Indigenous), which makes us the single largest employer of Indigenous people in the country.

The following policy proposals are informed by NACCHO's consultations with its Affiliates and Aboriginal Community Controlled Health Services:

1. Increase base funding of Aboriginal Community Controlled Health Services;
2. Increase funding for capital works and infrastructure;
3. Improve Aboriginal and Torres Strait Islander housing and community infrastructure;
4. Reduce the overrepresentation of Aboriginal and Torres Strait Islander children and young people in out-of-home care and detention; and
5. Strengthen the Mental Health and Social and Emotional Wellbeing of Aboriginal and Torres Strait Islander peoples.

The proposals included in this submission are based on the extensive experience NACCHO member services have of providing many years of comprehensive primary health care to Aboriginal and Torres Strait Islander peoples. We have long recognised that closing the gap on Aboriginal and Torres Strait Islander health and disadvantage will never be achieved until primary health care services' infrastructure hardware is fit for purpose; our people are living in safe and secure housing; culturally safe and trusted early intervention services are available for our children and their families; and our psychological, social, emotional and spiritual needs are acknowledged and supported.

If these proposals are adopted, fully funded and implemented, they provide a pathway forward where improvements in life expectancy can be confidently predicted.

NACCHO is committed to working with the Australian Government to further develop the proposals, including associated costings and implementation plans and identifying where current expenditure could be more appropriately targeted.

1. Increase base funding of Aboriginal Community Controlled Health Services

Proposal:

That the Australian Government:

- Commits to increasing the baseline funding for Aboriginal Community Controlled Health Services to support the sustainable delivery of high quality, comprehensive primary health care services to Aboriginal and Torres Strait Islander people and communities.
- Works together with NACCHO and Affiliates to agree to a new formula for the provision of comprehensive primary health care funding that is relative to need.

Rationale:

The Productivity Commission's 2017 Indigenous Expenditure Report found that per capita government spending on Indigenous services was twice as high as for the rest of the population. The view that enormous amounts of money have been spent on Indigenous Affairs has led many to conclude a different focus is required and that money is not the answer. Yet, the key question in understanding the relativities of expenditure on Indigenous is equity of total expenditure, both public and private and in relation to need.

The Commonwealth Government spends \$1.4 for every \$1 spent on the rest of the population, while Aboriginal and Torres Strait Islander people have 2.3 times the per capita need of the rest of the population because of much higher levels of illness and burden of disease. In its 2018 Report Card on Indigenous Health, the Australian Medical Association (AMA) states that spending less per capita on those with worse health, is 'untenable national policy and that must be rectified'.¹ The AMA also adds that long-term failure to adequately fund primary health care – especially Aboriginal Community Controlled Health Services (ACCHSs) – is a major contributing factor to failure in closing health and life expectancy gaps.

Despite the challenges of delivering services in fragmented and insufficient funding environments, studies have shown that ACCHSs deliver more cost-effective, equitable and effective primary health care services to Aboriginal and Torres Strait Islander peoples and are 23 per cent better at attracting and retaining Aboriginal and Torres Strait Islander clients than mainstream providers.² ACCHSs continue to specialise in providing comprehensive

¹https://ama.com.au/system/tdf/documents/2018%20AMA%20Report%20Card%20on%20Indigenous%20Health_1.pdf?file=1&type=node&id=49617, page 6.

² Ong, Katherine S, Rob Carter, Margaret Kelaheer, and Ian Anderson. 2012. Differences in Primary Health Care Delivery to Australia's Indigenous Population: A Template for Use in Economic Evaluations, *BMC Health Services Research* 12:307; Campbell, Megan Ann, Jennifer Hunt, David J Scrimgeour, Maureen Davey and Victoria Jones. 2017. Contribution of Aboriginal Community Controlled Health Services to improving Aboriginal

primary care consistent with clients' needs. This includes home and site visits; provision of medical, public health and health promotion services; allied health, nursing services; assistance with making appointments and transport; help accessing child care or dealing with the justice system; drug and alcohol services; and providing help with income support.

There are limits, however, to the extent that ACCHSs can continue to deliver quality, safe primary health care in fragmented and insufficient funding environments. This is particularly challenging to meet the health care needs of a fast-growing population.³ There is an urgent need to identify and fill the current health service gaps, particularly in primary health care, and with a focus on areas with high preventable hospital admissions and deaths and low use of the Medical Benefits Scheme and the Pharmaceutical Benefits Scheme.

An appropriately resourced Aboriginal Community Controlled Health sector represents an evidence-based, cost-effective and efficient solution for addressing the COAG Close the Gap and strategy and will result in gains for Aboriginal and Torres Strait Islander peoples' health and wellbeing.

Strengthening the workforce

NACCHO welcomes COAG's support for a National Aboriginal and Torres Strait Islander Health and Medical Workforce Plan. A long-term plan for building the workforce capabilities of ACCHSs is overdue. Many services struggle with the recruitment and retention of suitably qualified staff, and there are gaps in the number of professionals working in the sector.

