IMPROVING MENTAL HEALTH OUTCOMES FOR URBAN INDIGENOUS QUEENSLANDERS

Submission to the Mental Health Select Committee Inquiry into Opportunities to Improve Mental Health Outcomes for Queenslanders

Submitted by Adrian Carson, CEO IUIH
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Contact:
Adrian Carson
Chief Executive Officer, Institute for Urban Indigenous Health
[redacted]

Please note: Throughout this document, the term '*mainstream*'' is used to describe an organisation/practitioner that provides services to the general population (eg a private general practitioner, a hospital, a community mental health services) or a service or program that any eligible member of the Australian community may access. The terms '*Indigenous-specific*' or '*targeted service*' are used to describe services that are funded and delivered specifically to Aboriginal and/or Torres Strait Islander people. A *Community Controlled Health Service* is a particular model of Indigenous-led and Indigenous-specific healthcare operated by Aboriginal and/or Torres Strait Islander non-government organisations.

OVERVIEW

1. **Policy:** Over the last ten years, the Australian and Queensland government commitments under the 2009 *National Indigenous Reform Agreement* (also known as the Close the Gap Agreement)[1] focussed on chronic disease and completely ignored mental health. There was no dedicated funding for mental health, or any mental health/addiction/suicide prevention performance indicators/targets, in this agreement.

   i. In Queensland, the 2010 *Making Tracks* policy and accountability framework[2], which was developed to give effect to the national agreement, also focussed on chronic disease. Queensland Health tried to rectify this with its Indigenous Mental Health Strategy[3] in 2016, which recognised the important role of Aboriginal and Torres Strait Islander Community Controlled Health Services (CCHSs) but focussed primarily on improving Hospital and Health Service (HHS) service provision for Indigenous people and strengthening partnerships between HHS services and the CCHS sector.

   ii. In 2017, the *Fifth National Mental Health Plan* acknowledged that '*most Aboriginal and Torres Strait Islander peoples want to be able to access services where the best possible mental health and social and emotional wellbeing strategies are integrated into a culturally capable model of health care'.* The Plan highlighted the role of the CCHS sector as an *'important component of a culturally responsive mental health service system [which] can play a vital role in … enabling access to primary and specialist mental health services and allied health, facilitating the transition of consumers across the primary and specialist/acute interface … and working as part of multi-agency and multidisciplinary teams aimed at delivering shared care arrangements'*[4].

   iii. The renewed national close the gap agreement, signed by all governments in 2020, includes targets and funding for suicide prevention and aftercare, and strongly preferences the delivery of services by the CCHS sector. It includes a commitment to '*increasing the amount of government funding for Aboriginal and Torres Strait Islander programs and services going through Aboriginal and Torres Strait Islander community-controlled organisations'*[5]. These commitments, and the recent indication that the Australian Government will channel the Indigenous-specific funding for suicide prevention and aftercare announced in the 2021-22 Federal Budget through the CCHS sector, are welcomed by the Institute for Urban Indigenous Health (IUIH).

   iv. In 2020, the Australian Productivity Commission's mental health inquiry strongly supported the '*devolution of service provision for Aboriginal and Torres Strait Islander people to Aboriginal Community Controlled Health Services'* and stated that '*in the case of mental health services for Aboriginal and Torres Strait Islander people, Aboriginal Community Controlled Health Services should be identified as preferred providers*[6].

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[1] Council of Australian Governments 2009. *National Indigenous Reform Agreement*, Canberra.

[2] Queensland Health 2010: *Making Tracks towards closing the gap in health outcomes by 2033 – policy and accountability framework*, Brisbane 2010.

[3] Queensland Health, 2016. *Aboriginal and Torres Strait Islander Mental Health Strategy 2016-2021*, Brisbane

[4] National Mental Health Commission, 2017. Fifth National Mental Health and Suicide Prevention Plan. Available at https://www.mentalhealthcommission.gov.au/getmedia/0209d27b-1873-4245-b6e5-49e770084b81/Fifth-National-Mental-Health-and-Suicide-Prevention-Plan

[5] National Federation Reform Council, 2020. National Agreement on Closing the Gap. Available at https://www.closingthegap.gov.au/national-agreement/national-agreement-closing-the-gap

[6] Productivity Commission 2020, *Mental Health, Report no. 95*, Canberra

v. Even though the Australian Government is starting to respond to these recommendations, (such as by channelling funding for Indigenous specific services to the CCHS sector as indicated above), there has been no progress made or action taken by Queensland Health despite IUIH's advocacy. IUIH hopes that this Queensland Government Inquiry will make strong recommendations that recognise the important role that the CCHS sector can play in the mental health service system, particularly in SEQ where mental health and addiction services can be embedded into a comprehensive System of Care (see IUIH System of Care section).

vi. Given the significant impact of mental health and substance use on the health and life expectancy gaps, without serious attention to improving mental health outcomes for Indigenous Queenslanders over the next ten years, the national Close the Gap agenda will fail.

2. **Prevalence:** There is no population level data available on the prevalence of mental and substance use disorders in Australia's Indigenous populations. The information we do have predominantly comes from small, site-specific research projects, hospital and community mental health datasets that count people currently accessing services, and the *National Aboriginal and Torres Strait Islander Social Survey* which provides self-reported information on life stressors[7] and substance use[8]. Burden of disease estimates, which show that in South East Queensland (SEQ), mental and substance use disorders are the leading contributor to the Indigenous burden of disease contributing 39% to non-fatal burden[9], have also been derived from these sources and mortality data. To enhance the evidence base, and inform the planning and delivery of mental health services in SEQ, IUIH is collaborating with the Queensland Centre for Mental Health Research to undertake two research projects both of which are expected to report in July 2022:

   i. The *Queensland Urban Indigenous Health Survey* funded by Queensland Health in which IUIH is a partner organisation. This project aims to identify the SEQ Indigenous adult prevalence of mental and substance use disorders, the proportion of Indigenous adults in treatment for a mental or substance use disorder, the type and quality of services being accessed, barriers to service access and implications for service reform.

   ii. The *Indigenous SEQ National Mental Health Service Mapping Project* commissioned and funded by IUIH, with contributions from the four SEQ Primary Health Networks (PHNs) and the Gold Coast HHS. This project will, for the first time, apply the national mental health service planning tool used routinely by HHSs and PHNs to inform mental health service and workforce planning for the whole population, to a mental health needs assessment of Indigenous people in SEQ.

   iii. Based on our experience of mental health need in the Community and our 40,000 regular clients, IUIH expects these projects will quantify the mental health services that are already provided by IUIH, HHSs and other providers in the Community and in hospitals, as well as identify unmet need and a cohort of people that have had no contact with mental health services and have undiagnosed/untreated mental health conditions.

