Aboriginal Peak Organisations Northern Territory
An alliance of the CLC, NLC, CAALAS, NAAJA and AMSANT

SUBMISSION FROM APO NT TO THE LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY INQUIRY INTO YOUTH SUICIDE IN THE NT

OCTOBER 2011

Aboriginal Peak Organisations NT

Aboriginal Peak Organisations Northern Territory (APO NT) welcomes the opportunity to make a submission to the Legislative Assembly of the Northern Territory (NT) Inquiry into Youth Suicide in the NT ('the Inquiry').

APO NT is broadly representative of all Aboriginal peoples in the NT. Formed in October 2010, APO NT is an alliance between the Northern Land Council (NLC), Central Land Council (CLC), Aboriginal Medical Services Alliance Northern Territory (AMSANT), North Australian Aboriginal Justice Agency (NAAJA) and Central Australian Aboriginal Legal Aid Service (CAALAS).

APO NT is working to develop constructive policies on critical issues facing Aboriginal people in the NT and to influence the work of the Australian and NT governments. As representatives from peak organisations in the NT, we share the aim of protecting and advancing the wellbeing and rights of Aboriginal and Torres Strait Islander people and communities. We also aim to provide a representative voice for Aboriginal people in the NT and to enable effective communication and information distribution between and within communities and Aboriginal organisations.

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Introduction

The rate of suicide in the Northern Territory (NT)—especially youth suicide—is simply unacceptable.

Between 2005 and 2009, the NT had the highest rate of suicides compared to other Australian states and territories. For this reason alone, suicide is a significant concern in the Northern Territory, particularly amongst Aboriginal people.

But it goes much further than this: Aboriginal youth suicide is a cancer in our communities.

Data from Central Australia alone, between 2001 and 2011, demonstrates that 75 per cent of suicides in Central Australia involved Aboriginal people. This is despite the fact that only approximately 21,000 of the 45,000 total population of Central Australia is Aboriginal. Males are also clearly overrepresented in suicides and, in the last 12 months, nearly all suicides in the region have involved young people under 25 years of age.

In fact, it is difficult to comprehend a jurisdiction in Australia that is more conducive to our young people taking their lives.

Our young people are subject to lives of poverty and disenfranchisement that—on any measure—are among the worst in the nation. The overwhelming evidence is that each of these social factors—in public health terms, social determinants—are strong predictors of risk taking and suicidal behaviour amongst our young people.

Briefly: the social determinants of early childhood development, health, employment, housing, education, and access to justice and social control, are reflected in a social gradient of powerless and ill health. The dice is loaded against our people from before birth—let alone before they grow up. One of the absolute consequences of Aboriginal people's position on that social gradient is that our young people take their lives.

The grief that drives our young people to take such tragic steps both reflects and adds to the grief so many of our people experience. It touches all our lives.

It simply goes against nature for parents to bury their children … and mourn for the loss of a future for our people.

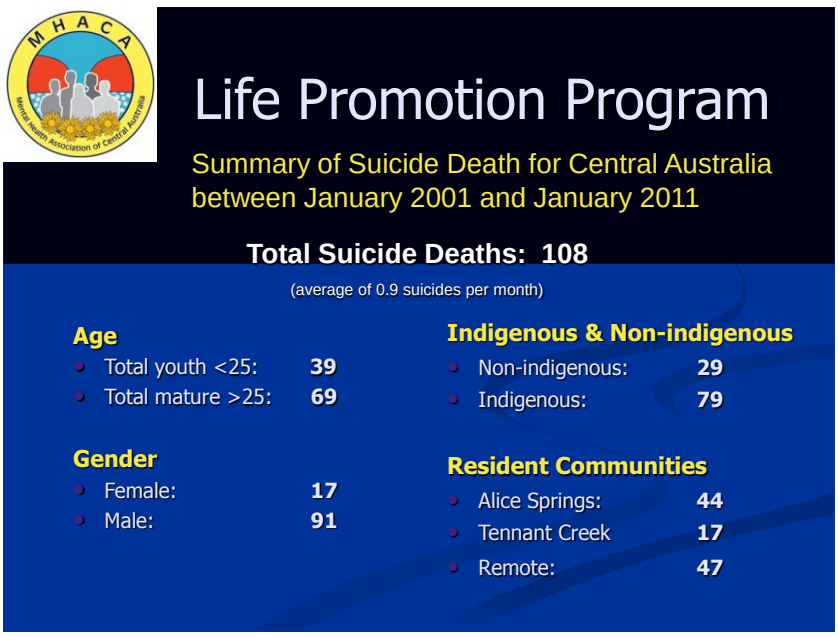
APO NT does not pretend that the solutions are in any way straightforward. Youth suicide is both a cause and consequence of much that bedevils our families and communities. What we *do* know is that just as the causes are multifactorial, the solutions must be likewise. Solutions lie within our families and communities, of course—but it goes beyond that. There also needs to be a social response. Although this is an inquiry of the Northern Territory Legislative Assembly, and there must be research and action at a local level, responsibilities also lie with the national government in responding to this ongoing tragedy.

APO NT discusses in this submission some factors that can contribute to suicidal behaviours.

APO NT also proposes recommendations to address those factors to reduce the risk of associated suicides amongst young Aboriginal people in the Northern Territory.

In particular, the submission considers the contextual and underlying risk factors for suicide and ways in which they may be managed to reduce the risk of suicide: measures relating to education and employment; the use of multi systemic therapy to address numerous concerns that together elevate risk of suicide; the importance of cultural continuity and community control; the need for community development approaches to address suicide; need to tackle alcohol and other drug (AOD) use,

including the the benefits of integrating alcohol and other drug and mental health care into primary health care (PHC); and the impact of over policing and the justice system on youth suicide.



Recommendations

1. The impact of past policies and history on the social and emotional wellbeing of contemporary Aboriginal youth must be acknowledged. Appropriate services and therapies must be made available to tackle the intergenerational trauma and grief that significantly increases the risk of youth suicide. Investments must be substantial and long term, in recognition of the lengthy history of dislocation and mistreatment and its consequent effects.

2. Ensure positive rather than negative messaging around parental responsibility and school attendance.

3. Ensure schools in the NT have flexible curricula that include Aboriginal languages, cultures and history as well as employing more Aboriginal staff.

4. Address the historic under-investment and inequitable provision of education to Aboriginal communities including recognising Home Learning Centres as proper schools with requisite school resources, and providing culturally-appropriate distance learning.

5. Reform current employment arrangements such as CDEP by focusing on 'job creation' through financial support to commercial enterprise development, social enterprise development and in the paid provision of services.

6. Support and implement evidence based research and programs such as multi systemic therapy which provides holistic support for youth in need.

7. Social and emotional well being services that are readily accessible, culturally appropriate and evidence based need to be accessible to all Aboriginal young people in the NT. This is achievable through the integration of social and emotional well being services (SEWB) including both AOD and mental health services) into Aboriginal primary health care.

8. Implement strategies to improve detection of mental illness such as training general practitioners (and other front line clinicians) to detect and manage depression.

9. Commit to supporting research to determine differences in suicide prevalence in NT communities and the factors that underlie high and low prevalence communities.

10. Ensure the provision of focused psychological therapies (particularly Cognitive Behavioural Therapy) for young people who have made a suicide attempt.

11. Adopt approaches that facilitate cultural continuity and community control.

12. Extend the availability and funding of high quality accessible alcohol and other drugs and mental health services in remote regions in the NT.

13. Give full consideration for AMSANT's evidence based model on the integration of alcohol and other drugs and mental health services into Aboriginal primary health care in the NT as provided in this submission. (Attachment 1)

14. Police should improve community engagement with Aboriginal young people and develop officers with expert skills in working effectively with young people in a therapeutic manner.

15. Police should develop and implement independent complaints procedures specific for young people that are 'youth-friendly'.

16. A specialist and independent youth court should be established, and should be co-located with youth specific government and non-government services.

17. Youth court proceedings should be conducted in a youth friendly fashion, and the Youth Justice Court should be serviced by youth-specific magistrates, prosecutors and defence counsel.

18. The Youth Justice Court should be required to inquire into a young person's mental health needs when a party to the proceedings raises the issue to ensure that court orders are specifically tailored to a young person's specific needs.

19. Diversion should be considered a core aspect of the Youth Justice system, and it should be offered in all remote communities.

20. Pro-bail, youth specific bail provisions should be inserted into either the *Bail Act*, or as part of a separate bail regime for young people in the *Youth Justice Act*. The starting point should be that remanding a young person in custody is to be the option of last resort.

21. Significant efforts should be made to identify and respond to the issues of victim status and trauma of young people in the youth justice system.

22. The role of Corrections Officers and DFC workers should be redefined. Client-centred approaches that assist young offenders deal with the issues linked to their offending that place a greater emphasis on support, supervision and mentoring should be preferred to the current approaches, which are characterised by a focus on statutory compliance.

23. The NT Government should commit to adequately funding youth specific rehabilitative services in all areas of the Northern Territory, including regional towns and remote communities.

24. The NT Government should ensure that appropriate facilities are in place for young people to access substance abuse counselling, rehabilitation and treatment, which are accessible to both regional and remote young people.

25. The NT Government should provide additional resources to programs across the NT that provide best-practice, safe and culturally relevant mentoring and youth camps.

Executive Summary

Aboriginal young people are subject to lives of poverty and disenfranchisement that are among the worst imaginable in the nation as well as developed nations worldwide. State and federal governments have long been presented with the overwhelming evidence of the unacceptably high youth suicide rate—and whilst APO NT acknowledges that the solutions are complex—bipartisan commitment is vital to strengthen families and communities so that self harm and suicidal behaviour is properly recognised and that young Aboriginal people are able to experience the *control* and *choices* that accompany stability of family and community life.

Factors underlying suicide

In this submission, APO NT discusses some factors that can contribute to suicidal behaviours. Risk factors for suicidal thoughts include experiencing racism; having a friend who had attempted or committed suicide; being exposed to family violence; having low self esteem or being at high risk of significant mental health issues. Ill health and powerlessness are results of the social determinants including early childhood development, health, employment, housing, education, and access to justice and social control.

Alcohol and drug use are associated with being at high risk of developing significant mental health issues whilst being involved in sport is considered protective.[1]

APO NT is concerned that whilst suicide prevention programs in Aboriginal communities both in Australia and overseas are widespread, their effectiveness is limited if they are not properly evaluated.[2] The available evidence supports the following strategies as being effective in reducing suicide:

1. Strategies to improve detection of mental illness such as training general practitioners (and other front line clinicians) to detect and manage depression[3]
2. Provision of focused psychological therapies (particularly Cognitive Behavioural Therapy) for young people who have made a suicide attempt[4]
3. Integration of mental health services into primary health care[5]
4. Community control of service delivery including mental health and AOD services[6]
5. Alcohol control measures[7]
6. Public health actions to reduce access to tools used in suicide such as firearms controls.

APO NT encourages communities as well as local, state and federal governments to commit to multifactoral solutions to address factors causing suicide as well addressing the desolation and grief that are brought with it.

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[1] The West Australian Aboriginal Child Health Survey, http://www.ichr.uwa.edu.au/waachs

[2] Krysinska, K., Martin, G. and Sheehan, N (2009). *Identity Voice, Place, Suicide prevention for Indigenous Australians. A Social and Emotional Well being Approach* I. The Centre for Rural and Remote Mental Health. The University of Queensland.

[3] Annette Beautrais, David Fergusson, Carolyn Coggan, Catherine Collings, Carolyn Doughty, Pete Ellis, Simon Hatcher, John Horwood, Sally Merry, Roger Mulder, Richie Poulton, Lois Surgenor (2007). 'Effective strategies for suicide prevention in New Zealand: a review of the evidence'. *New Zealand Medical Journal*. 23;120(1251).

[4] Robinson J, Hetrick SE, Martin C. (2011). 'Preventing suicide in young people: systematic review'. *Aust N Z J Psychiatry.* 2011 Jan;45(1):3-26., Campo J 2009 'Youth suicide prevention: does access to care matter?' *Curr Opin Pediatr.* Oct;21(5):628-

[5] Campo J 2009 'Youth suicide prevention: does access to care matter'? *Curr Opin Pediatr.* Oct;21(5):628-

[6] Kral M, Wiebe P, Nisbet K , Dallas , Okalik L, Enuaraq N, Cinotta J (2009). 'Canadian Inuit community engagement in suicide prevention'. *International Journal of Circumpolar Health*. Jun;68(3):292-308.

[7] Mind Matters http://www.mindmatters.edu.au/default.asp

School attendance and educational achievement

Evidence such as the Australian Early Development Index has revealed that Aboriginal children are greatly disadvantaged in the language and cognitive domains when they first enter school.[8] Consequences could include poor brain development, poor school performance, alcohol and other drug addictions and an increased risk of suicide.

APO NT submits that schools in the NT need to adopt measures outlined in the Closing the Gap Clearinghouse report, *What works to overcome Indigenous disadvantage* which found that positive rather than negative messaging around parental responsibility and school attendance encourages children to gain confidence and strive to perform.

Increasing community partnerships, commitment to teaching language and culture as well as addressing the historic under-investment and inadequate resourcing of schools (including Homeland Learning Centres) are just some of the ways that the rates of self harm and suicide rates can be reduced in Aboriginal young people.

Unemployment

Poor employment prospects or unemployment is a significant contributing factor to the high suicide and self harm rate among some groups of Aboriginal people in Australia. Attributes of 'work' contribute to family and child welfare as well as equipping children to participate in the economy:

- structure and routine in daily life;
- role modelling of disciplined and purposeful activity;
- re-framing expectations of self-reliance through economic engagement versus dependence on government payments;
- re-framing relationship between 'effort' and 'reward';
- developing understanding of relationship between education/skills acquisition pathways and timeframes and work opportunities and/or reward;
- understanding 'work' as an economic exchange/social contract;
- social inclusion (contributing to community, participating in and learning about responsibilities and benefits to broader society – tax, super, entitlements, OH&S, etc.); and
- Increased income to enable individuals/families to better address their own needs

These objectives can only be met if relationships are built between an 'employer' which are not based on welfare and are driven by rewards instead of sanctions.

APO NT is currently working closely with Aboriginal CDEP Providers in the Territory as well as DEEWR and FAHCSIA to present a submission to Government on the most appropriate model of CDEP reform which we believe will shape the employment opportunities for Aboriginal people.

Multi systemic therapy

APO NT supports evidenced based research and studies which have proven results such as keeping young people in school; keeping them out of detention; decreasing adolescent psychiatric symptoms; reducing out-of-home placements and reducing the use of drugs or alcohol. Multi systemic therapy (MST) is an intensive family and community-based treatment holistic program to assist chronic and violent youth offenders. MST works with juvenile offenders who often have long arrest histories. It has been proven to work and produce positive results by blending clinical treatments—cognitive

[8] Australian Early Development Index: http://www.rch.org.au/aedi/index.cfm?doc_id=13051

behavioural therapy, behaviour management training, family therapies and community psychology to reach this population.

Cultural continuity and community control

APO NT submits that enabling cultural continuity and community control is vital to ensure healthier Aboriginal communities in the NT with lower prevalence of suicide. Canadian research has shown that whilst Indigenous suicide rates are high, suicide is only prevalent or epidemic in certain Aboriginal communities. A 14-year study in British Columbia showed that communities where suicide rates were low or absent were those which exhibited high levels of "cultural continuity", characterised by a set of eight characteristics, having: achieved a measure of self-government; sought Aboriginal title to traditional lands; achieved community control over health, education, policing and fire services; included women in local governance; established facilities for the preservation of culture; and that have child and family services within the community.

The more of these factors present in a community the lower the suicide rate, with communities with all eight factors showing no suicides.

While many Aboriginal groups in the NT have been able to secure title to their traditional lands, the remaining factors—with the exception of community control health—are mostly absent from NT communities. Indeed, in relation to the self-government factor, communities that once had community government councils have lost local representation and control with the introduction of the super shires.

Alcohol and other substance misuse

Evidence based research suggests that a significant proportion of people who end their lives have undetected mental illness and/or substance use disorders. APO NT submits that detection of mental health /alcohol and other drugs problems is best achieved through the primary health care (PHC) sector. However, clinicians in PHC are much more likely to screen for mental health and alcohol and drug problems if they are confident that they can refer to high quality accessible alcohol and other drugs and mental health services.[9]

APO NT is concerned about the fragmented and uncoordinated delivery of mental health and alcohol and other drug services in remote communities. Some services are only funded to provide mental health services rather than a comprehensive service that also addresses alcohol and other drug issues.

AMSANT has developed an evidence based model on the integration of alcohol and other drugs and mental health services into Aboriginal primary health care in the NT. The model has both a clinical and a community development arm. Key features of the clinical component of the service delivery model are outlined in this submission: *Integration of Alcohol and Other Drugs and Mental Health Care into Primary Health Care: A Way Forward*

Policing and the Youth Criminal Justice System

Contact with the juvenile justice system is a significant factor recognised as leading to an increased risk of suicide amongst young people. In the Northern Territory, Aboriginal young people are highly over-represented in youth justice and detention statistics. In the period January to March 2011,

[9] Roche, A., Hotham, E. & Richmond, R. (2002). The GPs role in AOD issues: overcoming individual, professional and systematic barriers. *Drug and Alcohol Review*, 21: 223-230.

Aboriginal young people accounted for a staggering 98 per cent of young people in juvenile detention in the NT. Despite this data, there is a lack of NT specific research which documents the connection between suicide and episodes of incarceration and exposure to the criminal justice system. Given the NT's exponentially high youth suicide and youth incarceration rates, we consider that more research is critically needed in this area.

APO NT submits that current NT Police practices and the youth justice system predominantly operate in an anti-therapeutic fashion which negatively impacts on the social and emotional wellbeing of the young people with whom they have contact. This submission includes various case studies which reflect on the effects of inappropriate over-policing methods and confronting and culturally inappropriate court proceedings for young Aboriginal people.

Our members have witnessed that Aboriginal young people in the NT experience the youth justice system as alienating, isolating and stigmatising. It is our experience that the youth justice system as it currently operates is ill-equipped to deal with the criminogenic and socio-cultural needs of Aboriginal young people.

A Way Forward

APO NT members are willing to work closely with all appropriate government departments in order to assist young Aboriginal people with their interactions with the justice system. As discussed in this submission, we believe that the following actions are necessary:

- Youth specific mental health workers and psychologists
- Properly resourcing sentencing options
- employ Community Corrections workers which are specific to the needs of youth
- Develop Aboriginal-specific mentoring and positive role model programs in the NT.

Factors underlying suicide

There are innumerable factors that may contribute to suicidal behaviours. The Western Australian child health survey alarmingly found that 6.5 per cent of the young people surveyed aged 12-17 had made a suicide attempt in the previous 12 months.[10] Risk factors for suicidal thoughts included being female, experiencing racism, having a friend who had attempted or committed suicide, being exposed to family violence, having low self esteem or being at high risk of significant mental health issues. Alcohol and drug use were associated with being at high risk of having significant mental health issues, whilst being involved in sport was protective.

The report found that many of the factors associated with suicidal thought were interrelated and associated with the very high levels of stress and severe social disadvantage of many Aboriginal communities. This points to the need for a multifactoral response that includes action on social determinants, including racism.[11]

Research demonstrates that most people who complete suicide have demonstrated signs of mental illness which is undetected and untreated. NT figures demonstrate that up to 70 per cent of people who committed suicide in the NT have signs of untreated mental illness.[12]

[10] The West Australian Aboriginal Child Health Survey, http://www.ichr.uwa.edu.au/waachs
[11] Zubrick SR, Silburn SR, Lawrence DM, Mitrou FG, Dalby RB, Blair EM, Griffin J, Milroy H, De Maio JA, Cox A, Li J.(2005) *The Western Australian Aboriginal Child Health Survey: The Social and Emotional Wellbeing of Aboriginal Children and Young People*. Perth: Curtin University of Technology and Telethon Institute for Child Health Research, 2005
[12] Mindframe http://www.mindframe-media.info/site/index.cfm?display=84364

Aboriginal young people have been shown to have high rates of psychological distress.[13] The validated comprehensive survey conducted by Mindframe found that the rate of psychological distress in young people aged 12-17 was about double the rate in non-Aboriginal young people. Children in very remote communities had significantly lower levels of psychological distress.

Many suicide prevention programs in Aboriginal communities both in Australia and overseas are not evaluated and therefore there is limited evidence about their effectiveness.[14] The available evidence supports the following strategies as being effective in reducing suicide:

1 Strategies to improve detection of mental illness such as training general practitioners (and other front line clinicians) to detect and manage depression.[15]

2 Provision of focused psychological therapies (particularly Cognitive Behavioural Therapy) for young people who have made a suicide attempt[16]

3 Integration of mental health services into primary health care[17]

4 Community control of service delivery, including mental health and AOD services[18]

5 Alcohol control measures[19]

6 Public health actions to reduce access to tools used in suicide such as firearms controls.

Contextual risk factors for suicide

The high suicide rate among some groups of Aboriginal Australians is often attributed to a number of factors that combine to magnify the risk for suicidal behaviours and self-harm. These include environmental risk factors including poverty, low socio-economic status, lack of education, poor employment prospects, reduced access to services, living in rural or remote communities, domestic violence or abuse, and alcohol and other drug abuse.[20] Loss of cultural identity and social isolation is also known to cause a person to lose their sense of purpose and meaning in life. Suicide among Aboriginal people is likely to be a response to the broader social context of disintegration of their culture and communities.[21]

Trauma and grief

Trauma and grief are often present within Aboriginal communities as a result of the continuing loss and traumatisation from past dislocation and mistreatment, as well as grief from the deaths of family and community members and friends.