NACCHO believes that the plan will be strengthened by expanding its scope to include:

- metropolitan based services;
- expanding the range of workforce beyond doctors and nurses; and
- recognising that non-Indigenous staff comprise almost half of the workforce.

While Aboriginal and Torres Strait Islander health staff are critical to improving access to culturally appropriate care and Indigenous health outcomes, consideration to the non-Indigenous workforce who contribute to improving Aboriginal and Torres Strait Islander Health outcomes should also be given.

An increase in the baseline funding for Aboriginal Community Controlled Health Services, as set out in this proposal will enable our sector to plan for and build workforce capabilities in line with the Health and Medical Workforce Plan objectives.

health: an evidence review, *Australian Health Review* 42(2) 218-226; Department of Health. Aboriginal and Torres Strait Islander Health Performance Framework, Canberra 2017:172.

³ Between 2011 and 2016, the Aboriginal and Torres Strait Islander population grew by 22.98%.

<http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/3238.0.55.001Main%20Features1June%202016?opendocument&tabname=Summary&prodno=3238.0.55.001&issue=June%202016&num=&view>

2. Increase funding for capital works and infrastructure upgrades

Proposal:

That the Australian Government:

- Commits to increasing funding allocated through the Indigenous Australians' Health Programme for:
 - capital works and infrastructure upgrades, and
 - Telehealth services;

noting that at least \$500m is likely to be needed to address unmet needs, based on the estimations of 38.6 per cent of the ACCHO sector, and we anticipate that those needs may be replicated across the sector (see Table A below).

Rationale:

There is a current shortfall in infrastructure with a need for new buildings in existing and outreach locations, and renovations to increase amenities including consultation spaces. Additional funding is required for additional rooms and clinics mapped against areas of highest need with consideration to establishing satellite, outreach or permanent ACCHSs.

Many of the Aboriginal health clinics are 20 to 40 years old and require major refurbishment, capital works and updating to meet increasing population and patient numbers. The lack of consulting rooms and derelict infrastructure severely limits our services' ability to increase MBS access.

Further, whilst there may be some scope to increase MBS billing rates for Aboriginal and Torres Strait Islander peoples, this cannot be achieved without new services and infrastructure. A vital priority is seed funding for the provision of satellite and outreach Aboriginal Community Controlled Health Services that Aboriginal and Torres Strait Islander people will access, and which provide the comprehensive services needed to fill the service gaps, to boost the use of MBS and PBS services to more equitable levels, and to reduce preventable admissions and deaths.

Improvements to the building infrastructure of ACCHSs are required to strengthen their capacity to address gaps in service provision, attract and retain clinical staff, and support the safety and accessibility of clinics and residential staff facilities. However, the level of funding of \$15m per annum, under the Indigenous Australians' Health Programme allocated for Capital Works – Infrastructure, Support and Assessment and Service Maintenance, is not keeping up with demand.

In our consultations with Affiliates and ACCHSs, NACCHO is increasingly hearing that Telehealth services,⁴ including infrastructure/hardware and improved connectivity, is

⁴ ACCHSs may apply for Telehealth funding through the Indigenous Australians' Health Programme, Governance and System Effectiveness: Sector Support activity.

required to support the provision of NDIS, mental health and health specialist services. A total of 22 out of 56 survey responses (see Table A below) identified the need for Telehealth to support service provision.

NACCHO believes that insufficient funding to meet capital works and infrastructure needs is adversely impacting the capacity of some ACCHSs to safely deliver comprehensive, timely and responsive primary health care; employ sufficient staff; to improve their uptake of Medicare billing; and to keep up with their accreditation requirements. In January 2019, we surveyed ACCHSs about their capital works and infrastructure needs, including Telehealth services. We received 56 responses, representing a response rate of 38.6 per cent.

Survey respondents estimated the total costs of identified capital works and infrastructure upgrades (see Table A below). The estimated costs have not been verified; however, they do suggest there is a great level of unmet need in the sector. Please note that not all respondents were able to provide estimates.

Table A. Estimated costs of capital works and infrastructure upgrades identified by ACCHSs

Type	Number of respondents	Percentage of respondents	Total estimated costs
Replace existing building	43	76.7%	207,559,043
New location/satellite clinic	21	37.5%	53,480,000
Extension	24	42.8%	18,310,000
Refurbishment	29	51.7%	35,251,000
Staff accommodation	25	44.6%	39,450,000
Telehealth services	22	39.2%	6,018,763
Total estimated costs of capital works and infrastructure upgrades			\$361,068,806

37 survey respondents applied for funding for infrastructure improvements from the Australian Government Department of Health during 2017 and/or 2018. Of the 11 that were successful, four respondents stated that the allocated funds were not sufficient for requirements.

ACCHSs believe that the current state of their service infrastructure impedes the capacity of their services as depicted in Table B, below:

Table B: Impact of ACCHSs' infrastructure needs on service delivery

Infrastructure impeding service delivery	Highly affected	Somewhat affected
Safe delivery of quality health care	48.1%	51.9%
Increase client numbers	74.1%	25.9%
Expand the range of services and staff numbers	83.3%	16.7%
Increase Medicare billing	66%	34%

An extract of feedback provided by ACCHSs relating to their capital works and infrastructure needs is at **Appendix A**.

