



Feedback on the Draft National Preventative Health Strategy, June 2009

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The Australian Indigenous Psychologists Association (AIPA)

AIPA is committed to improving the social and emotional well-being and mental health of Aboriginal and Torres Strait Islander individuals, families and communities by collaborative change campaigns with Indigenous and non-Indigenous organisations and others committed to 'closing the gap between Indigenous and non-Indigenous health outcomes. Specifically AIPA is working to increase the number of Indigenous psychologists and to lead the change required to deliver equitable, accessible, sustainable, timely and culturally safe psychological care to Aboriginal and Torres Strait Islander peoples in urban, regional and remote Australia.

AIPA supports the following understanding of Indigenous social and emotional well being drawn from the *National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Well Being* (2004):

Aboriginal and Torres Strait Islander health is viewed in a holistic context that encompasses mental health, and physical, cultural and spiritual health. Land, family and spirituality are central to well being. It must be recognised that Aboriginal and Torres Strait Islander peoples have great strengths, creativity and endurance and a deep understanding of the relationships between human beings and their environment. The centrality of Aboriginal and Torres Strait Islander family and kinship must be recognized as well as the broader concepts of family, and the bonds of reciprocal affection, responsibility and caring.

Self-determination is central to the provision of Aboriginal and Torres Strait Islander health services. Culturally valid understandings must shape the provision of services and must guide assessment, care and management of Aboriginal and Torres Strait Islander people's health, mental health problems in particular.

(Social Health Reference Group, 2004).

Introduction

It is recognized that physical and mental health are interdependent and the contribution of physical health to mental wellbeing and the effect of mental health on physical health must be considered when looking at the overall health of population groups (Mrazek & Haggerty, 1994). In addition to the body of evidence which supports the impact of the social determinants of health on increased incidence and prevalence of disease, behavioural risk factors for ill health, and lower overall health status (which underpins the social gradient associated with disadvantage), there is an emerging body of evidence to suggest that stress which progresses to serious psychological *distress* can be an independent predictor and contributor to reduced life expectancy and premature mortality. Psychological distress should not be equated with 'mental illness', rather, it should be seen as 'normal human distress' in response to stressful or difficult circumstances. Serious psychological

distress can be seen as a final common pathway for those who find themselves psychologically overwhelmed or struggling to cope, regardless of the cause. The National Aboriginal and Torres Strait Islander Health Survey 2004-05 (NATSIHS) showed over one quarter of adult Indigenous respondents reported serious psychological distress, and were twice as likely than other Australians to report this: 27% compared to 13% across all age groups.

In its paper 'An Overview of Factors Impacting on the Social and Emotional Wellbeing of Aboriginal and Torres Strait Islander People: Risk and Protective Factors and Serious Psychological Distress' (2009), AIPA has collated epidemiological data which identifies the unique factors associated with serious psychological distress among Indigenous people and its contribution to health risk behaviours and preventable morbidity and mortality.

For example, studies in the United States examining data from National Health Interview Surveys found those with serious psychological distress were more likely to be obese, to be current smokers, and to have a higher prevalence of being diagnosed with heart disease, diabetes, arthritis, and stroke than those without serious psychological distress (Pratt, Dey & Cohen, 2007). A recent National Center for Health Statistics study in the United States used four years of national health surveys to examine whether those with serious psychological distress have a greater risk of mortality than those without serious psychological distress and whether distress has a dose-response relationship with mortality. The study found that serious psychological distress is associated with increased mortality, even after adjusting for potential confounders and distress scores were related to increased mortality in a dose-response fashion (Pratt, 2009).

The Centers for Disease Control and Prevention also recently examined the association between body mass index and serious psychological distress after taking into consideration obesity-related comorbidities, lifestyle factors, and emotional support, and found serious psychological distress was more strongly associated with obesity than any other variable (Zhao, Ford, Li, Strine, Dhingra, Berry & Mokdad, 2009). The same group examined the relationship between serious psychological distress and smoking. Those with serious psychological distress were 3 times more likely to be everyday smokers compared to non-smokers (Dube, Caraballo, Dhingra, Pearson, McClave, Strine, Berry & Mokdad, 2009).

Thus, while a large part of the difference in health status between advantaged and disadvantaged Australians can be attributed to health risk behaviours such as obesity, and use of tobacco and alcohol, these behaviours tend to be associated with serious psychological distress. The NATSIHS 2004-05 showed there was an inverse relationship between Indigenous wellbeing and psychological distress: the more distress, the less positive wellbeing (AIHW, 2008 p15). Interventions targeted to prevent the development of serious psychological distress will therefore help to decrease morbidity due to obesity and smoking, and reduce mortality due to ischaemic heart disease and respiratory disease. Measuring, monitoring and addressing serious psychological distress should result in a

range of beneficial *health* outcomes for Aboriginal and Torres Strait Islander people and make a major contribution to closing the gap in life expectancy between Indigenous and other Australians.