[7] Outcomes for Indigenous Australians are significantly poorer than for non-Indigenous Australians against every indicator of disadvantage. Life stressors, which data show impact more heavily on Indigenous Australians than the general population, include poverty, unemployment, discrimination/racism/social exclusion, risks of violence, continuous cycles of grief and loss, and physical ill-health.

[8] Queensland Health, 2016. *Aboriginal and Torres Strait Islander Mental Health Strategy 2016-2021*, Brisbane.

[9] Queensland Health, 2017. *The Burden of Disease and Injury in Queensland's Aboriginal and Torres Strait Islander people 2017 (reference year 2011), Main Report.* Queensland Health, Brisbane.

i. **Access:** Within a stretched public mental health service system and a mainstream service model, the access to and utilisation of mainstream mental health services is lower than expected given the burden of disease and level of intergenerational trauma[10]. The public health system and mainstream non-government organisations do not provide culturally capable care for Indigenous people. In contrast, the CCHS sector provides person-centred care which considers the social, economic, and physical environment in which the person is managing their condition. Barriers[11,12] that inhibit Indigenous people's access to mental health care include:

- Perceived potential for unwarranted intervention by government agencies
- Long wait times more than 1 year
- Lack of intersectoral collaboration
- A need for more culturally safe approaches, including in diagnosis, noting that most mental health services are delivered by non-Indigenous practitioners, and when these practitioners operate within a non-Indigenous service model, cultural safety can be compromised.

ii. In SEQ, the CCHS sector has become the default provider of clinical treatment and psychosocial support services for Indigenous people with low to moderate acuity mental and substance use disorders. IUIH's experience is that Indigenous Queenslanders prefer to be supported by Indigenous healthcare providers in the community and have difficulty accessing mainstream services, particularly where they have complex co-morbidities (addiction, physical health conditions), trauma and challenging socio-economic circumstances which require a multi-disciplinary and multi-faceted approach to care. People often fall through the cracks of rigid service siloes where no one organisation takes responsibility for providing holistic, person-centred care. In the words of the Australian Productivity Commission, *'put simply, Australia's mental health system is not 'person-centred'. It should be.'*[13] This is a fundamental point of difference between mainstream and CCHS models of care.

iii. As well as the low acuity cohort, IUIH contends that in SEQ there is a significant Indigenous population with needs that are more complex than those able to be managed in General Practice, but that may not meet the threshold for hospital-based mental health services – what the Australian Productivity Commission termed 'the missing middle' cohort. The Commission identified that there were significant access gaps for both the 'low acuity' cohort and the 'missing middle' cohort. IUIH believes that Indigenous people are potentially doubly 'missing' – they are already in the 'missing middle' and are additionally at risk of exclusion through lack of cultural safety in mainstream service systems.

iv. IUIH believes it can help address unmet need and alleviate some of the burden from the mainstream mental health system, by providing community-based care for Aboriginal and Torres Strait Islander people that fall into both the low acuity and missing middle cohorts, as

[10] Queensland Health, 2016. *Aboriginal and Torres Strait Islander Mental Health Strategy 2016-2021*, Brisbane.
[11] McGough S, Wynaden D & Wright M 2017. Experience of providing cultural safety in mental health to Aboriginal patients: A grounded theory study. *International Journal of Mental Health Nursing.*
[12] Williamson AB, Raphael B, Redman S, Daniels J, Eades SJ & Mayers N 2010. Emerging themes in Aboriginal child and adolescent mental health: findings from a qualitative study in Sydney, New South Wales. *The Medical Journal of Australia 192:603-5.*
[13] Productivity Commission 2020, *Mental Health, Report no. 95*, Canberra

an integral part of the mental health service system with formalised referral pathways into and out of hospital care (step up/down). The model could be informed by the Statewide Specialised Aboriginal Mental Health Service[14] located in Perth and the Kimberley, but community-controlled, integrated within the IUIH System of Care and occupying the space between primary and hospital care.

Funding: Neither the Commonwealth nor Queensland Government provides grant funding to the CCHS sector in SEQ for mental health treatment or addiction services. Commissioning for mental health services at both levels of government routinely applies a one size fits all approach through mainstream service models, despite the evidence clearly showing that mental health needs are best supported in the context of culturally safe, trauma-informed care[15]. For example, the Maga Barndi Mental Health Service, operated by the Geraldton Regional Aboriginal Medical Service, provides a culturally safe service to Indigenous Australians in the Geraldton region of Western Australia. After the service began operating, there was a significant increase in the use of mental health services by Indigenous Australians in the region and psychiatric admissions for Indigenous patients at the local hospital were reduced by 58%[16].

i. Funding opportunities, tenders etc, which invariably cite Aboriginal and Torres Strait Islander people as a priority group, favour mainstream providers of mental health, addiction, and psychosocial support services. Mainstream organisations are often funded by default for the delivery of Indigenous-specific programs because the organisations are better understood by, or have an existing funding relationship with, mental health funders. To overcome their lack of cultural capability, and to justify funding them for delivery of services to Indigenous people, mainstream organisations are routinely asked by funders to provide evidence of 'partnership' with an Indigenous organisation. Forced partnership, driven by competition for scarce resources in the context of an impending tender deadline, poses a threat to partnership itself, to the integrity of the community controlled approach to service delivery, and ultimately to the potential for positive impact of allocated resources. IUIH strongly contends that while this approach to funding is perpetuated and the expectation that mainstream services will somehow meet the needs of Indigenous Australians continues, nothing will change.

ii. The Commonwealth Government has historically provided grants for social and emotional wellbeing workers and some psychosocial support. In addition, the Commonwealth Outreach Program (contracted to IUIH by Checkup) contributes some funding towards the cost of specialist and allied health services (psychiatry and psychology) on a cost/visit basis, which IUIH tops up. IUIH receives Queensland Health funding to (1) support the transition of adults with a mental healthcare plan from prison to community for six-months post release and (2) for a worker to link youth aged 12-17 years into the IUIH System of Care. Despite this, IUIH is using its discretionary funding (e.g., reinvested MBS income and other own source revenue) to fund and deliver mental health treatment and addiction services, trying to cobble together a service

[14] Available at https://emhs.health.wa.gov.au/Hospitals-and-Services/Mental-Health/SAMHS

[15] Australian Institute of Health and Welfare, 2020. *Culturally Safe Health Care for Indigenous Australians* available at https://www.aihw.gov.au/reports/australias-health/culturally-safe-healthcare-indigenous-australians

[16] Laugharne J, Glennen M & Austin J 2002. The "Maga Barndi" mental health service for Aboriginal people in Western Australia. *Australasian Psychiatry 10:13-7.*

system as best it can. As a result, mental health and addiction services are the least systematised of all IUIH's service offerings.

