NACCHO
National Aboriginal Community Controlled Health Organisation
Aboriginal health in Aboriginal hands
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Inquiry into Mental Health and Suicide Prevention

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Submission to the House Select Committee on Mental Health and Suicide Prevention

June 2021

About NACCHO

NACCHO is the national peak body representing 143 Aboriginal Community Controlled Health Organisations (ACCHOs) Australia wide on Aboriginal and Torres Strait Islander health and wellbeing issues. NACCHO's work is focussed on liaising with governments, its membership, and other organisations on health and wellbeing policy and planning issues and advocacy relating to health service delivery, health information, research, public health, health financing and health programs.

Our Members provide about 3.1 million episodes of care per year for about 350,000 people across Australia, which includes about 800,000 episodes of care in very remote and outer regional areas.

Sector Support Organisations, also known as Affiliates, are State based and also represent ACCHOs offering a wide range of support services and Aboriginal and Torres Strait Islander health programs to their Members including advocacy, governance, training and advocacy on State and Territory Government health care policies and programs.

Affiliates also support ACCHOs to deliver accessible, responsive, and culturally safe services for Aboriginal and Torres Strait Islander people. The leadership and support provided by Affiliates strengthens governance and financial expertise in the Aboriginal and Torres Strait Islander community controlled health sector. Affiliates provide a strong interface for the Aboriginal and Torres Strait Islander community controlled health sector with the national reform agenda occurring in the health system. Together NACCHO and Affiliates harness better coordinated, more cohesive and cost-effective mechanisms for stakeholder and community engagement on Aboriginal and Torres Strait Islander health issues, and providing advice to State, Federal and Territory Governments.

ACCHOs range from large multi-functional services employing several medical practitioners and providing a wide range of services, to small services which rely on Aboriginal Health Workers/Practitioners and/or nurses to provide the bulk of primary care services, often with a preventive, health education focus. Our 143 ACCHOs operate approximately 700 facilities, including about 450 clinics. ACCHOs and their facilities and clinics contribute to improving Aboriginal and Torres Strait Islander health and wellbeing through the provision of comprehensive holistic primary health care, and by integrating and coordinating care and services. Many provide home and site visits; provision of medical, public health and health promotion services; allied health; nursing services; assistance with making appointments and transport; help accessing childcare or dealing with the justice system; drug and alcohol services; and providing help with income support.

Collectively, we employ about 6,000 staff, 56 per cent of whom are Indigenous, which makes us the single largest employer of Indigenous people in the country.

The COVID-19 pandemic has highlighted how effective the structure and combination of NACCHO, State and Territory Affiliates and Aboriginal Community Controlled Health Services is in responding to COVID-19.

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Recommendations

NACCHO recommends to the House Select Committee on Mental Health and Suicide Prevention that the Australian Government:

Implement Recommendations in line with the National Agreement on Closing the Gap, as follows:

1. Each of the specific recommendations regarding Aboriginal and Torres Strait Islander people contained in the Productivity Commission Inquiry Report into Mental Health, the Final Report of the National Suicide Prevention Officer, and the Victorian Royal Commission in Mental Health are implemented in alignment with the National Agreement on Closing the Gap (National Agreement) as a matter of urgency.
2. That Aboriginal Community Controlled Health Organisations (ACCHOs) must be the preferred provider of mental health, suicide prevention, and social and emotional well-being services to Aboriginal and Torres Strait Islander people.