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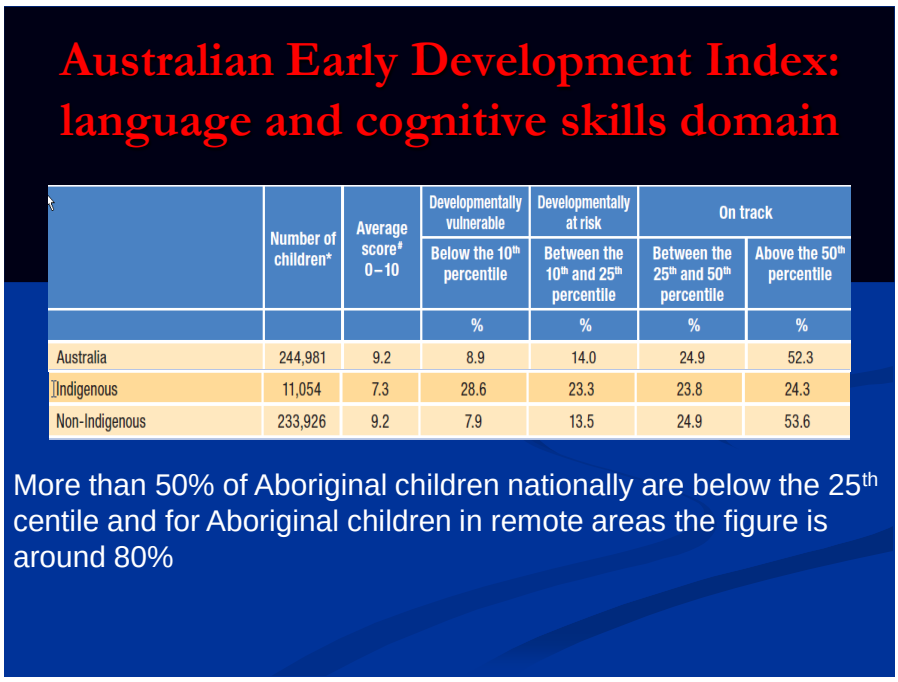
[13] ibid
[14] Krysinska et al, 2009
[15] Annette Beautrais, David Fergusson, Carolyn Coggan, Catherine Collings, Carolyn Doughty, Pete Ellis, Simon Hatcher, John Horwood, Sally Merry, Roger Mulder, Richie Poulton, Lois Surgenor (2007). Effective strategies for suicide prevention in New Zealand: a review of the evidence. *New Zealand Medical Journal*. 23;120(1251).
[16] Robinson J, Hetrick SE, Martin C. (2011).Preventing suicide in young people: systematic review. *Aust N Z J Psychiatry.* 2011 Jan;45(1):3-26., Campo J 2009 Youth suicide prevention: does access to care matter? *Curr Opin Pediatr.* Oct;21(5):628-
[17] Campo J 2009 Youth suicide prevention: does access to care matter? *Curr Opin Pediatr.* Oct;21(5):628-
[18] Kral M , . Wiebe P, Nisbet K , Dallas , Okalik L, Enuaraq N, Cinotta J (2009). Canadian Inuit community engagement in suicide prevention. *International Journal of Circumpolar Health*. Jun;68(3):292-308.
[19] Mind Matters http://www.mindmatters.edu.au/default.asp
20 N. Procter, 2005 'Parasuicide, self-harm and suicide in Aboriginal people in rural Australia- a review of the literature with implications for mental health nursing practice,' International Journal of Nursing Practice 11: 237-241
21 P. Swan B. Raphael, 1995 'Ways forward': National consultancy report on Aboriginal and Torres Strait Islander mental health: Part 1 and 2. Canberra: Australian Government Publications Service

The *Bringing them Home* Report notes that people forcibly removed from their families, subsequently abused, institutionalised and raised to believe in their own cultural inferiority will frequently lack attachment, have low self esteem, and have difficulties relating to others. These factors increase the likelihood of suicidal behaviours.[22]

There are significant intergenerational effects of this experience. For instance, many 'stolen generation' children are more likely to have children suffering from behavioural problems, with 25 per cent of boys and 33 per cent of girls having substantial behavioural problems such as delinquency, substance usage, self harm, and suicidal behaviours; difficulty with school and in relating to their peers.[23]

The impact of past policies and history on the social and emotional wellbeing of contemporary Aboriginal youth must be acknowledged. Appropriate services and therapies must be made available to tackle the intergenerational trauma and grief that significantly increases the risk of youth suicide. Investments must be substantial and long term, in recognition of the lengthy history of dislocation and mistreatment and its consequent effects.

School attendance and educational achievement



The Australian Early Development Index has revealed the extent of disadvantage that Aboriginal children experience in the language and cognitive domains when they first enter school.[24] It depicts the next generation of children who are likely to be impulsive and suffer from poor brain development. This may lead to poor school performance, alcohol and other drug addictions and an increased risk of suicide.

There are various measures NT schools need to take to ensure Aboriginal children are accessing and benefiting from the education system, which in turn strengthens a child's self esteem and lowers the

22 (Bringing them Home Report: National Inquiry into the Separation of ATSI Children from their families, 1997
23 Westerman, T. & Vicary, D. (2001). Preventing Aboriginal Youth Suicide. In Dudgeon, P., Pickett, H. & Garvey, D. Working With Aboriginal People: A Handbook for Psychologists. Curtin University, Perth WA: Centre for Aboriginal Studies.
24 Australian Early Development Index: http://www.rch.org.au/aedi/index.cfm?doc_id=13051

risk of self harm or suicide within Aboriginal young people. The Closing the Gap Clearinghouse report, *What works to overcome Indigenous disadvantage* found that positive rather than negative messaging around parental responsibility and school attendance encourages children to gain confidence and strive to perform.

Other factors that the NT and federal governments must consider include:

- ensuring schools have effective mechanisms for parental/family/community engagement and input;
- flexible curricula that include Aboriginal languages, cultures and history;
- more Aboriginal staff in schools;
- training in cross-cultural communication and engagement skills, cultural awareness and Aboriginal languages, cultures and histories for teachers;
- additional investment in remote Aboriginal schools to redress historic under-investment and provide equitable resourcing of schools;
- all Homeland Learning Centres should be recognised as proper schools and resourced as such;
- ensure comparable funding allocations to schools, including between government and non-government schools;
- providing culturally appropriate distance education; and
- consideration to be given to ongoing multiple areas of disadvantage faced by families, particularly in housing, in calibrating initiatives to engage parents and children in schooling.

Partnerships

Working in partnerships is the key to improving educational outcomes in remote communities. At the community level the most significant relationship in developing such a partnership is between teachers and the community. This approach is supported by the findings of the Closing the Gap Clearinghouse report, *What works to overcome Indigenous disadvantage*. The report summarises key evidence from Australian and international research which shows that:

- successful programs or strategies were supported by the local community, delivered by highly skilled and committed teachers and recognise Indigenous culture;
- projects characterised by a high degree of Indigenous involvement and control produced significant benefits for participants; and
- engaging parents in children's learning was of critical importance.

It is important for governments to commit to the provision of sufficient high quality teachers and adequately resourced schools. It is also vital that schools positively engage families and communities to provide a high degree of Indigenous involvement and control, and to recognise Indigenous culture.

Inclusive engagement rather than coercion

The current approach of both the NT Government (with primary responsibility for education) and Australian Government (via the NTER) is called into question by evidence of a worsening of school attendance figures in many schools, despite an increased focus on the issue by both governments.

In our view, both governments have focused too heavily on coercive measures — such as the SEAM trial and recent NT legislative changes that provide for fines and other coercive measures on parents

— while at the same time signalling a withdrawal of support for the inclusion of cultural aspects into schooling, including support for bilingual education and other language and culture programs.

Fines and other forms of coercion and rejection of cultural inclusion in schools play to populist desire for strong action but are not supported by available evidence as effective in improving school attendance, retention or achievement. Moreover, such approaches fuel the already widespread concern of Aboriginal parents that schools do not support their aspiration for their children to have a good education in both western schooling and traditional knowledge.

Structural impediments

In addition to these issues, there are broader structural issues that hinder progress on improving school outcomes. These include:

- the impacts of the historical under-investment in schools, particularly in remote communities;
- continuing inequities in education provision; and,
- the perennial lack of adequate housing and other education-related infrastructure in communities.

The Australian Government's Strategic Review of Indigenous Expenditure found that in relation to education, "the capacity of the Northern Territory Government is a particular concern". This is a major barrier to improving education outcomes.

An example of the historical under-investment and continuing inequities in the provision of education is the inadequate and arguably discriminatory Homeland Learning Centres in the NT. The 46 Homeland Learning Centres lack proper school infrastructure and full time teachers; are subject to resourcing criteria considerably less favourable than for comparatively-sized schools operating in small remote towns and cattle stations or those facilities established for new arrivals from non-English speaking backgrounds; and have been excluded from education improvement programs such as distance learning and the *Building Education Revolution*. This discriminatory situation is indefensible. All Homeland Learning Centres should be recognised as proper schools and resourced as such.

The lack of comprehensive policies for Aboriginal communities by both the NT and Australian governments is a major concern that is impacting on remote education.

The problems of under-investment and inequities in education provision and related housing and other infrastructure have been exacerbated by the absence of comprehensive, needs-based planning across all communities by both the NT and Australian governments. This includes the NT's *Future Directions* and COAG's remote service delivery and housing policies. Homeland, outstation and other smaller communities have been largely excluded.

Unemployment

As noted, poor employment prospects or unemployment is a significant contributing factor to the high suicide and self harm rate among some groups of Aboriginal people in Australia.

Attributes of 'work' contribute to family welfare

APO NT considers that key attributes of 'work' contribute to family and child welfare in the present, and equip children to participate in the economy in the future:

- structure and routine in daily life;
- role modelling of disciplined and purposeful activity;

- removing adult distractions from school attendance;
- re-framing expectations of self-reliance through economic engagement versus dependence on government payments;
- re-framing relationship between 'effort' and 'reward';
- developing understanding of relationship between education/skills acquisition pathways and timeframes and work opportunities and/or reward;
- understanding 'work' as an economic exchange/social contract;
- social inclusion (contributing to community, participating in and learning about responsibilities and benefits to broader society – tax, super, entitlements, OH&S, etc.); and
- Increased income to enable individuals/families to better address own needs

Most of the above objectives are dependent on a *relationship* existing with an 'employer' who wants to utilise a person's purposeful effort, and is willing and able to reward or pay for this. This cannot be achieved through a relationship based on welfare/mutual obligation.

Another key problem with the welfare/mutual obligation approach is that it is all about compliance and sanctions rather than reward/motivation. It is recognised almost universally in both psychology literature and human resource management literature that 'negative reinforcement' (punitive measures) is highly ineffective in changing behaviour and can result in 'learned helplessness' and other adverse consequences.[25]

A welfare/mutual obligation approach will therefore not only be ineffective in pushing people into taking up employment in a remote context, but will deny the opportunity for work relationships that contribute to family and child welfare and equip children for future economic participation.

The remote employment policy challenge for government

The fundamental challenge in remote areas is that existing labour markets cannot provide the required relationship for the vast majority of job seekers. The amount and nature of economic activity in these regions is simply inadequate to create market based employment relationships in anything like the quantities required. This is a result of:

- the very large number of job seekers relative to total demand;
- the generally 'high skill' level of many of the jobs in the market (i.e. mining engineers/trades, teachers, nurses, administrators/managers, trainers, construction trades, etc);
- low levels of literacy and numeracy, and skills gap;
- cultural factors and locational disadvantage; and
- industry characteristics and lack of endogenous economic activity and investment.

In the absence of 'market based' work relationships being available for the vast majority of Aboriginal people, the required work relationship must be created through government support to achieve the objectives for family and child welfare outlined above.

[25] Diener, C. & Dweck, C. (1978) An analysis of learned helplessness: Continuous changes in performance, strategy, and achievement cognitions following failure. Journal of Personality and Social Psychology, 36 451-461.

Re-directed focus of CDEP

APO NT believes that effective reform of current arrangements, particularly in relation to CDEP, offers the best solution to this policy challenge in remote areas. The focus of CDEP needs to change to real 'job creation' through financial support to commercial enterprise development, social enterprise development and in the paid provision of services. That is the creation of real 'work relationships' where the treatment and expectations, and development of these workers is as 'workers' who are an economic asset – not as 'participants'. It needs to be recognised that the social and economic returns from social investment in this direction, are likely to significantly outweigh the social returns/costs of a welfare-based approach.

APO NT is currently working closely with Aboriginal CDEP Providers in the Territory as well as DEEWR and FAHCSIA to present a submission to Government on the most appropriate model of CDEP reform. We look forward to an ongoing dialogue in this regard.

Multi systemic therapy[26]

In an environment in which young people are experiencing behavioural problems, substance misuse, excessive impulsivity and poor brain function, it is important to embrace models of therapy that have demonstrated success in connecting with at-risk young people.

Multi systemic therapy (MST) is an intensive family-and community-based treatment program which focuses on the entire world of chronic and violent youth offenders: the young person's home and family, school and teachers, neighbourhood and friends. MST works with the toughest offenders: adolescent males and females, between the ages of 12 and 17, who have long arrest histories.

Key features of MST are as follows:

- MST clinicians go to where the young person is and are on call 24 hours a day, seven days a week;
- MST clinicians work intensively with parents and caregivers to put them in control;
- MST clinicians works with the caregivers to keep the young person focused on school and gaining job skills;
- MST clinicians and caregivers introduce the young person to sports and recreational activities as an alternative to hanging out.

MST has been proven to work and produce positive results with the toughest young people. It blends the best clinical treatments—cognitive behavioural therapy, behaviour management training, family therapies and community psychology to reach this population.

After 30 years of research and 18 studies, MST repeatedly has been shown to:

- Keep young people in their home, reducing out-of-home placements up to 50 percent;
- Keep young people in school;
- Keep young people out of trouble, reducing re-arrest rates up to 70 percent;

[26] Stanley J. Huey, Scott W. Henggeler, Melisa D. Rowland, Colleen A Halliday-Boykins, Phillippe B. Cunningham, Susan G. Pickrel, James Edwards; Multisystemic Therapy Effects on Attempted Suicide by Youths Presenting Psychiatric Emergencies; *Journal of the American Academy of Child & Adolescent Psychiatry, Volume 43, Issue 2, February 2004, Pages 183-190*

- Improve family relations and functioning;
- Decrease adolescent psychiatric symptoms; and
- Decrease adolescent drug and alcohol use.

APO NT urges the Government to consider supporting and resourcing MST services to work with those young people most at-risk and assist them with the myriad of disadvantages in their life that may contribute to suicidal ideation or behaviours.

Cultural continuity and community control

APO NT submits that more research is needed in Australia regarding Aboriginal suicide and its prevalence across all communities. Extensive studies in Canada have shown that whilst indigenous suicide rates are high, suicide is only prevalent or epidemic in certain Aboriginal communities. Research in British Columbia over a 14 year period showed that communities where suicide rates were low or absent were those which exhibited high levels of cultural continuity.[27] The research found that cultural continuity was characterised by a set of eight factors:

(1) evidence that communities had taken steps to secure Aboriginal title to their traditional lands;
(2) evidence of having taken back from government agencies certain rights of self-government;
(3) evidence of having secured some degree of community control over educational services;
(4) evidence of having secured some degree of community control over police and fire services;
(5) evidence of having secured some degree of community control over health-delivery services;
(6) evidence of having established within their communities certain officially recognized "cultural facilities" to help preserve and enrich their cultural lives;
(7) the participation of women in local governance; and
(8) the provision of child and family services within the community.

The more of these factors present in a community the lower the suicide rate, with communities with all eight factors showing no suicides. Moreover, in relation to all the factors

> *the attainment of self-government constitutes something of a capstone. Self-government is, for example, the only factor that never appears in isolation. Among the communities that have attained self-government, just two have fewer than five of the remaining factors.*[28]

It must be observed that while many Aboriginal groups in the NT have been able to secure title to their traditional lands, the remaining factors—with the exception of community control health—are mostly absent from communities. Indeed, in relation to the 'capstone' self-government factor, communities that once had community government councils have lost local representation and control with the introduction of the super shires.

At the very least the Canadian findings suggests the need for research to determine differences in suicide prevalence in NT communities and the factors that underlie high and low prevalence communities. In addition, the growing evidence of superior social and economic outcomes from community control— including, in the NT, in relation to Aboriginal community controlled primary

[27] Chandler, M J and Lalonde, C (2008). 'Cultural continuity as a moderator of suicide risk among Canada's First Nations'. In L Kirmayer and G Valaskakis (eds.)
[28] ibid p240.

health care delivery—supports the extension of community control to other areas of governance and service delivery.

Also of concern is the apparent decline in support for Aboriginal culture and "cultural continuity" evident in government policies, for example, in relation to bilingual education, and the prohibition on considering customary law issues in determining bail and sentencing.

"Cultural continuity" has to do with the transmission of knowledge, values and identity from one generation to the next. Where this transmission is conducted with a sense of individual and collective health and wellness, belief in an optimistic future, and ability to make decisions today for tomorrow, there will be cultural continuity.[29] Culture and community are not static entities but constantly evolving and changing in response to changing social realities. As such, continuity does not mean simply maintaining the past or repeating actions prescribed by tradition, but re-creating and re-inventing communal practices in ways that maintain connections, honour the past, and incorporate a sense of shared history.

The methodology, findings, and recommendations from the Canadian studies have been widely accepted and endorsed across Canada.[30] For instance, the Suicide Prevention Advisory Group, (a panel of eight Aboriginal and non-Aboriginal researchers and health practitioners) were commissioned by National Chief Coon Come and Minister Rock to develop specific, viable strategies for short- and long-term action to address this issue, based on reviews of previous studies, current literature and assessment of service delivery gaps. Their research and review of the available literature showed that it should be possible to reduce suicide by making multi-level changes to the systems that youth, families and communities look to for support when they are in crisis. As in Aboriginal communities in the Northern Territory, many First Nations youth experience isolation, poverty, lack of basic amenities and family relationships which do not nourish and support them. Furthermore, colonisation, marginalisation and rapid cultural change have left them in the wake of foreign values and beliefs and deep conflicts about who they are.[31]

The advisory group have provided detailed recommendations in the paper, 'Acting on what we know: preventing youth suicide in first nations,' including:

1. *Ensure cultural continuity* (as above)
2. *Engage Community Members:* the collective historical experience of First Nations has included objectification and the imposition of externally developed systems. "Citizen engagement" is about restoring meaningful relations between citizens and their governments by engaging citizens, including youth, to direct fundamental changes by developing policy, clarifying values and shaping the outcomes of priority issues, such as youth suicide.

[29] Suicide Prevention Advisory Group, Health Canada, '*Acting on what we know: preventing youth suicide in first nations* 'http://www.hc-sc.gc.ca/fniah-spnia/pubs/promotion/_suicide/prev_youth-jeunes/index-eng.php#es

[30] In British Columbia the Office of the Provincial Health Officer and the BC Ministry of Health have adopted the methodology we developed as their de facto standard for surveillance of Aboriginal suicide.; The findings from the latest study were featured prominently in the provincial health officer's 2001 report on The health and well-being of Aboriginal people in British Columbia (BC Provincial Health Officer 2002)and formed the basis for three of the six major policy recommendations contained in the report.; the work was presented by Indian and Northern Affairs Canada to the House of Commons Standing Committee on Aboriginal Affairs during the committee's deliberations on the proposed First Nations Governance Initiative, and it has been presented by representatives of the Aboriginal Healing Foundation to the Senate Committee on Aboriginal Peoples. This research was also extensively quoted in the final report of the Advisory Group on Suicide Prevention, Acting on what we know: Preventing youth suicide in First Nations, jointly commissioned by National Chief Matthew Coon Come of the Assembly of First Nations and the federal minister of health, Allan Rock.

[31] Prevention Advisory Group, Health Canada, '*Acting on what we know, preventing youth suicide in first nations* 'http://www.hc-sc.gc.ca/fniah-spnia/pubs/promotion/_suicide/prev_youth-jeunes/index-eng.php#es

3. *Build Capacity:* Capacity-building improves the knowledge and skills of communities so they can solve problems and perform health functions on their own.[32] Capacity building can include ensuring that youth develop skills required for "learning how to learn" (e.g. literacy) and to resolve issues as well as building other skills.

Fundamentally, the Canadian research has shown that to find and implement solutions to the issue of suicide, Aboriginal people must be involved in:

- leading the shaping of research;
- building capacity;
- providing cultural continuity, including through community control; and
- channelling human and material resources for integrated services.

Individuals and organisations involved in programs and interventions at every level must be accountable to communities and to each other (through monitoring and evaluation to ensure provision of quality services). Programs and interventions need to be sustainable and responsive to community needs and best available evidence, with appropriate follow through.

Integration of Alcohol and Other Drugs and Mental Health Care into Primary Health Care

A significant proportion of people who end their lives have undetected mental illness and/or substance use disorders. Improving detection of mental health /alcohol and other drugs problems is best achieved through the primary health care (PHC) sector. The specialist sector can only support the primary health care sector in this role through education, training and provision of high quality services for those with the most complex issues. Detection in primary health care requires clinicians to actively enquire about young people's mental health. Research has shown that clinicians in PHC are much more likely to screen for mental health and alcohol and drug problems if they are confident that they can refer to high quality accessible alcohol and other drugs and mental health services.[33] Unfortunately most of remote NT receives fragmented and uncoordinated visiting services from external providers. Only the larger Aboriginal Community Controlled Health Services (ACCHSs) based in urban areas deliver comprehensive Social and Emotional Well Being [SEWB] services and even those services are rarely adequately funded to meet need.

Most remote communities have no on-site alcohol and other drug services. People are consequently reliant on regional residential services despite the evidence that ambulatory withdrawal and rehabilitation services provide equivalent outcomes to residential services. Young people and women with young children are poorly catered for by the current service mix. Furthermore, there are shortages in ongoing clinical services including focused psychological therapies, which are crucial for people with serious alcohol and other drug problems. As relapse rates with residential treatment are high, ongoing counselling and support is important in that evidence demonstrates it can reduce the likelihood of relapse. The dearth of sufficient services, particularly in remote areas, increases the risk of alcohol and other drug issues, subsequent mental health concerns and the risk of suicide.

There are also significant concerns about the fragmented and uncoordinated delivery of mental health and alcohol and other drug services in remote communities. Some services are only funded to provide mental health services rather than a comprehensive service that also addresses alcohol and other

[32] Pauline O'Connor, CPRN Mapping Social Cohesion Discussion Paper No. F/-1, April 1998.
33 Roche, A., Hotham, E. & Richmond, R. (2002). The GPs role in AOD issues: overcoming individual, professional and systematic barriers. Drug and Alcohol Review, 21: 223-230.

drug issues. Similarly, while some remote services now have funding for small alcohol and other drugs teams through COAG funding, these teams (usually of three people) often can only cover a small area and exclude mental health and therefore are not able to provide integrated service delivery. One small Central Australia community of 600 people has experienced 14 separate organisations delivering services with a Social and Emotional Well being component. Uncoordinated service delivery leads to suboptimal outcomes and is expensive, inefficient and burdensome for the primary health care service and community who deal with all the external visiting teams.[34]

People with dual diagnosis (both mental health and substance abuse problems) are very poorly catered for by the current service mix of alcohol and other drug and mental health services that provide services separately and communicate poorly. Yet, dual diagnosis is so common that it should be regarded as the norm rather than the exception as pointed out by the Senate Inquiry into Mental Health. It may be even more prevalent amongst Aboriginal people than in the Australian population generally (Senate Inquiry into Mental Health).