i. Notwithstanding the above, in 2020/21 IUIH had 763 psychiatry clients who completed 1,794 appointments, and 1,176 psychology clients who completed 3,002 appointments. There were also 44 completed appointments with IUIH's visiting Addiction Medicine specialist in 2020/21. Of these, Commonwealth Outreach Program Funding contributes to 236 psychiatry appointments (13%) and 1,558 psychology appointments (51.8%).

ii. In addition, IUIH has recently achieved accreditation from the Royal Australian and New Zealand College of Psychiatrists as a provider of adult psychiatry training for five years from 2022.

iii. Despite these service offerings and credentials, there is an ongoing misconception among mental health service funders within Queensland Health, and mental health service providers within HHSs, that the CCHS sector in SEQ does not deliver clinical mental health and addiction services. In fact, 89% of CCHSs nationally provide access to psychiatrists and 94% to psychologists[17] and in IUIH's case, directly employs both. This misconception results in the IUIH Network being repeatedly excluded from, or unsuccessful in gaining access to, funding opportunities and its place within the clinical mental health service system.

iv. While there is some acknowledgement that IUIH delivers psychosocial support services, the scope of our psychosocial support is not well understood by mental health service funders within government agencies. However, through the COVID Pandemic, HHS COVID leads have become very aware of the vital role that IUIH's psychosocial support services play in supporting the Indigenous Community of SEQ and in supporting Indigenous COVID care pathways

a. The *MobLink hot line and virtual care team* involves nurses, nurse practitioners and GPs in a virtual team, and provides transport and logistics such as meals, groceries, COVID monitoring packs, tests etc

b. *IUIH Connect Plus* supports people on discharge from Hospital to connect to the IUIH System of Care and to social support services as required

c. The *Transition Support Service* supports hard to reach Aboriginal and Torres Strait Islander adults who live within a 5 km radius of the Brisbane General Post Office. The team supports clients with their health needs (particularly mental health and addiction issues, and chronic disease management) and their social health needs (particularly homelessness) by linking them into the IUIH System of Care and connecting them with other service providers as required

d. Family Wellbeing Workers are attached to our primary healthcare clinics and to our Birthing in our Communities Hubs to ensure that psychosocial support is integrated across IUIH's System of Care.

[17] Australian Institute of Health and Welfare, 2019. *Aboriginal and Torres Strait Islander health organisations: Online Services Report—key results 2017–18. Aboriginal and Torres Strait Islander health services web report. Cat. no. IHW 212.* . Canberra: AIHW.

RECOMMENDATIONS

The following recommendations are respectfully submitted for the Committee's consideration to improve the responsiveness of the health system to the mental health and addiction needs of Aboriginal and Torres Strait Islander people in SEQ:

1. Support IUIH to establish a community controlled specialised mental health and addiction service for Aboriginal and Torres Strait Islander people in SEQ that caters for the 'missing middle', as a key component of the SEQ mental health service system. The service would be operated by IUIH with strong referrals into and out of HHS hospital services. It would be specifically commissioned by Queensland Health and co-designed with IUIH and once established, could potentially be replicated in North Queensland.
2. Consistent with the commitments under the National Close the Gap Agreement and the recommendations of the Australian Productivity Commission, preference CCHSs as the providers of mental health, addiction, suicide prevention, aftercare, and psychosocial support services for Indigenous Queenslanders, particularly in SEQ where there is a strong and comprehensive community controlled service system.
3. Utilise a place-based, targeted approach to commissioning Indigenous mental health, addiction, suicide prevention, aftercare, and psychosocial support services in line with the capacity of local CCHSs, noting that co-designed, Indigenous led service provision is also a key domain of the Queensland Government's First Nations Health Equity agenda.
4. Transition funding for Indigenous-specific mental health and addiction services to community control where service capacity and readiness exists, and where CCHS providers wish to undertake/expand clinical service provision.
5. Purchase psychosocial support to Indigenous Queenslanders from CCHSs where applicable.
6. Establish drug and alcohol diversion into health services as an alternative to the justice system for drug and alcohol related offences, especially for youth offenders.
7. Provide CCHSs with access to Consumer Integrated Mental Health Application (CIMHA) data for community mental health to support service planning and care coordination.
8. Expand Queensland Police Service, Queensland Ambulance Service and HHS Mental Health Service collaborations in mental health crisis intervention to involve CCHSs in the design and delivery of crisis intervention responses for Indigenous Queenslanders.
9. Establish at least one CCHS-led aftercare service in each HHS region to which all public hospitals connect Indigenous clients following a suicide attempt.
10. While CCHSs should be the preferred providers of mental health and addiction primary and non-hospital based services for Indigenous Queenslanders, enhance the cultural capability of HHS-run hospital, specialist, and prison mental health services by:
    i. Incorporating Indigenous leadership into governance arrangements
    ii. Actively supporting Indigenous personnel (mental health workers/social workers etc) into multidisciplinary clinical teams

iii. Use the routinely collected Indigenous status data to inform more culturally specific/appropriate intervention for clinical decision-making

iv. Deliver education and training on the impacts of institutional and inter-personal racism and discrimination on mental health and wellbeing and develop policies and processes to eliminate racism and discrimination from HHS mental health services.

11. Establish formal partnerships between HHS mental health services and CCHSs that include

    i. agreed clinical care pathways and clear responsibility for care coordination and psychosocial support

    ii. culturally appropriate discharge planning that ensures warm handover to the client's primary care provider with CCHSs as the default in the event the client has no preferred provider

    iii. tools to support routine data collection and linkage across service settings

    iv. in-reach and outreach models across CCHS and HHS services.

12. Support the recommendation in the *Royal Commission Report on the Protection and Detention of Children in the Northern Territory* to raise the age of criminal responsibility in Queensland from 10 years to at least 14 years.

13. Ensure that mental health services for Indigenous children in contact with the justice system are Indigenous-led and both culturally and clinically safe.

14. Improve equity of access to high quality mental health services for Indigenous Queenslanders in prison by

    iii. Applying the National Mental Health Service Standards to prison mental health services

    iv. Advocating at the national level for MBS and PBS subsidies to be available for prisoners and detained youth under Commonwealth/State funding arrangements.