Implement the following funding and associated reforms:

3. Funding for Aboriginal and Torres Strait Islander mental health and suicide prevention services should be redirected from Primary Health Networks (PHNs) to Aboriginal Community Controlled Health Organisations (ACCHOs).
4. Where ACCHOs are unable to provide services in an area, other Aboriginal Community Controlled Organisations (ACCOs) should be funded to deliver these services. Where this cannot occur, mainstream organisations should be funded with a view of transferring this to community controlled organisations as soon a local ACCO or ACCHO has capacity.
5. The National Aboriginal and Torres Strait Islander Suicide Prevention Strategy, developed by Gayaa Dhuwi (Proud Spirit) Australia, is fully implemented in line with the National Agreements priority reforms.
6. Long-term and sustainable funding is provided to ensure the recruitment and retention of appropriately trained staff and consistent access to services for clients in line with the strategies from the National Aboriginal and Torres Strait Islander Health Workforce Plan 2021-2031.
7. Access to culturally responsive trauma informed care is critical, requiring investment in training to ensure this is widely available.
8. There is significant investment in infrastructure to build telehealth and digital health capacities for ACCHOs, particularly in Remote and Very Remote areas.

Address and eliminate racism across the health system:

9. Action is be taken to establish a nationally co-ordinated approach to acknowledge, measure, and eliminate individual and institutional racism and discrimination that impacts Aboriginal and Torres Strait Islander people across the entire health system.
10. Develop robust systems of accountability and monitoring regarding the continuing presence of institutional and other forms of racism.

Grow the Aboriginal and Torres Strait Islander mental health and Social and emotional wellbeing (SEWB) workforce across Australia's health system:

11. A specialist SEWB workforce tailored training package is established to provide recognition and registration through the Australian Health Practitioner Regulation Agency (AHPRA) in line with what occurs for Aboriginal Health Worker qualifications.

12. The Medicare Benefits Schedule is amended to include an item for SEWB services delivered by a registered SEWB workforce for Aboriginal and Torres Strait Islander people.
13. That Aboriginal and Torres Strait Islander people are appropriately represented in all roles, levels, and locations across Australia's mental health system, including in mental health education and training as well as clinical and program/service delivery.
14. Addressing both the social determinants and cultural determinants of health is critical to ensuring a strengthened and sustained Aboriginal and Torres Strait Islander mental health workforce and the education and employment outcomes required to support the workforce.
15. Addressing the continuing presence of institutional and other forms of racism in hospitals (and particularly emergency rooms and psychiatric wards) as well as in mainstream services and its crippling impact on service and program delivery as well as the education and workforce recruitment, retention, and progression of Aboriginal and Torres Strait Islander staff members.

Introduction

NACCHO welcomes the Inquiry into Mental Health and Suicide Prevention and appreciates the opportunity to contribute to the *Select Committee on Mental Health and Suicide Prevention*. NACCHO has developed this submission with valuable input from our Affiliates and Members – Aboriginal Health and Medical Research Council (AH&MRC), Victorian Aboriginal Community Controlled Health Organisation (VACCHO), Queensland Aboriginal and Islander Health Council (QAIHC), Aboriginal Health Council of Western Australia (AHCWA), Aboriginal Medical Services Alliance North Territory (AMSANT) and Kimberley Aboriginal Medical Services (KAMS).

The National Agreement on Closing the Gap (National Agreement), agreed to by all Australian Governments, represents a new approach where policy making that impacts Aboriginal and Torres Strait Islander people occurs in full and genuine partnership with Aboriginal and Torres Strait Islander people[1]. In looking to improve the mental health system in Australia, and in seeking to improve outcomes for Aboriginal and Torres Strait Islander people, it is essential that all reforms align with the National Agreement. Self-determination must be at the heart of these reforms. The country is on the precipice of national mental health reform which provides an opportunity to address systematic reform of the mental health sector. The unique experiences and of Aboriginal and Torres Strait Islander people must be addressed in the coming changes.

Aboriginal and Torres Strait Islander people are disproportionately represented in mental health and suicide statistics in Australia. The Australian Institute of Health and Welfare has estimated that mental health and substance use are the biggest contributors to the overall burden of disease for Aboriginal and Torres Strait Islander people. Aboriginal and Torres Strait Islander adults are 2.7 times more likely to experience high or very high levels of psychological distress than other Australians[2]. Whiles Aboriginal and Torres Strait Islander people make up around 3% of the population, they comprise 11% of all emergency department mental health presentations across the country.[3]

The impacts and suffering by those who were a part of the Stolen Generations continues to have significant impacts on their health and wellbeing. The intergenerational impacts of this trauma can also be experienced by their children and grandchildren. In 2010, suicide was 2.6 times more likely to be the cause of death for Aboriginal and Torres Strait Islander people than for other Australians, increasing significantly for males under 25 years of age[4]. Each loss of life has an immeasurable impact on the person's family and community and serves to compound the trauma of past and future generations.