A way forward

AMSANT has developed an evidence based model on the integration of alcohol and other drugs and mental health services into Aboriginal primary health care in the NT. The model has both a clinical and a community development arm. Key features of the clinical component of the service delivery model include:

1) Aboriginal family support workers who are respected members of their community working in partnership with psychologists, social workers, Aboriginal AOD workers and mental health nurses.

2) A community of 1500 people would require four Aboriginal Family Support Workers, two skilled counsellors, and two of either an Aboriginal Mental Health Worker, Aboriginal AOD worker, or a nurse with mental health and/or AOD qualifications and experience and one psychologist.

3) There is no artificial divide between the management of people with alcohol and other drug and mental health problems. Dual diagnosis is very common and focused psychological therapies such as cognitive behavioural therapy are efficacious for both AOD and mental health problems. This is especially important for preventing suicide as those at the highest risk are likely to engage in high risk substance misuse and also demonstrate evidence of mental illness. In conventional service models, these people are poorly managed with neither the mental health nor the AOD specialist services wanting to take responsibility.

4) Screening within primary health care will occur during adult health checks and also opportunistically. People with significant problems will be referred to the Social and Emotional Team and will be managed through a care plan that incorporates the PHC team (including the GP for medication management) and the SEWB team.

5) The Team will provide treatment to all age groups including children and young people.

6) Focused psychological therapies including CBT are the core of the clinical treatment and all professionals will be trained to deliver these therapies.

7) Aboriginal family support workers do not require formal qualifications but will be encouraged to obtain further training including becoming an Aboriginal AOD worker or an Aboriginal

34 Haggerty J, Reid R, Freeman G, Starfield B, Adair C, McKendry R. (2003). Continuity of care: a multidisciplinary review. British Medical Journal. 327(7425): 1219-21.

health worker. They could also undertake studies in community development/ health promotion to support their work in community strengthening.

8) The community development arm of the model is described in the next section. In contrast to the clinical arm, it is led by the Aboriginal family support workers and Aboriginal management guided by the board of the ACCHS.

The model is fully described in Attachment 1 attached to this submission.

Community development approaches within ACCHSs

There has been significant work undertaken on developing community resilience as a way to reduce high suicide rates. Experience in Aboriginal communities suggests that this work needs to be led by the community rather than from experts brought into communities.[35] Grass roots and bottom up approaches to suicide prevention have been successful in places where suicide clusters have occurred (such as Yarrabah and Tiwi Islands). However, there is a paucity of evidence about what works in remote Aboriginal communities both in Australia and overseas[36]. It is important that community development work to reduce suicide risk has some methodological rigour and is well described and evaluated whilst not being driven by external experts. This type of approach is most likely to be successfully implemented by a comprehensive Social and Emotional Wellbeing service integrated into comprehensive primary health care within an ACCHS.

The community development arm of an integrated Social and Emotional Well Being service in the AMSANT model is based around the Aboriginal workforce and management but will also be supported by public health practitioners/health promotion officers within the service. Community work could include:

- development and support of alcohol management plans;
- activities and support for high risk groups including young people;
- working with other agencies in the community to develop community strengthening activities;
- education to the community about mental health problems in partnership with the clinical arm of the Social and Emotional Wellbeing team, which could be through using existing programs adapted for a local context; and
- responding to clusters of suicide attempts or suicides in conjunction with the clinical team, Aboriginal leadership and mental health experts.

Working with Aboriginal people and communities is pivotal to any plan to address suicide rates in the NT.

35 Kral M , . Wiebe P, Nisbet K , Dallas , Okalik L, Enuaraq N, Cinotta J (2009). 'Canadian Inuit community engagement in suicide prevention'. International Journal of Circumpolar Health. Jun;68(3):292-308; Krysinska, K., Martin, G. and Sheehan, N (2009).Identity Voice, Place, Suicide prevention for Indigenous Australians. A Social and Emotional Well being Approach. The Centre for Rural and Remote Mental health. The University of Queensland.

36 Hunter E, Reser J, Baird M, Reser P. (2001). 'An Analysis of Suicide in Aboriginal Communities of North Queensland: The Historical, Cultural and Symbolic Landscape'. Accessed at Indigenous HealthInfonet; Krysinska, K., Martin, G. and Sheehan, N (2009).Identity Voice, Place, Suicide prevention for Indigenous Australians. A Social and Emotional Well being Approach. The Centre for Rural and Remote Mental health. The University of Queensland.

Police and the youth justice system and their impact on youth suicide

Contact with the juvenile justice system is a significant factor recognised as leading to an increased risk of suicide amongst young people.[37] In the Northern Territory, Aboriginal young people are highly over-represented in youth justice and detention statistics. In the period January to March 2011, Aboriginal young people accounted for 98 per cent of young people in juvenile detention in the NT.[38] Correspondingly, across Australia, Aboriginal young people aged 12 to 24 years had suicide rates up to four times higher than non-Aboriginal Australians in the same age group. Between 2001-03 suicide rates for Aboriginal young people were 37 per 100,000 compared to 8 per 100,000 for non-Aboriginal young people.[39]

A study examining completed and attempted suicides involving young people in Victoria over a sixteen month period in 1993-94 found that in the 15-24 year old age bracket, 31.5 per cent of males who had completed suicide and 16.9 per cent of males who had attempted suicide had reported contact with police for property crimes.[40] Specifically in the 15-19 year old age bracket, 43.7 per cent of males who had completed suicide had experienced police contact for property crimes.[41]

Studies have shown that suicide attempts are often precipitated by an acute disciplinary crisis or a rejection. A case-controlled psychological autopsy study from New York found that nearly half the young people who had died by suicide had experienced a recent disciplinary crisis such as an appearance in a youth court.[42] A 2001 UK report, the result of a psychological autopsy study of 27 young people who had suicided, found that 52 per cent of the young people considered had had a problem involving police at some time in their short lives.[43] Similarly, research from Utah in the USA found that of 151 young people aged 13 to 21 who committed suicide between 1996 and 1999, 63 per cent had had previous contact with the juvenile justice system.[44]

We have not been able to locate any NT specific research which documents the connection between suicide and episodes of incarceration and exposure to the criminal justice system. Given the NT's exponentially high youth suicide and youth incarceration rates, we consider that more research is critically needed in this area.

APO NT believes that the over exposure of Aboriginal young people to over-policing practices, and the alienating nature of the current youth justice system, represent risk factors in a young person's trajectory towards suicide. In order to reduce the rates of youth suicide, it is vital to reduce the disproportionate negative contact Aboriginal young people have with police and the youth justice system. APO NT member organisations have experienced that current NT Police practices and the youth justice system predominantly operate in an anti-therapeutic fashion, negatively impacting on the social and emotional wellbeing of the young people with whom they have contact.

APO NT submits that more effective and equitable youth policing practices, and the development of a therapeutic and non-punitive youth justice system, could contribute to reducing risk factors associated

[37] House of Representatives Standing Committee on Ageing and Health, 'Before it's too late: Report on early intervention programs aimed at preventing youth suicide", The Parliament of Commonwealth of Australia (July 2011), p11.
[38] NT Department of Justice, 'Northern Territory Quarterly Crime and Justice Statistics Issue 35: March Quarter 2011', p93.
[39] House of Representatives Standing Committee on Ageing and Health, 'Before it's too late: Report on early intervention programs aimed at preventing youth suicide", The Parliament of Commonwealth of Australia (July 2011), p10.
40 Mitchell,P. (1999) 'Suicide and Young People in the Justice System', Youth Suicide Prevention Bulletin No. 1, Australian Institute of Family Studies, p13.
41 Ibid.
42 Kirmayer Brass Holton Paul Simpson Tait, (2007) 'Suicide Among Aboriginal People in Canada', The Aboriginal Healing Foundation, p47.
43 Houston K Hawton K Shepperd, R (2001) 'Suicide in young people aged 15-24: a psychological autopsy study', Journal of Affective Disorders, 63, 159-170.
44 Bender E, (2003 'Psychiatrists Use Intensive Intervention to Prevent Teen Suicides', Psychiatric News, 38 12, p13.

with youth suicide and should be considered amongst any developments aimed at reducing Aboriginal youth suicide rates.

Policing

While there are a myriad of factors that contribute to the over-representation of Aboriginal people in the NT youth justice system, one relevant factor is the over-policing of Aboriginal young people. In the experience of APO NT Aboriginal young people are more rigorously monitored by police and subject to greater prosecutions than non-Aboriginal young people.

Relationships between NT Police and young people are a crucial intersection of the youth justice system. Where these relationships are fractious, antagonistic, distrustful or hostile, there are serious implications for escalating situations of confrontation, and community safety generally. By contrast, if these relationships are open and built on mutual respect and open dialogue, significant benefits for the young people concerned, police and the community generally are possible.

Case Study:

A 15 year old Aboriginal youth was with friends at a Darwin shopping centre. Police apprehended him for breaching a trespass notice at the shopping centre. Police arrested the youth in front of his family and others present. In the course of putting him in the back of the paddy wagon, they caused the youth to strike his head on the side of the vehicle. The youth suffered a cut to his head. Police transported the youth to the Watch house for processing, and did not take him to seek medical treatment.

Case Study:

A young Aboriginal boy who was in the care of the Department of Children and Families (DCF) was approached by police while he was using an iPod. Police questioned him about how he came to be in possession of the iPod and the young boy honestly responded that it had been a gift from a DCF worker. The police did not accept this response and confiscated the iPod on suspicion of it being stolen. Later, it was necessary for the DCF worker to attend the Alice Springs police station to reclaim the iPod.

The consequences of over-policing

Unnecessary and continuous police contact has adverse effects on young people, often causing feelings of victimisation or discriminatory treatment. For instance, many CAALAS and NAAJA clients raise allegations of inappropriate police behaviour. These include the use of excessive force, sexual impropriety, threats, intimidation and unlawful arrests and detention. Aboriginal young people are also the least likely to make complaints against police. Some young people fear reprisals, whereas others think there is no point because they will never be believed when opposed to police.

Over-policing can result in Aboriginal young people being charged where non-Aboriginal young people would be warned, formally cautioned, or offered diversion. This results in increased contact with the criminal justice system. It can also occur in the context of police charging Aboriginal young people with numerous charges arising out of the same circumstances, or charging several co-accused based on the legal principle of common purpose.

Case Study

A twelve-year old young man in Katherine was charged with criminal damage and trespass for jumping the fence to gain access to the local pool. He had no criminal history. Police preferred to bail and charge him, rather than offer him diversion.

The reason for not diverting the young person at first instance was because the young boy spoke Gurundji, and could not communicate in English. He was also very shy, and so appeared to be non-cooperative to the police. An interpreter was not used.

Representations were made to police, asking that they reconsider the young person for diversion, however they were not accepted. The *Youth Justice Act* NT does not allow for the Magistrate to review a police denial of diversion.

CAALAS and NAAJA lawyers have heard police officers say that they prefer formal charges against a young person to 'teach them a lesson'. These practices can result in Aboriginal young people facing serious or multiple criminal charges at a young age. This widening of the net of criminality unnecessarily draws young people into contact with the youth justice system.

In light of the disproportionate contact Aboriginal young people have with police, we consider that there is urgent need for the following recommendations to be adopted:

- for Police to improve community engagement with Aboriginal young people and develop officers with expert skills in working effectively with young people; and
- for a system of independent investigation of police complaints to be introduced.

The Youth justice system

The NT currently has the highest youth incarceration rate in the country: 101 per 100,000 people.[45] Aboriginal young people represent 98 per cent of the NT youth detention population,[46] and only 47 per cent of the general youth population.[47] In a general sense, the connection between contact with the criminal justice system and suicide is well-documented.[48]

The negative operation of the youth justice system on young people

APO NT has witnessed that Aboriginal young people in the NT experience the youth justice system as alienating, isolating and stigmatising. It is our experience that the youth justice system as it currently operates is ill-equipped to deal with the criminogenic and socio-cultural needs of Aboriginal young people.

At times, the mere involvement of Aboriginal young people in the youth justice system can have tragic consequences.

Court proceedings

The current NT youth justice system can be characterised by its deficiencies. For instance, there are no youth specific magistrates in the NT. The same magistrates sit in both adult and youth jurisdictions: putting on and taking off their youth justice hat when appropriate. Whilst some magistrates may have a specific interest in the youth jurisdiction, and a concurrent commitment to maintaining a youth friendly court, other magistrates choose to hold the youth justice court in the same fashion as the adult jurisdiction, treating youth court users as 'mini-adults', as opposed to a category of offenders who have independent and specific needs.

[45] Richards, K. *Trends in Juvenile Detention in Australia* (May 2011) Australian Institute of Criminology http://www.aic.gov.au/documents/D/6/D/%7BD6D891BB-1D5B-45E2-A5BA-A80322537752%7Dtandi416.pdf
[46] NT Department of Justice, above n 7.
[47] Cunningham, above n 9.
[48] http://www.aic.gov.au/documents/2/9/4/%7B2945C409-3CE4-49C8-9F58-D8183A77CBD7%7Dti125.pdf

Magistrates in the Youth Justice Court will generally use complex legal language that Aboriginal young people do not understand. Discussions in court take place between the Magistrate, the prosecutor and defence counsel. In addition, court proceedings are protracted and can involve numerous court appearance and span several months. They often do not take place in a time frame relevant to young people. In some remote communities, court only sits once every three months. This means that where there are delays in proceedings (such as if a matter is contested or if a pre-sentencing report is called for), proceedings can very easily span over a one year period**.**

The unique circumstance surrounding youth offending, in particular Aboriginal youth offending, requires a unique and specialised criminal justice response. This is because young offenders are distinct from adult offenders criminogenically, psychologically, sociologically and biologically.[49] Having a specialist youth justice system in the NT would allow for practices and practitioners who are responsive to young people and their needs. It would go some distance to rectifying current patterns of Aboriginal young people cycling through a system tailored towards adult offenders, which fails to meaningfully address the underlying causes of offending.

Bail and remand

The NT recently made breach of bail a criminal offence. The implications of this are worrying. Most notable is the increased criminalisation of young people and the potential for significant increases in remand rates. Most young people in custody in the NT are held on remand.[50]

Case Study:

A 15 year old Aboriginal boy was on bail for several charges. A bail condition required him to attend school every day. He missed several days of school. Police arrested him and charged him with breach of bail for not going to school. He was remanded in custody and taken from his remote community to Darwin. This young person had never been in custody before.

The long term consequences of remanding young people include social isolation and alienation; family and community disharmony; stigmatisation; reduced opportunities to form pro-social, community-based friendships; increased disruption to education and employment prospects; reduced opportunities to participate in important cultural initiations and ceremonies; and reduced opportunities for rehabilitation. These are all significant suicide risk factors.

We recommend the insertion of pro-bail considerations into either the *Youth Justice Act* (NT), or the *Bail Act* (NT). Exposing young people to the risk factor of remand should be avoided, except in rare and exceptional circumstances. Bail and community based supervision should *always* be preferred over remand and this should be explicitly legislated. We suggest that the option for courts to remand a young person be removed where the young person is unlikely to receive a term of imprisonment, unless exceptional circumstances apply.

Detention

It is our experience that many remote Aboriginal young people as well as very young Aboriginal young people, some as young as 11 or 12, are unfairly and prematurely exposed to detention, with all of the negative ramifications of this exposure.

Many Aboriginal young people are distressed and dismayed at the prospect of being taken into custody. This is in stark contrast to the often-heard commentary that Aboriginal young people see

[49] Richards, above n 14.
[50] Department of Justice, Northern Territory Government, *Correctional Services Annual Statistics* (2008 – 2009) 7.

going to jail as a 'rite of passage'. It is our experience that the distress some Aboriginal young people feel at being remanded in custody can lead them to either threaten or attempt self-harm or suicide.

Case Study:

N was brought before the Darwin Magistrates Court having been arrested for minor offences. He applied for bail but this was refused due to the fact that the offences had occurred whilst he was on bail for other offences. This was to be the first time that N, who had just turned 18, was remanded in an adult correctional facility. In a state of desperation and distress, N jumped the dock. He shouted how he did not want to go to jail and be anally raped.

It is also our experience that young people are at times brutalised whilst in youth detention. We periodically receive complaints from detainees alleging inappropriate treatment at the hands of detention centre staff. We have also heard of instances of our clients being physically or sexually assaulted, victimised or harassed whilst in custody by other detainees.

Case study:

A is from a remote community and was in youth detention as a sentenced detainee.

Whilst in custody, he was sexually assaulted by two other male detainees.

He was released following an application for reconsideration of sentence, which allowed for this information to be brought to the attention of the sentencing magistrate.

A was released but returned to his home community with no support or supervision. He was shortly reincarcerated. Due to one of the two assaulting young people still remaining at Don Dale, A had to be declared at risk. This meant that A was placed in isolation, had very little contact with the outside world, and enjoyed none of the privileges afforded to the other youth detainees.

Police investigated the sexual assault allegation and it is not known if charges were laid.

Opportunities for improving the operation of the youth justice system to better meet the needs of Aboriginal young people

Contact by Aboriginal young people with police, the courts and custody often exacerbates feelings of marginalisation. We suggest that the system should rather focus on building self-esteem and promoting pro-social developments for young people.

The following section highlights areas in need of reform in the current NT youth justice system, and also suggests effective youth justice initiatives which address the underlying causes of offending. We consider that development of a therapeutic and non-punitive youth justice system should be part of policy developments aimed at reducing Aboriginal youth suicide rates.

Case study:

A CAALAS youth lawyer tendered medical reports relating to her client's mental health instability and recent attempted suicide. The attempted suicide occurred on the same day as the alleged offending, which involved breaching a domestic violence order.

In open court, before the young defendant, his mother, grandmother and partner, the Magistrate in the Youth Justice Court responded, 'the fact is that many people feel extremely guilty after subjecting their partners to severe beatings, and often use their own behaviour as a way in which to get people

to feel sorry for them….. Many people act in suicide bids in order to blackmail those that want to separate from them. It's common practice, and common in this town.'

A fortnight later, when the matter was again before the Youth Justice Court for plea and sentencing submissions, the medical records and attempted suicide were again referenced. Once again, in open court, the Magistrate responded, 'In my experience who attend to hang, largely do that because they feel so guilty for their behaviour and the difficulties that arise from the behaviour and they are trying to blackmail others into feeling sorry for them for the behaviour that they've taken up earlier in the day.'

The Magistrate consequently determined that the medical records indicated only that the young person had an alcohol issue as the diagnosis was 'suicidal ideation in the setting of alcohol intoxication' and were not evidence of an actual mental illness. This conclusion was reached despite evidence of the young person's admission into the psychiatric ward of the Alice Springs Hospital and evidence from the bar table that the young man was an ongoing client of the Child and Youth Mental Health Services.

A specialist youth court precinct

It is our experience that Aboriginal young people are alienated by the youth justice system in the NT because the system ignores, rather than actively engages, with their socio-cultural identity and reality.

There are a number of therapeutic, non-resource intensive practices which we recommend. These include making the Youth Justice Court more youth friendly through adopting simple language and informal procedures, increasing the role of elders, having specifically trained practitioners, magistrates and prosecutors, having separate court rooms and court days, placing Aboriginal art and symbols around the court room, and combining the Youth Justice and Child in Need of Protection (CINOP) jurisdictions.

We advocate for an integrated, independent youth court which can hear both criminal and CINOP matters. This combined jurisdiction occurs in both Western Australia and Victoria. It allows for a more holistic approach to youth offending, which is consistent with understanding youth offending in the context of many young people's experience as victims.

Establishing an independent youth court also facilitates the co-location of youth services. Having a co-located serviced with a youth court precinct enables smooth referral processes and also acts as a 'one-stop-shop' for addressing the varied issues underpinning youth offending.

A more streamlined version of an entire youth court precinct would be to have the services required present at the youth court on sitting days. Having coordinated Government and non-Government services present on youth court days enables holistic service provision and ensures the full spectrum of social issues contributing to a young person's propensity to offend are addressed.

Victim status and trauma

Many young people in the youth justice system are also victims of criminal offending, or have otherwise suffered trauma. Both of these are suicide risk factors. The NT Youth Justice System often fails to recognise this important connection, and simply treats young people as offenders.

WA Children's Court Magistrate Deen Potter points out that:

> *It is not a politically palatable fact to accept, discuss or champion, but the reality is that a very large proportion of young offenders, whether they are chronic recidivists or operating at the margins of the criminal justice system, are also victims of crime themselves.*[51]

Potter goes on to comment that 'the depth and range of investigations into Indigenous communities, [suggests] that many of these young people were unreported victims of crime well before they became offenders.'[52]

Evidence from the Balanu Foundation supports this assertion. David Cole notes that data collected from participants of the Balanu Foundation shows that the 'overall percentage of participants who have and or continue to experience violence is 89 per cent, with the boys at 87 per cent and 95 per cent for the girls.'[53]

Cole goes one step further. He speaks not just about prior and or contemporaneous experiences of violence, but to the trauma afflicting a great many Aboriginal young people in the NT:

> *The youth we see before us today I call the lost generation. They are hurting, traumatised, confused and angry and have been failed and neglected by family breakdown and a system which fails to see or address the trauma they have endured from an early age.*[54]

A properly resourced, holistic youth justice system, prefaced on rehabilitation and not punishment, affords a crucial window of opportunity to properly address issues of victim status and trauma. In this sense, the youth criminal justice system could act as an opportunity to reduce suicide risk factors.

Community and Family Driven responses

Real justice solutions are those that are driven by the local community, that empower Elders to show leadership and allow for Elders to be involved in mainstream justice processes. Effective justice responses must be developed in collaboration with local communities.

The 'Little Children are Sacred' report pointed to the evidence base to support community-driven justice initiatives:

> *There is now sufficient evidence to show that well resourced programs that are owned and run by the community are more successful than generic, short term, and sometimes inflexible programs imposed on communities.*
>
> *This is because community-based and community-owned initiatives inherently respond to the problems faced by the community and are culturally relevant to that community. They are driven by real community need rather than divorced governmental ideology.*[55]

It is essential that culturally relevant and effective support is provided to at-risk young people.

It is also crucial that therapeutic interventions involving Aboriginal young people facilitate and encourage involvement of family. We consider that Family Responsibility type agreements can play an important role in strengthening family and community, by supporting a young person's family to more effectively deal with their offending, if they are designed and implemented within a non-punitive, therapeutic framework.

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[51] Potter D, 'Indigenous Youth and restorative Justice in Western Australia' (2010) 20 JJA 92, at 100
[52] Ibid
[53] D Cole *The Social Determinants of Youth at Risk: reflections on the Balanu Healing Program with Darwin Youth* (2009) 41.
[54] Ibid 13.
[55] Pat Anderson and Rex Wild *Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse - AmpeAkelyernemaneMekemekarle ('Little Children are Sacred')* (2007) 53.