BACKGROUND

Indigenous Mental Health – Queensland and South East Queensland

- 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 (29% of total burden and 39% of non-fatal burden), whereas cardiovascular disease is the leading contributor in Remote/Very Remote areas (QH, 2017).
- Suicide rates amongst Indigenous Queenslanders are more than double those of Queensland's non-Indigenous population (16.7/100,000 in Indigenous people aged 0-24 years compared to 5.3/100,000, and 45.7/100,000 in Indigenous people aged 25-44 years compared to 16.4/100,000). Suicide/self-harm is listed as the second leading cause of death amongst Indigenous males (ABS, 2017 and in SEQ, 7% of total Indigenous deaths were attributed to suicide (QH, 2017).
- In Queensland, rates of juvenile detention and adult incarceration are 23.6 times and 10.6 times the non-Indigenous rates respectively (QH, 2016).
- Indigenous Queenslanders experience higher rates of hospitalisation than other Queenslanders for psychoactive substance use, schizophrenia, and other psychotic disorders but lower rates than other Queenslanders for depression and anxiety, despite higher rates against all determinants for these disorders and levels of psychological distress (QH, 2016).
- Indigenous Queenslanders experience higher rates of seclusion and restraint while in hospital and higher rates of Discharge Against Medical Advice (QH, 2016).

THE URBAN EXPERIENCE

Urban Indigenous people experience considerable health disadvantage relative to their non-Aboriginal counterparts and may experience challenges relating to dislocation, racism, and disempowerment[18]. The paradox of urbanisation is that, despite the positive opportunities which urban areas may present, Indigenous people in urban areas face particular and additional challenges, including limited access to services, discrimination, generalised language loss and cultural identity deterioration, as well as poor health and low socioeconomic outcomes[19].

There are trends of both isolation and segregation in urban Indigenous communities. In some cases, Indigenous enclaves exist in urban centres. In others, Indigenous communities are less geographically distinguishable, and identifying their needs is challenged by 'Indigenous invisibility'. To the outsider, the perceived lack of homogeneity, coupled with a geographical dispersion of Indigenous populations, reinforces the idea of Indigenous invisibility and overlooks the strong family and kinship ties that

[18] Eades S J, Taylor B, Bailey S, Williamson A B, Craig J C & Redman R. 2010. The health of urban Aboriginal people: insufficient data to close the gap. *Medical Journal of Australia, 193(9)*, 521-524.

[19] Brand E, Bond C, Shannon C. 2016b. *Community Control: The changing landscape of Indigenous health* (University of Queensland Poche Centre for Indigenous Health). Retrieved from https://poche.centre.uq.edu.au/publications/uq-poche-monograph-series

characterise Indigenous communities in urban areas. In urban areas, this perceived invisibility and population dispersal is more likely to lead to an assumption that mainstream services available for the general population will be sufficient to meet the needs of Indigenous people and there is a reliance on 'one size fits all' approaches to care which prove time and again to be ineffective, lacking cultural capability and often ignored by Indigenous Australians.

Many urban Indigenous people continue to experience high levels of exclusion, victimisation, discrimination, and racism at personal, societal, and institutional levels. Racism continues to have a significant impact on Aboriginal and Torres Strait Islander people's decisions about when and why they seek health services and their acceptance of and adherence to treatment. In the 2014–15 Aboriginal and Torres Strait Islander Social Survey[20], 33% of Aboriginal and Torres Strait Islander people aged 15 years and over felt that they had been treated unfairly at least once in the previous 12 months, because they were of Aboriginal or Torres Strait Islander origin. 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%)[21]. In remote areas, models of care (including those delivered by mainstream organisations) are more likely to be tailored towards Indigenous people because of the higher proportion on Indigenous people in the population. In urban areas Indigenous Australians are more likely to comprise a smaller relative proportion of a mainstream service's client base and expected to be accommodated within a mainstream service model.

In relation to housing, the Indigenous population in urban areas often experiences greater disadvantage in terms of affordability and habitability. Rising house prices in inner suburbs mean many urban Indigenous people are more likely to live on the urban fringe, impacting on mobility and access to services. The distribution of the urban Indigenous population in these high population density outer suburban areas perpetuates social disadvantage.

The Indigenous experience of urbanisation has sometimes been described as an experience of loss. Many Indigenous groups experience the loss of relationship to communities of origin, resulting in the break of transmission of culture, language, and history. While strong cultural resilience and resurgence are evident in some urban Indigenous populations, stress and other mental health issues are significantly more prevalent in urban populations (as discussed above) and present an ongoing additional barrier to accessing services, including health care.

The challenges faced by urban Indigenous people are not assisted in the context of policy and service delivery frameworks which rely on a mainstream response to meeting need.

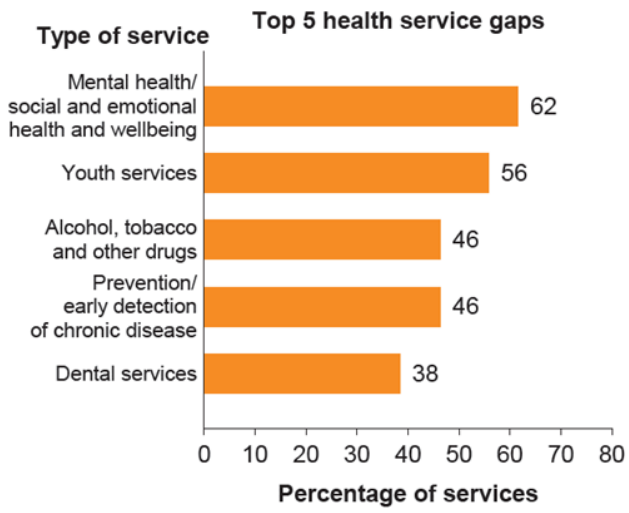
[20] AHMAC (Australian Health Ministers' Advisory Council) 2017. *Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report*, AHMAC, Canberra.

[21] AHMAC (Australian Health Ministers' Advisory Council) 2017. *Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report*, AHMAC, Canberra

INDIGENOUS ACCESS TO MENTAL HEALTH SERVICES

Indigenous people have lower than expected access to mental health services and professionals. In 2012–2013, the most common Closing the Gap service deficits reported by CCHSs related to mental health and social and emotional wellbeing services[22]. Refer Figure 1.

FIGURE 1. Top 5 service gaps identified by CCHS



As recognised by the Australian Productivity Commission and the *Fifth National Mental Health Plan*, most Aboriginal and Torres Strait Islander people want to be able to access services where the best possible mental health and social and emotional wellbeing strategies are integrated into a culturally capable model of health care. This approach needs an appropriate balance of clinical and culturally informed mental health system responses. Mental health service access challenges were again highlighted in the *My Life My Lead* consultations undertaken by the Commonwealth Department of Health in 2017[23]. The consultation report reiterated the importance of culturally valid understandings in shaping the provision of services and guiding the assessment, care, and management of mental disorders for Indigenous people. The report identified inpatient and specialist services as often the least culturally safe for Indigenous people accessing mental health care.