The historical, political, cultural, and social determinants of Aboriginal and Torres Strait Islander people's health must be addressed. Aboriginal and Torres Strait Islander people's health and wellbeing is intrinsically intertwined with other social determinants of health. The disproportionate rates of mental illness and suicide in Aboriginal and Torres Strait Islander people must be understood through the ongoing impacts of colonialisation, past government policies and practices, and those that still negatively impact Aboriginal and Torres Strait Islander people today.

[1] Coalition of Peaks (2020). National Agreement on Closing the Gap.
[2] AIHW, The Health and Wellbeing of Aboriginal and Torres Strait Islander peoples: 2015 https://www.aihw.gov.au/reports/indigenous-health-welfare/indigenous-health-welfare-2015/contents/determinants-of-health-key-points
[3] https://acem.org.au/getmedia/5ad5d20e-778c-4a2e-b76a-a7283799f60c/Nowhere-else-to-go-report_final_September-2020
[4] Ibid, AIHW.

The *Productivity Commission Inquiry Report into Mental Health*, the *Final Report of the National Suicide Prevention Officer*, and the *Royal Commission into Victoria's Mental Health System* each represent a welcome and comprehensive examination of the existing mental health systems and services. They also support what Aboriginal and Torres Strait Islander people (and research[5]) has been saying for decades – Aboriginal and Torres Strait Islander health services should be provided by Aboriginal Community Controlled Health Organisations. As the Productivity Commission states, this is "*the most effective way to get culturally capable mental health services and supports to people in rural, regional and remote Australia*"[6]. NACCHO strongly advocates that this is also the case for urban communities.

Policy Context

The upcoming *National Aboriginal and Torres Strait Islander Health Plan 2021 – 2031* and *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021 – 2031*, as well as the renewal of the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*, provide strategic direction for improvements to Aboriginal and Torres Strait Islander health and well-being over the next decade. In addition to the National Agreement, implementation of the recommendations of the various reports must also align with these frameworks.

Holistic responses are required from governments, in partnership with the community controlled sector, to ensure strong integration between policies across social services, early childhood and family support programs, aged care, disability, health, alcohol and other drugs, education, housing, employment and infrastructure.

It is important for Government to understand the cultural differences in the understanding of social and emotional wellbeing between Aboriginal and Torres Strait Islander cultures and mainstream Australia and do not attempt a 'one-size fits all' approach to mental health and suicide prevention. For Aboriginal and Torres Strait Islander people, health is understood as 'social and emotional wellbeing' which connects the health of a person to the health of their family, kin, community, connection to Country, culture, spirituality, and ancestry[7].

Mental health from an Aboriginal and Torres Strait Islander perspective is seen as an intrinsically linked aspect of a person's overall health. It is a more collective and holistic concept than the mainstream view. These concepts must be integrated into any mental health and suicide prevention policies and programs if they are going to be effective for Aboriginal and Torres Strait Islander people.

Reports and Reforms

The recommendations made to Governments through the *Productivity Commission Inquiry Report into Mental Health*, the *Final Report of the National Suicide Prevention Officer*, and the *Royal Commission into Victoria's Mental Health System* echo what NACCHO and Aboriginal and Torres Strait Islander people have long been calling for: that ACCHOs are best placed to provide mental health and suicide prevention services to Aboriginal and Torres Strait Islander people.

