



Submission to the Productivity Commission's inquiry into the role of improving mental health to support economic participation and enhancing productivity and economic growth.

January 2020

About Nunkuwarrin Yunti

Nunkuwarrin Yunti is an Aboriginal community-controlled health service that delivers comprehensive primary health care services to Aboriginal people in the Adelaide metropolitan region. It was established as a community organisation in the early 1970s.

As a small player within the wider South Australian health system, Nunkuwarrin Yunti's clinical services tend to focus on Aboriginal people and families who are at greater risk of receiving less than optimal care within the mainstream health system; particularly, those who carry complex and/or chronic conditions, including mental health conditions.

The organisation delivers social and emotional wellbeing (SEWB) and mental health services, which include mental health clinicians, sessional psychiatrist, counsellors, a social worker and Aboriginal SEWB workers. And these are directly supported by case workers.

Nunkuwarrin Yunti is also a Registered Training Organisation (RTO), which delivers, among other things, accredited training including the *10772NAT Diploma of Narrative Therapy for Aboriginal People* the *HLT40113 Certificate IV in Aboriginal Torres Strait Islander Primary Health Care* and the *10814NAT Certificate IV in Stolen Generation Family Research and Case Management*. The *Diploma* is also accredited by the Australian Counselling Association (ACA), which enables graduates to become members of the ACA.

The RTO is part of a broader SEWB Workforce Support Unit, which further to training, attempts to support Commonwealth-funded SEWB workers across South Australia by means including:

- Coordinate professional and/or clinical supervision and cultural mentoring;
- Identify, evaluate and promote best practice models for SEWB service delivery, as well as organisational and individual compliance with operational standards, by providing relevant and up-to-date SEWB service tools and facilitating training opportunities enhancing competency;
- Enhance and maintain professional support networks across the SEWB workforce;
- Hold forums open to the SEWB workforce, encouraging competency enhancement and providing peer support, networking, other professional development including externally sourced training and the sharing of best practice models for workers.

Introduction

The attention that the Productivity Commission is giving to mental health, including Indigenous mental health and social & emotional wellbeing (SEWB), through this inquiry is welcomed to say the least.

However, the inquiry is limited by the framing of its scope towards how improvements to mental health can support economic participation and productivity; there is to be no real consideration on how participation itself, whether through economic, social or cultural means can improve mental health. The limited scope of the inquiry is acknowledged within the draft report,¹ however we cannot emphasise enough the limitations of confining it to not much other than the functioning of the mental health system.

It is our submission that racially discriminatory and exclusionary legislation, policies and practices towards Indigenous peoples have not only limited the participation of Indigenous peoples within Indigenous and Australian societies and economies, but also severely impacted upon their mental health and SEWB. We further submit that greater participation by Indigenous peoples will lead to improvements in the mental health and SEWB of Indigenous peoples.

The Draft Report draws an association between social exclusion and poor mental health,² but it does not consider causality. A 'National Stigma Reduction Strategy' is recommended,³ however this is framed within the mental health system. It is our submission that systemic economic, social and cultural exclusion of Indigenous peoples often leads to poor mental health. Suggestions have been made by some researchers that:

... a causal pathway linking the stress of discrimination to an increase in negative health behaviors such as smoking and alcohol abuse as coping mechanisms, that then interfere with stress response and result in mental disorders. This pathway suggests that if we could intervene on the more upstream, structural forms of discrimination instead of on the behaviors that often follow it, we may be more successful in reducing disparities in mental health, among other outcomes.⁴

Draft Finding 20.2 recognises that a holistic approach is required for improving the mental health and SEWB of Indigenous peoples. But again, the scope of the inquiry has limited the consideration of how Indigenous peoples might participate more effectively in their own economic, social and cultural institutions and how these institutions might be better protected.

¹ At pp.123-124.

² Draft Finding 20.1.

³ Draft Recommendation 20.1.

⁴ Jackson J.S. & Knight K.M., 'Race and self-regulatory health behaviors: The role of the stress response and the HPA axis in physical and mental health disparities', in Schaie K.W., Carstensen L.L. (eds), *Societal Impact on Aging Series. Social Structures, Aging, and Self-regulation in the Elderly*, New York, 2006. p. 189–239, in Sampson, L. & Galea, D., 'An Argument for the Foundations of Population Mental Health', *Frontiers in Psychiatry*, 19/11/2018, <https://www.frontiersin.org/articles/10.3389/fpsy.2018.00600/full>

The recognition of the holistic nature of SEWB and its positioning against the medically-orientated mental health system is now enshrined in the *Fifth National Mental Health and Suicide Prevention Plan* and the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023*; SEWB is now recognised as being something that is much broader than a medicalised focus on mental health. But improvements to the mental health and SEWB of Indigenous peoples will require more than a policy framework.

