SUBMISSION: Inquiry into social isolation and loneliness in Queensland

INSTITUTE FOR URBAN INDIGENOUS HEALTH, BRISBANE
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Acknowledging:

- National Agreement on Closing the Gap 2020 (CTG Agreement) gives commitment and explicit priority to expanding community-controlled service delivery as the only way to address past closing the gap failures.
- Current funding and commissioning arrangements do not support the most efficient use of funding or the most effective health and social and emotional well-being (SEWB) responses for Indigenous people.
- The life expectancy gap between Indigenous and non-Indigenous Australians remains intolerably high (8.6 years for males and 7.8 years for females)
- The rapid urbanisation of Indigenous communities in Queensland, with the fastest and largest Indigenous population residing in South East Queensland, has resulted in increased demand for health and wellbeing services.
- The social and cultural determinments of health have a direct impact on rates of social isolation and loneliness among Indigenous Queenslanders.

IUIH contends that the government commit to giving priority to ensuring that:

- Community Controlled Health Services (CCHS) are the preferred provider of health and aged care services and programs aimed at closing the gap and achieving health equity. This will have the biggest impact on addressing social isolation and loneliness among Queensland's Indigenous population.
- CCHSs are funded holistically to allow for holistic service provision. Currently much of the funding allocated is siloed and does not allow adequate flexibility to provide necessary wrap-around services. CCHSs must be supported to ensure that comprehensive and integrated care models can be efficiently delivered, which are shown to have the biggest impacts on Indigenous health and wellbeing.
- Indigenous-led service planning and design, commissioning and decision making about investment for closing the gap initiatives is undertaken at a regional level.
- Accountability mechanisms are implemented that measure the impact of, and outcomes achieved from, close the gap initiatives implemented by whole-of-population services/programs system, and their direct impact on addressing social isolation and loneliness.

RECOMMENDATIONS

- Community Controlled Health Services (CCHS) must be the preferred provider of health and aged care services and programs aimed at closing the gap and achieving health equity.
- CCHSs must be funded and supported to ensure that comprehensive and integrated care models can be efficiently delivered, which are shown to have the biggest impacts on Indigenous health and wellbeing.
- Indigenous-led service planning and design, commissioning and decision making about investment for closing the gap initiatives is undertaken at a regional level.
- Accountability mechanisms are implemented that measure the impact of, and outcomes achieved from, close the gap initiatives implemented by whole-of-population services/programs system, and their direct impact on addressing social isolation and loneliness.

Executive Summary

The Institute for Urban Indigenous Health (IUIH) welcomes the opportunity to provide input to *Inquiry into social isolation and loneliness in Queensland.*

About IUIH

IUIH was established in 2009 as a regional strategic response to the significant growth and geographic dispersal of Indigenous people within South East Queensland (SEQ). As Australia's largest CCHS, IUIH represents a network of five CCHSs in SEQ, Australia's largest and fastest-growing Indigenous region and home to close to 40% of Queensland's and 11% of Australia's Indigenous population. Since 2011, it is estimated that the IUIH Network population footprint population has dramatically increased by 70%, from 59,483 people in 2011 to an estimated population of 100,194 Indigenous people in 2021.

The IUIH regional network provides care to around 35,000 Indigenous people through 20 community-controlled clinics operated by IUIH Network Members in SEQ. This includes:

- Aboriginal and Torres Strait Islander Community Health Service (ATSICHS) Brisbane Limited
- Kalwun Development Corporation Limited (Kalwun Health Service)
- Kambu Aboriginal and Torres Strait Islander Corporation for Health
- Yulu-Burri-Ba Aboriginal Corporation for Community Health
- Moreton Aboriginal and Torres Strait Islander Community Health Service (Moreton ATSICHS)

Since 2009, the IUIH Network has developed into an integrated regional ecosystem of services delivering health and social support services across South East Queensland. This one-stop-shop model of integrated health and social support services for Aboriginal and Torres Strait Islander families, is known as the IUIH System of Care.
Several examples of IUIH's approach to integrated and culturally safe care, are outlined below.

Social Health services

The IUIH Network delivers a range of mental health and substance misuse services specifically tailored for Aboriginal and Torres Strait Islander people. These include culturally and clinically capable individual and group therapy services, psychosocial support, transitional support services (i.e. prison transition), youth wellbeing services, support services for homeless people, and social support services specifically targeted to Aboriginal and Torres Strait Islander people in South East Queensland.

Particular Social Health services, like the Inner-City Referral Service (ICRS) are critical for addressing and preventing social isolation and loneliness for Indigenous people living in the Brisbane area. The ICRS provides intensive support for the most disadvantaged and vulnerable Indigenous people in the Brisbane inner city area, with a priority focus to enhance the safety and wellbeing of those substantively affected by substance misuse, violence, abuse and homelessness. A key success factor in the ICRS model includes the wrap-round care arrangements which, in a highly seamless and holistic way, support safe and supported transitions towards improved safety, wellbeing and quality of life for the program participants – all critical components for addressing social isolation and loneliness.