Diversion

Research consistently tells us that Aboriginal young people are less likely to be diverted compared with non-Aboriginal young people.[56] This discrepancy is compounded by the stark statistic that Aboriginal young people represent 80 per cent of police apprehensions[57], and almost 100 per cent of the NT's youth detention population.[58] The consequence of this is Aboriginal young people have a higher rate of entrenchment in the more punitive aspects of the criminal justice system.[59]

A recent study by the Australian Institute of Criminology found that young people who were diverted from the court system were less likely to have further involvement in the criminal justice system.[60] The *Youth Justice Act* should be amended to strongly encourage diversion for certain minor offences, and certain types of offenders (such as first time offenders).

Section 44 of the *Youth Justice Act* (NT) gives police an absolute and unappealable discretion over both the decision to divert a young person and to determine whether they have successfully completed diversion. The court only has a referral power through s 64, and the prosecution must consent for a court referral to be valid. This gives police a veto power over the Magistrate's decision to refer a young person to diversion.

We advocate for both the police and the judiciary to have diversion referral and decision making powers. For diversion to be effective in the NT, it needs to take into account the fraught relationship many Aboriginal people have with both the police and the criminal justice system. It also needs to be culturally relevant and accessible for Aboriginal young people.

Diversion is not available in most regional and remote areas across the NT. Lack of access to diversion is likely to be one of the main reasons why Aboriginal young people are diverted at a lower rate, when compared with non-Aboriginal young people. Increased resources must be made available to ensure that remote Aboriginal young people are offered the same opportunities for diversion that are available to young people in metropolitan areas.

Need for youth specific mental health workers and psychologists

The connection between youth offending, mental illness and intellectual disability is an under-explored area in the NT. A NSW study found that intellectual disability was particularly high amongst Aboriginal young offenders, and that over 88 per cent of young people in custody reported symptoms consistent with mental illness.[61]

It is our experience that many Aboriginal young offenders have never been properly assessed, despite presenting with obvious symptoms. This vulnerable group of young people is repeatedly exposed to the harmful impacts of ill-thought out criminal justice interventions. These young people cycle through the criminal justice system without receiving the specialist interventions which could identify and begin to address the underlying cases of offending.

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[56] Kelly Richards, *Police Referred Restorative Justice for Juveniles in Australia* (August 2010) Australian Institute of Criminology http://www.aic.gov.au/documents/8/B/B/{8BB6EC00-2FDD-4CB9-A70FDC451C3C22BD} tandi398.pdf
[57] Ibid.
[58] above, n7.
[59] Larissa Behrendt, Chris Cunneen and Terri Libesman (eds), *Indigenous Legal Relations in Australia* (Oxford University Press 2000) 101.
[60] Troy Allard, Anna Stewart, April Chrzanowski, James Ogilvie, Dan Birks and Simon Little, *Police Diversion of Young Offenders and Indigenous Over Representation* (March 2010) Australian Institute of Criminology <http://www.aic.gov.au/documents/0/9/2/{092C048E-7721-4CD8-99A6-1BC89C47D329}tandi390.pdf>
[61] Kelly Richards, *Trends in Juvenile Detention in Australia* (May 2011) Australian Institute of Criminology <http://www.aic.gov.au/documents/D/6/D/{D6D891BB-1D5B-45E2-A5BA-A80322537752}tandi416.pdf>.

Both NSW and Victoria have recognised the importance of addressing this issue when administering youth justice. The Victorian Children's Court has an attached 'Children's Court Clinic', staffed by specialist psychologists and psychiatrists. Clinic practitioners provide assessment and reports recommending specific treatment needs, and also act as a referral service.[62] In NSW mental health nurses are available at youth courts. They provide assessment and referral services, ensuring the court is fully informed of a young person's mental health status at the time of sentencing. This means that court processes and sentences can be tailored to a young person's developmental and cognitive needs.

We submit that it is essential for the youth justice system to address the complex connection between youth crime, mental illness, developmental disorders, and intellectual disability. Central to this is making skilled professionals available to at-risk young people exposed to the criminal justice system.

Properly resourcing sentencing options

The lack of availability of non-custodial sentencing options leads to a more accelerated ascent up the sentencing ladder, resulting in early exposure to incarceration. The current *Youth Justice Act* has a number of positive community based, therapeutic sentencing options, however these are not properly resourced. This is particularly the case for regional areas and remote communities.

Community work is sporadically available, but there are no specialist alcohol and drug rehabilitation services for young people, no youth-specific mental health programs, very limited access to restorative justice initiatives such as pre-sentence conferencing or community courts, and limited programs to assist young people convicted of violent offences.

A young person in Darwin may be able to attend psychological counselling or an alcohol rehabilitation centre, however, in most remote communities, a person would either not have recourse to these options, or in the case of a residential option, have to travel sometimes thousands of kilometres and be separated from family and other pro-social factors to participate in such a program. This represents a major failing in that at-risk young people from remote or regional areas have scarce access to expert, professional support.

Department of Children and Families (DCF) Workers

It is CAALAS and NAAJA's experience that many young people involved in the criminal justice system, have been, or are, also in the care of the Minister. This creates an inherent tension between one court focussing on the young person as victim in need of protection, and the other court focussing on the young person as a perpetrator, from whom the community needs protection. Combining both jurisdictions would promote better understanding of the inter-connection between youth offending, and youth experiences of victimisation.[63] It would also require DCF workers to be actively engaged in a young person's criminal matters.

Our experience is that some DCF workers do not have capacity or incentives to take ownership of young people in their care. NAAJA has observed an unwillingness by some DCF workers to take responsibility for, and independently and forcefully advocate in the best interests of, young people in their care. In an extreme example, NAAJA has acted for clients where their DCF worker has advocated against bail, preferring Don Dale over community based accommodation. CAALAS has similarly had

62 See: Children's Court of Victoria, Children's Court Clinic (2009) <http://www.childrenscourt.vic.gov.au/CA256CA800017845/page/Family+Division-Clinic?OpenDocument&1=20-Family+Division~&2=90-Clinic~&3=~>.
63 Kelly Richards, What Makes Juvenile Offenders Different from Adult Offenders? (February 2011) Australian Institute of Criminology, 4 <http://www.aic.gov.au/documents/4/2/2/%7B4227C0AD-AD0A-47E6-88AF-399535916190%7Dtandi409.pdf>

clients for whom the Court required a plan from DCF prior to considering bail or sentencing and who have been consequently remanded in custody for inordinate periods due to DCF's inability to provide or endorse any plan.

It is central to a young person's well being that DCF workers operate collaboratively to provide for the holistic needs of the young person concerned. Juvenile Detention Centres should never be used as quasi crisis-accommodation.

Community Corrections workers

There is no specific youth justice division of NT Community Corrections. This means that young people are assessed, treated and supervised by Community Corrections officers who may not have any youth specific training, or an appreciation for the specific criminogenic and developmental needs of young people in the criminal justice system.

Community Corrections are uniquely placed to work with young people to address the reasons underpinning their offending. At present, Community Corrections have a generic approach to adults and young people alike, and a strict compliance-based approach to all persons in the criminal justice system.

The WA Youth Justice Review lamented the shift in WA Corrections in recent years towards this compliance-focussed model:

> *The role (of juvenile justice workers) seems to have moved away from engagement of the young person and their families and has moved towards ensuring compliance and writing reports.*[64]

Along similar lines, the New Zealand Chief Justice, Sean Elias, noted the current over-emphasis on compliance, policing and risk assessment by Corrections Officers in New Zealand. She too suggested that '…the functions of advising, assisting and befriending ought to be reinstated'.[65]

A compliance-based approach fails in two crucial areas:

Firstly, it does not prioritise addressing the underlying issues that a young person might be dealing with, and imposes a barrier to the building of a positive, open relationship between the supervising officer and the client.

Secondly, it results in young people having their supervisory orders breached for non-compliance. It is questionable whether the interests of the community are protected when young people are conditionally breached.

It is essential that agencies such as Community Corrections embrace client-centred approaches to dealing with the reasons underpinning a young person's offending.

Mentoring programs

There is a need for Aboriginal-specific mentoring and positive role model programs to be developed in the NT. We endorse the comments of the recently released 'Doing Time - Time for Doing Indigenous youth in the criminal justice system' report. The Standing Committee points out that:

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[64] Harry Blagg, 'Youth Justice in Western Australia' (Report for the Commissioner for Children and Young People WA, 17 December 2009) 12.

[65] Sian Elias, 'Blameless Babes' (Speech delivered at the Annual Shirley Smith Address, Wellington, 9 July 2009) http://www.courtsofnz.govt.nz/speechpapers/Shirley%20Smith%202009%20lecture-Blameless%20Babes-9%20July%202009.pdf

> *Discussions in support of Indigenous mentoring referred to its value in all aspects of life, for example in the arts, sport, music, culture, school, family, community, police force, and government representation. Mentors and role models can assist youth at risk to develop self esteem, self worth, future aspirations and a commitment to community responsibility. They can contribute to rehabilitation and mentor on healthy lifestyles, sport, and education and employment goals.*[66]

We agree that 'young Indigenous people respond well to the Indigenous mentors who are from their local community'.[67] Priority should be given to establishing a large pool of Elders, both male and female and from various communities and regions, who can assist in identifying appropriate mentors for Aboriginal young people in the youth justice system.

Conclusion

APO NT shares the concerns of many individuals, communities and organisations in the NT and Australia about youth suicide. Through our work, we represent many young Aboriginal people who have experienced trauma and significant stressors in their life that could make them particularly vulnerable to suicide. Accordingly, we consider that reform is needed to ensure that Aboriginal young people's lives are secure, and that their adult lives are safe and productive.

It has often been said that societies should be judged on how they treat their elders. Surely the converse is true: we should be judged on how successful we are in protecting the lives of our young people.

If this can be the avowed objective—and result—of the deliberations of the Legislative Assembly Inquiry, its work shall be a success.

We ask that the Inquiry take strong note of the suggestions and recommendations we make in this submission.

[66] House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs, *Doing Time - Time for Doing Indigenous youth in the criminal justice system* (2011) 61. See: http://www.aph.gov.au/house/committee/atsia/sentencing/report/fullreport.pdf
[67] Ibid.

References

Allard, T. Stewart, A. Chrzanowski, A. Ogilvie, J. Birks, J and Little, S. (2010). *Police Diversion of Young Offenders and Indigenous Over Representation* (March 2010) Australian Institute of Criminology http://www.aic.gov.au/documents/0/9/2/{092C048E-7721-4CD8-99A6-1BC89C47D329}tandi390.pdf

Anderson, P. (2003a). The risk of alcohol. What general practice can do (PhD thesis). Chapter 8: Engaging GPs in the management of alcohol problems: Results of a meta analysis. p 127-137. Accessed at http://webdoc.ubn.kun.nl/mono/a/anderson_p/riskofal.pdf

Anderson, P., Kaner, E., Wutzke, S., Funk, M., Heather, N., Wensing, M., Grol, R., Heather, N., & Saunders, N. (2003). Attitudes and management of alcohol problems in general practice. A descriptive analysis based on findings of a World Health Organization International Collaborative Survey. *Alcohol and Alcoholism*, 38(6): 597-601

Anderson, P. and Wild, R. (2007). *Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse - AmpeAkelyernemaneMekemekarle ('Little Children are Sacred'*) 53

Beautrais, Fergusson, Coggan, Collings, Doughty, Ellis, Hatcher, Horwood, Merry, Mulder, Poulton, Surgenor (2007). Effective strategies for suicide prevention in New Zealand: a review of the evidence. *New Zealand Medical Journal.* 23;120(1251)

Behrendt, L. Cunneen, C. and Terri Libesman, T. (eds), (2000). *Indigenous Legal Relations in Australia.* Oxford University Press. 101.

Bende, E. (2003). 'Psychiatrists Use Intensive Intervention to Prevent Teen Suicides', *Psychiatric News*, 38 12 p13

Campo J (2009). Youth suicide prevention: does access to care matter? *Curr Opin Pediatr.* Oct;21(5):628

Chandler, M J and Lalonde, C (2008). 'Cultural continuity as a moderator of suicide risk among Canada's First Nations'. In L Kirmayer and G Valaskakis (eds.)

Cole, D. (2009) *The Social Determinants of Youth at Risk: reflections on the Balanu Healing Program with Darwin Youth* 41.

Diener, C. & Dweck, C. (1978). An analysis of learned helplessness: Continuous changes in performance, strategy, and achievement cognitions following failure. *Journal of Personality and Social Psychology, 36 451-461.*

Haggerty J, Reid R, Freeman G, Starfield B, Adair C, McKendry R. (2003). Continuity of care: a multidisciplinary review. *British Medical Journal*. 327(7425): 1219-21.

Hunter E, Reser J, Baird M, Reser P. (2001). An Analysis of Suicide in Aboriginal Communities of North Queensland: The Historical, Cultural and Symbolic Landscape. Accessed at Indigenous HealthInfonet.

Houston K Hawton K Shepperd, R, (2001). 'Suicide in young people aged 15-24: a psychological autopsy study', *Journal of Affective Disorders*, **63**, 159-170

Kirmayer Brass Holton Paul Simpson Tait, (2007) 'Suicide Among Aboriginal People in Canada', The Aboriginal Healing Foundation, p47.

Kral M, Wiebe P, Nisbet K , Dallas , Okalik L, Enuaraq N, Cinotta J (2009). Canadian Inuit community engagement in suicide prevention. *International Journal of Circumpolar Health*. Jun;68(3):292-308.

Krysinska, K., Martin, G. and Sheehan, N (2009). *Identity Voice, Place, Suicide prevention for Indigenous Australians: A Social and Emotional Well being Approach*. The Centre for Rural and Remote Mental health. The University of Queensland.

Mitchell, P. (1999). 'Suicide and Young People in the Justice System', *Youth Suicide Prevention Bulletin No. 1*, Australian Institute of Family Studies, p13

O'Connor, P (1998). CPRN Mapping Social Cohesion Discussion Paper No. F/-1, April

Potter, D. (2010). 'Indigenous Youth and restorative Justice in Western Australia' 20 *JJA* 92, at 100

Procter, N. (2005). 'Parasuicide, self-harm and suicide in Aboriginal people in rural Australia- a review of the literature with implications for mental health nursing practice,' *International Journal of Nursing Practice* 11: 237-241

Richards, K. (2010). *Police Referred Restorative Justice for Juveniles in Australia* (August 2010) Australian Institute of Criminology http://www.aic.gov.au/documents/8/B/B/{8BB6EC00-2FDD-4CB9-A70FDC451C3C22BD} tandi398.pdf

Richards, K. *Trends in Juvenile Detention in Australia* (May 2011). Australian Institute of Criminology http://www.aic.gov.au/documents/D/6/D/%7BD6D891BB-1D5B-45E2-A5BA-A80322537752%7Dtandi416.pdf

Robinson J, Hetrick SE, Martin C. (2011). Preventing suicide in young people: systematic review. *Aust N Z J Psychiatry*. 2011 Jan;45(1):3-26.

Roche, A., Hotham, E. & Richmond, R. (2002). The GPs role in Alcohol and Other drugs issues: overcoming individual, professional and systematic barriers. *Drug and Alcohol Review*, 21: 223-230.

Stanley J. Huey, Scott W. Henggeler, Melisa D. Rowland, Colleen A Halliday-Boykins, Phillippe B. Cunningham, Susan G. Pickrel, James Edwards (2004). Multisystemic Therapy Effects on Attempted Suicide by Youths Presenting Psychiatric Emergencies; *Journal of the American Academy of Child & Adolescent Psychiatry, Volume 43, Issue 2, February 2004, Pages 183-190*

P. Swan B. Raphael, (1995). 'Ways forward': *National consultancy report on Aboriginal and Torres Strait Islander mental health: Part 1 and 2.* Canberra: Australian Government Publications Service

Westerman, T. & Vicary, D. (2001). Preventing Aboriginal Youth Suicide. In Dudgeon, P., Pickett, H. & Garvey, D. Working With Aboriginal People: A Handbook for Psychologists. Curtin University, Perth WA: Centre for Aboriginal Studies.

Zubrick SR, Silburn SR, Lawrence DM, Mitrou FG, Dalby RB, Blair EM, Griffin J, Milroy H, De Maio JA, Cox A, Li J.(2005). The *Western Australian Aboriginal Child Health Survey: The Social and Emotional Wellbeing of Aboriginal Children and Young People.* Perth: Curtin University of Technology and Telethon Institute for Child Health Research

Reports and Websites

House of Representatives Standing Committee on Ageing and Health, 'Before it's too late: Report on early intervention programs aimed at preventing youth suicide", The Parliament of Commonwealth of Australia (July 2011), p11.

NT Department of Justice, 'Northern Territory Quarterly Crime and Justice Statistics Issue 35: March Quarter 2011', p93.

House of Representatives Standing Committee on Ageing and Health, 'Before it's too late: Report on early intervention programs aimed at preventing youth suicide", The Parliament of Commonwealth of Australia (July 2011), p10.

The West Australian Aboriginal Child Health Survey, http://www.ichr.uwa.edu.au/waachs

Mindframe http://www.mindframe-media.info/site/index.cfm?display=84364

Australian Early Development Index: http://www.rch.org.au/aedi/index.cfm?doc_id=13051

Suicide Prevention Advisory Group, Health Canada, '*Acting on what we know: preventing youth suicide in first nations* 'http://www.hc-sc.gc.ca/fniah-spnia/pubs/promotion/_suicide/prev_youth-jeunes/index-eng.php#es

Attachment 1

A model for integrating alcohol and other drugs, community mental health and primary health care in Aboriginal Medical Services in the Northern Territory.

Aboriginal Medical Services Alliance of the Northern Territory (AMSANT), 2008

(Revised 2011)

Contents

Preface to the 2011 revised policy document

The AMSANT model has been revised as a result of ACCHSs having greater experience in providing Social and Emotional Well Being (SEWB) services over the last 3 years. When the model was developed, SEWB services had largely been provided by ACCHSs in regional areas but limited services are now being provided within primary health care in more remote regions. There was thus an opportunity for a range of ACCHSs to provide feedback on the strengths and weaknesses of the model. There have also been some constraints that have made it difficult for ACCHSs to implement the model. Key factors include lack of funding for SEWB services to ACCHSs as discussed further below. Additional factors include workforce shortages in remote areas, lack of clarity about training and support pathways for a local Aboriginal workforce, lack of staff accommodation and a complicated evolving PHC landscape that is now undergoing a transition to a regionalised model of community controlled service delivery as part of the Expanding Health Service Delivery Initiative (EHSDI).

Most services do not have the level of funding required to implement the full AMSANT model. This is largely because a significant proportion of new funding for mental health/AOD services for Aboriginal people continues to be allocated via competitive tendering processes rather than being directed towards primary health care. Also, in the last 3 years, SEWB service expansion has mainly occurred through AOD funding from the NTER (Northern Territory Emergency Response) and COAG funding. This has meant that these new services have been required to target people whose primary problem is substance abuse rather than cater to the full range of mental health and AOD issues in the community.

The Remote AOD workforce is supported by a Remote AOD support unit based in the Department of Health (Northern Territory Government). This unit has developed a Best Practice Model, assessment pathways and other resources. There are significant differences between some elements of the Best Practice Model and the AMSANT model which required further exploration.

As a result of all these factors, AMSANT held a workshop on alcohol and other drug treatment in primary health care in November 2009. The key agreed outcomes from the workshop included:

1) Currently the AMSANT model cannot be fully implemented because of insufficient funding and also because smaller ACCHSs do not have the capacity or population to employ the whole team. Staff accommodation is also a constraint. Therefore the model is currently aspirational and needs to be implemented in a staged fashion by ACCHSs depending on capacity and funding. There may need to be additional positions located in hubs (e.g regional ACCHSs) to support smaller ACCHSs in service delivery until regionalisation is complete.

2) Key principles of the workforce component of the model include that local Aboriginal people are central to SEWB teams, that there should be an appropriate gender balance in the workforce, and that a multidisciplinary team is required to deliver a full suite of effective AOD /mental health services.
3) Aboriginal AOD workers need to be included in the model and will be employed to do the same work as Aboriginal mental health workers or mental health nurses. Both AOD workers and mental health professionals will need upskilling to be competent in assessing and treating both AOD and mental health problems.

4) Some services have employed AOD nurses through specific AOD funding. It is important to assess the skills and proficiencies of the workforce rather than make assumptions about skills based on the professional background of the worker.
5) The community development arm of the model is just as important as the clinical arm. However, it is not useful to be too prescriptive about community development: it needs to develop from the ground up but also be informed by evidence.
6) Aboriginal health workers (AHWs) who have AOD/mental health training or who are keen to undertake this training are scarce but highly valuable members of SEWB teams. AHWs need to be supported to undertake mental health/AOD training. The lack of support for the AHW profession is impacting on the availability of AHWs to undertake SEWB training.
7) Training pathways for the workforce needs to be clearer in the model and in particular, how the Aboriginal workforce will be trained and supported needs further development.
8) The trend to fund services through competitive tendering continues and this is leading to further fragmentation of service delivery.

Executive Summary

Burden of disease

Aboriginal people in the Northern Territory experience a disproportionate morbidity and mortality burden from mental health and alcohol and other drug (AOD) problems. This includes a dramatic increase in suicide rates since the 1980s, growing rates of Aboriginal mental health admissions, high death rates from alcohol-related causes and increasing rates of alcohol-related problems, including injuries and criminal offences. There is also evidence of increasing harm from illicit drugs and gambling. There are common determinants of AOD and mental health issues, including the ongoing legacy of colonisation, dispossession, racism, poor educational opportunities, loss of autonomy and control, welfare dependency, high unemployment and lack of access to services. Dual diagnosis (coexistence of both mental health and AOD conditions in the one individual) is common, likely to be more prevalent in Aboriginal populations, and often poorly dealt with in specialist AOD and mental health services.

Responses to mental health and AOD issues

Multiple Aboriginal health strategies have recommended that AOD and mental health services be located in Aboriginal Community-Controlled Health Services (ACCHSs). Advantages include an approach that is community-controlled, culturally-appropriate to the needs of the community and is integrated with other primary health care services, including medical care. The 2006 Senate Inquiry into Mental Health focused attention on the deficiencies in the provision of services for people with dual diagnosis and the lack of progress in providing mental health and AOD services in ACCHSs.

The evidence base for Aboriginal mental health and alcohol and other drug issues

Counseling techniques that have proven efficacy in both AOD and mental health conditions include cognitive behaviour therapy (CBT), problem solving therapy and family therapy. Narrative and art therapy have also been found to be effective in Aboriginal contexts.