There is plenty of good policy to support improvements, however it is often: (i) undermined by other policy or legislation; or (ii) not being implemented effectively through government administered programs.

Changes to governance and financing arrangements, not only in the field of Indigenous mental health but across all areas of Indigenous affairs, is a prerequisite to improving the participation of Indigenous peoples and thereby improving their mental health and SEWB.

Human rights perspective

The Draft Report identifies a number of international human rights instruments that have been ratified or endorsed by Australia.⁵ These provide a foundation for the improvement of mental health and social & emotional wellbeing services for Aboriginal peoples.

The *Declaration on the Rights of Indigenous Peoples* is rightly identified as an instrument that has not created legal obligations following its endorsement, however it should be noted that the *Declaration* provides a focus on existing human rights that apply to indigenous peoples rather than providing any new rights. A key example of this is the right of self-determination, that is provided for in Article 3 of the *Declaration*. This right is already provided for within Article 1 of both the *International Covenant on Civil and Political Rights (ICCPR)* and the *International Covenant on Economic, Social and Cultural Rights (ICESCR)* The *Declaration* is important though in clarifying that this right applies to indigenous peoples.

Furthermore, in relation to the design and development of health and other programs for indigenous peoples, Article 23 of the *Declaration* provides for indigenous peoples to be in the driver's seat, viz:

Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.

Another human rights instrument relevant to this discussion is *International Labour Organization Convention No. 169, concerning Indigenous and Tribal Peoples (ILO 169)*. Whilst this human rights treaty has not been ratified by Australia, it also provides standards and guidance on how human

⁵ At pp.888-889.

rights that are expressed and provided for within other treaties should be implemented. *ILO 169* provides such guidance in relation to consultation and participation rights in particular.⁶ In relation to health (which is otherwise provided for in Article 12 of *ICESCR*), Article 25 provides:

1. Governments shall ensure that adequate health services are made available to the peoples concerned, or shall provide them with resources to allow them to design and deliver such services under their own responsibility and control, so that they may enjoy the highest attainable standard of physical and mental health.
2. Health services shall, to the extent possible, be community-based. These services shall be planned and administered in co-operation with the peoples concerned and take into account their economic, geographic, social and cultural conditions as well as their traditional preventive care, healing practices and medicines.
3. The health care system shall give preference to the training and employment of local community health workers, and focus on primary health care while maintaining strong links with other levels of health care services.
4. The provision of such health services shall be co-ordinated with other social, economic and cultural measures in the country.

Such standards guide governments on how to do things *with*, not *to* Indigenous peoples.⁷

More generally, the application of a human rights approach to improving Indigenous wellbeing requires the implementation of:

- participation rights, which are grounded in the right of self-determination;
- a substantive approach to equality, which is grounded in the principle of non-discrimination; and
- cultural rights, which among other things, are provided for in Article 15 of *ICESCR* and Article 27 of the *ICCPR*.

Indigenous participation through effective consultation is reflected in Article 6(1) of *ILO 169*, viz:

1. In applying the provisions of this Convention, governments shall:
 - (a) consult the peoples concerned, through appropriate procedures and in particular through their representative institutions, whenever consideration is being given to legislative or administrative measures which may affect them directly;
 - (b) establish means by which these peoples can freely participate, to at least the same extent as other sectors of the population, at all levels of decision-making in elective institutions and administrative and other bodies responsible for policies and programmes which concern them;
 - (c) establish means for the full development of these peoples' own institutions and initiatives, and in appropriate cases provide the resources necessary for this purpose.

⁶ Amongst other things, refer to Article 6.

⁷ Per the former Prime Minister, Hon Malcolm Turnbull upon tabling the 10th annual *Closing the Gap* report to the House of Representatives in 2018.

2. The consultations carried out in application of this Convention shall be undertaken, in good faith and in a form appropriate to the circumstances, with the objective of achieving agreement or consent to the proposed measures.

