



**Submission to the External Reference
Group of the 'Towards a National Primary
Health Care Strategy' Discussion Paper
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Executive Summary

The Australian Indigenous Psychologists Association (AIPA) has chosen to respond to the question 'What measures have been, or could be, effective in addressing prevention for specific population groups (eg Indigenous, rural and remote, low socio-economic status, CALD)'. We have focused on the need to measure, prevent and report against high levels of psychological distress in Indigenous populations and the need to provide universal access to social and emotional wellbeing and primary mental health care services for Aboriginal and Torres Strait Islander peoples and communities. AIPA proposes the following recommendations to the External Reference Group of the Primary Health Care Strategy:

Developing the Means to Measure the Gap in Social and Emotional Wellbeing

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.

High Levels of Psychological Distress Among Indigenous Peoples

Recommendation 2: That disparities between Indigenous people and other Australians experiencing high levels of psychological distress as measured by the Kessler scale, be a performance indicator for promotion, prevention and early intervention in the primary mental health sector.

Indigenous Access to Social and Emotional Wellbeing and Primary Mental Health Care

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

1. Introduction

In 2008, the World Health Organization released the final report of the Commission on Social Determinants of Health entitled '*Closing the gap in a generation: Health equity through action on the social determinants of health*'. The report outlines the results of research to compile evidence and make recommendations on reducing health inequities.

The report states that 'social injustice is killing people on a grand scale' (2008, p.8). It defines social determinants of health as the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. Health inequalities are seen to arise from a 'toxic combination of poor social policies, unfair economic arrangements and bad politics' (2008, p.9). Dealing with preventable causes of illness requires social action.

The report praised the National Apology to the Stolen Generation and endorsed the Australian Government's initiatives to close the 17-year gap in life expectancy between Indigenous and non-Indigenous Australians. The Close the Gap Campaign for Indigenous Health Equality and the National Indigenous Health Equality Council are working with the Council of Australian Government's (COAG) to form a partnership between all levels of government and Indigenous communities and their representatives to achieve the target of closing the gap on Indigenous disadvantage.

The Australian Indigenous Psychologists Association (AIPA) has membership on the Close the Gap Campaign Steering Committee which has developed a set of *National Indigenous Health Equality Targets* to further Indigenous health equality. This includes targets around Indigenous mental health and social and emotional wellbeing that are of particular interest to AIPA.

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 mental health and 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.

There is no single Aboriginal and Torres Strait Islander group, but numerous groupings, languages, kinships, and tribes as well as ways of living. There is great diversity within the group and also between Aboriginal and Torres Strait Islander people. These differences need to be acknowledged.

When addressing Aboriginal and Torres Strait Islander matters these key issues must underpin the dialogue: the human rights of Aboriginal and Torres Strait Islander people; that their experience of trauma and loss is a direct outcome of the disruption to cultural well being; and that racism stigma, environmental adversity and social disadvantage constitute ongoing stressors with negative impacts on Aboriginal and Torres Strait Islander mental health and well being".

(Social Health Reference Group, 2004).

2 . Developing the Means to Measure the Gap in Social and Emotional Wellbeing

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.

The need to find a way to measure the social and emotional wellbeing of Indigenous Australians resulted in the development of an interim module of social and emotional wellbeing which was used for the first time in the 2004–05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS). The recently published report, *Measuring the Social and Emotional Wellbeing of Aboriginal and Torres Strait Islander Peoples*, by the Australian Institute of Health and Welfare provides a comprehensive collection of data about Indigenous

social and emotional wellbeing based on the findings of the NATSIHS (AIHW, 2009).

The interim social and emotional wellbeing module has eight domains: psychological distress, impact of psychological distress, positive wellbeing, anger, life stressors, discrimination, cultural identification and removal from natural family.

Some of the domains show promise in capturing some of the factors associated with Indigenous social and emotional wellbeing. It may be possible to refine these so it becomes possible to identify and measure the risk and preventative factors for high levels of psychological distress among Aboriginal and Torres Strait Islander peoples and to support the development of policies which better target resources to manage the risks and to increase the resilience of individuals, families and communities. To that end, AIPA recommends questions relating to sense of mastery and control of one's life, resilience and protective factors, spirituality, isolation and loneliness and family and community cohesion are included in future surveys (AIHW, 2009).