There is evidence from non-Aboriginal populations that AOD treatments provide the same degree of benefit as for other chronic conditions such as diabetes. Integrating alcohol treatment and primary health care treatment has been shown to improve abstinence rates. There is also good evidence that screening and brief interventions result in reduced drinking, including ethnographic evidence from Aboriginal populations. Community-based withdrawal and rehabilitation has equivalent outcomes to residential treatment provided the person has adequate supports and is medically stable. However, as these conditions are less likely to be met in Aboriginal community settings, it is important that residential rehabilitation services are available as well. Other proven relapse prevention strategies include alcohol pharmacotherapies (Naltrexone and Acamprosate) and counseling techniques, including CBT. There is also some evidence and considerable anecdotal experience with therapies that may be particularly suited to Aboriginal populations, such as narrative therapy and art therapy.

Current service system

The current AOD and mental health service system in the NT is based in the five larger regional centres. The larger urban ACCHSs have Social and Emotional Well Being (SEWB) teams. As a result of COAG funding for alcohol services in remote communities and NTER (Northern Territory Emergency Response) initiatives targeting alcohol abuse, there has been an increase in provision of AOD services

in Aboriginal PHC in the NT over the last four years. However, this funding is targeting AOD problems only rather than the full spectrum of Social and Emotional Well Being services. Coverage remains incomplete with most remote ACCHSs still relying entirely on infrequent visiting specialist mental health services and regionally based AOD services. . This reflects a national trend of poor access to mental health and AOD services by Aboriginal people in remote areas. Nationally and in the NT, AOD services have been noted to be based on an abstinence model, focus on residential rehabilitation, and be less-suited to the needs of illicit drug users compared to alcohol users. There is a lack of attention to prevention and early intervention strategies. Recently, with the advent of the COAG mental health reforms and competitive tendering processes, as well as the delivery of funding through Divisions, there is increasing fragmentation of services with multiple new providers entering into "the market". This represents a departure from the established collaborative needs-based planning approach through the Northern Territory Aboriginal Health Forum, resulting in increasing service fragmentation.

An integrated model for providing mental health and AOD services in Aboriginal Community-Controlled Health Services

The rationale for a new approach to the provision of SEWB (including mental health) services and AOD services for Aboriginal people in the NT includes recognising:

- Current high rates of morbidity and mortality and unmet need for AOD and mental health services;
- Current high rates of dual diagnosis and a lack of effective systems to deal with dual diagnosis;
- Common evidence-based treatments for both AOD and mental health problems;
- An approach is required that addresses social and historical determinants of illness and that treats problems in a culturally-acceptable, holistic way through community-controlled services;
- Integrated treatment and rehabilitation that addresses physical and mental health issues concurrently along with prevention and promotion within a single comprehensive primary health care service provider is likely to lead to better health outcomes;
- The existing primary health care infrastructure in remote communities is the only efficient and effective way to provide these services in the community compared with either duplicating that infrastructure in the community or centralised service models with visiting practitioners.

The model locates relevant SEWB and AOD services within comprehensive primary health care. It includes both community development and clinical components. Aboriginal Family Support Workers will be the core of the community development approach. Each community will have at least one female and one male Aboriginal Family Support Worker. They will lead preventative and health promotion approaches to AOD and mental health problems in conjunction with other practitioners in ACCHSs and external agencies. The work will be developed in line with local priorities and community concerns. Aboriginal Family Support Workers will also have a key role in facilitating access to clinical services, where they will be supported by other professional staff.

Clinical service delivery

The clinical service delivery component of the model is based on integrating AOD and mental health services utilising common evidence-based approaches such as cognitive behaviour therapy**.** Aboriginal Family Support Workers will be supported by counselors including Aboriginal AOD workers, mental health nurses and psychologists skilled in both AOD and mental health treatment. Their work will be guided by clinical pathways and referral protocols tailored to local needs. Nurses with AOD experience and qualifications should not be excluded as a potential workforce. However, they would need to be proficient in mental health assessment and treatment in order to provide integrated holistic treatment and so may need further training.

The model provides multiple entry points to the clinical service component, including self-referral and referral through the primary health care clinic. ACCHSs will aim to screen all patients for mental health and AOD issues as part of a yearly adult health check, as well as detecting AOD and mental health problems opportunistically. Those with early problems or at risk of developing problems will be offered brief interventions.

Patients with significant AOD and/or mental health diagnosis will be offered a comprehensive assessment by a skilled counselor. A mental health care plan will be formulated in conjunction with the patient, family, GP, Aboriginal Family Support Worker, counselor and other professionals as appropriate. This will include psychosocial supports and assistance with housing and employment as required.

Patients with alcohol dependence will be offered home-based withdrawal if medically suitable. If their home environment is unsuitable, they will be offered supported accommodation for the withdrawal period where available. Those with complex comorbidities and psychosocial issues will be referred for residential withdrawal and rehabilitation. Community-based treatments for alcohol and drug problems will include Naltrexone and Acamprosate for relapse prevention, evidence-based counseling and rehabilitation assistance.

Patients with anxiety, depression, grief and loss will be treated according to clinical pathways which will incorporate psychosocial and family support. The SEWB team will also support young people and children with behavioural problems. Patients with dual diagnosis problems will be treated for both problems concurrently. Patients with more complex problems, including those with dual diagnosis, will be offered intensive case management. Medication management will mainly occur through the general practitioners in ACCHSs, with specialist support. The services will develop referral pathways and protocols with other agencies, including specialist mental health and AOD agencies.

Training, peer supervision and support are essential components of the model. Aboriginal Family Support Workers will be offered training in basic AOD and mental health assessment and treatment and community development approaches to prevention and health promotion. They could also progress to more formal AOD/mental health training to become an Aboriginal mental health or AOD worker. Or their basic training may assist with a transition to AHW training. All professionals will be trained so they are competent in both AOD and mental health assessment and treatment but the Aboriginal Family Support Workers will only be expected to recognise AOD and mental health issues,

offer brief interventions and refer on to other team members for more detailed assessment and treatment.

Workforce and Funding

A community of 1500 people would require four Aboriginal Family Support Workers, two skilled counselors, and two of either an Aboriginal Mental Health Worker, Aboriginal AOD worker, or a nurse with mental health and /or AOD qualifications and experience. There would be one psychologist for 1500 people. SEWB teams would either be located in ACCHSs or be based zonally and work across smaller services. However, each community would have their own Aboriginal Family Support Worker. This model is likely to result in savings from reduced admissions and readmissions for psychiatric care and reduced demand for residential withdrawal and rehabilitation services. Funding would be sourced from the COAG mental health and AOD funds and through the Northern Territory Government. Supplementary funds would be obtained through Medicare. Funds would need to be pooled and allocated in a planned manner according to needs measured largely, but not exclusively, through staffing population ratios. This model will not be achieved with the current funding allocation processes.

1. Introduction

This document outlines a proposal for an integrated model of social and emotional well-being (SEWB) services, including mental health and alcohol and other drug (AOD) services, in Aboriginal Community-Controlled Services (ACCHSs) in the Northern Territory. Mental health and AOD problems have common underlying causes related to social and historical determinants, and many Aboriginal people present with both mental health and AOD problems. There is evidence of growing unmet need for mental health and AOD services for Aboriginal people in the NT. Current specialist sector responses are largely focused on severe illness with remote areas having particularly poor access to community-based treatment.

The response to these issues needs to be determined by the local community, be culturally-appropriate and be applied at the community, family and individual levels. The range of interventions should include prevention, early intervention, treatment and rehabilitation. It also needs to be suitable for the range of services found in the NT, including smaller remote services. The model needs to adapt to the changing PHC landscape as the PHC reforms underway through the Expanding Health Service Delivery Initiative result in a shift to community control and a regionalised model of health service delivery. The model proposed allows for both a community development and clinical approach to social and emotional well-being services. The model places Aboriginal Family Support Workers at the core of the service response. It uses the same evidence-based counselling techniques for both mental health and AOD issues.

The role of AMSANT

The integrated model has been developed by the Aboriginal Medical Services Alliance of the Northern Territory (AMSANT). AMSANT is the peak body of Aboriginal community-controlled health services (ACCHSs) in the Northern Territory. It has a key role in representing the interests of ACCHSs and the communities they serve in the NT. AMSANT is active in advocacy and provision of policy advice in the Northern Territory and at a national level.

2. Burden of disease

There is evidence of a high burden of disease both nationally and particularly in the NT for both AOD and mental health morbidity and mortality. Morbidity data is largely limited to hospital and mortality data in the NT. Hospital data has several limitations as it underestimates the burden due to illness that is more likely to go undetected and less likely to result in admission (GPPHCNT 2007).

Burden of disease related to mental health

Nationally, Aboriginal males are four times and women 1.9 times more likely to die from a mental health cause than non-Aboriginal people (OATSIH 2006). Suicide rates have more than doubled amongst Aboriginal people in the NT since the 1980s so that in 2002-2003, the NT Aboriginal rate was two to three times the national non-Aboriginal rate (Measey et al 2005, Nagel and Thompson 2007). The NT suicide rate has continued to rise whilst the national rate has stabilised over the last decade (GPPHCNT 2007). The rates of admission for self-inflicted injury in Aboriginal males have increased fivefold from 1991 to 2002, with a less dramatic rise in women (Measey et al 2005).

The rate of admissions for mental health problems for Aboriginal people in the NT is also increasing at a much higher rate than for the non-Aboriginal population (NT Government 2006). The mental health admission rate for women in 1999-2003 was nearly double the rate for non-Aboriginal women at 757 admissions per 100,000 Aboriginal women compared to 374 admissions per 100,000 non-Aboriginal women (GPPHCNT 2007). The admission diagnoses that are substantially higher for Aboriginal people are psychotic disorders, including schizophrenia and drug-related psychoses and disorders related to alcohol. The rate of Aboriginal female mental health admissions due to psychoactive substance was six times the non-Aboriginal rate in 2003, whilst the delusion disorder admission rate was 2.5 times higher than the non-Aboriginal rate (GPPHCNT 2007).

Diagnoses related to affective illness, personality disorders and neurosis are lower than the non-Aboriginal rate and have been relatively stable over the last ten years (GPPHCNT 2007). However, the prevalence of affective illness in areas without culturally-appropriate and effective community-based mental health services is likely to be underestimated due to a lack of mental health and cross-cultural skills in primary health care practitioners (Nagel 2006, GPPHCNT 2007). The NT has the lowest per capita spending on PBS medications for psychiatric conditions in Australia. This is at least partly due to the lack of prescribers in primary health care and community-based specialist practice (GPPHCNT 2007). Central Australian Aboriginal Congress has a Social and Emotional Wellbeing Unit as part of its primary health care services, staffed by Aboriginal mental health workers, mental health nurses and psychologists. The most common presenting illness to this Unit is depression (GPPHCNT 2007). However, many ACCHSs lack the resources and staff to provide comprehensive SEWB programs.

Institutional racism can also influence detection of illness. The Royal Commission into Aboriginal Deaths in Custody noted that many Aboriginal men with a forensic history are diagnosed as having personality disorders and their depression is missed (GPPHCNT 2007). High rates of psychosis may be partly accounted for by misdiagnosing people from remote communities, especially given the lack of trained Aboriginal mental health workers who are best placed to distinguish between the normal expression of grief and other intense emotional states and psychotic illness (GPPHCNT 2007).

The rising rates of mental health-related admissions may also be partly due to increased access to services, especially hospital services. However, the high rates of substance abuse (which commonly occurs with affective disorders) and also high rates of self-inflicted injury and suicide, suggests that there is a substantial mental health disease burden (especially of affective disorders) that is not being detected and treated (GPPHCNT 2007, Measey et al 2005).

Burden of disease due to alcohol and other drugs

Alcohol

In the NT, the average per capita alcohol consumption is almost double the national per capita consumption (GPPHCNT 2007). Nationally, Aboriginal men die at seven times the rate, and women at nine times the rate of non-Aboriginal people, from alcohol-related causes (DoHA 2007). The death rate from alcohol-related causes in Central Australia (14 per 10,000) was three times the national Aboriginal rate of 4.17 per 10,000 in 2004 (National Drug Research Institute 2007). The morbidity burden was also noted to be worsening in some regions with increasing rates of alcohol-related admissions in the Darwin, Katherine and Alice Springs regions (Healthcare Management Advisors 2005).

Criminal justice data in Tennant Creek and Alice Springs also indicate a rising burden of crime related to alcohol. Around 70-90% of cases of family violence are related to alcohol (Healthcare Management Advisors 2005). The proportion of suicides in which alcohol or other drugs were implicated in the Top End between 2000 and 2002 was 72% (Measey 2005). Aboriginal patients with self-inflicted injuries in the NT were also more likely to be diagnosed with an AOD problem and less likely to be diagnosed with a mental health problem than non-Aboriginal people, although this may be partly due to diagnostic bias (GPPHCNT 2007). Other problems strongly associated with alcohol include car accidents and violent crime (Measey et al 2005, Chikritzhs et al 2005).

Other licit drugs

Other major licit drug concerns include smoking, petrol and kava. Smoking rates are particularly high for Aboriginal people with an estimated 44% of women and 57% of men smoking in the NT (Jones et al 2005).

Illicit drugs

There are higher rates of illicit drugs use, including cannabis and amphetamines, in the NT than in other jurisdictions (Healthcare Management Advisors 2005). There is a lack of evidence about Aboriginal illicit drug use in the NT. Data from the National Aboriginal and Torres Strait Islander Health Survey for Northern Territory Aboriginal non-remote people aged 18 and over, indicate that about 30% reported using illicit substances in the 12 months prior to interview (28% used marijuana, hashish or cannabis resin, less than 3% amphetamines or speed and less than 2% analgesics and sedatives for non-medical purposes). About 50% stated they had never used illicit substances. This data may be an underestimate because it did not include homeless people. This compares to national Aboriginal rates of 23% for cannabis and 7% for amphetamines (Australian Bureau of Statistics 2005).

Central Australian Aboriginal Congress noted that cannabis is implicated in 10-15% of drug-related presentations to Congress (GPPHCNT 2007). A longitudinal study from three remote communities in Arnhem Land identified two thirds of males and 22% of females in the age group of 16-39 as current cannabis users (Clough et al 2004). Cannabis and associated behavioural effects, including violence, was a key concern of Aboriginal people consulted by the Taskforce on Illicit Drugs (Taskforce on Illicit Drugs 2001). Problematic amphetamine use by Aboriginal people in the two major urban centres is relatively common, whilst there is also anecdotal and police evidence of a growing amphetamine use in remote areas (Moon 2006, Putt and Delahunty 2006). Opiate misuse occurs in the larger urban centres at rates equivalent to national rates (Moon 2006). Poly-drug use is noted to be common in both Darwin (Moon 2006) and Alice Springs (GPPHCNT 2007).

Gambling

Both unregulated gambling and regulated gambling is common in Aboriginal communities, although there is a lack of formal research. Anecdotally, high stake card games are increasing in remote communities, and a significant proportion of patrons at poker machine venues and the NT's two casinos are Aboriginal. There is also a link between gambling and substance abuse. Other adverse consequences are loss of income for other purposes and neglect of children and other family responsibilities (Brady 2004).

3. Underlying determinants and dual diagnosis

Determinants of mental health and AOD conditions

There are common determinants related to Aboriginal dispossession and continuing entrenched disadvantage for both mental health and AOD health problems. These include loss of land, stolen generation policies, unemployment, overcrowding, loss of autonomy and control, welfare dependency and lack of educational opportunities. Primary health care workers in the Top End reported that the rising burden of AOD and mental health problems over the last ten years was due to declining educational opportunities and literacy levels, high unemployment, fewer community activities and boredom (GPPHCNT 2007). In addition to this, the lack of access to effective treatment and rehabilitation services means we are failing to prevent the progression of early AOD and mental health problems into more long term and disabling illnesses.

There are high rates of dual diagnosis in mainstream service systems, although dual diagnosis is often under recognised (Senate Inquiry into Mental Health 2006). Dual diagnosis refers to patients who have both a mental health and an AOD diagnosis. Dual diagnosis was noted to be "the norm rather than the exception" (Senate Inquiry into Mental Health 2006). Service utilisation rates are higher for people with dual diagnosis and outcomes are poorer, with high rates of incarceration, homelessness and family violence (Condon et al 2005, Ministerial Council on Drug Strategy 2006b, Senate Inquiry into Mental Health 2006).

There is evidence both nationally and in the NT that dual diagnosis is common in Aboriginal people. OATSIH-funded alcohol and other drug services nationally noted that the most common emotional problems encountered in their clients were depression, hopelessness or despair (95%), anxiety or stress (90%), family/relationship issues (90%), and family and/or community violence (90%) (OATSIH 2006).

Morbidity and mortality from dual diagnosis in the NT

High and rising rates of suicide and self-inflicted injury are linked to both alcohol and mental illness (Nagel 2006). There are also high rates of Aboriginal admissions for psychosis due to psychoactive substances, which is nearly four times the non-Aboriginal rate (NT Govt 2006). The drugs associated with these illnesses were alcohol, followed by cannabis and other drugs (GPPHCNT 2007). Mental health disorders due to substance misuse were the most common diagnosis in Aboriginal men attending specialist community mental health services and the second most common diagnosis in Aboriginal women (GPPHCNT 2007). Cannabis use in remote communities in Arnhem Land was associated with high rates of anxiety symptoms in a longitudinal survey (Clough et al 2005). Primary health care evidence from Wurli Wurlinjang (an ACCHS servicing Katherine) identifies alcohol as the most frequent reason for presentation to their Social and Emotional Wellbeing Unit, ahead of domestic violence, family issues, grief and loss (GPPHCNT 2007).

4. Aboriginal recommendations for mental health and AOD services

Overview

Many recent major reports and strategies (including the National Aboriginal Health Strategy, Royal Commission into Aboriginal Deaths in Custody, Aboriginal Drug and Alcohol Complementary Plan, National Strategy for Aboriginal and Torres Strait Islander Health, Senate Inquiry into Mental Health,

and the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Social and Emotional Wellbeing and Mental Health 2004-2009) have recommended that Aboriginal people control their own mental health and AOD services in order to provide services that are culturally-appropriate and effective (Social Reference Group OATSIH 2004, Ministerial Council on Drug Strategy 2006b). There has been a consensus that these services should be provided in Aboriginal community-controlled health services (ACCHSs), given that these services aim to provide comprehensive primary health care, are controlled by the community, employ Aboriginal staff and are thus able to reduce the effects of institutionalised racism in health care delivery.

Senate Inquiry into Mental Health 2006

The Senate Inquiry into Mental Health found marked deficiencies in publicly-funded mental health services, including a lack of resources, poor communication with families and a lack of integration with AOD services. The report noted that in the past, AOD services and mental health services had been integrated but were now completely separate and had quite different treatment and service cultures. This was noted to be detrimental for patient care by many respondents to the inquiry, with significant "buck passing" between overloaded mental health and AOD services. Dual diagnosis was noted to be particularly prevalent in Aboriginal people. The Inquiry noted the lack of progress in expanding SEWB services in Aboriginal medical services. The inquiry also recommended more mental health training for Aboriginal health professionals, including Aboriginal health workers, and better screening for mental health and AOD problems in Aboriginal primary health care (Senate Inquiry into Mental Health 2006).

Emotional and Social Well Being Strategy 2004-2009

The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Social and Emotional Wellbeing and Mental Health 2004-2009, emphasised the importance of mental health services being delivered by Aboriginal workers in ACCHSs who were well-supported and trained. The strategy noted that larger ACCHSs could become the provider of choice for Aboriginal people with serious mental health disorders, providing case management, psychosocial support, medication management and family support. It noted the need to provide a spectrum of responses, including early intervention and prevention. Strategies to provide a trained Aboriginal workforce included formal education and on the job training. The strategy also identified the need for more psychologists, psychiatrists and other allied health professionals to work in the community-controlled sector (Social Health Reference Group 2004).

NT Aboriginal Health Forum Strategy for Social and Emotional Well Being

The NT Aboriginal Health Forum's Strategic Plan for Social and Emotional Well-Being emphasised the holistic view of Aboriginal mental health and building on strengths, whilst recognising trauma, loss, racial discrimination and social disadvantage. The key feature of this strategy was the recommendation to ensure that multidisciplinary social and emotional wellbeing teams were part of every Aboriginal community-controlled health service. The report noted that the recommendation from the *Bringing Them Home* report that Social and Emotional Well-Being units be established in ACCHSs had only partially been implemented. The plan supported the use of culturally-specific ways of healing from grief, loss and other psychological sequelae of Aboriginal history. It recommended expansion of services to remote areas, and a focus on prevention and health promotion in a range of areas, including suicide prevention and family violence (Northern Territory Aboriginal Health Forum Emotional and Social Wellbeing Working Party 2003).

National Drug Strategy: Aboriginal and Torres Strait Islander Peoples Complementary Action Plan (2003-2009)

The Complementary Aboriginal AOD Plan (2003-2009) recommended services be controlled by the community (Ministerial Council on Drug Strategy 2006). The strategy noted the growing evidence base for early interventions in primary health care, including Aboriginal evidence, and emphasised a broad approach encompassing prevention (Ministerial Council on Drug Strategy 2006a).

Common themes from major reports and strategies

Common themes from major reports and strategies include:

- An approach that addresses social and historical determinants (Social Health Reference Group 2004, Ministerial Council on Drug Strategy 2006a).
- The need for multidisciplinary Social and Emotional Well-being teams in every Aboriginal community-controlled health service, which will require:
    - Well-supported and trained Aboriginal mental health and AOD workers (Social Health Reference Group 2004, Ministerial Council on Drug Strategy 2006a).
    - Culturally-competent non-Aboriginal staff (National Aboriginal and Torres Strait Islander Health Council 2003, Ministerial Council on Drug Strategy 2006, Social Health Reference Group 2004).
- Well-defined links and protocols to other services, including specialist mainstream services (National Aboriginal and Torres Strait Islander Health Council 2003, Ministerial Council on Drug Strategy 2006, Social Health Reference Group 2004).
- Regionalised planning involving Aboriginal people (Social Health Reference Group 2004, Ministerial Council on Drug Strategy 2006a).
- Evidence-based interventions that are also culturally-acceptable (Ministerial Council on Drug Strategy 2006).

5. Aboriginal-specific evidence base

The following section briefly summarises findings from the literature that are relevant to the provision of integrated alcohol and other drug and mental health services in Aboriginal community-controlled health services.

There is a lack of Aboriginal-specific evidence for management of AOD and mental health issues, with most of the evidence drawn from mainstream research (OATSIH 2006, Ministerial Council on Drug Strategy 2006b). Much of the mainstream evidence is from specialist centres rather than primary health care.