These standards for consulting with Indigenous peoples should be adopted by all governments, regardless of whether the Convention is ratified or not.

Consultation process

From a national policy perspective, the Federal Government has done well in respect to the development of some key policy documents in the area of Indigenous mental health and suicide prevention, including:

- *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023*; and
- *Fifth National Mental Health and Suicide Prevention Plan*.

Whilst it must be said that these documents build upon previous work, they were developed through the agency or with the influence of effective Indigenous leadership.

The *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023* was developed by the Aboriginal and Torres Strait Islander Mental Health & Suicide Prevention Advisory Group (ATSIMHSPAG), which is an adviser to the Commonwealth Government.

The development of the *Fifth National Mental Health and Suicide Prevention Plan* was influenced by the National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH), particularly in respect to the positioning of social and emotional wellbeing for Indigenous peoples against the medically-orientated mental health system.

At a regional and local level, the same may not generally be said. This is largely due a failure the Commonwealth Government to implement such policy through program development and administration.

Nunkuwarrin Yunti receives Commonwealth monies for Indigenous mental health and SEWB from three sources, viz:

1. Primary Health Network (PHN);
2. National Indigenous Australians Agency (NIAA); and
3. Medicare Benefits Schedule (MBS).

Our experience with the PHN has not been a positive one. Among other things, it has taken some time for the PHN to accept and fund the role of our Narrative Therapists, even though narrative therapy (for Aboriginal and Torres Strait Islander people) has been approved as an acceptable

strategy for use by allied mental health professionals utilising the 'Focussed Psychological Strategies' items under the MBS for some time.⁸

The NIAA funds most of our SEWB services and SEWB workforce support, under the 'safety and wellbeing' stream of the 'Indigenous Advancement Strategy' appropriation. Previously, these projects were funded under the Department of Health's 'Bringing Them Home' appropriation. Thus, the funding is less secure than it previously was.

In regard to the MBS, Nunkumarirri Yunti (along with other Aboriginal community-controlled health services) has an exemption under ss.19(2) of the *Health Insurance Act* (Cth) 1973, which enables it to use grant funding to employ Medical Officers and other health practitioners and have them bulk-bill patients and assign the benefit to the organisation. In this way, mental health services are supported through MBS items such as the 'Focussed Psychological Strategies' items⁹ and the 'GP Mental Health Treatment' items.¹⁰

A new approach to developing, delivering and coordinating mental health and SEWB services for Indigenous peoples is required.

Governance and Financing

A more holistic approach for Aboriginal and Torres Strait Islander peoples lends itself to a population health approach further to the population health approach that is recommended for the general Australian population. As recognised in the Draft Report, a population health approach is necessary for improving cohesion, coordination and cooperation and for reducing duplication of service.

The Department of Health's submission¹¹ (no. 556) presents a good summary of the key issues challenges facing government and government-funded services in improving mental health. Among other things, the Department recognises the importance of creating an integrated human services system to improving mental health:

It is through integrating mental healthcare with mainstream healthcare and other systems such as the education, social employment, social services, and housing and justice systems that a truly person-centred approach to mental health and wellbeing, across the lifespan, can be achieved.

NB: the Department then presents a list of programs that it administers, which appears counter to the holistic and integrated approach that it prescribes.

⁸ Refer to *Medicare Benefits Schedule - Note MN.7.1*, <http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=MN.7.1&qt=noteID&criteria=narrative>

⁹ MBS items 2721 to 2731

¹⁰ MBS items 2700, 2701, 2712, 2713, 2715 and 2717

¹¹ Department of Health, *Initial Submission to the Productivity Commission Inquiry into Mental Health*, 2019, https://www.pc.gov.au/data/assets/pdf_file/0005/244967/sub556-mental-health.pdf

The PHNs play a commissioning role respect to primary mental health. But as mentioned previously, the Department of Health’s funding of Primary Health Networks (PHNs) to commission primary mental health care has not gone according to plan from Nunkuwarrin Yunti’s experience.

As stated in the draft report, ‘the Department of Health expects PHNs to apply co-design processes in developing regional mental health and suicide prevention plans’¹² and they may have achieved some success in this respect in relation to partnering with state health departments and general practitioners. However, our experience with the Adelaide PHN has been full of challenges and disappointments.

The ‘Option 2 Rebuild Model’ which would create Regional Commissioning Authorities appears to be a more suitable approach although the commission of Indigenous primary mental health services by Indigenous regional commissioning authorities would be preferred. Indeed, there is a precedent for this model.