At IUIH, we refer to the collection of mental health and substance misuse services as Social Health Services, which sit within a broader Family Health and Wellbeing Service. The Family Health and Wellbeing Service also includes the IUIH Legal Service, birthing and early learning programs, and paediatric services. Social Health Services play an integral role in driving the IUIH Child and Family Centred Practice Framework (Framework) across the broader IUIH System of Care.

The IUIH Network employs over 90 staff within Social Health. This includes psychiatrists, child and family psychologists, counsellors, social workers (including mental health accredited), case coordinators (social worker and/or counsellor qualified), intensive transitional support workers, youth wellbeing support workers, youth practitioners (counsellor or psychologist) and wellbeing support workers with mental health and alcohol and other drugs qualifications. These services are fully integrated into a comprehensive primary healthcare model which means that anyone receiving IUIH's Social Health services is exposed to and can access (depending on their specific needs) the full range of GP, allied health, targeted social and cultural support programs, dental and other services available through the IUIH Network of 20 clinics across the region.

At the core of the IUIH Social Health Program is an integrated model providing early intervention service responses. A team of senior clinicians provides regional supports and develop, including clinical supervision across all social health program areas, targeted clinical service coordination and oversight (specifically child therapeutic and assessment services), and service quality improvement and development.

The IUIH Social Health program focuses on:

- Building the capacity of individuals and families to work through challenges and improve their well-being through ongoing, targeted, and client and goal centred services.
- Providing targeted, evidence-based, therapeutic treatment, including counselling, psychological services, psychosocial support and specific treatments for alcohol and other drug issues, with a big emphasis on alcohol and other drug, and mental health education support.

Aged care services

Appropriate access to aged care services is key to addressing the social isolation of Indigenous Elders. This includes access a range of culturally appropriate services - from entry-level supports such as the Commonwealth Home Support Program, through to permanent residential aged care.

IUIH is the largest Indigenous community aged care provider in Australia - providing care to 3,278 Elders in SEQ, Sunshine Coast and Wide Bay and operating under a unique and nationally recognised service delivery and financial model integrating aged care with comprehensive primary health care.

To protect vulnerable Elders that had become socially isolated from family and community supports as a result of COVID-19, IUIH has led a national COVID-19 Elder's response in every capital city of Australia, including throughout South East Queensland to provide critical welfare checking, meals and other supports. Through leveraging the existing and trusted client relationships with the Community Controlled Health Sector (CCHS) and a fully integrated aged care, health and disability model of care, this successful measure has highlighted the strength and capability of the CCHS sector for identifying and addressing the needs of most vulnerable Elders.

Funded by the Commonwealth Government, IUIH partnered with 12 community-controlled health and aged care services across Australia to deliver support to vulnerable Elders who were not in receipt of aged care services. These supports have been deemed critical for this most vulnerable cohort during a time of continued risk and uncertainty around the management of the COVID pandemic. An important outcome of the COVID response measure has been the strengthened relationships and cultural connectedness built between clients and the community-controlled providers. This has enabled clients, for the first time, to have the trust and confidence to be able to identify, express and seek assistance for their ongoing support needs, including their social and emotional wellbeing.

Text box 1 provides a case study from one client experiencing social isolation and loneliness.

TEXT BOX 1: Case study from the COVID-19 Elders Response, 'Gordon's story'.

Gordon had minimal support from family and friends and had lost his job due to health issues, which were also heavily impacted due to COVID-19. Gordon had been struggling with his mental health and had been experiencing financial issues for some time. He had expressed concerns about becoming homeless and being unsure of what the future held. Before receiving help, he was unable to store food safely due to lack of facilities and would often go without food or resort to purchasing unhealthy options that lacked nutritional value. Through assistance from the National Elders COVID Response, Gordon now has better information regarding COVID-19 through his weekly check-ins and his overall mental health has improved. Gordon has been placed into more suitable accommodation, is receiving meal support and has commented how much better he feels having nutritious meals. Gordon has expressed that his life has improved significantly due to the COVID Elder's program and is very thankful for the support. He is looking forward to transitioning back into being independent again.*

**Name changed to protect privacy*

IUIH Connect/IUIH Connect Plus

The IUIH Connect program was established in 2013, aiming to reduce avoidable hospital admissions, Discharge Against Medical Advice (DAMA) rates and improve access to health and social care supports for Aboriginal and Torres Strait Islander people. The integration of tertiary and primary healthcare results in improved performance of the healthcare system and improved health care journeys for clients. In response to the COVID-19 pandemic with increasing pressure on medical supply chains, hospitals, and the healthcare workforce, IUIH Connect received additional funding to expand services, operationally and geographically.

Given the elevated and critical need to increase coordination of support for vulnerable people in the context of the COVID-19 pandemic, IUIH sought Queensland Government funding to expand IUIH

Connect, tailoring it to become part of its critical COVID-19 response to the needs of Aboriginal and Torres Strait Islander people – this specific pandemic response is known as 'IUIH Connect Plus.

IUIH Connect Plus connects care for Aboriginal and Torres Strait Islanders by providing a single point of contact for individuals, carers, families, community members and service providers. The IUIH Connect Plus team is committed to working together with all providers and stakeholders to provide holistic, culturally safe and quality care for clients and their families. Within the healthcare system, there are significant points of risk in a client's health and wellbeing journey, especially when care is transferred between primary and tertiary care providers. The IUIH Connect Plus team supports clients and their families by connecting with referral providers to ensure care is connected and culturally responsive.