3. Improve Aboriginal and Torres Strait Islander housing and community infrastructure

Proposals:

That the Australian Government:

- Expand the funding and timeframe of the current National Partnership on Remote Housing to match AT LEAST that of the former National Partnership Agreement on Remote Indigenous Housing.
- Establish and fund a program that supports healthy living environments in urban, regional and remote Aboriginal and Torres Strait Islander communities, similar to the Fixing Houses for Better Health program. Ensure that rigorous data collection and program evaluation structures are developed and built into the program, to provide the Commonwealth Government with information to enable analysis of how housing improvements impact on health indicators.⁵
- Update and promote the National Indigenous Housing Guide, a best practice resource for the design, construction and maintenance of housing for Aboriginal and Torres Strait Islander peoples.⁶

Rationale:

Safe and decent housing is one of the biggest social determinants of health and we cannot overlook this when working to close the gap in life expectancy.

1. Remote Indigenous Housing

The National Partnership Agreement on Remote Indigenous Housing 2008-2018 was a COAG initiative that committed funding of \$5.4b towards new builds, refurbishments, housing quality, cyclical maintenance, and community engagement and employment and business initiatives.

In 2016, the National Partnership Agreement on Remote Indigenous Housing was replaced by the National Partnership on Remote Housing. Under this new partnership, the Commonwealth Government committed:

- \$776.403m in 2016, to support remote housing in the Northern Territory, Queensland, South Australia, Western Australia, and the Northern Territory over a two-year period; and
- \$550m in 2018, to support remote housing in the Northern Territory, over a five-year period.

New South Wales, Victoria and Tasmania are not part of discussions with the Commonwealth Government on housing needs.

⁵ <https://www.anao.gov.au/work/performance-audit/indigenous-housing-initiatives-fixing-houses-better-health-program>

⁶ http://web.archive.org/web/20140213221536/http://www.dss.gov.au/sites/default/files/documents/05_2012/housing_guide_info_intro.pdf

A review of the National Partnership Agreement on Remote Indigenous Housing (2018) found that:

- An additional 5,500 homes are required by 2028 to reduce levels of overcrowding in remote areas to acceptable levels
- A planned cyclic maintenance program, with a focus on health-related hardware and houses functioning, is required.
- Systematic property and tenancy management needs to be faster.
- More effort is required to mobilise the local workforces to do repairs and maintenance work.⁷

There is currently a disconnect between the levels of government investment into remote housing and the identified housing needs of remote communities. This disconnect is increasingly exacerbated by population increases in Aboriginal communities.⁸

There is a comprehensive, evidence-based literature which investigates the powerful links between housing and health, education and employment outcomes.⁹ Healthy living conditions are the basis from which Closing the Gap objectives may be achieved.

Commonwealth Government leadership is urgently needed to appropriately invest into remote housing.

2. Environmental health

The importance of environmental health to health outcomes is well established. A healthy living environment with adequate housing supports not only the health of individuals and families; it also enhances educational achievements, community safety and economic participation.¹⁰

Commonwealth and State and Territory Governments have a shared responsibility for housing. Overcrowding is a key contributor to poor health of Aboriginal and Torres Strait Islander peoples. In addition to overcrowding, poor and derelict health hardware (including water, sewerage, electricity) leads to the spread of preventable diseases for Aboriginal and Torres Strait Islander peoples. Healthy homes are vital to ensuring that preventable diseases that have been eradicated in most countries do not exist in Aboriginal and Torres Strait Islander communities and homes.

⁷ <https://www.pmc.gov.au/resource-centre/indigenous-affairs/remote-housing-review>, page 3.

⁸ <https://www.caac.org.au/uploads/pdfs/Congress-Housing-and-Health-Discussion-Paper-Final-March-2018.pdf>

⁹ <https://www.pmc.gov.au/resource-centre/indigenous-affairs/health-performance-framework-2017-report>; <https://www.mja.com.au/journal/2011/195/11/closing-gap-and-indigenous-housing>; <https://probonoaustralia.com.au/news/2016/02/housing-key-closing-gap/>; <https://ama.com.au/position-statement/aboriginal-and-torres-strait-islander-health-revised-2015>; <https://www.caac.org.au/uploads/pdfs/Congress-Housing-and-Health-Discussion-Paper-Final-March-2018.pdf>.

¹⁰ <https://www.anao.gov.au/work/performance-audit/indigenous-housing-initiatives-fixing-houses-better-health-program>

4. Reduce the overrepresentation of Aboriginal and Torres Strait Islander children and young people in out-of-home care and detention

Proposals:

That the Australian Government:

- Establishes an additional elective within the existing Aboriginal Health Worker curriculum, that provides students with early childhood outreach, preventative health care and parenting support skills
- Waives the upfront fees of the first 100 Indigenous students to undertake the Aboriginal Health Worker (Early Childhood stream) Certificate IV course.
- Funds an additional 145 Aboriginal Health Worker (early childhood) places across ACCHSs.