In 2002, the Commonwealth Department of Health & Ageing began rolling out the Primary Health Care Access Program (PHCAP), which provided significant new funding to be applied at a regional level. The funding was released upon the development of regional Indigenous primary health plans, which were typically coordinated by Aboriginal community-controlled health services. The prospect of funding attracted state/territory government and some other relevant primary health services to the negotiating table.

To this day, Nunkuwarrin Yunti has in place an Aboriginal primary health plan and agreement with the State for the Adelaide metropolitan region, and distributes funding that is made available by the Commonwealth Department of Health for this purpose.

This approach could be extended for Indigenous primary mental health services; Aboriginal community-controlled health services could be funded to plan and commission Aboriginal mental health services from a range of providers and at a regional level.

Aboriginal Health Workers

INFORMATION REQUEST 11.1 — ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH WORKERS

The Productivity Commission is seeking information from participants on any barriers impeding career progression for Aboriginal and Torres Strait Islander health workers, including barriers to the ability to move to broader health professions, such as mental health nursing.

¹² Productivity Commission, *Mental Health: Productivity Commission Draft Report, Volume 2*, Productivity Commission, October 2019, p.908, <https://www.pc.gov.au/inquiries/current/mental-health/draft/mental-health-draft-volume2.pdf>

The Commonwealth Government has for many years provided funding for SEWB workers to become qualified at the Certificate IV level.

Typically, Aboriginal SEWB workers who are not already qualified at a Certificate IV level will be encouraged to complete the *HLT40113 Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care*. This qualification used to be referred to as the 'community care' stream, as distinct from the clinically-orientated *HLT40213 Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Practice)* qualification.

Further to the *HLT40113 Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care* qualification, Nunkuwarrin Yunti offers and delivers the *NAT10772 Diploma of Narrative Approaches for Aboriginal People*.¹³ The *Diploma* is accredited by the Australian Counselling Association, which enables graduates to apply for membership to this professional association.

Neither the graduates of the *HLT40113 Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care* qualification or the *NAT10772 Diploma of Narrative Approaches for Aboriginal People* course are able to apply for registration with the Australian Health Practitioner Regulation Agency (AHPRA) as this qualification and course are not accredited by AHPRA. To date, AHPRA has only accredited the *HLT40213 Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Practice)* qualification that is delivered by a number of Registered Training Organisations.¹⁴

There is little difference between the *HLT40113 Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care* and *HLT40213 Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Practice)* qualifications. As illustrated in Appendix 1, the core units of competency for each are the same except for two. Furthermore, the packaging rules¹⁵ allow for the seven elective units of competency that are currently used in the delivery of the *HLT40113 Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care* qualification by Nunkuwarrin Yunti to also be used in the delivery of the *HLT40213 Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Practice)* qualification.

With over 120 elective units of competency to select from, the *HLT40213 Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Practice)* qualification is typically given a more clinical orientation. However, it can also be given more of a social and emotional wellbeing orientation, and hence the question has to be asked as to why the Aboriginal and Torres Strait Islander Health Practice Board have been so reluctant to consider the accreditation of the *HLT40113 Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care* qualification. Moreover, the registration of SEWB Aboriginal Health Workers was always intended, but was placed on the back-burner circa 2012 in favour of getting the clinical Aboriginal Health Worker registered first.

¹³ The *Diploma* is a course that has been developed by and is owned by Nunkuwarrin Yunti.

¹⁴ The current list of approved programs of study are available at <https://www.ahpra.gov.au/education/approved-programs-of-study.aspx?ref=aboriginal%20and%20torres%20strait%20islander%20health%20practitioner>

¹⁵ The packaging rules are contained in the qualification details for *HLT40113 - Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care* at <https://training.gov.au/Training/Details/HLT40113>

Furthermore, the Aboriginal and Torres Strait Islander Health Practice Board's preparedness to contemplate the accreditation of other qualifications has extended only to those clinical Aboriginal and Torres Strait Islander primary health care courses that are at higher Australian Qualification Framework levels.