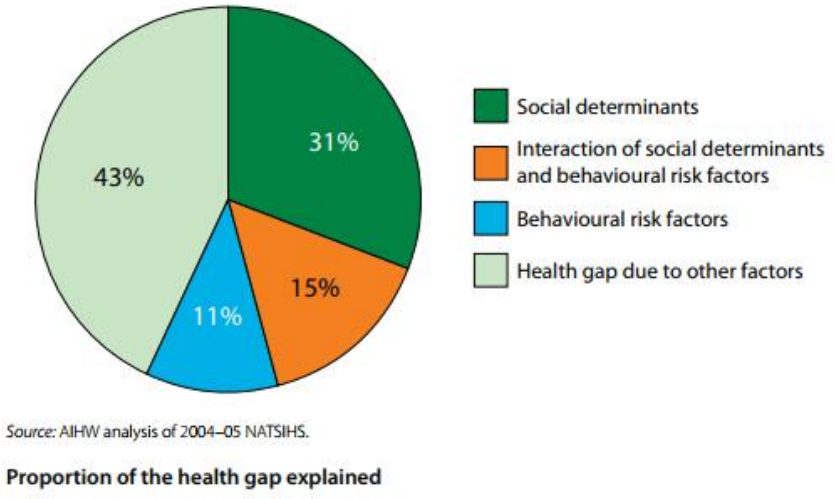
The impact of intergenerational trauma and social and economic disadvantage at individual, family and community levels also continues to challenge the mental and physical health and wellbeing of Aboriginal and Torres Strait Islander people, who can present to mental health services with a complex and interrelated mix of problems. Indeed, IUIH contends that a significant proportion of mental health and well-being issues impacting Aboriginal and Torres Strait Islander people will be at least in large part alleviated if not resolved by addressing their determinants/drivers. [Figure 2 shows that social determinants account for almost one-third of the health gap]. Improving cultural and social connection, reducing financial stress, building esteem and purpose through education and

[22] Australian Institute of Health and Welfare 2016. *Healthy Futures—Aboriginal Community Controlled Health Services: Report Card 2016. Cat. no. IHW 171*. Canberra.

[23] Department of Health 2017b. *My Life My Lead - Opportunities for strengthening approaches to the social determinants and cultural determinants of Indigenous health: Report on the national consultations*. December 2017

employment, and enacting rights through direct access to legal services are essential prerequisites for good mental health and well-being services.

FIGURE 2: Contribution of Social Determinants of Health to the Health Gap



Source: AIHW analysis of 2004–05 NATSIHS.

Proportion of the health gap explained

To meet these needs CCHSs must have an integral role in the design and delivery of an appropriately responsive mental health and well-being service system for Indigenous Australians. Large regional CCHSs such as IUIH can and are supporting families to access programs and services which address these determinants of mental health challenges either through direct provision of programs or by walking with families being referred to other providers.

Unfortunately, the current mental health funding framework is not conducive to a systemic approach to Indigenous mental health care. At the State Government level, an overt preference for funding mainstream providers to deliver services that are largely ineffective for Indigenous Queenslanders invariably prevails. Unlike service delivery partnership arrangements between HHSs and CCHSs for chronic disease, birthing, surgical pathways and dental services, HHS mental health and addiction services in SEQ have almost no relationship with the CCHS sector.

At the Commonwealth Government level, an entirely inefficient and fragmented program arrangement is in place. Indigenous mental health, social and emotional well-being, suicide prevention and substance use responsibilities and funding are now split between the Department of Health and the Department of Prime Minister and Cabinet. Further, specific mental health appropriations for Indigenous people are directed through Primary Health Networks (PHNs) to commission, which adds an inefficient additional layer of administration at best, and at worst, the risk of additional service fragmentation through PHN 'market driven' procurement practices, that have also traditionally preferenced mainstream service providers. The administrative inefficiency of this fragmentation impacts heavily on funded organisations through the impost of an extreme burden of reporting. For example, even coming from one department, there may be multiple streams with different labels that require separate reporting, often by provider, or by service-specific type. While a CCHS, such as IUIH, will make significant effort to cobble together various sources of funding to deliver an integrated and seamless service for clients, the effort needed to dis-integrate data to meet reporting requirements, taxes stretched resources that could otherwise be spent attending to clients. Notwithstanding these comments, IUIH acknowledges and commends the Australian Government for responding to the Productivity Commission's recommendation to preference CCHSs by its recent decision to channel its

Indigenous suicide prevention and aftercare funding, announced in the 2021-22 Federal Budget, directly to the CCHS Sector rather than through PHNs.

Aboriginal and Torres Strait Islander people in SEQ would benefit greatly from the establishment of a CCHS-led specialised mental health/addiction service that provides Step Up/Down care for clients that fall between primary and hospital care. The state-run Statewide Specialist Aboriginal Mental Health Service (SSAMHS) operating in Perth and the Kimberley is an Indigenous-led (but not community controlled), model of mental health service provision, which utilises partnerships with mainstream general practice. Although a preferred model would be one where a CCHS manages the service, utilising partnerships with state-run mainstream mental health services and private specialists, the SSAMHS model provides valuable insight that would assist in establishing a CCHS-led service in SEQ. IUIH believes it is well positioned to co-design and operate a service in SEQ which, with appropriate resourcing, would build upon and systematise the mental health and addiction services it currently provides to low acuity patients and address the needs of the 'missing middle'.

INDIGENOUS ACCESS TO THE NATIONAL DISABILITY INSURANCE SCHEME

NDIS Disability Profile, SEQ

National Disability Insurance Agency (NDIA) actuaries have provided data on the primary disability types experienced by Aboriginal and Torres Strait Islander NDIS participants with an approved NDIS Plan. In SEQ, 6 groups of conditions account for almost 75% of all primary disabilities:

- 29.5% of participants have "autism";
- 20% have "Intellectual disability";
- 8.7% have "Psychosocial Disability";
- 5.6% have "Cerebral Palsy";
- 5.5% have "Other Physical"; and
- 5.3% have "Other Neurological" as their primary disability.

IUIH's strategic priority to deliver a broader range of social health programs includes a focus on the NDIS rollout to ensure that the design and implementation of this scheme supports Indigenous people having culturally appropriate access to services – particularly in relation to the SEQ region.

IUIH has significant and ongoing concerns regarding:

- The NDIS investment strategy
- The NDIS engagement strategy

NDIS investment strategy

The NDIA has allocated what it calls *Service Area Participant Volumes* on a regional basis. However, because these participant numbers do not reference or set targets for Indigenous people, there is a serious risk that the needs of the most disabled and disadvantaged cohort of the NDIS Participant population will not be adequately met.

Indigenous people have higher rates of disability compared to non-Indigenous people in every age cohort. When applying these rates to the IUIH Network footprint, it is estimated that there are at least 4,225 Indigenous people[24] with profound or severe disability in SEQ (ABS, 2016). These estimates are

[24] This is most likely an undercount

consistent with Indigenous demographic profiles which show that SEQ has the second largest and fastest growing Indigenous population in Australia. In addition, the current NDIS numbers are expected to exponentially increase in line with the projected rapid Indigenous population growth to 2031. It is imperative that investment and resource allocation methodologies are in place and ensure equitable NDIS access by this large and high-need urban Indigenous population in SEQ.