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[5] Panaretto et al. (2013) *Prevention and management of chronic disease in Aboriginal and Islander Community Controlled Health Services in Queensland.* BMJ Open doi: 10.1136/bmjopen-2012-002083

[6] Productivity Commission (2020) *Mental Health: Productivity Commission Inquiry Report Volume 1 pg 35.*

[7] Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (2016). *Solutions that work: What the evidence and our people tell us.*

There must be active involvement from Aboriginal and Torres Strait Islander people in every level of decision making structures. Aboriginal and Torres Strait Islander people must be involved in co-designing, planning, and implementing social and emotional wellbeing and suicide prevention services and programs. To ensure consistent improvements across the country, a national approach is needed. Covid-19 grants, bushfire recovery funding, and sexual health programs are successful examples of approaches that have been nationally co-ordinated by NACCHO and targeted to local community needs.

ACCHOs deliver culturally safe, trauma informed services in communities dealing with extreme social and economic disadvantage, compounded by intergenerational trauma, and are supporting positive changes in the lives of their members.

ACCHOs are an intrinsic part of the Australian primary healthcare architecture. During the Covid-19 pandemic, the Australian Government, along with its counterparts in the States and Territories, recognised Aboriginal and Torres Strait Islander people were highly vulnerable and that it would be catastrophic if the COVID-19 virus were to spread to communities. The high level of collaboration by the National Cabinet has been instrumental in achieving the low number of COVID-19 cases among Aboriginal and Torres Strait Islander peoples, together with the leadership of Aboriginal and Torres Strait Islander people across our health sector. To date, Aboriginal and Torres Strait Islander people contracted the virus at a rate six times lower than non-Indigenous Australians, with zero deaths. This model of genuine partnership must be utilised in the mental health and suicide prevention sectors.

Furthermore, in alignment with the National Agreement, Health Plan and Health Workforce Plan, ACCHOs must be the preferred providers of mental health and social and emotional wellbeing programs and services within communities. In areas where there are no ACCHOS, Aboriginal community-controlled organisations (ACCOs) should be prioritised. In instances where funding is unable to be provided to a community-controlled organisation, governments and PHNs must ensure that funded organisations are held accountable for providing culturally competent services to Aboriginal and Torres Strait Islander people. These services must prioritise shared decision-making and service delivery with Aboriginal and Torres Strait Islander organisations.

Additionally, clinical and non-clinical staff in the mental health sector need to be trained in social and emotional wellbeing and its intersection with mental health to ensure Aboriginal and Torres Strait Islander people's viewpoint is understood and utilised. There is also a need for greater promotion and an increased evidence-base for therapeutic modalities that better align with Aboriginal and Torres Strait Islander practices and worldviews.

Hospitals, and particularly emergency rooms, are a critical first point of access for many Aboriginal and Torres Strait Islander people needing mental health support. Hospitals must be accountable for the provision of services free of racism and discrimination. Between 2015 and 2017 Aboriginal and Torres Strait Islander people were 6.1 times more likely to be discharged from hospital against medical advice[8]. Institutional racism, a lack of cultural safety, isolation from culture and family, and a lack of culturally appropriate communication with patients is resulting in people leaving hospital before finishing treatment and receiving appropriate referrals and increases their risk of readmission[9]. Urgent systems reform, for example to Commonwealth/state hospital agreements, is

[8] AIHW, 2021, *Health System Performance*. https://www.indigenoushpf.gov.au/Measures/3-09-Discharge-against-medical-advice

[9] Shaw, C. 2016. *An evidence-based approach to reducing discharge against medical advice amongst Aboriginal and Torres Strait Islander patients.*

needed to address this so that Aboriginal and Torres Strait Islander people receive the treatment they are entitled to.

Noting that it is still in development, NACCHO notes that key actions from the *National Aboriginal and Torres Strait Islander Suicide Prevention Implementation Plan* must be committed to and adequately funded.