During January to June 2021, IUIH Connect Plus continued to provide culturally appropriate and responsive services to the community, between 7am to 7pm, seven days a week through the 1800 hotline number and other referral pathways. IUIH Connect Plus continued to engage and partner with Hospital Health Services (HHSs), Community Controlled Health Services (CCHSs), Queensland Police Service (QPS), mainstream health service providers and other community stakeholders, the IUIH Connect Plus program has connected clients to high quality and culturally responsive services.

Birthing in Our Community (BiOC)

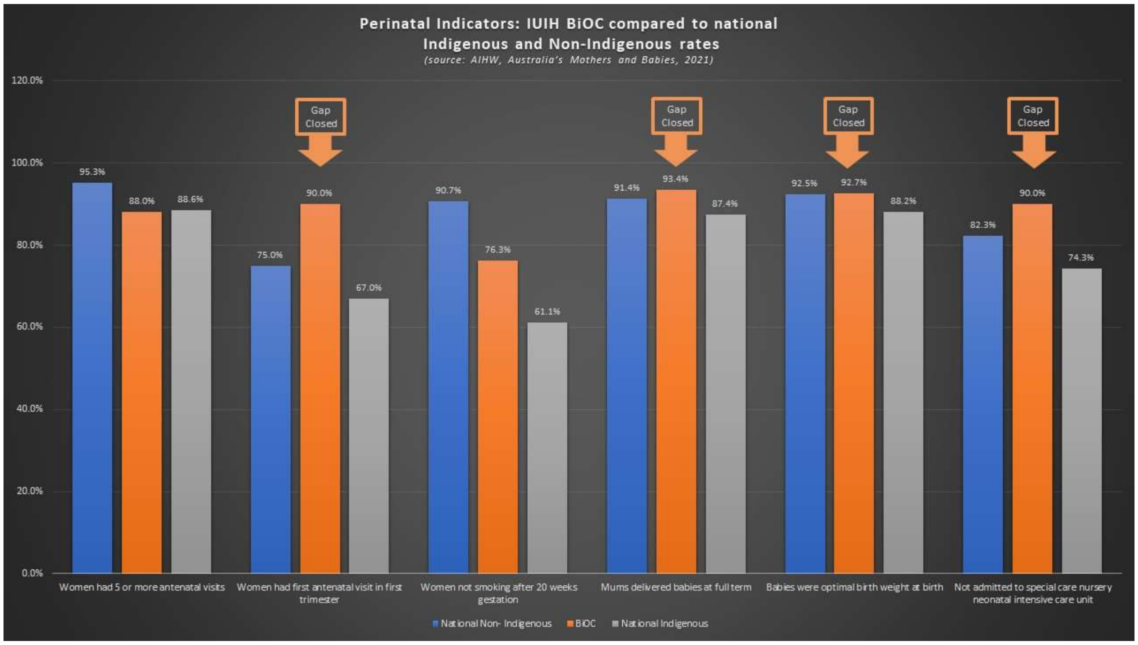
IUIH's BiOC Program is a Partnership between IUIH, Aboriginal and Torres Strait Islander Community Health Service (ATSICHS) Brisbane and the Mater Mothers' Hospital. BiOC was established in response to a lack of culturally safe maternity care and a widening of the gap in pre-term birth outcomes for Indigenous mothers. Since its establishment, BiOC continues to produce outstanding outcomes for Indigenous mothers and babies. BiOC provides a culturally enabling environment, where women and families not only access multidisciplinary maternity and infant care, but also connect, interact, share and learn from each other, staff and from elders. These important characteristics are protective factors for families developing social isolation and loneliness.

Key features of BiOC are outlined below:

- BiOC integrates the midwifery services and expertise of the Mater Mothers' Hospital with the cultural knowledge and clinical expertise of IUIH and ATSICHS Brisbane, enabling a unique approach to service delivery. The BiOC Model offers Aboriginal and Torres Strait Islander mothers with:
- Midwifery group practice with 24/7 access to pregnancy, birthing and postnatal care provided by the same midwife, backed up when necessary by other midwives who are all part of the same BiOC team
- Support from Aboriginal and Torres Strait Islander Family Support Workers and student midwives as core members of the team, along with other health services as needed
- Transport services to access care as well as home visits as needed
- Intensive support for women to quit smoking (throughout their pregnancy and for up to 6 months after birth).

A five-year National Health and Medical Research Council (NHMRC) study on BiOC's foundational Brisbane South program was recently published in The Lancet Global Health journal (May 2021), confirming that preterm birth rates for Indigenous women have been halved through the program. These results are both dramatic and unprecedented - not only closing the preterm birth gap but delivering rates (6.6%) that are now better than mainstream (8.2%). In a further astonishing result, BiOC has not only already exceeded the 2031 CTG Agreement healthy birthweight target (91%) but is delivering optimal birthweights at a better rate than mainstream (92.7% compared to 92.5%) (**Figure 1**). This is a remarkable outcome, where the BiOC model has actually closed the gap in two of the most important indicators impacting life expectancy

Figure 1. Perinatal Indicators: IUIH compared to national Indigenous and Non-Indigenous rates.