The IUIH has advocated to the Australian Government the implementation of a targeted investment strategy which incorporates mandatory Indigenous number or percentage targets commensurate with the estimated Indigenous NDIS participant rate and level of need.

NDIS Engagement Strategy

The NDIS Engagement Strategy includes the principle of a 'community by community' approach:

> "*Underpinning effective engagement is the recognition that the NDIA's community by community approach will involve building community capability and capacity to develop local solutions and a deliberate focus on options to grow the number of Indigenous registered providers of support"* [25].

Notwithstanding this principle, the NDIA Engagement Strategy confusingly also places an equal emphasis on mainstream services which it argues are as important as services delivered by specialist disability services. This is advocated despite an acknowledgment that the NDIS runs a risk of creating access barriers to Indigenous people with disabilities, as has occurred in the implementation of previous mainstream disability service initiatives. This ambivalent mainstreaming strategy is like that discussed earlier in relation to mental health services for urban Indigenous people and is at odds with best practice community-controlled service responses. The Indigenous engagement and participation strategies outlined in the current NDIS framework have not been developed on evidence-based policies which would ensure that the NDIS, along with all other service areas, must have Indigenous-led arrangements to ensure culturally appropriate access and holistic support is provided for Indigenous Participants.

Representations have been made by the IUIH to the NDIA to address these concerns and seek engagement in, and co-design of, NDIS implementation. Suggested design enhancements have included:

- Redress of the functional and siloed constraints inherent in the current NDIS model, including in relation to Local Area Coordination (LAC) services, Early Childhood Early Intervention (ECEI) services, Registered Providers of Supports and Integration Linkage and Coordination (ILC) services
- Acknowledgement that Indigenous community-controlled organisations are best placed to engage with Indigenous Participants to navigate these barriers – and specifically to generate functional impact Access Request Forms, develop Participant service plans for the next 12 months ('Plan Build"), and submit these to the NDIA Planner and

[25] National Disability Insurance Agency, 2017. National Disability Insurance Scheme Aboriginal and Torres Strait Islander Engagement Strategy. Retrieved from https://www.ndis.gov.au/Aboriginal-and-Torres-Strait-Islander-Strategy

- Reconstruction of the NDIS model to allow active engagement by Indigenous organisations in the above process, including contracting Indigenous organisation on a preferred provider basis to undertake these functions.

In response, the NDIA has acknowledged that the mainstream NDIS system architecture is flawed and funded IUIH to conduct a Pilot of National Significance in SEQ. This pilot completely departed from the mainstream approach and included replacing LACs with IUIH Indigenous staff who support Indigenous Participants in all aspects of the NDIS eligibility application and plan building processes. The Pilot of National Significance had a very high success rate in supporting indigenous people with disability to access the NDIS and link to appropriate funded supports. Unfortunately despite these outcomes the NDIA was unwilling to continue or expand this pilot model and reverted to the mainstream LAC approach in attempting to support indigenous applicants which had been acknowledged as ineffective in the first place. IUIH continues to advocate for reform to the NDIS to improve access by Indigenous Australians and recently made a submission to the Joint Standing Committee Inquiry into NDIS Implementation and Forecasting which outlines its concerns about the NDIS investment and engagement strategies and implementation to date.

ABOUT THE IUIH NETWORK

IUIH was established in 2009 as a strategic response to the significant growth and geographic dispersal of Indigenous people within the SEQ region – where 38 percent of the State's and 11 percent of the nation's Indigenous population live. This region represents the second largest and fastest growing Indigenous population in Australia – the 2019 estimated resident population of SEQ was 85,800 Indigenous people, which is projected to grow to over 130,000 by 2031[26]. Between the 2011 and 2016 Census counts, the Indigenous population of SEQ grew by 33%, compared to a national Indigenous population growth of 18%[27].

FIGURE 3: IUIH Network Clinics 2022

As the 'backbone organisation' for a regional network of member CCHSs in SEQ, IUIH was created by its members to drive the development and implementation of transformational change to the way health care services were delivered for urban Indigenous Australians in the region. IUIH is now the largest CCHS in Australia, with an annual budget of more than $100 million. With more than 700 staff, around half of whom

[26] Biddle N, 2013. *Census Papers (2011): Population Projections. Census Paper no 14*. Centre for Aboriginal Economic Policy Research, Australian National University, Canberra.

[27] Markham F and Biddle N, 2017. *Indigenous Population Change in the 2016 Census. 2016 Census Paper No 1.* Centre for Aboriginal Economic Policy Research, Australian National University, Canberra.

identify as Aboriginal and/or Torres Strait Islander, IUIH is now the largest employer of Indigenous people in SEQ.

The IUIH Network, including its member CCHSs – ATSICHS Brisbane, Yulu-Burri-Ba, Kambu, and Kalwun Development Corporation – and the Moreton ATSICHS (operated by IUIH) collectively operate 19 community controlled primary health care clinics and three GP Respiratory Clinics across SEQ (see Figure 3), which covers a geographic area from the Gold Coast to Caboolture and out to Ipswich. The Network has a combined annual budget of over $130 million and more than 1,300 staff of which around 60% identify as Aboriginal and/or Torres Strait Islander.

THE IUIH SYSTEM OF CARE

In SEQ, IUIH has pioneered a new regional and systematised model that has delivered unprecedented improvements in health access and outcomes validated through research, including an increase in regular client numbers from 8,000 in 2009 to 40,000 in 2020-21, and an increase in annual Health Assessments (from 550 in 2009 to over 21,000 in 2020-21).

IUIH understands the complexity and fragmented nature of the health system in SEQ and that the solution to exponentially increase access to comprehensive care lay firstly in the integration of the health system at a regional level, to ensure integrated care at the local level. IUIH focusses on integrating a fragmented health system and disparate funding programs (Indigenous-specific and mainstream) to support a coherent regional strategy which spans the care continuum and life course. In this way, the *IUIH System of Care* is characterised by a highly systematic approach to the delivery of accessible, efficient, and comprehensive health care by CCHSs within a regional framework.

The point of difference of this radically new approach is that it isn't just about implementing a 'model of care' at the local clinic, but rather embedding frontline clinical care into a broader **regional 'ecosystem'** which promotes integration at, and between, every level of the IUIH Network operations. At the health systems level, IUIH is an integrator for regionally-led reforms around strategic planning, service development, business modelling, funding/investment, IT, data, clinical and corporate governance, CQI, workforce development (including student placements), cross-sector connectivity, research. At the Clinic level, IUIH provides universal (no-cost), consistent and evidence-based 'single point of care' for clients, supplemented by locally accessible but regionally managed programs delivered 'on-site' such as allied health, mental health, dental, Specialist, '*IUIH Connect Plus*' (which provides care coordination and an interface with the tertiary health system and social support services), aged care, legal services, birthing, family well-being, and child protection services. At the Community level, IUIH utilises preventative health/social marketing campaigns such as *Deadly Choices* to engage the community and empower behavioural change in addition to addressing social determinants of health.