Rationale:

*The overrepresentation of Aboriginal and Torres Strait Islander children and young people in the child protection system is one of the most pressing human rights challenges facing Australia today.*¹¹

*Young people placed in out-of-home care are 16 times more likely than the equivalent general population to be under youth justice supervision in the same year.*¹²

Government investment in early childhood is an urgent priority to reduce the overrepresentation of Aboriginal and Torres Strait Islander children in out of home care and youth detention. Research reveals that almost half of the Aboriginal and Torres Strait Islander children who are placed to out of home care are removed by the age of four¹³ and, secondly, demonstrates the strong link between children and young people in detention who have both current and/or previous experiences of out of home care.¹⁴ There is also compelling evidence of the impact of repetitive, prolonged trauma on children and young people and how, if left untreated, this may lead to mental health and substance use disorders, and intergenerational experiences of out-of-home care and exposure to the criminal justice system.¹⁵

¹¹ Australia Human Rights Commission *Social Justice and Native Title Report 2015*, cited in the Australian Law Reform Commission publication, *Pathways to Justice—Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (ALRC Report 133) - <https://www.alrc.gov.au/publications/crossover-out-home-care-detention>.

¹² <https://www.alrc.gov.au/publications/crossover-out-home-care-detention>;
<https://www.aihw.gov.au/getmedia/06341e00-a08f-4a0b-9d33-d6c4cf1e3379/aihw-csi-025.pdf.aspx?inline=true>

¹³ <https://www.snaicc.org.au/ensuring-fair-start-children-need-dedicated-funding-stream-aboriginal-torres-strait-islander-early-years-sector/>

¹⁴ <https://www.alrc.gov.au/publications/crossover-out-home-care-detention>;
<https://aifs.gov.au/cfca/publications/intersection-between-child-protection-and-youth-justice-systems>

¹⁵ <https://aifs.gov.au/cfca/sites/default/files/publication-documents/cfca-practice-brain-development-v6-040618.pdf>; <https://www.orygen.org.au/Policy-Advocacy/Policy-Reports/Trauma-and-young-people-Moving->

Despite previous investments by governments, the Aboriginal and Torres Strait Islander children and young people remain overrepresented in the children protection and youth detention systems. The Council of Australian Governments (COAG) *Protecting Children is Everyone's Business National Framework for Protecting Australia's Children 2009–2020* ('National Framework') was established to develop a unified approach for protecting children. It recognises that 'Australia needs a shared agenda for change, with national leadership and a common goal'.

One of the six outcomes of the National Framework is that Aboriginal and Torres Strait Islander children are supported and safe in their families and communities, with this overarching goal:

*Indigenous children are supported and safe in strong, thriving families and communities to reduce the over-representation of Indigenous children in child protection systems. For those Indigenous children in child protection systems, culturally appropriate care and support is provided to enhance their wellbeing.*¹⁶

Findings presented in the 2018 *Family Matters Report* reveal, however, that the aims and objectives of the National Framework have failed to protect Aboriginal and Torres Strait Islander children:

*Aboriginal and Torres Strait Islander children make up just over 36 per cent of all children living in out-of-home care; the rate of Aboriginal and Torres Strait Islander children in out-of-home care is 10.1 times that of other children, and disproportionate representation continues to grow (Australian Institute of Health and Welfare [AIHW], 2018b). Since the last Family Matters Report over-representation in out-of-home care has either increased or remained the same in every state and territory.*¹⁷

Furthermore, statistics on the incarceration of Aboriginal and Torres Strait Islander children and young people in detention facilities reveal alarmingly high trends of overrepresentation:

- On an average night in the June quarter 2018, nearly 3 in 5 (59%) young people aged 10–17 in detention were Aboriginal and Torres Strait Islander, despite Aboriginal and Torres Strait Islander young people making up only 5% of the general population aged 10–17.
- Indigenous young people aged 10–17 were 26 times as likely as non-Indigenous young people to be in detention on an average night.
- A higher proportion of Indigenous young people in detention were aged 10–17 than non-Indigenous young people—in the June quarter 2018, 92% of Aboriginal and Torres Strait Islander young people in detention were aged 10–17, compared with 74% of non-Indigenous Islander young people.¹⁸

[toward-trauma-info/Orygen trauma and young people policy report.aspx?ext=;](https://www.facs.nsw.gov.au/_data/assets/pdf_file/0016/421531/FACS_SAR.pdf)
https://www.facs.nsw.gov.au/_data/assets/pdf_file/0016/421531/FACS_SAR.pdf

¹⁶ https://www.dss.gov.au/sites/default/files/documents/child_protection_framework.pdf, page 28.

¹⁷ <http://www.familymatters.org.au/wp-content/uploads/2018/11/Family-Matters-Report-2018.pdf>, page 5.

¹⁸ Australian Institute of Health and Welfare. 2018. *Youth detention population in Australia*. AIHW Bulletin 145.