The need

Indigenous social and emotional wellbeing

Social isolation and loneliness are not just social issues – they can have profound impacts on overall physical and mental wellbeing. Systematic reviews have identified a significant association between social isolation and loneliness and all-cause mortality, cardiovascular disease, cognitive decline and poorer mental health outcomes, including depression and social anxiety (Leigh-Hunt, et al., 2017).

Loneliness and social isolation must also be understood as a product of colonization. Colonisation has had a profound and lasting impact on Indigenous people, resulting in unresolved trauma, which continues to be passed down through generations. Ensuring connection to family, culture, land and community are all part of healing from the impacts of colonization and restoring SEWB (Dudgeon & Walker, 2015). Therefore, addressing social isolation and loneliness is about addressing their social and cultural determinants/drivers. Physical, mental, social and emotional health and wellbeing (SEWB) for Indigenous people sits within a holistic and whole-of-life view of health, which recognises the importance of connection to land, culture, spirituality, ancestry, family and community, and the significance of these connections for individuals (Dudgeon, Milroy, & Walker, 2014). When these domains are not met or disrupted, this will likely lead to poorer SEWB outcomes, including increased risk of depression and suicide (Gayaa Dhuwi Australia, 2021).

Cultural determinants of health originate from and promote a strength-based perspective, acknowledging that stronger connections to culture and country build stronger individual and collective identities, a sense of self-esteem, resilience, and improved outcomes across the other determinants of health, including education, economic stability and community safety. In this way, culture is a protective factor for health and wellbeing, and cultural expression is healing and has health benefits.

Burden of disease

Aboriginal and Torres Strait Islander peoples suffer disproportionately from mental health conditions compared to non-Indigenous Australians:

- In Queensland, mental and substance use disorders were the leading cause of total disease burden for Indigenous Australians, followed by injuries, cardiovascular disease and cancer (Australian Institute of Health and Welfare, 2016).
- In 2018–19, around 3 in 10 Indigenous Queenslanders had high to very high levels of psychological distress (31%, age-standardised)—a proportion that has not changed significantly since 2008—compared with 13% of non-Indigenous Australians (Australian Institute of Health and Welfare, 2020).
- In 2016–17, the age-standardised rate of hospitalisations due to injury or poisoning among Indigenous Queenslanders was 50 per 1,000 population, compared with 34 per 1,000 in 2004–05 (Australian Institute of Health and Welfare, 2020).
- The leading contributors to the burden of disease and injury amongst Queensland's Indigenous population varies by remoteness. Mental disorders contributed 28.8% to the Indigenous burden of disease in Queensland's Major Cities, 21.19% in Regional areas and 9.1% in Remote/Very Remote areas. In SEQ, mental disorders are the largest contributor to the Indigenous burden of disease, whereas cardiovascular disease is the leading contributor in Remote/Very Remote areas (Queensland Health, 2017).
- Suicide rates amongst Indigenous Queenslanders in the 25–34 and 35–44 age group are more than double those of Queensland's non-Indigenous population (Australian Institute for Health and Welfare, 2021).

The breadth and depth of such high levels of distress on individuals, their families, and their communities is profound. The high rates of chronic disease in Aboriginal and Torres Strait Islander people mean that many people are likely to experience coexisting physical and social/emotional health problems. Meeting Closing the Gap targets will require simultaneous action to address chronic disease and mental illness in Indigenous people, families, and communities. To meet these needs, CCHSs must have a leading role in the design and delivery of health and wellbeing services (including SEWB services) for Indigenous Queenslanders.

The urban Indigenous experience

Indigenous Queenslanders living in urban areas experience disadvantages in terms of housing affordability and are more likely to live in areas on the urban fringe, resulting on poor mobility and access to services and transport (Brand, Bond, & Shannon, 2016).

Proximity to mainstream health services has also not translated to improved health outcomes for Aboriginal and Torres Strait Islander people, for example:

- In SEQ, the Health Adjusted Life Expectancy (HALE) Gap is 1.5 times greater than in remote Queensland (Queensland Health, 2017)
- Nationally, according to AIHW Burden of Disease data:
  - The relative disadvantage between Indigenous and non-Indigenous people is greater in urban areas, with Indigenous people in major cities experience 2.1 times the rate of health disadvantage compared to non-Indigenous people in the same area. For a similar comparison in very remote areas, Indigenous people experience 1.9 times the rate of disadvantage
- Nationally, according to the latest (2015) Aboriginal and Torres Strait Islander Social Survey (AHMAC, 2017):
  - Indigenous people in non-remote areas were more likely than those in remote areas to feel that they had been treated unfairly in the last 12 months (35% compared with 28%). Indigenous people in non-remote areas further reported that in the last 12 months their GP or specialist did not always show them respect (15%), listen carefully to them (20%) or spend enough time with them (21%)
- Nationally, according to the latest (2019) Aboriginal and Torres Strait Islander Health Survey (Australian Bureau of Statistics, 2019):
  - The proportion of people with one or more selected chronic conditions was higher for people living in non-remote areas (48%) than in remote areas (33%)
  - the proportion of people with a mental or behavioural condition was around three times higher for people living in non-remote areas (28%) than remote areas (10%)
  - the proportion of people who did not see a General Practitioner when needed in the last 12 months was higher for those living in non-remote areas (14%) compared to remote (8%)
- The majority (74%) of the health gap between mainstream and First Nations people also occur in urban areas. While these numbers are national figures, it has been shown that 76% of the total Indigenous burden of disease in Queensland is also in urban areas (Australian Institute of Health and Welfare, 2016).
- Urban Indigenous families and children have a much higher recorded prevalence (1.4 times) of exposure to stressful life events, compared with non-Indigenous people (Commonwealth of Australia, 2017).