At the same time, it cannot be assumed that the risk and protective factors for serious psychological distress are the same across Indigenous and non-Indigenous cultures and the application of preventive strategies and interventions requires in-depth knowledge of Indigenous cultures and communities. For example, as well as factors which influence the 'mental health' of all Australians, additional factors impacting on social and emotional wellbeing and contributing to serious psychological distress among Indigenous people have been identified as: unresolved grief and loss, trauma and abuse, domestic violence, removal from family, substance misuse, family breakdown, cultural dislocation, racism and discrimination, and social disadvantage (Social Health Reference Group, 2004 p.9). In addition, Indigenous cultural concepts such as connection to land, culture, spirituality, ancestry and family and community are identified as protective factors which can serve as sources of resilience and moderate the impact of stressful circumstances on social and emotional wellbeing at individual, family and community level. For Indigenous people, these factors can serve as a unique reservoir of resilience and recovery in the face of adversity and should be an integral part of preventative health strategies.

Multiple morbidity and serious psychological distress: Obesity, tobacco and alcohol contribute to preventable morbidity and mortality in Indigenous communities. The NATSIH survey 2004-05 reported serious illness or disability affected 28% of Indigenous respondents. Overall, only 19% of respondents did not report a serious illness of 6 month duration or more, with 18% reporting one condition, 30% reporting two or three conditions and 33% reporting four or more long-term health conditions. The majority (62%) of those with four or more health conditions reported serious psychological distress (AIHW, 2009 p23). The combination of multi-morbidity and serious psychological distress has been shown to inhibit the capacity to manage these presentations in primary care settings (Fortin, Bravo, Hudon, LaPointe, Dubois & Almirall, 2006), unless support to manage psychological distress is provided as part of general health care – as it is in Aboriginal Community Controlled Health Services.

Smoking and Serious Psychological Distress: The NATSIHS 2004 – 05 found that 50% of Indigenous Australians were smokers. Smoking was more commonly reported among males and females in every age group when compared with the non-Indigenous population. Overall, Indigenous Australians were more than twice as likely than others to be current daily smokers. Indigenous respondents who had experienced more than one life stressor in the last 12 months had higher rates of current daily smoking (54%) than did those who reported that they had experienced one or no stressful circumstances (46%). Those reporting high levels of psychological distress were more likely to be smokers (32%) than non-smokers (20%).

Harmful Alcohol Use and Serious Psychological Distress: Despite experiencing serious

psychological distress at twice the rate of other Australians, more than half (51%) of Indigenous respondents to the NATSIHS 2004-05 reported they had not drunk any alcohol in the previous week, and over 80% of respondents reported they had not drunk alcohol at risky / high-risk levels in the last 12 months (AIHW, 2008).

Alcohol related problems were reported by 20% of Indigenous respondents and this was highest (24.1%) in remote areas (NATSIHS, 2006). Half of those who reported using alcohol, reported drinking at short-term risky levels (ie 'binge' drinking') at least once in the previous 12 months. The proportion of Indigenous adults who reported drinking at long-term high-risk levels (16%) was similar to that of non-Indigenous Australians (14%). This was lowest in the NT (8%) and highest in Qld and WA (19%).

Despite the similar prevalence of high risk alcohol use among Indigenous and other Australians, those who had used alcohol appeared to be exposed to a range of risks to social and emotional wellbeing and the development of serious psychological distress, not experienced by others:

- Indigenous people were taken into custody for public drunkenness at 43 times the rate of other Australians in 2002 (AIHW, 2008 p896).
- Indigenous males and females were hospitalised for diagnoses related to alcohol use at 5 and 3 times the rate of other males and females.
- Indigenous Australians were hospitalised for acute alcohol intoxication at 8 times the rate of other Australians; for withdrawal states at 10 times the rate of other Australians; and for alcoholic liver disease and accidental poisoning by alcohol at 5 times the rate of other Australians (AIHW, 2008, p1007).
- Indigenous Australians died from mental and behavioural disorders due to alcohol use at 10 times the rate of non-Indigenous Australians, from alcoholic liver disease at 8 times the rate and from poisoning by alcohol at 9 times the rate of others.

Yet, in 2006 – 2007 there were only 41 Australian Government funded Aboriginal and Torres Strait Islander substance abuse services (AIHW, 2008). 29 were residential and 11 were non-residential.

Any preventative health strategies targeted to obesity, tobacco use and harmful use of alcohol should simultaneously address and manage any serious psychological distress associated with these health risk behaviours. The integration of vertical targeted programs on alcohol, tobacco and obesity into broad based comprehensive primary health care under Aboriginal control should also help to avoid the unintended consequence of increasing Indigenous psychological distress as a result of implementing preventative interventions.