NACCHO believes an adequately funded, culturally safe, preventative response is needed to reduce the number and proportion of Aboriginal and Torres Strait Islander children in child protection and youth detention systems. It is vital that Aboriginal and Torres Strait Islander families who are struggling with chronic, complex and challenging circumstances are able to access culturally appropriate, holistic, preventative services with trusted service providers that have expertise in working with whole families affected by intergenerational trauma. The child protection and justice literature are united in that best practice principles for developing solutions to these preventable problems begin with self-determination, community control, cultural safety and a holistic response.¹⁹ For these reasons, we are proposing that the new Aboriginal Health Worker (Early Childhood) be based within the service setting of the Aboriginal Community Controlled Health Service.

The cultural safety in which ACCHSs' services are delivered is a key factor in their success. ACCHSs have expert understanding and knowledge of the interplays between intergenerational trauma, the social determinants of health, family violence, and institutional racism, and the risks these contributing factors carry in increasing Aboriginal and Torres Strait Islander peoples' exposure to the child protection and criminal justice systems. Our services have developed trauma informed care responses that acknowledge historical and contemporary experiences of colonisation, dispossession and discrimination and build this knowledge into service delivery. Further, they are staffed by health and medical professionals who understand the importance of providing a comprehensive health service, including the vital importance of regular screening and treatment for infants and children aged 0-4, and providing at risk families with early support. Within the principles, values and beliefs of the Aboriginal community controlled service model lay the groundwork for children's better health, education, and employment outcomes. The addition of Aboriginal Health Workers with early childhood skills and training will provide an important, much needed role in preventing and reducing Aboriginal and Torres Strait Islander children and young peoples' exposure to child protection and criminal justice systems.

¹⁹ <http://www.familymatters.org.au/wp-content/uploads/2018/11/Family-Matters-Report-2018.pdf>; Thorburn, Kathryn and Melissa Marshall. 2017. The Yiriman Project in the West Kimberley: an example of justice reinvestment? Indigenous Justice Clearinghouse, Current Initiatives Paper 5; McCausland, Ruth, Elizabeth McEntyre, Eileen Baldry. 2017. Indigenous People, Mental Health, Cognitive Disability and the Criminal Justice System. Indigenous Justice Clearinghouse. Brief 22; AMA Report Card on Indigenous Health 2015. Treating the high rates of imprisonment of Aboriginal and Torres Strait Islander peoples as a symptom of the health gap: an integrated approach to both; Richards, Kelly, Lisa Rosevear and Robyn Gilbert. 2011. Promising interventions for reducing Indigenous juvenile offending. Indigenous Justice Clearinghouse, Brief 10.

Aboriginal Peak Organisations of the Northern Territory, Submission to the Royal Commission into the Protection and Detention of Children in the Northern Territory, 2017

NACCHO supports the position and recommendations of Aboriginal Peak Organisations in the NT, that:

- Aboriginal community control, empowerment and a trauma informed approach should underpin the delivery of all services to Aboriginal children and their families. This applies to service design and delivery across areas including early childhood, education, health, housing, welfare, prevention of substance misuse, family violence prevention, policing, child protection and youth justice.
- The Australian Government develops and implements a comprehensive, adequately resourced national strategy and target, developed in partnership with Aboriginal and Torres Strait Islander peoples, to eliminate the over-representation of Aboriginal and Torres Strait Islander children in out-of-home care.
- There is an urgent need for a child-centred, trauma-informed and culturally relevant approach to youth justice proceedings which ultimately seeks to altogether remove the need for the detention of children.
- Early childhood programs and related clinical and public health services are provided equitably to all Aboriginal children (across the NT) through the development and implementation of a three-tiered model of family health care – universal, targeted and indicated – to meet children's needs from before birth to school age. Services should be provided across eight key areas:
 - quality antenatal and postnatal care;
 - clinical and public health services for children and families;
 - a nurse home visiting program;
 - parenting programs;
 - child development programs;
 - two years of preschool;
 - targeted services for vulnerable children and families; and
 - supportive social determinants policies.
- These services need to be responsive to, and driven by, the community at a local level.

5. Strengthen the mental health and social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples

Proposal:

That the Australian Government:

- Provide secure and long-term funding to ACCHSs to expand their mental health, social and emotional wellbeing, suicide prevention, alcohol and other drugs services, using best practice trauma informed approaches.
- Urgently increase funding for ACCHSs to employ staff to deliver mental health and social and emotional wellbeing services, including psychologists, psychiatrists, speech pathologists, mental health workers and other professionals and workers; and
- Urgently increase the delivery of training to Aboriginal health practitioners to establish and/or consolidate skills development in mental health care and support, including suicide prevention; and
- Return funding for Aboriginal and Torres Strait Islander suicide prevention, health and wellbeing and alcohol and other drugs from the Indigenous Advancement Strategy to the Indigenous Australians' Health Programme.

Rationale:

The Australian Institute of Health and Welfare has estimated that mental health and substance use are the biggest contributors to the overall burden of disease for Aboriginal and Torres Strait Islander peoples. Indigenous adults are 2.7 times more likely to experience high or very high levels of psychological distress than other Australians.²⁰ They are also hospitalised for mental and behavioural disorders and suicide at almost twice the rate of non-Indigenous population and are missing out on much needed mental health services.