Urban Indigenous people also experience other challenges relating to dislocation, racism and disempowerment (Eades, et al., 2010). Racism continues to have a significant impact on Aboriginal and Torres Strait Islander people's decisions about when and why they seek health services. According to a report on *Addressing Institutional Barriers to Health Equity for Aboriginal and Torres Strait Islander People in Queensland's Public Hospital and Health Services,* that reported on levels of institutional racism within Queensland Hospital and Health Services (HHS)s, 10 of the 16 HHSs rated within the extreme range of institutional racism, with the remaining six in the very high range. Therefore, all HHSs in Queensland rated in the very high to extremely high levels of institutional racism (Marrie, 2017).

The above findings and data highlight the urgent need for an urban Indigenous focus, when addressing the issues and drivers associated with social isolation and loneliness. This imperative to give priority attention to the needs of urban regions has not, however, been reflected in funding and commissioning frameworks for addressing urban Indigenous SEWB. Further, the challenges which are emerging through Indigenous population trends are not well understood. These trends reveal some dramatic demographic changes:

- There is a continued urbanisation of the Indigenous population, with 79% of Australia's Indigenous people living in urban areas
- There is a slowed or, in some cases, declining remote Indigenous population.

Figures 1, 2 and 3 highlight these population characteristics.

To address these demographic and geographic challenges, priority must be given to addressing urban Indigenous disadvantage, including:

- Examining the need for increased funding of, and access to, community-controlled health services for urban Indigenous Australians, relative to disease and disability burden and projected population growth and
- Examining the need for allocating specific infrastructure funding to support enhanced service accessibility in urban settings, including expanded clinic development.

Figure 1. National Indigenous urban population trends 1971-2016 by size of town/city (Markham & Biddle, 2018)

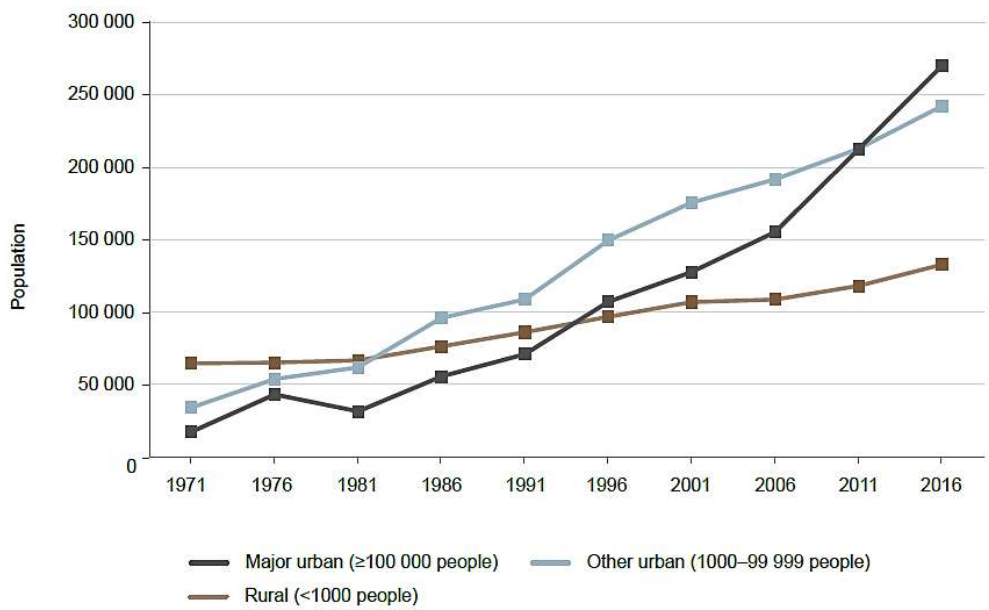


Figure 2. Projections of Indigenous Population to 2031, by Indigenous Region, ABS