Funding Arrangements

Practical steps must be made to ensure that the recommendations from these reports and inquiries are acted on. Current funding of mental health, social and emotional wellbeing, and suicide prevention services for Aboriginal and Torres strait Islander people must be considered in implementation, including the movement of this funding from Primary Health Networks (PHNs) and Local Health Networks (LHNs) to ACCHOs. This would be an embodiment of Governments' commitments as outlined in the National Agreement. Currently funding is:

- allocated to PHNs who then distribute to ACCHOs to deliver services creating an additional layer of reporting and administration that diminishes the effectiveness and efficiency of the funding. Many of the service providers are already overstretched and the complex reporting arrangements act as a barrier to providing greatly required services; or
- funding is given to non-Indigenous organisations to provide services that are culturally inappropriate, draw funding away from ACCHOs and ACCOs and do not work in partnership with the Aboriginal and Torres Strait Islander community.

To add complexity, mental health and SEWB funding sits in different Departments. NACCHO recommends that SEWB funding be moved to the Department of Health from the National Indigenous Australians Agency to ensure a more integrated approach to funding proposals. The ACCHO sector has also been concerned for several years now about the unexpected transfer of 'Safety and Wellbeing' funding from the Indigenous Australians' Health Plan (IAHP) to the Indigenous Advancement Strategy (IAS). This program is better delivered directly by ACCHOs rather than being brokered by third parties or delivered by NGOs with little or no direct connection to Aboriginal and Torres Strait Islander communities. In many cases, NGOs are simply subcontracting ACCHOs to provide these services, which complicates administrative and reporting arrangements, increases costs to Government, and dilutes the effectiveness of the programs provided.

These funding arrangements are incongruent with the commitments of the National Agreement and the principles of self-determination for Aboriginal and Torres Strait Islander people. Directly funding ACCHOs to deliver mental health and suicide prevention services aligns with each of the four priority reforms[10] in the National Agreement.

Workforce

A lack of Aboriginal and Torres Strait Islander mental health service providers and culturally competent services is one of the main drivers for poor access to services and poorer mental health outcomes for Aboriginal and Torres Strait Islander people. Sufficient recommendations to address this shortfall were missing from the recent reports presented to governments, however urgent action is required in this space. The Lowitja Institute found that Australia's mental health system is not aligned with Aboriginal and Torres Strait Islander people's worldviews and is unable to respond

[10] Coalition of Peaks (2020) *National Agreement on Closing the Gap.* https://coalitionofpeaks.org.au/priority-reforms/

effectively to their distinct mental health needs[11]. This is exacerbated in regional and remote areas where there are additional cultural barriers, a lack of culturally appropriate support, and thin markets, specifically a shortage of psychiatric leadership and trained mental health professionals, particularly clinical psychologists[12]. New measures are needed to attract and retain these professionals in both mainstream services and ACCHOs[13].

Cultural safety and the availability of culturally competent supports is critical in the mental health sector because of the need to recognise and respect the individual's own psychosocial processes, which are strongly influenced by culture and the social determinants of health for Aboriginal and Torres Strait Islander people. Mental healthcare must recognise the dignity of the individual and be free of racism and stigma to be effective[14]. A lack of cultural competence has been identified as a key barrier to better health and wellbeing outcomes for Aboriginal and Torres Strait Islander people.

A key element to building culturally safe workplaces is increased recognition of the cultural, healing and language skills and knowledge of local Aboriginal and Torres Strait Islander people working alongside those with clinical skills. This is supported within Pillar 3 'Valuing Cultural Strengths' of the Lowitja (2020) report *We are Working for Our People*[15].

ACCHOs are both the predominant primary health care providers to Aboriginal and Torres Strait Islander people and provide the culturally competent support required to achieve positive outcomes. To ensure that ACCHOs can attract and retain specialised staff, Governments need to commit to long-term funding. This is essential to support growth in the Aboriginal and Torres Strait Islander Workforce, and to build the cultural competence of the mainstream mental health workforce. Without this commitment, there will be a continued shortfall in services for Aboriginal and Torres Strait Islander people, particularly in Regional, Remote, and Very Remote areas.