Suicide is the leading cause of death for Aboriginal people aged 5-34 years, the second leading cause of death for Aboriginal and Torres Strait Islander men. In 2016, the rate of suicide for Aboriginal and Torres Strait Islander peoples was 24 per 100,000, twice the rate for non-Indigenous Australians.²¹ Aboriginal people living in the Kimberley region are seven times more likely to suicide than non-Aboriginal people.

Many Aboriginal Community Controlled Health Services deliver culturally safe, trauma informed services in communities dealing with extreme social and economic disadvantage that are affected and compounded by intergenerational trauma and are supporting positive changes in the lives of their members. The case study provided by Derby Aboriginal Health Service demonstrates not only the impact that this ACCHS is having on its community. It also illustrates the rationale for each of the proposals described in this pre-budget submission.

²⁰ Australian Institute of Health and Welfare. 2018. *Australia's Health 2018*. Australia's health series no. 16. AUS 221. Canberra: AIHW.

²¹ *Ibid.*

Case Study: Derby Aboriginal Health Service, WA

Derby Aboriginal Health Service's Social and Emotional Wellbeing Unit (SEWB) have partnered with another organisation to employ someone in our SEWB unit to work directly with families on issues that contribute to them losing their children to Department of Child Protection (DCP). This program is designed to help prevent the children from being removed by DCP by working one to one with families on issues such as budgeting, education, substance misuse, a safe and healthy home etc.

Our SEWB unit has a community engagement approach which involves working directly with clients and their families, counselling with the psychologist and mental health worker, the male Aboriginal Mental Health Worker taking men out on country trips as part of mental health activities for men, the youth at risk program (Shine), the Body Clinic, the prenatal program working directly with mums, dads and bubs around parenting, relationships between mums, dads and children etc. The team work directly with the community.

We are now introducing a new SEWB designed program into the Derby prison which focuses on exploring men and women's strengths and abilities rather than looking at their deficits. Using a strengths based program was very successfully delivered with a group of 22 Aboriginal men and 16 Aboriginal women where, for many of the participants, they were told for the first time in their lives that they matter and that they have good things about them and they are strong men and women (this naturally brought in some behavior modification that they could attempt in making changes in their lives; e.g. one participant said that when he went home, he was going to make his wife a cup of tea instead of expecting her to make him tea – he said he had never thought of that before). The SEWB team presented this at the National Mental Health Conference in Adelaide, August last year.

Given the deep and respectful footprint the SEWB team has in the town and surrounding communities, they, and the people, deserve and need a new building in which to continue their important work. If we can help people deal with the issues above, then they will be much more empowered to prevent/deal with their own health issues – perhaps then we can Close the Gap.

Given the burden of mental, psychological distress and trauma that our communities are responding to and the impact this has on Aboriginal and Torres Strait Islander peoples' life expectancy, educational outcomes, and workforce participation, NACCHO believes it is imperative that a funded implementation plan for the National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing 2017-2023 ('the Framework') be developed as a priority. The following Action Areas of the Framework relate to this proposal:

- Action Area 1 – Strengthen the foundations (An effective and empowered mental health and social and emotional wellbeing workforce);
- Action Area 2 - Promote wellness (all outcome areas);²² and
- Action Area 4 - Provide care for people who are mildly or moderately ill (Aboriginal and Torres Strait Islander people living with a mild or moderate mental illness are able to access culturally and clinically appropriate primary mental health care according to need).

As the above case study suggests, our trusted local Aboriginal community controlled services are best placed to be the preferred providers of mental health, social and emotional wellbeing, and suicide prevention activities to their communities. Australian Government funding should be prioritised to on the ground Aboriginal services to deliver suicide prevention, trauma and other wellbeing services. Delivering these much-needed services through ACCHSs, rather than establishing a new service, would deliver economies of scale and would draw from an already demonstrated successful model of service delivery.

Further, NACCHO believes that the current artificial distinction between separating mental health, social and emotional wellbeing and alcohol and drug funding from primary health care funding, must be abolished. Primary health care, within the holistic health provision of ACCHS, provides the sound structure to address all aspects of health care arising from social, emotional and physical factors. Primary health care is a comprehensive approach to health in accordance with the Aboriginal holistic definition of health and arises out of the practical experience within the Aboriginal community itself having to provide effective and culturally appropriate health services to its communities.

The current artificial distinction, as exemplified by program funding for ACCHS activities being administered across two Australian Government Departments, does not support our definition of health and wellbeing. It also leads to inefficiencies and unnecessarily increases red tape, by imposing additional reporting burdens on a sector that is delivering services under challenging circumstances.

²² Outcome areas: Aboriginal and Torres Strait Islander communities and cultures are strong and support social and emotional wellbeing and mental health; Aboriginal and Torres Strait Islander families are strong and supported; Infants get the best possible developmental start to life and mental health; Aboriginal and Torres Strait Islander children and young people get the services and support they need to thrive and grow into mentally healthy adults.