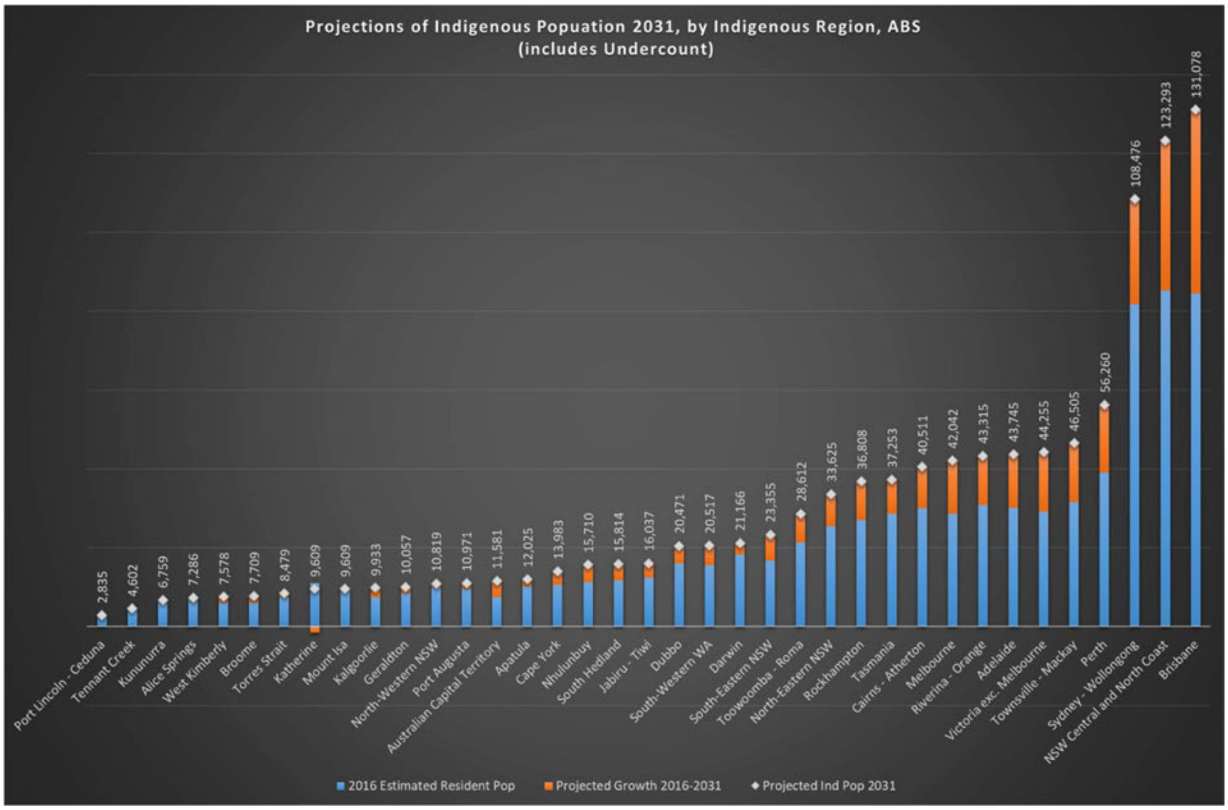
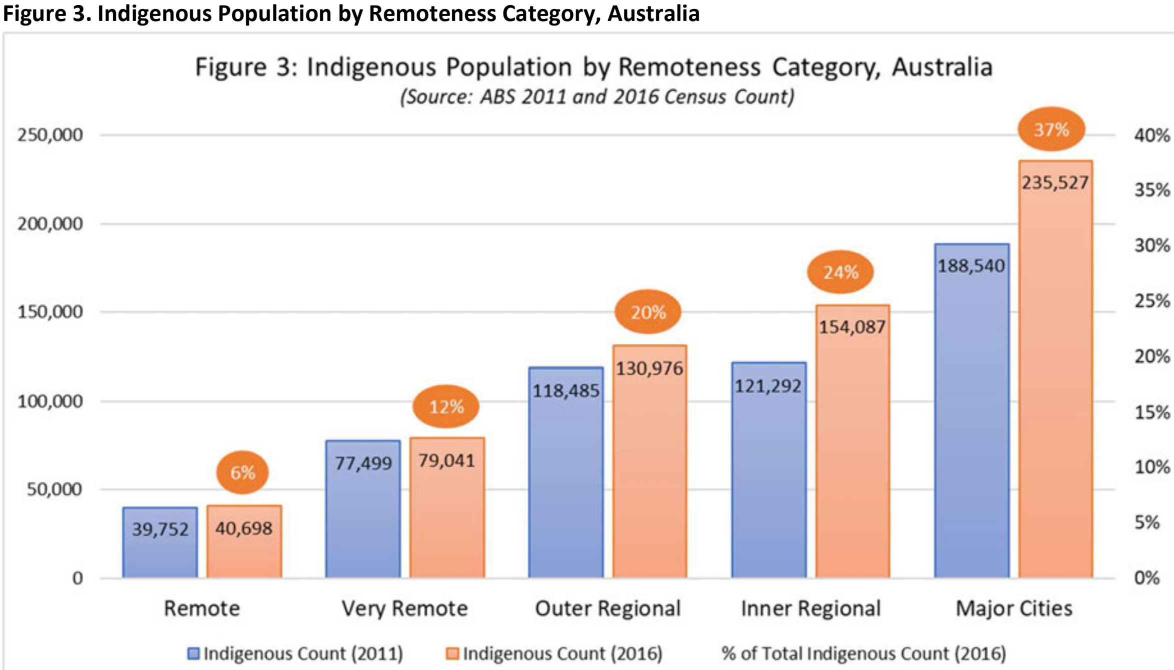


Figure 3. Indigenous Population by Remoteness Category, Australia



Drivers and risk factors social isolation and loneliness

According to Members of the IUIH Network (Yulu-Burri-Ba Aboriginal Corporation for Community Health and Kambu Aboriginal and Torres Strait Islander Corporation for Health), some of the drivers or risk factors for social isolation and loneliness are outlined below:

Domestic and family violence

People who experience domestic and family violence are more likely to be socially isolated and experience feelings of loneliness. People can either be cut-off from family and friends, as a form of coercive control, or may choose to socially isolate for fear of repercussions or out of feelings of shame. Protections orders may also have unintended consequences, such as social isolation and loneliness.