Further work is required to develop the social and emotional module to effectively reflect the factors impacting on the wellbeing of Indigenous Australians, as well as allowing comparisons with non-Indigenous Australians.

3. High Levels of Psychological Distress Among Indigenous Peoples

Recommendation 2: That disparities between Indigenous people and other Australians in levels of psychological distress as measured by the Kessler scale, be a performance indicator for promotion, prevention and early intervention in the primary mental health sector.

The possibilities presented by the concept of psychological distress in Aboriginal and Torres Strait Islander populations is promising. We believe measuring non-specific psychological distress may provide a key to understanding the burden of human distress that Aboriginal and Torres Strait Islander peoples carry each day as a result of unremitting disadvantage and inequality.

The measure selected and modified to measure psychological distress in the NATSIH Survey 2004-05 was the Kessler Psychological Distress Scale (Kessler scale). This scale was originally developed to yield a global measure of non-specific psychological distress based on questions about the level of nervousness, agitation and psychological fatigue in the past 4 weeks. It spans the range from few or minimal symptoms through to extreme levels of distress, and is commonly used in public health surveys here and overseas.

The psychological distress measured by the Kessler scale is that which -- if left unaddressed over a long period of time -- may tip over into common or high prevalence disorders such as anxiety and depression. In fact, the non-specific psychological distress being measured by the Kessler appears to reflect the 'insecurity and anxiety' identified by Aboriginal and Torres Strait Islander people and more recently the World Health Organisation (Wilkinson & Marmot, 2003) as a major social determinant for most diseases and causes of death:

'Continuing anxiety, insecurity, low self-esteem, social isolation and lack of control over work and home life, have powerful effects on health. Such psychosocial risks accumulate during life and increase the chances of poor mental health and premature death. For brief periods, this does not matter; but if people feel tense too often or the tension goes on for too long, they become more vulnerable to a wide range of conditions including infections, diabetes, high blood pressure, heart attack, stroke, depression and aggression' (Wilkinson & Marmot, 2003 p12).

The NATSIHS 2004-05 showed that just over one quarter (27%) of Indigenous adults reported high or very high levels of psychological distress. Apparently this ratio was the same as that reported in New York City population eight months after the attack on the World Trade Centre (Andrews, 2006).

Indigenous people were twice as likely than other Australians to report high or very high levels of psychological distress: 27% compared to 13% across all age groups. More Indigenous women (32.2%) reported high or very high levels of psychological distress than men (21.4%).

Psychological distress should not be equated with 'mental illness'. Rather, it should be seen as 'normal human suffering' in response to stressful circumstances. However, where psychological distress becomes so great that the person is no longer able to function, then it may be possible they have reached the clinical threshold for a diagnosis of an anxiety or mood disorder such as depression. In this survey, 21.2% or one in five respondents reported psychological distress so severe they were unable to function on some days in the month before the survey.

It is important to note that the majority of respondents (71.3%) reported only lower levels of psychological distress, which is seen to require a low-level intervention such as social support from friends and family or information i.e. social and emotional wellbeing support as opposed to clinical assessments or interventions.

High Levels of Psychological Distress: A Determinant of Indigenous Health Outcomes

A social determinant is a factor operating at the system or community level which affects the likelihood that a population or group of people will be exposed to a disease or condition or, when exposed, the likelihood they will develop the condition (Commonwealth Department of Health and Aged Care, 2000). We believe high levels of psychological distress is a determinant of mental illness, poor health choices and a range of general health outcomes.

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 creating vulnerability for mental illness, non-specific psychological distress itself has been shown to be a risk factor for a range of negative health outcomes.