APPENDIX A

Qualitative feedback from Aboriginal Community Controlled Health Services capital works and infrastructure needs

The following comments from ACCHSs have been extracted from a survey administered by NACCHO in January 2019:

- Currently at capacity and as the government focusses more on Medicare earnings and less on funding we need the ability to expand into this area as well as the NDIS in order to meet our client service needs and build sustainability.
- The facility that our service currently occupies is state government owned, on state crown land, is over 40 years old and is 'sick' – it is not fit for purpose with an irreparable roof, significant asbestos contamination, water ingress, mould and recurrent power outages. The maintenance costs are an unsustainable burden, it is unreliable, unsuitable and unsafe for clients and staff, and there is no room for expansion for program and community areas. We applied for funding from the Australian Government Department of Health, but the application was not successful. This figure is inclusive of early works transportable - temporary accommodation, building works, demolition works, services infrastructure, external works, design development contingency, construction contingency, builder preliminaries and margin, loose furniture and equipment, specialist/medical equipment, ICT & PABX, AV equipment, professional including disbursements (to be confirmed), statutory fees, locality loading, and goods and services tax.
- We are in need of kitchen renovations to each of our community care sites that do meals on wheels. The WA Environmental Health unit has informed us that we need to upgrade all our kitchens to meet Food Safety requirements or they will enforce closure of some of our kitchens, which would then mean we are unable to do our Meals on Wheels service in some communities
- Currently limited by space to employ support staff and increase our GP's, our waiting room is around 3x4m and we are always having clients standing up or waiting outside until there is space for them. We currently have three buildings in the one township with two being rentals, if we could co-locate all services, we could offer a higher level of integrated care and save wasted money on rent.
- Not currently enough space to house staff and visiting clinicians.
- Have been applying for grants in infrastructure and included in Action Plan for quite a few years and still not successful.
- We need a multi-purpose building to bring together our comprehensive range of services in a way that enables community to gather, express their culture and feel safe and welcome whilst receiving a fully integrated service delivery model of supports. We have more than doubled in staffing and program delivery and are still trying to operate out of the same space. The need for further expansion is inevitable and the co-operative welcomes the opportunity to bring more services to our community, but infrastructure

is a barrier and we have taken the strategic decision to acquire vacant land near our main headquarters with the view to obtaining future infrastructure funding – it is much needed.

- The three sites we currently lease are all commercial premises and we have to make our business fit, the buildings are not culturally appropriate nor are they designed for a clinical setting.
- For eight years we have struggled to grow in line with our community service needs and the requirement to become more self-sufficient in the face of a funding environment which is declining in real terms (not keeping pace with CPI and wages growth). Further to this, every time we add a building our running costs go up so even capital expansion comes at a cost to the organisation as it takes time to build up to the operating capacity that the new/improved buildings provide. This is the ongoing struggle in our space.
- Our service was established in 1999 and has been operating from an 80 year old converted holiday house, with a couple of minor extensions. The clinic does not meet the contemporary set up for an efficient clinic from viewpoint of staff, medical services and for community members. Space is very limited, and service delivery is also limited due to room availability. Demand for services both for physical and mental health/SEWB is growing strongly. We have 425 Community Members (with 70 currently in prisons in our region) and our actual patient numbers accessing services over 12 months have increased 50%.
- We never received support or funding to acquire a purpose-built facility from the outset and as there was no suitable accommodation for rent or lease, we acquired two small houses to deliver our services from. These were totally inadequate but all we could acquire at the time. We have 31 staff accommodated through three locations and require a purpose-built facility to deliver quality primary health care to our Community.
- Over the last two years we have been able to purchase the site it is currently located on. This site is based on five contiguous residential properties, with each property containing a 2-3 bedroom, approximately 40 year old house. Two of these houses have been joined together to form the Medical Clinic, the other three houses have all been renovated and upgraded to various levels in order to make them usable by the service. The next step in the plan is to redevelop the entire site to build an all-in-one centre to replace the current four separate buildings. In our 12 years of service we have moved from renting at a number of locations to being able to purchase our current site. The current site of old, converted residential buildings while viable in the short term, does not allow for efficient use of the site nor capacity for growth. Parking is scattered around the site, staff are scattered and continually moving from building to building to serve clients. There is no excess accommodation capacity to allow for growth of services. Our intention is to re-develop the site to house all staff in one building, which will be configured for growth over the long term and allow efficient use of the available grounds for parking, an Elders shed, and so on.
- We have run out of room. Every office is shared, including the CEO's office. We can't hire any staff - nowhere to house them. Whenever a visiting service is operating - GP clinic, podiatry, optometry, audiology, chiropractor etc, offices have to be vacated to house

them, displaced staff basically have nowhere to go. Fine balancing act to schedule things to displace as few people as possible.