The Aboriginal and Torres Strait Islander Health Practice Board's steadfastness in refusing to accredit qualifications such as the *HLT40113 Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care* qualification is even more perplexing given that not all Aboriginal Health Practitioners perform a clinical role. Registration is purely for the protection of title;¹⁶ the job role of an Aboriginal Health Practitioner is not of consequence, other than that they must have performed either 450 hours of practice in the previous three years, or 150 hours of practice in the previous 12 months.¹⁷

Furthermore, 'Practice' is defined as:

any role, whether remunerated or not, in which the individual uses their skills and knowledge as a health practitioner in their profession. Practice in this context is not restricted to the provision of direct clinical care. It also includes using professional knowledge (working) in a direct non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on the safe, effective delivery of services in the profession.¹⁸

And 'scope of practice' means 'the professional role and services that an individual health practitioner is educated and competent to perform'.¹⁹ So, if an Aboriginal Health Practitioner is trained, competent and authorised to perform work and is working within a social and emotional wellbeing setting more than a clinical setting, then this will be their scope of practice. Indeed, there are already graduates of *HLT40213 Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Practice)* qualification who do not perform clinical work.

As it stands, the scope of practice of an Aboriginal Health Practitioner is defined by the programs of study that have been accredited by the Aboriginal and Torres Strait Islander Health Practice Board; ie, the *HLT40213 Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Practice)* qualification that is delivered by a number of Registered Training Organisations. Hence, the argument of the ATSIHPB is circular.

Nunkuwarri Yunti will now need to consider placing the *HLT40213 Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Practice)* qualification on its scope and delivering

¹⁶ ie, 'Aboriginal Health Practitioner'.

¹⁷ Aboriginal and Torres Strait Islander Health Practice Board of Australia, *Registration Standard: Recency of Practice*, 1 December 2019, <https://www.atsihealthpracticeboard.gov.au/Registration-Standards/recency-of-practice-reg-std.aspx>

¹⁸ Aboriginal and Torres Strait Islander Health Practice Board of Australia, *Registration Standard: Recency of Practice*, 1 December 2019, <https://www.atsihealthpracticeboard.gov.au/Registration-Standards/recency-of-practice-reg-std.aspx>

¹⁹ Aboriginal and Torres Strait Islander Health Practice Board of Australia, *Registration Standard: Recency of Practice*, 1 December 2019, <https://www.atsihealthpracticeboard.gov.au/Registration-Standards/recency-of-practice-reg-std.aspx>

essentially the same program of learning as it has with the *HLT40113 Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care* with the exception of two units of competency.

Appendix 1: Comparison of core units of competency between HLT40113 and HLT40213

HLT40113 Certificate IV in Aboriginal and Torres Strait Islander Primary Health Care core units

CHCLEG001	Work legally and ethically
HLTAHW005	Work in an Aboriginal and/or Torres Strait Islander primary health care context
HLTAHW006	Facilitate and advocate for the rights and needs of clients and community members
HLTAHW007	Undertake basic health assessments
-	
HLTAHW017	Assess and support client's social and emotional wellbeing
HLTAHW018	Plan, implement and monitor health care in a primary health care context
HLTAHW019	Deliver primary health care programs for Aboriginal and/or Torres Strait Islander communities
HLTAHW021	Provide nutrition guidance for specific health care
HLTAHW022	Address social determinants of Aboriginal and/or Torres Strait Islander health
HLTAHW023	Plan, develop and evaluate health promotion and community development programs
HLTAHW037	Support the safe use of medications
HLTAID003	Provide first aid
HLTINF001	Comply with infection prevention and control policies and procedures
HLTWHS001	Participate in workplace health and safety

HLT40213 Certificate IV in Aboriginal and Torres Strait Islander Primary Health Care (Practice) core units

CHCLEG001	Work legally and ethically
HLTAHW005	Work in an Aboriginal and/or Torres Strait Islander primary health care context
HLTAHW006	Facilitate and advocate for the rights and needs of clients and community members
HLTAHW016	Assess client's physical wellbeing
HLTAHW017	Assess and support client's social and emotional wellbeing
HLTAHW018	Plan, implement and monitor health care in a primary health care context
HLTAHW019	Deliver primary health care programs for Aboriginal and/or Torres Strait Islander communities
HLTAHW020	Administer medications
HLTAHW021	Provide nutrition guidance for specific health care
HLTAHW022	Address social determinants of Aboriginal and/or Torres Strait Islander health
HLTAHW037	Support the safe use of medications
HLTAID003	Provide first aid
HLTINF001	Comply with infection prevention and control policies and procedures
HLTWHS001	Participate in workplace health and safety