The following case study demonstrates the success than can be achieved when a community controlled program is well resourced and underpinned by a skilled workforce.

[11] The Lowitja Institute. (2018). Journeys to healing and strong wellbeing: Final report. The Lowitja Institute, Melbourne. Retrieved from https://www.lowitja.org.au/content/Document/LowitjaPublishing/lowitja_consulting_journeys_to_healing_report.pdf

[12] AIHW, 2016. https://www.indigenoushpf.gov.au/measures/3-10-access-mental-health-services#references

[13] Duggan, M., Harris, B., Chislett, W., & Calder, R. (2020). *Nowhere else to go: Why Australia's health system results in people with mental illness getting stuck in emergency departments.*

[14] Parker, R. (2010). Australia's Aboriginal population and mental health. *The Journal of Nervous and Mental Disease*, 198(1), 3–7.

[15] The Lowitja Institute. (2020). We are working For Our People: Career Pathways Project Report. The Lowitja Institute, Melbourne. Retrieved from https://www.lowitja.org.au/content/Image/Career_Pathways_Report_Working_for_Our_People_2020.pdf.

Case study: Community-led Suicide Prevention Trials

The Kimberley Suicide Prevention Trial and the Darwin Suicide Prevention Trial are both examples of successful, community-led suicide prevention programs. These trials have helped navigate and develop suitable support services for the diverse needs of the Kimberley and Northern Territory (NT) Aboriginal and Torres Strait Islander communities.

The Kimberley Aboriginal Suicide Prevention Trial is helping to develop a suicide prevention model suitable for the unique needs of Kimberley Aboriginal communities[16].

In the NT, AMSANT and Danila Dilba Health Service (DDHS) have recently been successful in establishing a partnership with NT Primary Health Network which includes an Aboriginal decision-making group and a position relocated from the PHN to the community-controlled sector.

Suicide prevention for Aboriginal and Torres Strait Islander people requires an Indigenous systems-based approach involving Aboriginal leadership in decision making and community-level Aboriginal employment and training. This kind of approach empowers local Aboriginal communities through the development and implementation of place-based suicide prevention programs and initiatives. This strengthens the patient journey, cultural safety and relevance of local and regional mental health and suicide prevention services for Aboriginal and Torres Strait Islander people.

While the evaluation of these trials is ongoing, NACCHO has heard anecdotally that these programs are transforming communities and saving lives. Ongoing funding for these programs must be urgently provided so that they can continue providing these supports and services and sustainably plan for the future. Short-term funding jeopardises the focus, coordination, and significant progress made to date to prevent self-harm and suicide in each site and increases the risk to Aboriginal children and young people. Additionally, similar programs should be funded by Government and developed by the local ACCHO to ensure it is targeted and meets the local need.

Other considerations for the Committee include:

Supporting families and young people

Support for community-led healing approaches in mental health and suicide prevention should promote wider family and community safety and strength. Noting data from 2015 in the AIHW Australian Burden of Disease Study (2019) describes exposure to child abuse and neglect as a strong determinant of incident suicide and self-inflicted injuries and represents the leading contributor to years of life lost for both males and females[17].

Similarly, the AIHW's Suicide and Self Harm monitoring data suggests that intimate partner violence is the second most significant risk factor for women who self-harm or suicide, after child abuse and neglect[18].

[16] Kimberley Aboriginal Medical Service (2021) https://kams.org.au/kamsc-services/social-emotional-well-being/suicide-prevention-trial/

[17] AIHW (2019). Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015. https://www.aihw.gov.au/reports/burden-of-disease/burden-disease-study-illness-death2015/contents/table-of-contents

[18] AIHW (2020). Intentional self-harm hospitalisations by PHN areas. Suicide and self-harm monitoring. https://www.aihw.gov.au/suicide-self-harm-monitoring/data/geography/intentional-self-harmhospitalisations-by-phn-area

ACCHOs and other community controlled organisations are best suited to support children and young people in their community. This was recognised and recommended by the Victorian Royal Commission and should be implemented nationally. There is a need for increased investment in primary prevention measures including access to early childhood programs and intensive family support; mental health and SEWB support that builds resilience, reinforces positive cultural identity, and addresses trauma; community-based youth recreation and drop-in centres; and public health measures to reduce harm from alcohol and other drugs.