Separation and divorce

The effects of separation and divorce can have a direct impact on social isolation and loneliness, resulting from a loss of social networks and supports, less time to spend with family and friends due to increased parenting responsibilities, and less financial resources.

Unemployment

The National Indigenous Reform Agreement 2009 (NIRA) aimed to halve the gap in employment outcomes within a decade. That target was not achieved either nationally or in Queensland and the gap in employment outcomes is widening. It is well reported that compared with employed people, those who lack employment are more likely to experience high or very high levels of psychological distress. The employment rate for Indigenous Queenslanders has not changed significantly between 2014–15 and 2017–19. In 2018–19, around 50% of Indigenous Australians in Queensland aged 15–64 were employed, compared with 75% of non-Indigenous Australians (Australian Institute of Health and Welfare, 2020). Emphasis must be placed on improving education, training and employment outcomes for Indigenous Queenslanders, through the establishment of an Indigenous designed and led Registered Training Organisation in South East Queensland, which is where the fastest and largest growing Indigenous population of Queensland lives.

Poor access to legal services

There is a growing body of evidence that indicates that people at risk of poor health and legal outcomes experience barriers to accessing legal services. Issues including anxiety, lack of familiarity, fear of detention, and reluctance to use non-Aboriginal and Torres Strait Islander specific legal assistance services have been demonstrated to affect access to justice for Indigenous people. Critically, these compounding health and legal issues can significantly exacerbate their disadvantage. Conversely, factors leading to poor justice outcomes (such as incarceration, child protection interventions, and debt) may also be directly associated with (unaddressed) health and SEWB issues (Wei & Macdonald, 2018). CCHSs like IUIH play a critical role in supporting community members encountering the justice system and the child protection system, by providing legal services embedded within a fully integrated model of primary healthcare that values and affirms cultural identity, and asserts the link between rights, responsibilities, self-determination and well-being.

COVID-19 protection measures

The mental health impacts of the COVID-19 pandemic are well reported. COVID-19 protection measures (such as lockdowns, quarantine and isolation orders, social distancing, and restrictions on service delivery), resulting loss of employment/business, home-schooling and remote-work on communities have shown to have negative mental health effects.

For Indigenous Australians, COVID-19 has the potential to amplify the social determinants of health and affect direct access to health care. CCHSs realised the potential of these impacts at the start of the pandemic and worked quickly to adapt models of care to protect communities from the spread of COVID-19. For the IUIH Network, this involved activating regional governance structures, capabilities and resources to enable a rapid response. While most people will only experience short term impacts, the recent sudden and prolonged 'lockdowns' could have the potential to contribute to or exacerbate long-term mental illness including anxiety, depression, PTSD and substance misuse (Australian Institute of Health and Welfare, 2021). The Australian Bureau of Statistics' national Household impacts of COVID-19 survey of 1000 adults found that 28% of women and 16% of men reported feeling lonely as result of the pandemic, and that this was the most common personal stressor identified. Indigenous Australians reported relatively higher levels of anxiety and worry (Australian Bureau of Statistics, 2020).

Lack of access to culturally appropriate disability supports through the NDIS

Compared with non-Indigenous Australians, Indigenous Australians are (Australian Institute for Health and Welfare, 2019):

- 1.8x as likely to have disability
- 2.0x as likely to use disability support provided under the NDIS

For Indigenous Australians, it is often more complex in terms of more than one disability or health issue occurring together, and it is compressed within a shorter life expectancy. Indigenous Queenslanders living with a disability also experience significant barriers to access the NDIS. Based on latest NDIS and ABS data, only half (47%) of the expected Indigenous NDIS Participant population in Australia requiring assistance are receiving NDIS supports, compared to 93% of expected NDIS Participants for all Australians (NDIS, 2020). This represents a major access gap for one of the most disadvantaged groups of Australians and is a direct result of a total lack of systemic Indigenous-specific pathways within the NDIS system – pathways which are essential to support culturally safe access, assessment, and care.

Lack of access to culturally appropriate aged care services

Only 16% of Indigenous Elders are currently receiving an aged care service compared to 26% of older Australians (Australian Institute for Health and Welfare, 2020). This is largely due to a complete lack of culturally safe aged care providers. Elders who are social isolated can also be at risk of Elders abuse and exploitation (Australian Institute of Health and Welfare, 2019). Supporting our Aboriginal and Torres Strait Islander Elders by maintaining their healthy lifestyle and connection to culture and helping them to stay independent and at home for longer, goes to the heart of respecting and protecting Elders to undertake their role as the custodians of our culture and as the heart of our communities. Agreed and funded targets attached to any aged care reform must be set to address the massive underrepresentation of Indigenous Elders in aged care.