Case management

There is some evidence of benefit of case management for both AOD and mental health problems in primary health care. Successful models have the following features (Wilson et al 2006):

- Readily-available psychiatric assessment in the primary care setting;
- Active screening in the primary care setting to identify high-risk patients who have psychiatric illnesses/disorders;
- Ability to apply pharmacotherapeutic and psychosocial interventions that have proven effectiveness;
- Coordination and integration of medical and psychiatric care among clinicians, and case management for patients with chronic or complex illnesses;
- Support for practitioners and treatment teams.

Case management has also been found in a randomised controlled trial to improve outcomes in addiction treatment centres, including reduced drinking and social outcomes such as housing and employment (McClellan et al 1999). This has been confirmed by other studies (Gerstein & Harwood 1990, Volpicelli et al 2000). However, it has also been shown that case management is less effective in overcoming the difficulties created when the multidisciplinary team is employed by multiple providers. This situation can lead to service fragmentation and poorer outcomes than with a single provider model, even with a multidisciplinary approach (Haggerty et al 2003). It is therefore not useful to create new providers unless existing providers are either unwilling or unable to provide mental health and AOD services. Unfortunately, at present, competitive tendering and the channelling of some funds through the Divisions is leading to the establishment of multiple new providers requiring a plethora of new "MOUs" in an attempt to get service coordination. In the Northern Territory there is a comprehensive primary health care sector that, if supported to provide these mental health and AOD services, could provide more efficient and effective outcomes.

Counselling

There is *not* good evidence for the effectiveness of generalist counselling, even though that is generally what is provided (Healthcare Management Advisors 2005). There is good evidence for structured counselling that derives from a theoretical base. These include the therapies listed below:

- Cognitive Behavioral Therapy (CBT). Cognitive Behaviour Therapy has proven to have considerable efficacy for a range of mental health conditions, including anxiety and panic disorder (Hunot et al 2007, Butler et al 2005), post traumatic stress disorder (Bisson et al 2007, Butler et al 2005), depression (Butler et al 2005), social phobia (Butler et al 2005), and childhood depressive disorders (Butler et al 2005). CBT is also moderately effective in marital distress, anger, childhood somatic disorders, and chronic pain (Butler et al 2005). There is strong evidence for the effectiveness of CBT in addictive behaviours (Irvin et al 1999, Shand et al 2004) and gambling (Petry et al 2006).

- Motivational interviewing has a good evidence base in treating AOD problems (Shand et al 2004), and is useful in chronic disease management (Resicnow et al 2002, Rubak et al 2005). There is also growing evidence of its effectiveness in treating psychological conditions, including depression (Rubak et al 2005, Arkowitz et al 2004).

- Problem solving therapy has been shown to be effective in AOD treatment (DoHA 2007, Best Practice in Alcohol and Other Drug Interventions Working Group 2000) and is also effective in primary care for depression and anxiety (Huibers et al 2007, Pierce and Gunn 2007).

- Family therapy is effective in treating AOD conditions if the person has a functioning relationship with their family (Edwards and Steinglass 1995, Miller and Hester 1986, Stanton et al 1982, Mattick, Ward & Hall 1998). It is also effective in a wide range of psychological disorders (Shadis et al 1995), and is effective in children and adolescents, especially for conduct disorders, eating disorders and substance misuse (Cottrell et al 2002).

- Therapy specifically tailored to the cultural needs of Aboriginal people, including narrative therapy and art therapy. Narrative therapy has been adopted as a respectful, empowering therapeutic style in which the patient is the expert on their own life (Swan and Raphael 1995). It is recommended for AOD problems (DoHA 2007) and also in a wide spectrum of psychological disorders (Hunter 2004).

There is no available evidence about the efficacy of focused psychological therapies in Aboriginal contexts. Some practitioners believe that Aboriginal people are unable to express their thoughts in enough detail to enable CBT to be effective. However, psychologists at the Social and Emotional Well Being Unit at Central Australian Aboriginal Congress have been using CBT and other focused psychological therapies successfully for several years (personal communication, Central Australian Aboriginal Congress). There is every reason to believe that focused psychological therapies will be just as effective amongst Aboriginal people as they are amongst all other populations.

Addiction treatment evidence base

The strongest evidence for improving outcomes in Aboriginal AOD conditions is from socio economic initiatives that improve social determinants and supply reduction measures (Ministerial Council on Drug Strategy 2006b, D'abbs and Togni 2000). These two key strategies are not dealt with in this paper. However, AMSANT has been a key player in the alcohol debate in the Northern Territory and has an endorsed policy on alcohol supply. AMSANT and Aboriginal community-controlled services strongly advocate for action on improving the social determinants of health.

Mainstream treatment outcomes for AOD conditions are similar to those for other chronic diseases such as diabetes and asthma, despite the perception that treatment may be of limited effectiveness (Taskforce on Illicit Drugs 2001). A considerable proportion of both Aboriginal and non-Aboriginal problem drinkers stop or moderate their alcohol intake without any formal treatment (Brady 1993, Brady 1995, Hunter et al 2000). However, adverse social circumstances and other co-morbidities are often experienced by Aboriginal people and effort may need to be more intensive than in non-Aboriginal settings (Hunter et al 2000).

Integrated alcohol treatment and primary health care

Patients with drug and alcohol problems seen in specialist centres may lack a comprehensive primary health care approach to their problems (Furler et al 2000). A comprehensive approach is particularly important in treating Aboriginal people, given the high burden of chronic disease. A randomised trial found that integrated treatment which provided medical outpatient care and alcohol interventions in a combined outpatient clinic resulted in more attendances and improved rates of abstinence compared to medical treatment and referrals to specialist alcohol and drug treatment centres (Willenberg and Olson 1999). Another study found that those patients treated at AOD facilities with primary care providers on site had lower addiction severity (as measured by validated scales) at 12

months compared to those treated at sites without primary health care facilities (Friedman et al 2003). A prospective cohort study of patients with alcohol and heroin dependence followed patients for two years after residential withdrawal treatment and measured addiction severity at two years and visits to primary care providers. There was an inverse relationship between the number of visits to primary care providers and addiction severity with those who had visited primary care providers twice or more during the two year follow up, having significantly lower addiction severity compared to those with no visits to primary care providers (Saitz et al 2005).

Screening and Brief interventions

Screening and brief interventions in primary health care settings are generally well-received by patients (Saunders and Lee 1999). Without screening, around three quarters of alcohol problems will be missed in general practice (Saunders and Lee 1999). Compared to those receiving no intervention, studies have routinely found those receiving a brief intervention are at least twice as likely to modify their drinking (Wilk et al 1997). This finding has been confirmed by a Cochrane review (Kaner et al 2008). Qualitative evidence also suggests that Aboriginal patients accept brief intervention advice well from a health practitioner and that it can be effective, even late in a drinking career (Brady 1993, 1995). Introducing screening and brief intervention into general practice in a sustainable way is possible but requires both multi-faceted practitioner education and system support (Anderson et al 2004, Anderson 2003a). General practitioners are more likely to screen for alcohol problems if they can easily refer patients with more severe problems to specialist alcohol treatment services (Anderson 2003a, 2003b, Roche et al 2002).

Withdrawal treatment

Community withdrawal is recommended as the first option if the person has good social support, no major medical or psychological co morbidity, low risk of complicated withdrawal and good access to 24 hour medical support (NSW Health Department 1999). This may exclude many Aboriginal people because of the lack of a supportive home environment. However, if a home-like supported environment can be provided, this option may be available to a much higher proportion of Aboriginal people. Withdrawal (whether residential or community-based) should be best regarded as a gateway to further treatment rather than a treatment in itself (Healthcare Management Advisors 2005).

Rehabilitation

Outcomes for community-based rehabilitation are equivalent to residential rehabilitation if the person has adequate family and social supports (Healthcare Management Advisors 2005). Some people find it difficult to access residential services because of their family, social or work responsibilities and they may not wish to be away from their communities for long periods. However, an extended period of residential rehabilitation can be very beneficial for people whose social and family situation does not support them in stopping or reducing their alcohol or drug use (Ministerial Council on Drug Strategy 2006b). Residential rehabilitation should be reserved for those with more severe problems, lack of social and family support and past treatment failure, given its cost and evidence that outcomes of community-based treatment are equivalent (Healthcare Management Advisors 2005).

Alcoholics Anonymous

A recent Cochrane review found Alcoholics Anonymous to have equivalent efficacy to Cognitive Behaviour Therapy and motivational enhancement (Feri et al 2007). Some Aboriginal people may find AA too shameful and may prefer one-on-one interaction (Hunter et al 2000).

Pharmacotherapies

Acamprosate and Naltrexone have been shown to be effective in the prevention of relapse to heavy alcohol consumption. Both medications are well-tolerated and safe and have a modest but definite effect (Bouza et al 2004, Garbutt West et al 2001, Mason 2001, Streeton and Whelan 2001, Sirisuraponont and Jarururaisin 2003). There is limited evidence of the efficacy of Acamprosate and Naltrexone in general practice. A French primary care study found that Acamprosate did reduce drinking and improve quality of life compared to standard GP care and that retention rates were high (80%) at 12 months compared to trials in specialist centres (Kiritize-Topor et al 2005). Pharmacotherapies have been recommended in national guidelines for general practice treatment of alcohol problems but are generally under-utilised (Shand et al 2004).

Opiate replacement treatments have been proven to reduce drug use, overdose, HIV risk, and social and criminal consequences of drug use. Opiate replacement treatment is prescribed by general practitioners in Australia, provided they have undertaken accredited training, and is prescribed in AMSs in larger urban centres (Taskforce on Illicit Drugs 2001). More intensive specialist-based treatment has marginal benefit over community-based settings (Taskforce on Illicit Drugs 2001). Medications to assist with smoking cessation should be promoted to Aboriginal people given the high burden of smoking-related disease in this population.

Mental health and Dual Diagnosis Services

Mental health services have been provided successfully through Social and Emotional Well Being (SEWB) services for twenty or more years (Cooperative Research Centre on Aboriginal Health 2006). However, only the larger ACCHSs in the NT are able to provide a comprehensive SEWB service despite the documented need for these services in remote communities (Northern Territory Aboriginal Health Forum Emotional and Social Wellbeing Working Party 2003). People with dual diagnosis are usually believed to require specialist services even though dual diagnosis is common in primary care settings and specialist services are difficult to access. However, core counseling techniques such as CBT and problem solving therapy are effective in both mental health and AOD problems. There is also evidence of their efficacy in people with dual diagnosis (Best Practice in Alcohol and Other Drug Interventions Working Group 2000). An indigenous-specific screening tool has now been developed that can detect mental health and drug and alcohol issues as well as dual diagnosis. The tool (known as IRIS or Indigenous Risk Impact Screen and Brief Intervention) has been validated with other AOD and mental health scales, including the Audit Dependence Scale, Leeds Dependence Scale and the Depression, Anxiety and Stress Scale (Schlesinger et al 2007). It will enable detection of these problems at the primary health care level and allow for early intervention.

The multidisciplinary team

Recruitment and retention of health professionals

Recruitment and retention of health professionals is likely to be a major barrier to expanding the capacity of primary health care in remote areas for many years to come. Professional support from colleagues (medical and non-medical) has been found to be a positive factor in influencing retention in rural general practitioners (Gardiner et al 2005). Working in a multidisciplinary team including Aboriginal Health Workers is cited as a positive factor influencing retention by general practitioners in the NT (Ball 2005).

Lack of specialist services and professional isolation are key issues negatively impacting on GP retention (Ball 2006). Evidence from primary health care in the Top End indicates that general practitioners and other primary health care workforce do not feel confident in assessing Aboriginal mental health issues (Nagel 2006). The lack of a mental health workforce has been reported as a considerable source of stress in the remote primary health workforce (Harris and Robinson 2007).

Retention of Aboriginal staff

It is recognised that an Aboriginal workforce is vital to improving primary mental health and alcohol and other drug care and this includes Aboriginal psychologists, mental health nurses and social workers and not only certificate level paraprofessionals (Social Health Reference Group 2004, Ministerial Council on Drug Strategy 2006a). Issues contributing to poor retention of the Aboriginal health workforce include remuneration, high stress levels, lack of professional recognition and training and lack of career pathways (Mitchell and Hussey 2007). Aboriginal mental health, AOD and family support workers need to be well-supported and integrated into existing primary health care structures in ACCHSs (Harris and Robinson et al 2007). A program to incorporate Aboriginal mental health workers into primary health care in the Top End was hampered by a lack of clarity about their role in both mental health promotion and clinical illness and who would supervise and support them in these roles, poor support by management, rapid staff turnover and the resistance of other health professionals to the role of Aboriginal mental health workers (Harris and Robinson 2007).

These findings reinforce the need for a well-structured, comprehensive team-based approach to SEWB services in Aboriginal community-controlled services. It is clear that the valuable role being played by Aboriginal mental health workers was one of cultural broker and community liaison. In our model, we have called these workers Aboriginal Family Support Workers. AMSANT believes that the term 'Aboriginal mental health worker' should be reserved and used for a registered Aboriginal health worker who has completed the necessary mental health training in the new competency standards to become a specialised mental health worker. It is envisaged that with adequate training and support, such workers would be able to replace the need for mental health nurses. If this is shown to be the case, then Aboriginal mental health workers will need to be given the same access to Medicare item numbers as mental health nurses. The major constraint here is the stagnating number of registered AHWs and the lack of new people entering the profession.

Aboriginal AOD workers have certificate four level training in alcohol and other drugs. These workers are valuable team members in SEWB services but may require support and additional training to provide integrated AOD and mental health services.

Community development approaches

There is a lack of research on community-driven approaches to mental health promotion. The Family Life Promotion Program in Yarrabah in North Queensland is a well-documented example of local people successfully developing their own service model. The program arose because of three waves of suicides starting in the late eighties. The Aboriginal community received visiting mental health services from Cairns. They were concerned that people were referred to psychiatric services without consultation with families and returned "damaged". They identified a need for local people to respond rather than totally relying on outside visiting professionals (Hunter et al 2001).

The community received funding for local Aboriginal people to be trained to deal with mental health crisis. After initial success, a third wave of suicides occurred in the 1990s. A crisis group was formed and a large number of volunteer counselors were identified. The group gradually shifted its focus towards health promotion and was successful in obtaining funding for Aboriginal mental health workers. The workers did not have substantial formal training and dealt with a challenging environment, leading to worker stress and burnout. Training support was eventually obtained and protocols for dealing with mental health crisis and liaising with specialist services were developed. The visiting professional staff also provided mentoring and support.

Key features of the Family Life Promotion Program included:

- The program was driven by the community with active involvement of elders;
- It identified and worked with young people at risk;
- It was based on strengthening family and community supports and resources as well as identifying and treating illness;
- There were effective linkages with mainstream AOD and mental health agencies;
- The program worked collaboratively with agencies outside the health sphere, such as sporting bodies and recreation officers, to promote healthy activity (Hunter et al 2001).

6. Current services

Mental health services

Specialist mental health services in the NT are largely provided through stand-alone mainstream mental health services with remote outreach teams. Psychiatric inpatient beds are located in Alice Springs and Darwin hospitals. Major ACCHSs in urban areas have SEWB units, but the smaller ACCHSs usually do not provide mental health services and rely on infrequent remote visiting services. However, with the advent of the COAG mental health reforms, Divisions, the Red Cross and other private providers are now beginning to provide mental health services.

Only one third of ACCHSs can provide ongoing mental health care for the full range of common problems found in Aboriginal people, despite the majority identifying mental health as a major issue (OATSIH 2006). The lack of mental health services is particularly dire for remote communities. A study of 50 discrete Aboriginal communities located more than 10 kilometers from a hospital found that less than half (47%) had access to mental health professionals (OATSIH 2006).

In 2002-2003, nearly one quarter of all mental health admissions in the Top End were readmitted as an emergency within 28 days, indicating deficiencies in community mental health care (Nagel 2006). A review of mental health utilisation by Aboriginal people found that Aboriginal people were 1.6 -2.6 times more likely to have contact with mental health professionals compared to non-Aboriginal people (DoHA 2006). However, in the NT, contact for Aboriginal people was 11% less than the national average. This is likely to indicate unmet need rather than lower illness rates (DoHA 2006).

Other factors contributing to poor community mental health care for remote Aboriginal people include language barriers, insufficient capacity in primary health care, including a lack of GPs and nurse practitioners with appropriate mental health and cross cultural skills, a lack of appropriately-skilled Aboriginal Health Workers and poor mental health literacy in Aboriginal communities (GPPHCNT 2007, Nagel and Thompson 2007, Nagel 2006).

Alcohol and other drug services

AOD services are largely concentrated in the five regional centers (Darwin, Nhulunbuy, Katherine, Tennant Creek and Alice Springs) and include detoxification centres, residential rehabilitation services, sobering-up shelters and specialist community AOD treatment centres. Community-controlled and/or Aboriginal services included CAAAPU (Central Australian Aboriginal Alcohol Program Unit) and CAAPS (Council for Aboriginal Alcohol Program Services) both of which provide residential rehabilitation in the Alice Springs and Darwin area respectively. CAAPS also provides drug and alcohol training. The five ACCHSs located in regional towns all have Social and Emotional Well Being services. However, the level of resourcing of these services is not adequate to meet the demand and until relatively recently, some were not funded to provide alcohol and other drug services. Most do now have dedicated AOD positions through COAG funding. This has increased capacity but has worked against realising the AMSANT model where clinicians provide integrated rather than siloed care to people with AOD and /or mental health problems.

Nationally and in the NT, the proportion of AOD treatment services delivered to Aboriginal people is significantly higher than their population proportion. In the NT, 60% of services were delivered to Aboriginal people whereas nationally it was 9% (Jones et al 2005). Nationally and in the NT, there is a focus on residential rehabilitation in Aboriginal-specific services and these are usually based on an abstinence model. Many services have been designed for drinkers with a relative lack of services for other drugs, including injecting drug users and poly drug users (Ministerial Council on Drug Strategy 2006b, Healthcare Management Advisors 2005). In the NT, two thirds of services are provided primarily for alcohol misuse (Jones et al 2005). Nationally and in the NT, there has also been a lack of emphasis on prevention (apart from largely ineffective stand-alone events that are not integrated into ongoing care) and early intervention, especially in primary health care (Ministerial Council on Drugs 2006b, Healthcare Management Advisors 2005). There is also a lack of effective after care systems for those discharged from residential rehabilitation (Healthcare Management Advisors 2005).

In the NT, mainstream services have not always modified their services to suit Aboriginal needs. There is a lack of services in some areas (Katherine, Tennant creek, all remote areas) and a lack of linkage between services in AOD and between AOD and mental health and AOD and welfare/ancillary support services (Healthcare Management Advisors 2005). The Taskforce on Illicit Drugs in 2001 identified several areas of weakness, including services to people under eighteen, aftercare and early

intervention, and community-based responses. The Taskforce recommended a proactive strategy with Aboriginal illicit drug use, given the concerns about cannabis use and the potential for rapid uptake of other illicit drugs (Taskforce on Illicit Drugs 2001).

Recent Developments in Alcohol and Other drug treatments in primary health care

In 2007, COAG funding was provided to improve AOD services in remote communities by funding AOD workers in selected remote communities in both government and community controlled clinics. These workers were supported by a central workforce coordinator unit within Remote Health (DoH NTG). At the same time, short term funding was made available to respond to alcohol issues through the NTER, with this funding initially only guaranteed from late 2007 to 30th June 2008. This funding provided for 24 additional AOD positions in primary health care in five ACCHSs and one AOD service. A clinical director was also appointed with a pre requisite that this position be a doctor with AOD experience. At the end of the NTER funding, all of the ACCHSs that had appointed additional short term positions received funding for ongoing positions through COAG 2008 AOD funding, although some teams had to be reduced in size. The Clinical Director position was continued but when it became vacant in 2010, a decision was made that the primary need of the remote AOD workforce was for clinical supervision of counselling rather than for medical oversight. Importantly, despite these recent workforce developments, the majority of remote communities do not have access to on site AOD workers and still rely on infrequent visiting mental health services.

Regional ACCHSs that have been supported through COAG funding have generally employed teams of workers usually consisting of one professional with relevant AOD experience and two community workers who are supported to undergo further training.

The remote AOD workforce support unit is located within Remote Health and now consists of a remote workforce coordinator, a clinical psychologist and a training position. This unit has provided support to the workforce in both the community controlled sector and workers based within Remote Health (DHF) and has also produced resources such as assessment forms and treatment resources.

As noted in the preface, aspects of the NTG Remote AOD support unit's Best Practice Model conflict with AMSANT's model. However, there is also significant agreement over core principles, including that both community development and clinical treatment are required and that Aboriginal workforce is crucial. The Best Practice Model developed by the workforce unit states that a key principle is that if one worker only is to be employed in a remote clinic, that this worker should be an Aboriginal person. AMSANT believes that a multidisciplinary team is required and that a single AOD worker within a PHC service will only be able to provide a very limited service and is an unsustainable model.

Central Australian Aboriginal Congress has also received funding through the Alice Springs Transformation Plan to provide ambulatory treatment for people with alcohol related problems in Alice Springs.

Legislative Alcohol reforms in the NT

The NT is currently implementing major AOD reforms (Enough is enough) based on the principle that access to alcohol is a privilege rather than a right and that it is justifiable to withdraw that privilege if a person is putting others at significant harm from their drinking. The reforms include

1) Establishment of an AOD tribunal that can assess people referred because of harmful alcohol consumption, particularly if it is harming others. This is a non-criminal tribunal which will have the power to ban someone from buying takeaway alcohol and to quarantine welfare income.
2) A system of banning orders issued for drink driving offences, violent offences related to alcohol and being in protective custody repeatedly. People who are banned may be reviewed by a clinician (doctor, nurse or AHW) and have their banning order reduced if the clinician feels this is appropriate. This is not possible if the banning order was issued because of alcohol related violent offences.
3) Requirement to show photo ID when buying takeaway alcohol so that those who are on a banning order can be refused purchase.
4) Reforms to the criminal justice system so that people charged with alcohol related offences will be dealt with by a specific alcohol court which will also be able to issue banning orders and where people will be assessed by a clinician and can have their sentence reduced if they engage in treatment.

AMSANT is strongly supportive of these reforms but is disappointed that a floor price has not been introduced as outlined in AMSANT's Alcohol control policy. The reforms will enable clinicians to help those with the most entrenched drinking problems. Reducing a person's access to alcohol is likely to assist them even if they will not accept drug and alcohol treatment. Importantly, alcohol and other drug treatment can only be recommended by the Tribunal but cannot be made mandatory. There is little evidence that mandatory treatment is effective and there are considerable ethical issues with enforced treatment out of the criminal justice system (Pritchard et al, 2007).