The architecture of this ecosystem is based on the premise of providing a completely integrated and seamless client experience. This 'no wrong door' approach means that a person or family entering the IUIH System of Care at any point can be connected to any of the range of services provided under the IUIH Network umbrella as their needs dictate (*see Figure 4*). The client's worry about access to services is our worry, not theirs, with the conversation about integrated care starting and ending with the client. Accordingly, the *IUIH System of Care* which has emerged is now characterised by arguably one of the most comprehensive range of service offerings available for clients.

FIGURE 4: IUIH's No Wrong Door Approach to its System of Care

The value-add of this regional ecosystem (*System of Care*) is that it has sufficient strength, scope, and resources to be impactful in addressing, and in some cases replacing, the systemic barriers and fragmentation which have been serious inhibitors to improving access and outcomes.

As a regional integrator of this *System of Care*, IUIH has been able to implement enabling strategies which, at the regional level, are delivering dramatic reforms to the health system in SEQ in terms of improved effectiveness and efficiency:

- *Financial sustainability*: Through its regional business development role, IUIH has led the design of a more sustainable financial architecture across the network, including optimisation of non-grant revenue streams. This has enabled it to spearhead rapid clinic expansion across SEQ and re-invest in services not otherwise grant funded or accessible for a client population with complex needs and a limited disposable income
- *Harnessing efficiencies through regionally scaled solutions*: The capacity of IUIH to leverage economies of scale through region-wide funds pooling and its enhanced purchasing power has delivered significant savings which are reinvested to support additional services and programs. Examples include:
  - The establishment of a large regional allied health and specialist workforce 'pool' funded from multiple funding sources, centrally based, and regionally servicing SEQ through an outreach model to all clinics. This has allowed unprecedented cost-effective and universal (free) client access to a comprehensive range of disciplines, otherwise not possible if

managed independently by individual CCHSs. It has also ensured consistent quality and cultural competency and reduced the number of resources otherwise required to interface IUIH clients with other providers

- through the establishment of a regional logistics hub/warehouse, IUIH has implemented an integrated supply-chain solution for all Network members and clinics, including the storage and distribution of clinical supplies/consumables and equipment. Bulk purchasing, capability for competitive price procurement and a fully automated stock inventory system are delivering significant cost savings and economies of scale (to be reinvested in supporting additional services)
- the prorating of a portion of Queensland Health's mainstream dental program to the IUIH has led to increased integration and efficiency, where dental services can be delivered within IUIH clinics as part of a holistic system of client care

Driving quality improvement: As the regional 'backbone' organisation, the IUIH plays a key role in leading the development of shared measurement systems, targets. and trajectories as part of a monitoring and evaluation framework. The capacity of IUIH to leverage concentrated expertise to provide regional ICT, CQI, data analytics and clinical governance services for its SEQ network members has delivered standardised systems and consistent quality improvement outcomes. This has supported embedding the *System of Care* throughout the IUIH Network and ensured systematised accountability frameworks to monitor and benchmark National Key Performance Indicators (nKPIs), care cycle and Medicare targets. Combined, these enablers have produced nationally best practice results and demonstrated validated progress in closing the gap at a faster rate in SEQ.

Deloitte Review of IUIH's System of Care 2021

In October 2020, Queensland Health's Healthcare Purchasing and System Performance Division commissioned Deloitte to undertake a review of IUIH's regional backbone function. The review, which reported in January 2021, illustrated IUIH's value proposition through a 'deep dive' into three programs which have successfully connected CCHS Primary Healthcare with hospital services and demonstrated value for money, coordinated service delivery pathways and outcomes for clients. These programs were the Birthing in Our Community Program, the Eye and Ear Health Surgical Pathways Program, and the IUIH Connect Plus Program.

Key Findings:

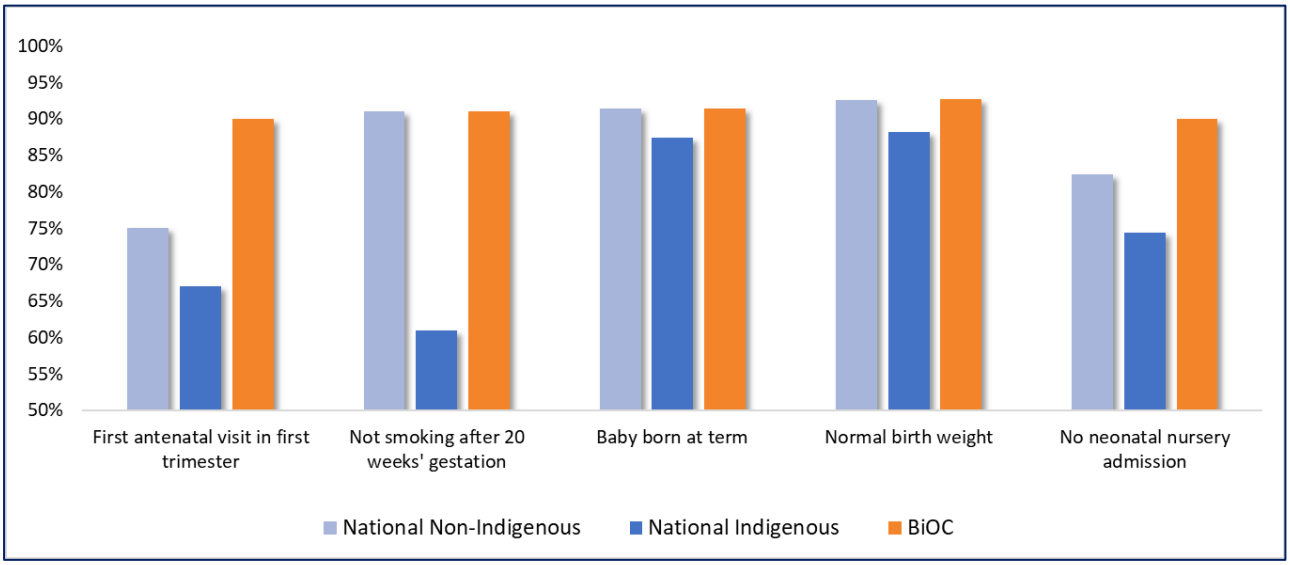
- *"The IUIH model drives value through its role as a centralised network connection facilitator of Community Controlled Health Services (CCHSs) within SEQ and through its role as a service provider*
- *The three Case Studies – Birthing in Our Community Program, Eye and Ear Surgical Pathways Program and IUIH Connect Plus Program – exemplified the importance of IUIH's enabling infrastructure. The Programs have demonstrated:*
    a. *Increased access*
    b. *Improved outcomes*
    c. *The importance of culturally appropriate care*
- *There are further opportunities to expand service delivery partnerships between HHSs and the CCHS sector, such as expanded/new eye and ear surgery pathways and new pathways for additional surgery types".*