Addressing social isolation and loneliness

As part of the Closing the Gap National Reform Federation Council reforms, has now called for a radical new approach to addressing Indigenous disadvantage. In his 2020 Closing the Gap Statement to Parliament, the Prime Minister made it clear that continued reliance on existing programs and policies will no longer deliver the required outcomes.

Instead, the new National Agreement on Closing the Gap acknowledges that Aboriginal and Torres Strait Islander community-controlled services are better for Indigenous people, achieve better results, and employ more Indigenous people over mainstream services. Accordingly, the Agreement commits all jurisdictions to an entirely new approach, including to give preference to community-controlled organisations to design and deliver community-led solutions in achieving closing the gap targets, including those with a focus on addressing the drivers of social isolation and loneliness.

It is well documented that many of the key drivers of health reside in our everyday living and working conditions, and often sit outside the health system (Queensland Health, 2016). These social determinants of health (including inequity, stigma and discrimination, environmental and socio-cultural factors, including exposure to trauma and violence) are mostly responsible for health inequities and are critical to achieving the Closing the Gap targets, particularly the headline target of closing the life expectancy gap.

Improving cultural and social connection, reducing financial stress, building esteem and purpose through education and employment, enacting rights through direct access to legal services are essential prerequisites for good mental health and well-being services. In recognition of this principle and the vital contribution that social and cultural determinments have on health outcomes, programs and services targeted at addressing social isolation and loneliness must focus on a broad range of areas early education, employment, family well-being, justice, child protection, aged care, and disability.

Examples discussed earlier, such as BiOC are important contributors to improved SEWB among urban Indigenous communities. Not only do they have a direct impact on providing culturally safe maternity care and connecting and pathways for families, but they also have a strong focus on SEWB, creating cultural connections across the lifespan, early childhood development, early intervention and fully integrated and wrap-around supports. Supporting CCHSs in their whole-of-community approach, will help to ensure people are culturally and socially connected, and linked with a range of health and social services that prevent the risk of social isolation and loneliness.

Support for CCHSs to deliver mental health services

There are numerous examples which show a preference for mainstream mental health services to deliver 'universal' mental health services for the whole population rather than targeted approaches through ACCHOs. This results in:

- mainstream service models which are less appropriate, less likely to be utilised, and less likely to be effective and
- ACCHOs which are insufficiently resourced to deal with the significant numbers of patients with SEWB, mental health, and substance issues at their clinics.

Despite significant rhetoric in government policies programs ascribing to the importance of culture, for the most part these have failed to structurally and systemically translate into program practice and design. It should also be noted that ACCHOs are generally funded for SEWB programs (preventive mental health programs), rather than for the clinically indicated mental health treatment services that their clients require.

In IUIH's experience, most Aboriginal and Torres Strait Islander people want to access services where mental health and social and emotional programs are integrated into a culturally capable model of health care. Recognising that mental health issues contribute to social isolation and loneliness, it is therefore critical for the Queensland Government to invest in strategies to improve the cultural capability of mainstream services, while simultaneously enhancing the capacity of the CCHSs sector to deliver clinical mental health services. The Queensland Government's 2021 budget announcement of $8.3 million to support greater representation of Aboriginal and Torres Strait Islander people in the mental health workforce is a positive step, however it is yet to be seen whether this funding will be allocated to CCHSs, who are best delivered to provide mental health services to their communities.

A focus on Indigenous Elders

A priory focus must be given to Indigenous people most at risk of social isolation, such as Indigenous Elders. As discussed above, rates of Indigenous Elders accessing aged care services are extremely low, and Indigenous Elders experience multiple barriers in accessing culturally safe care. This lack of cultural safety has demonstratively had as great an impact on poor care outcomes as other quality and safety issues highlighted by the Royal Commission. For example, compared to non-Indigenous Australians, Indigenous people are:

- 2.3 times more likely to die early or live with poor health (Australian Institute of Health and Welfare, 2016).
- 2.1 times more likely to have a profound/severe core activity limitation (Australian Institute of Health and Welfare, 2015)
- 3 to 5 times more likely to have dementia (Australian Institute of Health and Welfare, 2015)
- 2.7 times more likely to live in disadvantaged areas (Australian Bureau of Statistics, 2016)

The Royal Commission into Aged Care Quality and Safety (Royal Commission) Final Report set out a blueprint for long advocated transformational change in Indigenous aged care. For the first time, Indigenous Elders were listened to – most clearly through the Royal Commission's ground-breaking recommendations to create specific Indigenous aged care pathways.

Addressing the needs of urban Elders through community-led solutions such as the highly successful COVID-19 Elders Response are premised on the overwhelming evidence that Indigenous led, designed and delivered solutions are the only way forward if efforts to close the gap are to succeed. This highlights the critical role of CCHSs in engaging and supporting the most vulnerable and hard-to-reach Elders living in urban settings, whose physical and mental health would have been severely compromised in the absence of this measure. CCHSs must therefore be funded as aged care providers to provide genuine choice for Indigenous Elders to receive culturally safe care from Indigenous community-controlled organisations, through fully integrated models of health, aged care, and disability. This includes a priority focus and direct investment to respond to the rapid growth of Indigenous Elders in urban regions, including to fix a significant shortfall of Indigenous providers in capital cities.

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