7. The AMSANT model for integrating AOD and community mental health care into Aboriginal Medical Services in the NT

Rationale for the AMSANT model

The rationale for an enhanced social and emotional well-being (SEWB) system in ACCHSs, including remote services, that includes both drug and alcohol and mental health services, can be summarised as follows:

- AOD and mental health issues cause a high burden of both mortality and morbidity in the Aboriginal population in the NT.
- There is unmet need for services for Aboriginal people, especially in remote areas.
- The most effective and efficient way to provide these services is to ensure they are community-based and operating through the existing primary health care service infrastructure. The creation of multiple service providers, especially in remote areas, is making the service system unnecessarily complex and more fragmented.
- Dual diagnosis is common and generally poorly dealt with in the specialist AOD and mental health sectors.
- Treatment for both AOD and mental health issues needs to be addressed in a culturally-effective, holistic way that also addresses determinants of these problems at a community and individual level. Aboriginal communities should control theses services.

- Therapies such as Cognitive Behaviour Therapy and problem solving therapy are effective in both mental health and AOD problems.
- Treatment for mental health and AOD problems needs to be integrated with other aspects of primary health care, including medical care and health promotion.
- There is a paucity of Australian research evidence for Aboriginal mental health and AOD services, either in specialist or Aboriginal services. However, many ACCHSs have been successfully providing mental health and AOD services in SEWB units during the last twenty years.
- A model is required that allows for the full range of services to be provided to remote populations through Aboriginal community-controlled health services.
- The model needs to be centred on multidisciplinary SEWB health teams, including a strong Aboriginal workforce.

AMSANT Model and comprehensive primary health care

Comprehensive primary health care is first level care which is universally available, scientifically sound as well as socially and culturally acceptable. It addresses equity both at the individual level but also at the political and community level and collaborates with other sectors to improve health outcomes. Community participation and control is a key feature of comprehensive primary health care as defined by the declaration of Alma Ata (World Health Organization).

Aboriginal community-controlled health services deliver comprehensive primary health care which encompasses:

- Health promotion
- Illness prevention
- Treatment and care of the sick
- Community developments
- Advocacy
- Rehabilitation (World Health Organization)

SEWB services are a key part of this model, in line with the Aboriginal view of emotional and physical health being inseparable. The model advocated by AMSANT is based on the provision of SEWB and AOD services within ACCHSs as part of comprehensive primary health care[68]. The model encompasses the full spectrum of responses, including prevention, screening and early intervention, treatment, rehabilitation and welfare support. Specialist services would be provided within the comprehensive primary health framework. The model also allows for flexibility at the local level.

Community development approach

The AMSANT model is based on a community development approach, utilising Aboriginal Family Support Workers whose core function will be around working with families and building resilience in their communities using an approach that builds on cultural and community strengths. They will also work with individuals and families with significant mental health and AOD issues in conjunction with

[68] The model recognises that some AOD and mental health services are not part of PHC, including residential rehabilitation and treatment; community-based residential withdrawal and hospital withdrawal; respite care and supported accommodation services; acute psychiatric hospital services; and supported employment programs.

counselors and psychologists. The Aboriginal Family Support Workers will be local people with strong community and kinship networks. This will enable them to work at an individual, family and community level. Each remote community will have at least one male and one female worker.

The workers will be provided supervision and support from counselors and psychologists for their work with individual patients and families. However, they will determine their own work priorities and preventative approaches in conjunction with senior Aboriginal management. These work priorities would focus on health promotion and preventative activities within their own communities. This will allow for a culturally-strengthening approach that enhances access to cultural interventions and psychological and other treatments. The Aboriginal Family Support Workers will work with other preventative services, including universal home visitation services for women with young children and other welfare and family support services. Aboriginal family/community workers have been at the core of the SEWB unit at Anyinginyi Congress in Tennant Creek for several years.

Clinical service delivery

Overview

The clinical service delivery is based on integrating AOD and mental health services utilising common evidence-based approaches such as Cognitive Behaviour Therapy. Aboriginal Family Support Workers will be supported by counselors, mental health nurses and psychologists skilled in both AOD and mental health treatment.

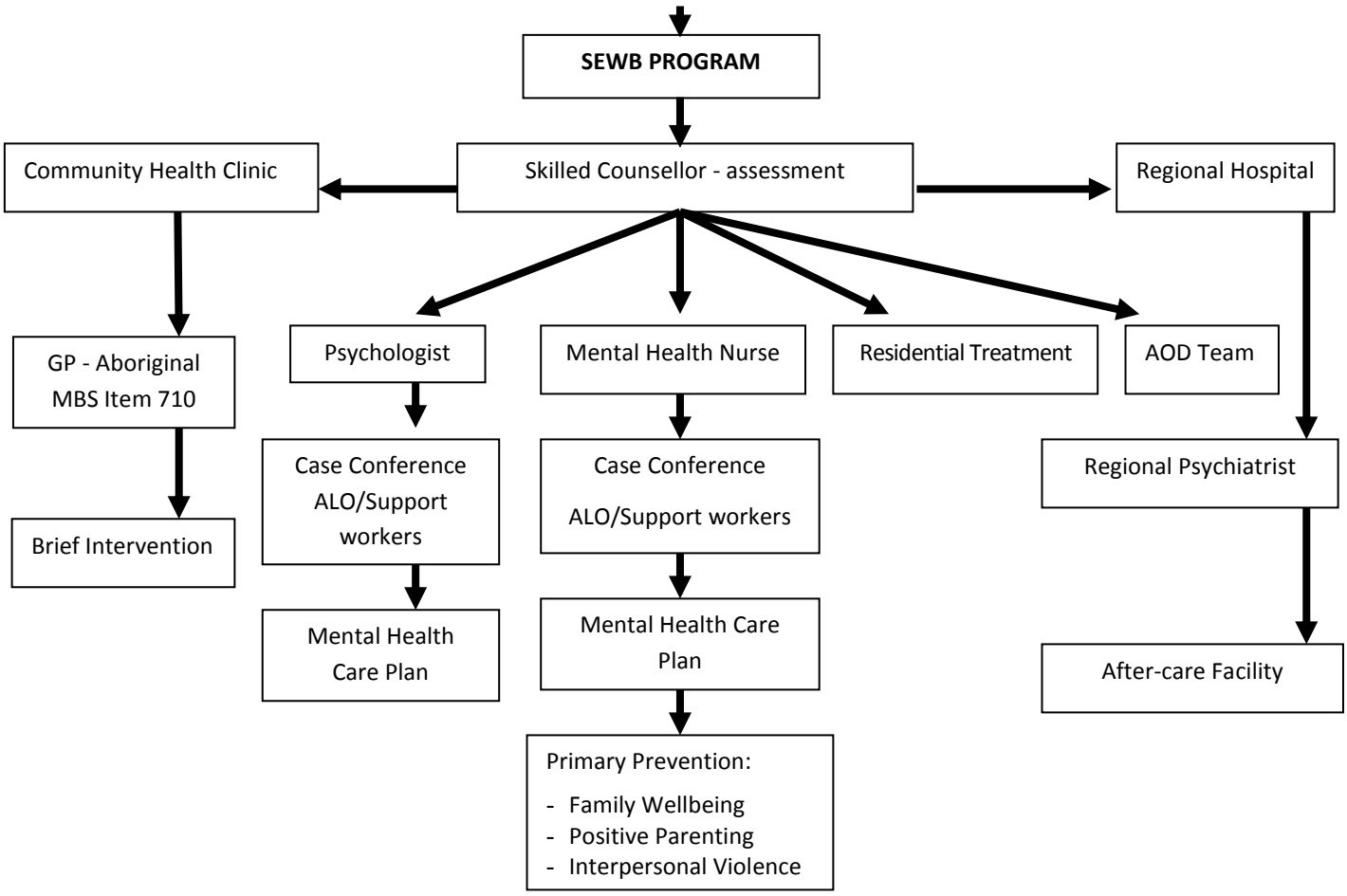
The following clinical components will be provided through this model:

- Entry through multiple points including self referral;
- Screening and brief interventions for clinical AOD and mental health problems and people at high risk of developing problems;
- Multidisciplinary care plans and mental health care plans for those with significant AOD and mental health issues involving client, family and community;
- Clinical pathways for common mental health and alcohol conditions;
- Rehabilitation and case management;
- Clear protocols and pathways for referrals to external agencies and shared care;
- Professional support and training for mental health workers;
- A workforce model based on population.

Entry to the SEWB service

Patients or families can self-refer to Aboriginal Family Support Workers or counselors in the SEWB unit and be triaged according to the assessment, with options including the primary health care team, the psychologist, mental health nurse, acute psychiatric services, the AOD worker and residential withdrawal services (see flow chart for SEWB referral). Other referral points include through primary health care (either via screening or via a presenting problem), external agencies, including schools and welfare agencies, and from secondary or tertiary services (see Entry Via Social and Emotional Wellbeing Pathway).

ENTRY VIA SOCIAL & EMOTIONAL WELLBEING PROGRAM



Screening and brief interventions

ACCHSs aim to screen all adult patients yearly using the Medicare item 710 (Aboriginal adult health check). Screening for AOD and mental health problems will incorporate into this screen, using the Audit C and Iris screening tools. Screening for illicit drugs will also be incorporated into the assessment. Screening will also occur opportunistically especially when the person is at high risk e.g. if they have a family history of mental illness or they have previously had mental illness or AOD problems. If the person is identified as being at risk of mental health or AOD problems, a brief intervention will be offered with an invitation for more help if required. Brief interventions will also be offered if the individual has a major AOD and/or mental health problem, but does not want in-depth assessment at that point.

Multidisciplinary care plans

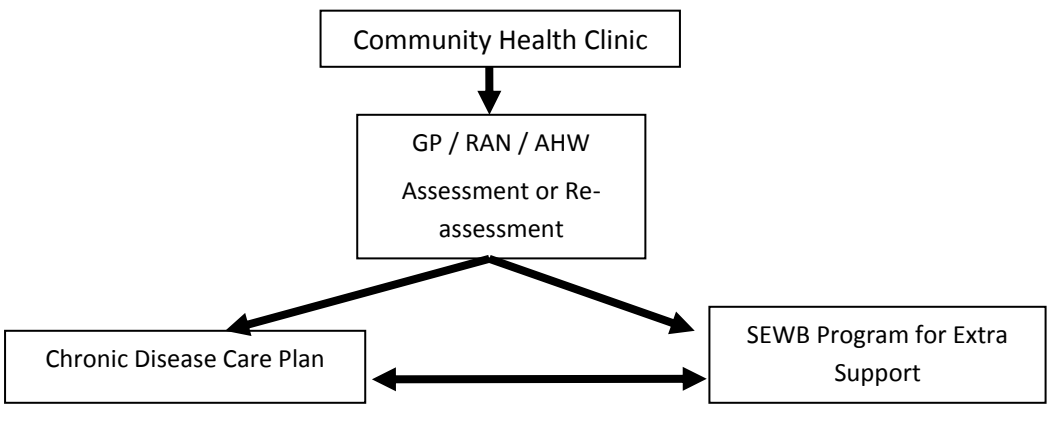
Patients are eligible for a Medicare Extended Primary Care mental health care plan for a wide range of AOD and mental health problems. At assessment, eligible patients who are willing to participate in ongoing care will have a care plan formulated. The planning process would include the patient and their family as well as other significant people in the person's life. The professionals involved would depend on the presenting problem but would always include the general practitioner and the Aboriginal Family Support Worker and would include at least one of the allied health professionals involved in the team (counselor, Aboriginal mental health /AOD worker, mental health /AOD nurse or psychologist). The plans will include clinical components but also focus on broader psychosocial aspects including home support and supported employment where appropriate.

Clinical pathways

Community health pathway

Patients with significant AOD and/or mental health problems who present to the primary health care team and who want further help will be referred for assessment by a qualified mental health worker. Patients who are dealing with chronic illness and may be struggling to maintain their health and adapt to treatment regimes will also be referred for supportive counseling and treatment of associated depression or grief (see comprehensive primary health care - chronic disease flow chart).

COMPREHENSIVE PRIMARY HEALTH CARE (CHRONIC DISEASE)



Alcohol and other drug pathway

The following steps will be followed in those presenting with AOD problems:

- Assess for dependence and the need for withdrawal services (including whether the person requires supported accommodation or referral to residential or hospital withdrawal);
- Manage community-based withdrawal according to CARPA (Central Australian Remote Practitioner Association) guidelines if the patient meets the criteria for home-based withdrawal. This will involve daily supervision and working with the family;
- If the person is not physically dependent, they can be offered ongoing support as for dependent patients post-withdrawal.

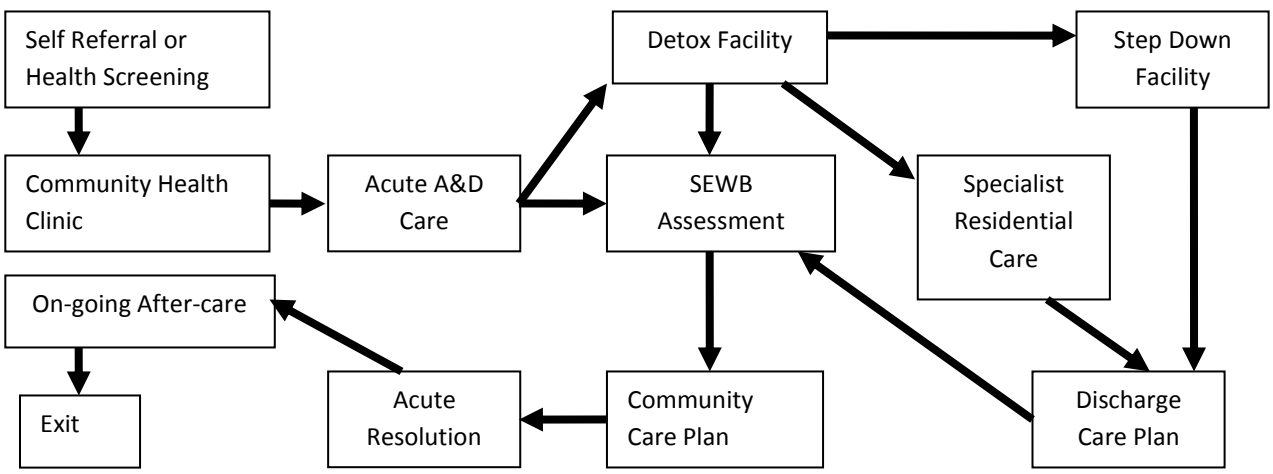
Those who are suitable can be offered a supported home withdrawal. If the person does not have major medical complications but does not have suitable home environment, they can be offered supported accommodation whilst undertaking a home withdrawal. This would greatly increase the number of people eligible for home withdrawal. Those who are not suitable for supported home withdrawal will be referred to a residential withdrawal service.

After-care and relapse prevention

After-care is required in the community where the client lives, following the successful completion of residential treatment. It is a service that needs to be embedded in the local community-based primary health care service and cannot be effectively provided on a visiting outreach basis.

A plan for ongoing care will be formulated in conjunction with the patient, family, Aboriginal Family Support Worker, counselor and, if required, other allied health professionals and the general practitioner. Evidence-based approaches to relapse prevention and counseling will be offered, including CBT and motivational interviewing. Alcoholics Anonymous will also be offered to those interested. Patients who do have a major relapse will be able to re-enter treatment through the primary health care clinic or the SEWB unit (See acute alcohol rehabilitation pathway).

ACUTE ALCOHOL REHABILITATION PATHWAY

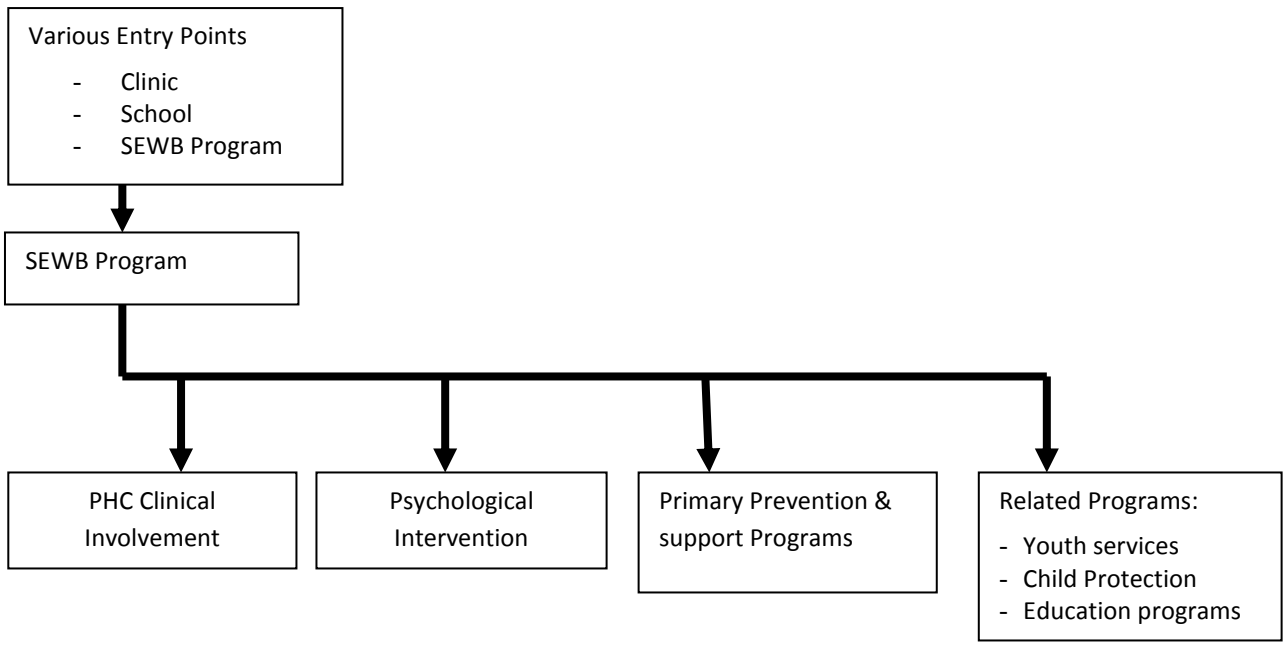


In order to ensure the seamless transition and continuity of care from residential treatment facilities to community-based follow-up or after-care, the psychologists and Aboriginal Family Support Workers in the primary health care SEWB teams should be involved in providing care to clients while they are within residential treatment. For clients from the same town as the residential treatment centre, the psychologist could provide all of the necessary CBT sessions. For clients from more remote communities, the psychologist would need to enter a shared-care arrangement with a resident psychologist in the rehabilitation service.

Grief and loss pathway

Issues relating to grief and loss and family stress could be identified through the clinic, school or by direct referral. Individuals or families with these problems would be supported through primary prevention programs such as family visiting and support services, but would also be supported through psychological assistance to the family or individuals. Other programs which could provide support as needed to individuals and families include youth programs and education support. See grief/loss flow chart.

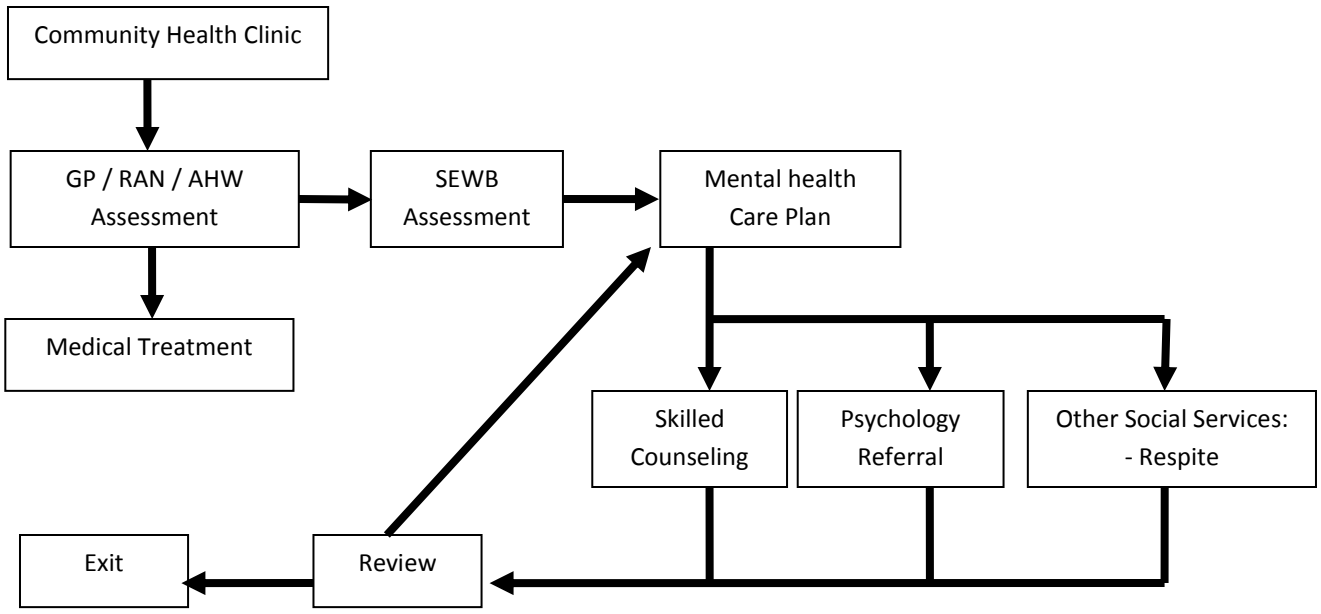
GRIEF AND LOSS (FAMILY STRESS)



Anxiety and depression pathway

People with anxiety and depression will have an Extended Primary Care mental health care plan and be referred for counseling by either the counselor or the psychologist. If severe or not improving, they will be referred back to the primary health care team for consideration of medications. Other supports, such as respite from family responsibilities, can be organised in conjunction with Aboriginal Family Support Workers. Patients who fail to improve will be referred for specialist assessment. This is outlined in the basic depression/anxiety pathway.

BASIC DEPRESSION/ANXIETY PATHWAY



Low prevalence psychotic disorders pathway

Low prevalence psychotic disorders (schizophrenia, bipolar disorders etc) need psychiatric review and case management. The management may need to be through a shared-care arrangement until the person's health is stable. However, many of these chronic disorders would be best managed within a comprehensive primary health care framework with yearly or six monthly psychiatric review when stable, case management within the ACCHSs, and referral for urgent assessment if unstable.

Clinical pathway for young people

Young people aged 12-18 will be provided with support through Aboriginal Family Support Workers and counselors. Young people could be referred to youth-specific services if available and appropriate. Young people with particularly complex problems will be seen by the psychologist and may need to be referred on to child and adolescent specialist services However, local community people would initially be best placed to identify troubled young people and work with them and their families.