Deloitte, 2021

While the construct and operation of this IUIH regional ecosystem are driving change, these changes have not always been matched by complementary and enabling government funding, program, and policy parameters. At the Commonwealth level, barriers of duplication, red tape and involvement of middlemen persist. At the State level, the ongoing preferencing of mainstream 'one size fits all' approaches to mental health services provision hampers both access and outcomes for Indigenous Queenslanders. The challenge for governments, and the imperative for further systems reform is to understand that integration of care is dependent on the integration of systems at the regional level.

The IUIH *System of Care* is contributing to significant improvements in health outcomes for Indigenous Australians in SEQ. Against the COAG Close the Gap health targets (life expectancy and child mortality), the IUIH is demonstrating national best practice improvements. For example, in contrast to national trends where the life expectancy gap is still widening, validated research that the Health Adjusted Life Expectancy gap in SEQ is closing at a rate faster than predicted trajectories, represents a national-first achievement and a major policy and service delivery breakthrough. The internationally recognised Birthing in Our Community Program[28] has demonstrated significant improvement in key birthing outcomes, including closing the gap in preterm birth rates and birth weights – see Figure 5. In addition, a significant contribution is being made in relation to meeting CTG employment targets, with a substantial increase in Indigenous employment across the IUIH Network. This reflects the interdependencies of health and employment and the benefits of a highly integrated regional model.

FIGURE 5: Birthing in Our Community Program Outcomes 2020-21



[28] S Kildea, et al (2019). Reducing preterm birth amongst Aboriginal and Torres Strait Islander babies: A prospective cohort study Brisbane, Australia. Lancet E*clinicalMedicine* 23 June 2019. https://doi.org/10.1016/j.eclinm.2019.06.001

IUIH'S SOCIAL HEALTH (MENTAL HEALTH) SERVICES

The IUIH Network delivers a range of mental health and substance misuse services specifically tailored for Aboriginal and Torres Strait Islander people. Mental health and substance use services are embedded within the 19 primary health care clinics, the Birthing in Our Communities hubs and other programs. Programs and services, most of which are self-funded by IUIH, include:

- individual and group mental health treatment and addiction services
- psychosocial support services
- transition services for people leaving prison with a mental healthcare plan
- psychosocial support services and care coordination for homeless people in the inner city
- youth wellbeing services
- family wellbeing services for vulnerable families including those involved with the child protection system.

At IUIH, we refer to this collection of mental health and substance misuse services as Social Health Services.

Service elements of the IUIH Social Health Model of Care include:

- Crisis intervention, support, and opportunistic engagement
- Therapeutic modalities ranging from brief intervention to specialised care
- Intensive case management
- Psychoeducation and information at both community and individual levels
- Alcohol and other drugs counselling and support
- Paediatric psychological assessments and provision of paediatric medical and allied health services
- Team care planning and family centred care planning
- Referrals to internal and external services as required – this includes transport and warm handover to external service providers to maintain continuity of care
- Psychosocial support and care coordination
- Advocacy services such as to enable access to housing, crisis accommodation, domestic and family violence services and Centrelink
- Transition care planning for people in prisons with a mental health care plan – including six weeks pre-release planning and six months post-release community based support and connection to healthcare
- Clinical governance, risk management and quality improvement

Our Social Health Program practice principles include:

- Culturally based and responsive therapeutic and social support services
- A focus on autonomy and connectedness for clients, their families, and communities
- Work across the continuum of mental health care, including symptom reduction, recovery and ongoing support, health promotion and prevention
- A multidisciplinary team approach, with the Social Health programs fully integrated into the IUIH System of Care
- Holistic assessment of client and family needs and support planning

- Trauma-informed practice that is safe, respectful, and promotes healing and sustainable change across the lifespan
- Flexible, multi-modal, person-centred, efficient service access and response
- Evidence-based approaches to therapeutic and support service delivery
- Clinical governance and safety

The IUIH Network across SEQ employs 90 staff within Social Health. These include:

- Psychiatrists and an Addiction Medicine Specialist
- Adult and child psychologists and counsellors
- Social Workers (including mental health accredited)
- Case Coordinators (social worker and/or counsellor qualified)
- Intensive transitional support workers
- Youth wellbeing support workers and youth practitioners (counsellors or psychologists)
- Wellbeing support workers with mental health and addiction qualifications – their role is like that of peer support workers within mainstream mental health services in that they support Indigenous people to navigate the health system, but they also have a wider scope. Although having lived experience, they are often trained therapists who undertake case management and coordination and early intervention activities and deliver practical supports and lead cultural connectedness activities. Importantly, as they are from the Indigenous community, they help to develop trust in the services that helps facilitate strong therapeutic relationships.

As indicated above, under IUIH's care umbrella these providers are integrated into the comprehensive primary healthcare System of Care which means that anyone accessing IUIH's Social Health programs and services are exposed to, and can access as appropriate, the full range of GP, allied health, dental, aged care, disability, legal and other services available through our clinics and programs. Our strong links with more than 70 local Indigenous and mainstream government and community providers of psychosocial support means that we can provide wrap-around care as well as strong clinical care and aftercare services. Our workforce of Community Liaison Officers assist in identifying and supporting community members not otherwise connected to our clinics, including some of the most marginalised and disconnected families. In addition, our workforce development programs provide training opportunities for those affected by mental health and substance use problems to gain qualifications and employment, thereby contributing to both health and employment outcome targets.

Since the early days of the National Mental Health Strategy, this type of integrated service model has long been discussed in mainstream mental health as something to aspire to. It currently exists for Indigenous people in SEQ. IUIH urges that rather than perpetuate trying to prioritise service provision to Indigenous Queenslanders through existing mainstream models which are already stretched trying to support the general population and are not equipped to provide targeted Indigenous services effectively, the Queensland Government support IUIH to build on and systematise this service system.

No other organisation in SEQ (including HHSs) is equipped to deliver such a comprehensive and integrated model of culturally capable primary mental health care. The establishment of a community-controlled Aboriginal and Torres Strait Islander specialised mental health service in SEQ,

which would have a strong referral relationship into and out of SEQ HHS mental health services, would significantly strengthen the system's capacity to respond to the mental health needs of the region's Indigenous people.

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