Culturally Responsive Trauma Informed Care

Access to culturally responsive trauma informed care is critical for ensuring that community priorities are addressed, and cultural safety is at the centre of the work. There is an expanding demand for trauma-informed care training nationally. Training programs that are Aboriginal and Torres Strait Islander-led and delivered must take precedence where services are being delivered to Aboriginal and Torres Strait Islander people.

Mental Health Literacy

Building the capacity of the Community-Controlled sector is vital to improve mental health literacy, reduce the stigma around mental health issues, and to improve community engagement with mental health services. The ongoing prevalence of racism in mainstream services, coupled with culturally inappropriate and unengaging clinical messaging, acts as an ongoing barrier in achieving these goals.

ACCHOs have strong connections in their communities and a deep understanding of cultural issues and language in their regions. It is essential that Governments work in partnership with ACCHOs, through NACCHO, to translate clinical messages to local communities that address local issues, concerns, misinformation, accurately interpret Government messaging and are delivered in ways that are understood by the local community.

ACCHOs can develop and dissipate targeted messaging about mental health supports and services that are culturally relevant. Ideally, these services will have be developed by the ACCHOs for their local communities and specifically address the broader SEWB framework.

Digital and Telehealth Services

ACCHOs are critical in delivering social support programs, including alcohol and other drug services, social and emotional wellbeing projects, family support and youth engagement and diversion programs. However, there are limits to the extent that ACCHOs can continue to deliver quality, safe comprehensive primary health care to a fast-growing population when faced with pressing capital works and infrastructural needs.

There is an urgent need to develop and invest heavily in tele-health and digital social and emotional wellbeing supports and services for Aboriginal and Torres Strait Islander communities. This has been highlighted by Covid-19 pandemic. Measures introduced by the Australian Government at this time significantly improved access to remote health, including access to general practitioner (GPs), specialist, allied health, and nurse practitioner health services. That 4.3 million health and medical services were delivered to over 3 million people shows that people are ready and willing to use telehealth services[19]. The health system's ability to realise the opportunity of virtual health through

[19] https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/australians-embrace-telehealth-to-save-lives-during-covid-19

continued innovation is constrained by the digital maturity of providers and consumers. Investment in technology and infrastructure is needed to support a national digital skills uplift program.

Telehealth may provide several advantages for delivering Aboriginal and Torres Strait Islander healthcare services. Aboriginal and Torres Strait Islander people have reported that poor access to culturally competent health services, dislocation from cultural support systems, exposure to racism and poor communication with healthcare professionals negatively affect their health and well-being[20]. Opportunities for telehealth expansion should be supported but not at the expense of the further development of the local workforce. Funding is required for ACCHOs to enable them to improve infrastructure. To optimise outcomes achieved by telehealth a well-trained and adequately sized workforce is essential, including a greater presence of allied health professionals and other health workers. This will allow ACCHOs to increase their service delivery, provide more services to a wider area, and extend their reach into areas where there are only mainstream options available. This have become even more critical in the wake of the profound mental health impacts of the Covid-19 pandemic.

Conclusion

The recommendations provided to Government across numerous reports all support the need to strengthen the Aboriginal Community Controlled Health sector. All Australian Governments have committed to this in the National Agreement and NACCHO welcomes the opportunity to partner with Governments to implement the recommendations.

[20] Aspin C, Brown N, Jowsey T, et al. *Strategic approaches to enhanced health service delivery for Aboriginal and Torres Strait Islander people with chronic illness: A qualitative study*. BMC Health Serv Res. 2012; 12:143.