- We are currently located in two refurbished community buildings as there is no suitable accommodation for lease. Our organisation is growing very quickly, and we need all services located under one roof - one identity, one culture.
- Rapidly reaching the point where services will be diminished because of failing infrastructure or insufficient housing for the nursing staff required.
- Some clinical rooms are not fit for purpose. Clinicians working from rooms without hand washing facilities. Medical Clinic is old, out of date, some rooms not fit for purpose, ineffective air conditioning, clinical staff sharing rooms, no room for expansion, difficult to house students due to lack of appropriate space.
- We have made a number of applications to improve infrastructure, and to replace current infrastructure, all have been unsuccessful, in some cases we have purchase buildings & land to try and demonstrate a commitment to ongoing growth and servicing of clients. We get little feedback in relation to funding applications.
- Spread across three sites with some providers having to share rooms and staff being required to work outside on laptops at times. Desperately needing to build a purpose-built facility in order to stop paying high amounts of rent and allow effective primary health care to an increasing client number.

Derby Aboriginal Health Service

The Derby Aboriginal Health Service (DAHS) Social and Emotional Wellbeing (SEWB) unit is housed in a 60+ year old asbestos building that was originally a family home. It has an old and small transport unit connected to the house by an exposed verandah. There are 6 staff working from the house who provide individual and family counselling and support. The clients who come to SEWB experience mental health issues, family violence, poverty, Department of Child Protection (DCP) issues around removal of children, alcohol and other drug issues and supporting those released from the Derby local Prison (approx. 200 prisoners). It is difficult to safely secure SEWB to the extent it is required given the age and asbestos nature of the building (security alarms etc). In the photos, you can see the buildings are old and are of asbestos. The transportable out the back houses the manager who is also the psychologist - this means she is in a vulnerable position when counselling should the session not go as planned (potential for a violent situation – see photo showing external verandah connecting to the donga). The size of the house means that counselling clients privately is difficult as everything happens in close quarters. The number of clients the team work with exceeds the capacity of the building which impacts on the number of Aboriginal clients the team can help. The SEWB building has been broken into a number of times the last being during the long weekend in September 2018 where significant damage was done. Given the age of the house, during the past 18 months, parts of the internal ceiling including cornices have been falling away from the structures creating potential issues of asbestos fibre being released into the air. In addition, there are plumbing problems and the wooden floor is becoming a safety issue in one area of the building.



SEWB runs a vulnerable youth programme (the Shine Group) and a Body Shop clinic for youth who will not attend the main clinic for shame and fear reasons (special appointments are made with a doctor so that the young person doesn't have to wait in the waiting area. In addition, a doctor runs a monthly session at the SEWB building with youth around health education and also sees them if there is a clinical need). These programmes run out of another 60+ year old asbestos family house some distance from the main SEWB house. Not only is the house not suitable but there may be security risks for the staff member working with vulnerable youth. The Shine House was also broken into in September 2018 where significant damage was done (see photos).

The DAHS main building has no further office or other space to house staff. This is particularly the case for 2019 as DAHS takes on new programmes (e.g. 2 staff for the new Syphilis Programme). DAHS is acutely aware of the need to source funding to build new administration offices in order to release current admin offices for clinical and programme purposes.

DAHS requires a new or upgraded SEWB building. DAHS first applied for service maintenance funding in March 2017 but were unsuccessful. DAHS applied in June 2018 for Capital Works but were unsuccessful because it didn't fit in with IAHP Primary Health Care as it was about mental health. DAHS also paid for an Architect to draw up the plans for a new SEWB building. It is my view that one of the main issues is that the government separates SEWB from primary health care.



Social and emotional wellbeing issues CANNOT be separated from primary health care. As is well known, a person's SEWB impacts on the physical health of an individual. Physical ill-health is frequently caused by the SEWB condition of an individual (i.e. historical and current experiences of trauma frequently commencing in the pre-natal phase of a child's life, family violence, alcohol and other drug use, smoking, anxiety, removal of children, mental health issues etc). Aboriginal people suffer greatly from SEWB issues which impacts on their overall physical health. Mental health in all its forms is part and parcel of physical health so it must be included in primary health care. However, both state and commonwealth governments do not seem to prioritise or even support funding for SEWB (such as service and maintenance work, capital works or funding to continue key positions in the SEWB team - in fact, the government actively separates funding for SEWB and primary health care). DAHS also provides clinical services to 7 remote communities most of whom are up to 400 kms away with Kandiwal Community 600kms away where we supply a fly in/fly out clinical service. There are many demands placed on a team of SEWB workers stationed in a working environment that does not allow them to function to the best of their abilities or offer increased services to our clients. Passion for the cause alone does not help in Closing the Gap. Working with one hand tied behind one's back is not effective in reducing mental health issues and chronic diseases.

Part of an upgrade we requested was to renovate reception to make it safer for receptionist staff and to increase confidentiality when clients speak with reception staff (it also doesn't meet the needs of disabled clients). There are a number of times throughout the year when

receptionist staff are verbally abused with threats of physical harm. The current reception was designed prior to more recent events of aggression exhibited by clients under the influence of drugs. The design now enables abusive clients to quite easily reach across the reception counter and hurt staff or can jump over the same counter to gain access to staff. In addition, given there is no screen and the current open nature of the reception area, sharing confidential information can be compromised. DAHS applied for services and maintenance funding to make the changes but were unsuccessful.