High levels of psychological stress / distress can lead to increased insulin resistance, greater incidence of lipid and clotting disorders, and other biomedical insults that are precursors to adult disease such as heart disease and diabetes (Brunner & Marmot, 2006). In addition, difficult environments determine whether individuals take up tobacco, use alcohol, experience poor diets, and have low levels of physical activity. Tobacco and excessive alcohol use, and carbohydrate-dense diets are often used as a means of coping with difficult circumstances (Wilkinson, 1996). The most powerful predictors of heart disease, stroke and Type 2 diabetes among populations are less about the poor health choices made by individuals, and more about living under conditions of material deprivation, the stress associated with such conditions, and the adoption of health threatening behaviours as means of coping with these difficult circumstances (Wilkinson & Marmot, 2003; Jarvis & Wardle, 2003).

The social and emotional wellbeing and level of psychological distress experienced by Indigenous peoples is influenced by 'a broad range of problems such 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). If unaddressed, risk factors in the social and emotional domain can increase the likelihood that mental health problems will develop. Protective factors can help provide resilience in the face of adversity and moderate the impact of stressful circumstances on social and emotional wellbeing, thereby reducing the likelihood that mental health problems will develop (Commonwealth Department of Health and Aged Care, 2000).

Modifying the social determinants that lead to high levels of psychological distress should therefore result in a range of beneficial *health* as well as *mental 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.

The first step to the development of interventions to improve social and emotional wellbeing and ultimately mental health of Indigenous peoples is to acknowledge that most of the protective and risk factors for high levels of psychological distress lie in the social determinants, rather than within the mental health sector. Of equal importance is the recognition that effective interventions to promote social and emotional wellbeing and to prevent high levels of psychological distress will have positive outcomes beyond the mental health domain.

An essential component to preventing high levels of psychological distress from yielding a high burden of mental illness among Indigenous peoples, particularly high prevalence disorders such as anxiety disorders, depression and substance abuse disorders, is universal access to culturally appropriate social and emotional wellbeing and primary mental health care which is integrated into primary care services in order to reduce stigma associated with help-seeking.

3. Indigenous Access to Social and Emotional Wellbeing & Primary Mental Health Care

Recommendation 3: That as a part of the Primary Health Care Strategy, measures are taken to ensure that Indigenous people are able access to social and emotional wellbeing and primary mental health care services in accordance with need and that these services are universally available through Aboriginal Community Controlled Health Services.

There is a significant evidence base that suggests access to primary mental health care is instrumental in preventing high levels of psychological distress from developing into mental illness, particularly in young people. This is reflected in the recent reform directions of the National Health and Hospital Reform Commission's interim report *Better Health for All Australians*.

However, there is also strong evidence to demonstrate that Indigenous peoples are not able to access these services.

For example, the Kessler scale was used in the NATSIH Survey 2004-05 and this tool is often used to identify population groups at risk but who are not accessing services to gain support (Saunders & Daly, 2000). Despite widespread high levels of psychological distress, 87% of respondents to the NATSIH Survey 2004-05 had not sought help from a doctor or other health professional to cope with their feelings in the month before the survey. One in ten (12%) did seek help by seeing a doctor or other health professional, while 5.3% made a single visit to get help, and 6.4% made two or more visits. More women (14%) sought help

compared with 9% of men. This may have been influenced by a lack of access to primary mental health care:

- **Lack of Access to General Practitioners**

GPs are often the first health professionals to be consulted about mental health concerns in Australia. In the NATSIH Survey 2004-05, 15% of Indigenous people did not visit a doctor when they needed to, with transport/distance being a major reason especially in remote areas. Other reasons included cost, waiting time and cultural issues (AIHW, 2008).

- **Lack of Access to Psychologists**

The full time equivalent rate of employed psychologists was highest in areas where less than 1% of the population was Indigenous (89 per 100,000) and lowest in areas where 20% or more of the population was Indigenous (7 per 100,000) (AIHW, 2008).