Market failure and the inverse care law, which has resulted in uneven distribution of inequities in discrete Indigenous communities in remote Australia.

Universal access to comprehensive primary health care is particularly important to a National Preventative Health Strategy in remote Australia where an estimated 92,960 Aboriginal people live in over one thousand communities located on traditional and other lands (ABS, 2007). Only 332 communities have more than 50 permanent residents and just 17 contain one thousand people or more. None contain more than 4,000 people. Usually, the larger discrete communities have a single health service which receives the bulk of its funding either from the Australian Government as Aboriginal Community Controlled Health Services, or from State / Territory Governments, designated as Other Primary Health Services.

Less than half (47% or 41,450) of the Indigenous population in larger discrete communities has access to Aboriginal Community Controlled Health Services that provide social and emotional wellbeing support as part of culturally appropriate comprehensive primary health care, and where Aboriginal Health Workers are the first point of contact (ABS, 2007 p43).

The remaining 35,737 (43%) of the population in the larger discrete Aboriginal communities has access to 104 state-funded Other Primary Health Services, which are administered without community input, are not funded to provide comprehensive primary health care, have poor retention of Aboriginal Health Workers, and use nurses to substitute care usually provided by doctors (ABS, 2007 p88). Only 14 of the Other Primary Health Services (serving a population 11,344) provide access to a doctor on a daily basis, and only 4 of these are GP's which can provide access to major national programs such as Medicare and Better Access to Psychiatrists, Psychologists, PBS items etc (AIHW, 2008 p1392). Nurses in the remaining 90 Other Primary Health Services substitute a range of GP services outside their scope of practice and without accountability or quality assurance mechanisms in place to protect consumers. As a result, Indigenous adults are hospitalised at 6 times the rate of other Australians for conditions usually managed in primary care settings (AIHW, 2008 p1223). This situation should be seen as an example of market and policy failure which has contributed to Indigenous psychological distress associated with preventable grief and loss, ill-health, multiple morbidity, preventable admissions to hospitals and preventable mortality due to poorly managed ambulatory care sensitive conditions. Nationally, one in five (22%) of all Indigenous admissions to hospitals could have been prevented if effective treatment had been available in primary health care settings (AIHW, 2008).

It is essential that the Aboriginal Community Controlled Health sector is resourced to provide universal access to comprehensive primary health care in all discrete Indigenous communities, including preventative health strategies to address alcohol, obesity and smoking. This is particularly important since the most effective form of social marketing in Indigenous communities (all of which are small) is community engagement and 'word of mouth'. 'Fly in, fly out' or media delivered preventative health strategies are less likely to be effective than community based initiatives developed and implemented by local people.

Conclusion

Stabilising and then reducing the prevalence of serious psychological distress among Indigenous people should be a key strategy for the National Preventative Health Strategy. Serious psychological distress appears to be the 'common causal pathway' which translates the social determinants of health to individual risk of morbidity and mortality. Preventative health strategies which address serious psychological distress as part of reducing health risks associated with obesity, tobacco and alcohol, need to be universally available to all Indigenous populations and communities regardless of where they are located: urban, regional or remote Australia.

There is a need to develop and implement policies and programs that aim to enhance the resilience and capacity of Indigenous individuals, families and communities as part of a National Preventative Health Strategy. If this can be achieved, benefits will be seen across all sectors and will make a substantial contribution to closing the gap in health outcomes between Indigenous and other Australians. Primary prevention programs to intervene early with psychological distress and to improve the social and emotional wellbeing of Indigenous populations should be funded, coordinated and be universally available through the National Aboriginal Community Controlled Health Organisation (NACCHO).

On-going assessments of psychological distress and other measures of positive wellbeing could be used to increase the accountability of policy makers and service providers by measuring whether distress has been eased by programs targeted to risk factors and whether positive wellbeing has been increased at an individual, community and population level.

To that end, AIPA proposes the following recommendations:

Recommendation 1: *That relevant Indigenous professional bodies (including AIPA) work in partnership with the Australian Government to develop and refine the emotional and social well-being assessment module for Indigenous Australians used in national data collections (including the measurement of serious psychological distress).*

Recommendation 2: *That serious psychological distress is included as a determinant of obesity, alcohol consumption and tobacco use, and disparities between Indigenous people and other Australians experiencing serious psychological distress be a performance indicator for the National Preventative Health Strategy.*

Recommendation 3: *That as a part of the National Preventative Health Strategy measures are taken to ensure Indigenous peoples' and communities are able to access social and emotional wellbeing care in accordance with need, and that these services are made universally available through Aboriginal Community Controlled Health Services.*

Recommendation 4: *There is a need to implement primary prevention policies and programs that aim to enhance the resilience and capacity of Indigenous individuals, families and communities to cope with a range of adverse life events (eg SEWB counselling) that contribute to the development of serious psychological distress and health risk factors.*

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