- **Restricted Access to Social and Emotional Support as Part of Comprehensive Primary Health Care**

The barriers and enablers for Indigenous people seeking help for psychological distress and mental health issues was the focus of a recent Australian Psychological Society project funded by the Australian Government, which AIPA members were involved in. There are approximately 140 Australian Government-funded Aboriginal community controlled primary health-care services in Australia and it is estimated that these services reach around 40% of the Indigenous population. The study found that while many Aboriginal Community Controlled Health Services (ACCHS) provided access to specialised counselling for Stolen Generation survivors, only 19 (13%) of the 140 had been resourced to provide access to additional social and emotional wellbeing counseling services as part of comprehensive primary health care for all Aboriginal people. Although psychological distress is managed as a component of holistic health in ACCHS's, this sector is under-resourced generally and very few had the 'social health teams' as recommended in the Ways Forward Report (1995) and the National Strategic Aboriginal and Torres Strait Islander Social and Emotional Wellbeing and Mental Health Framework 2004 – 2009.

- **Restricted Access to Primary Mental Health Care**

Aboriginal and Torres Strait Islander people access a range of systems and services for primary health care according to availability. The proportion of Indigenous Australians who use Aboriginal Community Controlled Health Services for their regular health care increases with remoteness, from 15% in major cities to 76% in very remote areas. The proportion of Indigenous Australians using a doctor for their regular health care decreased with remoteness from 80% in major cities and inner regional areas to 6% in

very remote areas (AIHW, 2008).

Significant differences existed between jurisdictions in the type of service Indigenous people used for health care. Most Indigenous people in the Australian Capital Territory, South Australia, Victoria, New South Wales and Tasmania used a doctor for their regular health care. A higher proportion of Indigenous people used public hospitals for regular health care in Queensland and Western Australia (12% and 14%, respectively) compared with other jurisdictions. Public hospital use was higher in remote and very remote areas (AIHW, 2008). The public hospital system is over-burdened and does not have the capacity to offer primary care or primary mental health care services.

Yet, Aboriginal and Torres Strait Islander peoples accounted for 5.0% of mental health-related emergency department occasions of service and 6.2% of separations for mental health care in public hospitals. This was more than three times the rate of other Australians (AIHW, 2008). Those presenting to public hospitals for assistance to deal with psychological distress or mental health issues are likely to be attended by health professionals with limited training in the understanding, assessment or management of such issues.

- **Lack of Access to Culturally Appropriate Primary Mental Health Care in Discrete Aboriginal Communities in Remote Areas**

There are an estimated 92,960 Aboriginal people living in communities on traditional and other lands, most of which are located in remote Australia (CHINS, 2007). Approximately half (47% or 43,691) of this population has access to Aboriginal Community Controlled Health Services which provide social and emotional wellbeing support as part of culturally appropriate comprehensive primary health care.

The remaining 43% (35,737) of the population in Aboriginal communities only has access only to state-funded community health centres, which are administered without community input, are not funded to provide comprehensive primary health care, and have poor retention of Aboriginal Health Workers (Ibid).

While 14,090 (15.3%) people living in Aboriginal communities have access to a hospital in their community, only four remote Aboriginal communities have access to general practitioners on a day to day basis, and seven have access to on-site substance abuse services (CHINS, 2007; AIHW, 2008).

At the same time, Indigenous people in remote Australia were more likely to report speaking an Indigenous language (42%) than those living in non-remote areas (2%), and to report difficulties in communicating with service providers: 19% and 8%, respectively

(NATSISS, 2004).

4. Summary

There is a clear unmet need for culturally appropriate social and emotional wellbeing well-being and primary mental health care services in urban, regional and remote Indigenous communities to promote social and emotional wellbeing, to intervene early with psychological distress and to prevent the development of mental health problems.

AIPA believes that the integration of culturally appropriate social and emotional wellbeing and primary mental health care services into Indigenous primary health care settings is an essential component of the sustained effort required to address the high levels of psychological distress among Aboriginal peoples and populations. These services need to be universally available to all Indigenous populations and communities regardless of where they are located: urban, regional or remote Australia.

At the same time, it must be remembered that improvements in Indigenous social and emotional wellbeing cannot be achieved by improved access to primary mental health care alone, and that the determinants of serious psychological distress need to be prevented or managed. If this can be achieved, benefits will be seen across all sectors, not just in improved mental health outcomes.

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