Pathway for families with younger children

Families in which children are having behavioral problems will be supported by Aboriginal Family Support Workers and counselors, in conjunction with other specialist workers if required, including paediatric review. Common behavioral issues will usually be dealt with by a community-based family strengthening approach. Mental health, AOD, welfare and housing issues affecting the parenting capacity of the family can be addressed in a holistic way through this model.

Dual diagnosis

It is expected that some degree of dual diagnosis will be very common. Patients with dual diagnosis will be assessed and managed for their presenting problems by the SEWB team without requiring specialist dual diagnosis workers or services. This will stop the "buck-passing" that occurs between

specialist AOD and mental health services. Alcohol dependence and other addictions may need to be dealt with first before the psychological issues can be fully treated. However, they will generally be treated concurrently.

Rehabilitation and Case Management

Patients and families will be referred to services that can assist with housing, employment and education. Patients with more severe problems, including those with psychotic disorders, dual diagnosis and individuals or families with multiple social and family issues, will be offered more intensive case management by an experienced member of the team. This will include liaison with the family and other agencies involved in the care of the individual and regular review of the care plan in conjunction with other members of the treatment team, including the primary health care team.

Pharmacotherapies and Psychiatric Medication

With appropriate specialist support and training, general practitioners would provide most of the medical management. In the larger regional centres, visiting psychiatrists would be part of the SEWB teams and would be directly responsible for the management of clients with more complex and severe problems. They would also visit remote communities to see complex patients. Treatments provided by general practitioners would include:

- Pharmacotherapies for alcohol relapse prevention (Naltrexone and Acamprosate);
- Opiate replacement therapy;
- Smoking therapies (Nicotine Replacement Therapy, Variciline, Bupinorphone);
- Psychiatric medication, including antidepressants and antipsychotic medication.

Referrals and shared-care

A coordinated approach to referral and post discharge care would be required with:

- Residential and hospital detoxification centres;
- Residential rehab/therapeutic communities;
- Acute psychiatric services.

A coordinated approach to referral and shared-care would be required for:

- Specialist drug and alcohol services;
- Community mental health service.

An effective referral system and joint case management for complex clients would be required for:

- Supported employment services;
- Housing services;
- Educational support.

Support and professional development

Primary health care staff

Primary health care staff would require some up-skilling in screening, brief interventions and other basic techniques such as motivational interviewing. This could be provided through larger ACCHSs or through Divisional programs.

Aboriginal Family Support Workers

Aboriginal Family Support Workers will be offered training in community development approaches and mental health and AOD assessment and treatment through the community health worker stream of health worker training at certificate 1 and 2 levels. They will also be encouraged to qualify as Aboriginal mental health workers through accredited training, but this won't be mandatory.

Nurses

Nurses will often have experience and training predominantly in AOD or mental health assessment and management. They will need appropriate upskilling tailored to their specific needs. This may include training in cognitive behavioural therapy and other focused psychological therapies.

Allied health: Training in dual diagnosis and cultural training

Mostly psychologists and counselors will have experience in either the AOD or mental health system. They will be offered appropriate up-skilling through professional associations so they are competent in mental health, AOD and dual diagnosis problems. Allied health staff will also be provided with cultural orientation and mentoring through working with Aboriginal Family Support Workers.

Ongoing support for workers

Aboriginal Family Support Workers will need support if this model is to be sustainable, given the level of distress and grief in Aboriginal communities. Aboriginal Family Support Workers would be supported by senior Aboriginal management in ACCHSs and by their peers. Psychologists would provide professional support and training to counselors, Aboriginal mental health workers and Aboriginal Family Support Workers in dealing with clinical issues. Each professional group in the model would be encouraged to join peer networks for professional support with workers from groups of smaller services forming professional networks. Ongoing professional development would be provided as part of this model.

Workforce

The core social and emotional well-being team

A community of 1500 people would require four Aboriginal Family Support Workers (including at least one of each gender) with one position identified as a manager, two skilled counselors able to deliver CBT, and two of either a mental health/AOD nurse or registered Aboriginal Mental Health/AOD Worker. It would be important to ensure that the whole team had an appropriate mix of competencies across mental health and AOD problems and that a training strategy was developed for the workforce. This workforce would be in addition to the core primary health care clinical staff of two general practitioners, six nurses and eight Aboriginal Health Workers. If the population size was 750 or more, the team would be based in the clinic. If the population size was smaller than 750, the team would be zonal but would be based in the largest community in the zone. However, the Aboriginal Family Support Workers would be based in their own communities.

Specialist workforce: Psychologists and psychiatrists

Psychologists would be based zonally with one for every 1500 people. They would provide supervision to counselors and see those with more complex situations, including addiction, interpersonal violence and complex problems in young people. There would be one psychiatrist for every 8,000 people, based in the regional centres of Nhullunbuy, Katherine, Tennant Creek, Alice Springs and Darwin. This is slightly higher ration than the national average of 1 per 10 000 because of the higher rates of AOD and mental health problems in the Northern Territory (Australian Medical Workforce Advisory Committee 1999).

Funding

Funding sources include the COAG mental health and AOD funds. Supplementary funds would be procured through Medicare mental health care items. There should also be a funds pooling arrangement with the Department of Health and Community Services, as much of the workload of community mental health and AOD treatment currently provided in the specialist community mental health and AOD sector would be provided through ACCHSs in this model. Also, increase in community care should result in reduced admissions and readmissions for psychiatric care as well as reduced need for residential withdrawal and rehabilitation services.

Funds should be allocated in a planned manner according to need through the Northern Territory Aboriginal Health Forum and not through a competitive tendering approach. They should also be allocated according to the population staffing ratios outlined in this document given the evidence of unmet need with current service provision and the strong endorsement of SEWB services being provided through ACCHSs in multiple inquiries and government strategies. This model is evidence-based and will cater to the diverse needs of the NT Aboriginal population.

References

Anderson, P., Kaner, E., Wutzke, S., Funk, M., Heather, N., Wensing, M., Grol, R., Gual, A., & Pas, L. (2004). Attitudes and managing alcohol problems in general practice: An interaction analysis based on findings from a WHO Collaborative Study. *Alcohol and Alcoholism* 39(4): 351-356.

Anderson, P. (2003a). The risk of alcohol. What general practice can do (PhD thesis). Chapter 8: Engaging GPs in the management of alcohol problems: Results of a meta analysis. Accessed at http://webdoc.ubn.kun.nl/mono/a/anderson_p/riskofal.pdf p 127-137.

Anderson, P., Kaner, E., Wutzke, S., Funk, M., Heather, N., Wensing, M., Grol, R., Heather, N., & Saunders, N. (2003). Attitudes and management of alcohol problems in general practice. A descriptive analysis based on findings of a World Health Organization International Collaborative Survey. *Alcohol and Alcoholism*, 38(6): 597-601.

Arkowitz H, Westra H. (2004). Integrating motivational interviewing and cognitive behaviour therapy in the treatment of depression and anxiety. *J Cognitive Psychother*. 18:337-350.

Australian Bureau of Statistics: *National Aboriginal and Torres Strait Islander Health Survey, 2004-05.* Accessed at www.abs.gov.au/AUSSTATS/abs@.nsf/ProductsbyCatalogue/C36E019CD56EDE1FCA256C76007A9D36?OpenDocument.

Australian Medical Workforce Advisory Committee (1999). The specialist psychiatry workforce in Australia, supply requirements and projections, 1999-2010. Accessed at www.health.nsw.gov.au/amwac/amwac/pdf/psychiatrya201999.7.pdf on 26.2.2008.

Ball C (2006). GP recruitment and retention in NT Aboriginal health. GPPHCNT, Darwin.

Best Practice in Alcohol and Other Drug Interventions Working Group (2000). Evidence Based Practice Indicators. For Alcohol and Other Drug Interventions. Literature Review. September 2000.

Bignault I and Ryder C (1997). Abstinence and alcohol use amongst urban Aborigines in Western Australia. *Drug and Alcohol Review* 16 :(4): 365 -371.

Bisson J, Andrew M (2007). Psychological treatment of post-traumatic stress disorder (PTSD). *Cochrane Database Systematic Rev*. 18 (3):CD003388.

Bouza C, Magro A, Mufioz A, Maria A. (2004). Efficacy and safety of Naltrexone and Acamprosate in the treatment of alcohol dependence: a systematic review. *Addiction*. 99:811–28.

Brady M (2004). *Regulating Social Problems: The Pokies, the Productivity Commission and an Aboriginal Community*. The Centre for Aboriginal Economic Policy Research. Discussion paper No. 269/2004 T.

Brady M (1995). *Giving away the Grog, Aboriginal accounts of drinking and not drinking*. The Drug Offensive, Department of Human Services and Health. AGPS Canberra.

Brady (1993). Giving away the grog. An ethnography of Aboriginal drinkers who quit without help. *Drug and Alcohol Review* 12(4).401-414.

Butler A, Chapman J, Forman E, Beck A. (2005). The empirical status of cognitive-behavioral therapy: a review of meta-analyses. 26(1):17-31. *Epub* 2005 Sep 30.

Chikritzhs, Tanya; Stockwell, Tim; Pascal, Richard (2005). The impact of the Northern Territory's Living With Alcohol program, 1992-2002: revisiting the evaluation**.** *Addiction.* 100(11):1625-1636.

Clough AR, d'Abbs P, Cairney S, Gray D, Maruff P, Parker R, O'Reilly B.(2005). Adverse mental health effects of cannabis use in two indigenous communities in Arnhem Land, Northern Territory, Australia: exploratory study. *Australian and New Zealand Journal of Psychiatry*. 39(7):612-20.

Clough AR, D'Abbs P, Cairney S, Gray D, Maruff P, Parker R, O'Reilly B. (2004). Emerging patterns of cannabis and other substance use in Aboriginal communities in Arnhem Land, Northern Territory: a study of two communities. *Drug and Alcohol Review*. 23(4):381-90.

Condon JR, Warman G, Arnold L (editors). (2001). *The Health and Welfare of Territorians*. Epidemiology Branch, Territory Health Services, Darwin.

Cottrell D, Boston P Practitioner Review (2002). The effectiveness of systemic family therapy for children and adolescents. *Journal of Child Psychiatry and psychology and allied disciplines*. 43(5): 573-586.

Cooperative Research Centre for Aboriginal Health (2006). Research Program Statement: Social and Emotional Wellbeing. http://www.crcah.org.au/research/socialandemotionalwellbeing.html (Accessed February 2008).

D'abbs, Togni S. (2000). Liquor licensing and community action in regional and remote Australia: a review of recent initiatives. *Aust N Z J Public Health*. Feb; 24(1):45-53.

DoHA (2007). Alcohol treatment guidelines for Indigenous Australians. Accessed at www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2006-cp-pyn073.htm

DoHA (2006). Aboriginal and Torres Strait Islander Health Performance Framework 2006. Accessed at www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2006-cp-pyn073.htm

Edwards, M. & Steinglass, P. (1995). Family therapy treatment outcomes for alcoholism. *Journal of Marital & Family Therapy*, 21(4): 475-509.

Ferri M, Amata L, Davoli M. Efficacy of Alcoholics Anonymous and other 12 step programs. *Cochrane Database of Systematic Reviews*, 2006.

Friedmann P, Zhang Z, Hendrickson J, Stein MD, Gerstein D. (2003). Effect of primary medical care on addiction and medical severity in substance abuse treatment programs. *J Gen Intern Med.* 2003 Jan; 18(1):1-8.

Furler, J., Patterson, S., Clark, C., King, T., & Roeg, S. (2000). *Shared Care: Specialist Alcohol and Drug Services and GPs working together.* Turning Point Drug and Alcohol Service Inc. Fitzroy, Victoria.

Garbutt, J., West, C. et al. (1999). Pharmacological treatment of alcohol dependence: a review of the evidence. *JAMA,* 281(14): 1318-25.

Gardiner M, Sexton R, Durbridge M, Garrard K. (2005). The role of psychological well-being in retaining rural general practitioners. : *Aust J Rural Health* : 13(3):149-55.

General Practice and Primary Health Care Northern Territory (GPPHCNT) (2007). Indigenous mental health in the NT. Allied Health work force study. Epidemiology of Aboriginal mental illness in the Northern Territory- Literature review.

Gerstein D, Harwood H (eds) (1990). *Treating drug problems. Volume 1: A study of effectiveness and financing of public and private drug treatment systems.* Washington DC: National Academy Press.

Haggerty J, Reid R, Freeman G, Starfield B, Adair C, McKendry R. (2003). Continuity of care: a multidisciplinary review*. British Medical Journal*. **327**(7425): 1219-21.

Harris A and Robinson G (2007). The Aboriginal Mental Health Worker Program: The challenge of supporting Aboriginal involvement in mental health care in the remote community context. *Australian e-Journal for the Advancement of Mental Health (AeJAMH).* 6(1) ISSN: 1446-7984.

Healthcare Management Advisors: Northern Territory Department of Health and Community Services. (2005*). Alcohol and Other Drug Program: Profile of Services and Interventions Project. Final Report*.

Huibers M, Beurskens AHJM, Bleijenberg G, Schayck CP van (2007). Psychosocial interventions by general practitioners. *Cochrane Database of Systematic Reviews 2007*, Issue 3. Art. No.: CD003494. DOI: 10.1002/14651858.CD003494.pub2.

Human Rights and Equal Opportunity Commission (1997). *Bringing them Home. Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families*. Canberra.

Hunot V, Churchill R, Silva de Lima M, Teixeira V (2007). Psychological therapies for generalised anxiety disorder. *Cochrane Database Syst Rev*. 24; (1):CD001848.

Hunter J (2004). Commonality, difference and confusion: Changing constructions of indigenous mental health. *Australian e-Journal for the Advancement of Mental Health (AeJAMH)*.3, (3).

Hunter E, Reser J, Baird M, Reser P. (2001). An Analysis of Suicide in Aboriginal Communities of North Queensland: The Historical, Cultural and Symbolic Landscape. Accessed at Indigenous HealthInfonet.

Hunter E, Brady M, Hall W (2000). Recommendations for the clinical management of alcohol related problems in Aboriginal primary care settings. Accessed at Indigenous HealthInfonet: Alcohol: Resources /Guidelines and Recommendations.

Irvin JE, Bowers CA, Dunn ME, Wang MC. (1999).Efficacy of relapse prevention: a meta-analytic review. *J Consult Clin Psychol*. 67:563–70.

Jones C, Zhang X, Dempsey K, Schwarz N, Guthridge S (2005). *The Health and Wellbeing of Northern Territory Women: From the Desert to the Sea*. Department of Health and Community Services, Darwin.

Johnston E (1997). Royal Commission into Aboriginal Deaths in Custody. Accessed at www.austlii.edu.au/au/special/rsjproject/rsjlibrary/rciadic on 24/2/2008.

Kane E, Heather N, McAvoy B, Lock C, Gilvarry E (1999). *Intervention for excessive alcohol consumption in primary health care: attitudes and practices of English general practitioners*. 34:559–66.

Kane, E, Beyer F, Dickinson H, Piennar E, Campbell F, Schleisinger C, Heather N, Saunders J and Burnaud B. (2008). Effectiveness of brief alcohol interventions in primary care populations (Cochrane Review). *The Cochrane Library*. Issue 2.

Kiritze-Toper P, Huas D, Rosenzweig C, Comte S, Paille F, Lehert P. (2005). A pragmatic trial of Acamprosate in the treatment of alcohol dependence in primary care. *Alcohol* 39:520–7.

Mason, B. (2001). Treatment of alcohol-dependent outpatients with Acamprosate: a clinical review. *Journal of Clinical Psychiatry* 62 (Supplement 20): 42-8.

Mattick RP, Ward J, Hall W (1998). 'The role of counseling and psychological therapy'. In Ward J, Mattick RP, Hall W (eds.) *Methadone maintenance treatment and other opioid replacement therapies*. Netherlands: Harwood Academic Publishers.

Mclellan A, Hagan A , Levine M, Meyers K, Gould F, Bencivengo M, Durrel J, Jaffe J.(1999).Does clinical case management improve outpatient addiction treatment? *Drug and Alcohol Dependence* 55(1-2):91-103.

Measey M, Li S, Parker R. (2005). *Suicide in the Northern Territory 1981-2002*. (2005). Health Gains Planning, Department of Health and Community Services.

Miller WR, Hester RK (1986).The effectiveness of alcohol treatment: What research reveals. In Miller WR, Heather N (eds). *Treating addictive behaviours: Processes of change*. New York: Plenum Press.

Ministerial Council on Drug Strategy. (2006a). *National Drug Strategy. Aboriginal and Torres Strait Islander People Complementary Action Plan. 2003-2009*.

Ministerial Council on Drug Strategy. (2006b). *National Drug Strategy. Aboriginal and Torres Strait Islander People Complementary Action Plan: 2003-2009. Background Paper.*

Mitchell M and Hussey L. (2006). The Aboriginal health worker. *eMJA.* 184 (10): 529-530.

Moon C. (2006). *Northern Territory Drug Trends. Findings from the Illicit drug reporting system: Injecting Drug Reporting System*. National Drug and Alcohol Research Centre. Technical Report no 271.

Nagel T. (2006). The need for relapse prevention strategies in Top End remote indigenous mental health. *Australian e-Journal for the Advancement of Mental Health (AeJAMH)*.5, (1).

Nagel T and Thompson C. (2007).AIMHI NT 'Mental Health Story Teller Mob': Developing stories in mental health. *Australian e-Journal for the Advancement of Mental Health (AeJAMH)*. 6 (2).

National Drug Research Institute (2007).National alcohol indicators. Trends in alcohol-attributable deaths among Indigenous Australians, 1998–2004. Accessed at Indigenous Health Infonet- Alcohol- Specific Topics/ Health Impacts.

National Aboriginal and Torres Strait Islander Health Council (2003). *National Strategic Framework for Aboriginal and Torres Strait Islander Health: framework for action by governments.* Canberra: National Aboriginal l and Torres Strait Islander Health Council.

National Aboriginal Health Strategy Working Party. (1989). *A national health strategy*. Canberra: National Aboriginal Health Strategy Working Party, Commonwealth of Australia.

New South Wales Health Department. (1999). *Review of New South Wales Detoxification Services*. NSW Detoxification Clinical Practice Guidelines.

Northern Territory Government. Submission to Senate Inquiry into Mental Health. Attachment 24.

Northern Territory Aboriginal Health Forum Emotional and Social Well being Working Party. (2003) *Northern Territory Aboriginal Emotional and Social Well being Strategic Plan.*

OATSIH (2006). Submission to Senate Inquiry into Mental health. Attachment 24.

Petry N, Ammerman Y, Bohl J, Doersch A, Gay H, Kadden R, Molina C, Steinberg K. (2006). Cognitive-behavioral therapy for pathological gamblers. *Journal of Consulting and Clinical Psychology*, 74, 555-567.

Pierce D, Gunn J, (2007). Using problem solving therapy in general practice. *Australian Family Physician*.36 (4); 230-233.

Pritchard E, Mjugavin J, Swan A (2007). Compulsory treatment in Australia. A discussion paper on the compulsory treatment of people dependant on alcohol and/or other drugs. *Turning Point Drug and Alcohol Centre.*

Putt J and Delahunty B (2006).*Trends and issues in crime and criminal justice*, no. 322 .ISBN 1 921185 16 3; ISSN 0817-8542 .Canberra: Australian Institute of criminology accessed at www.aic.gov.au/publications/tandi2/tandi322t.html on 25/2/2008.

Resnicow K, DiIorio C, Soet JE, Ernst D, Borrelli B, Hecht J. (2002). Motivational interviewing in health promotion: it sounds like something is changing. *Health Psychol.* 21(5):444-51.

Roche, A., Hotham, E. & Richmond, R. (2002). The GPs role in AOD issues: overcoming individual, professional and systematic barriers. *Drug and Alcohol Review*, 21: 223-230.

Rubak S, Sandbaek A, Lauritzen T, Christensen B (2005). Motivational interviewing: a systematic review and meta-analysis. *Br J Gen Pract*. 55(513):305-12.

Saitz R, Horton NJ, Larson MJ, Winter M, Samet J (.2005). *Primary medical care and reductions in addiction severity: a prospective cohort study*. 100(1):70-8.

Saunders JB, Lee NK. (1999). Opportunistic brief interventions. *Medicine*. 27:22–3.

Schlesinger CM, Ober C, McCarthy MM, Watson JD, Seinen A (2007). *The development and validation of the Indigenous Risk Impact Screen. (IRIS): a 13-item screening instrument for alcohol and drug and mental health risk*. 26(2):109-117.

Senate Inquiry into Mental Health (2006): A national approach to mental health. From Crisis to Community. The first report. Accessed at www.aph.gov.au/**senate**/committee/**mentalhealth**_ctte

Shadis W, Ragsdale K, Glaser R, Montgomery L. (1995). The efficacy and effectiveness of marital and family therapy: A perspective from meta- analysis .21(4):345-360.

Shand F., Gates, J., Fawcett J. and Mattick R. (2004). *The treatment of Alcohol problems. A review of the Evidence*. National Drug and Alcohol Research Centre, Sydney.

Social Health Reference Group. (2004). *Social and emotional well being framework: A national strategic framework for Aboriginal and Torres Strait Islander mental health and social and emotional well being 2004-2009.* Canberra: Australian Government.

Srisurapanont, M &, Jarusuraisin, N. (2003). Opioid antagonists for alcohol dependence (Cochrane Review). *The Cochrane Library*. Issue 2.

Stanton MD, Todd TC, Stein F, Van Deusen J, Cook L (1982). 'Treatment outcome'. In Stanton M, Todds T (eds.). *The family therapy of drug abuse and addiction.* New York: Guildford Press.

Streeton, C. & Whelan, G. (2001). Naltrexone, a relapse prevention maintenance treatment of alcohol dependence: a meta-analysis of randomised controlled trials. *Alcohol and Alcoholism,* 36(6): 544-52.

Swan P & B Raphael, (1995). *Ways Forward: National Consultancy Report: Aboriginal and Torres Strait Islander Mental Health*, Commonwealth Department of Human Services and Health, Canberra.

Taskforce on Illicit Drugs. (2001). *Report on Illicit Drugs in the Northern Territory*.

Volpicelli JR, Markman I, Monterosso J, Filing J, O'Brien CP.(2000). Psychosocially enhanced treatment for cocaine-dependent mothers: evidence of efficacy. *Journal of Substance Abuse Treat.* 18(1):41-9.

Wilk AI, Jensen NM, Havighurst TC. (1997). Meta-analysis of randomized control trials addressing brief interventions in heavy alcohol drinkers. *J Gen Intern Med*; 12:274–83.

Willenbring M, Olson D **(** 1999**).** A randomized trial of integrated outpatient treatment for medically ill alcoholic men. *Archives of Internal Medicine*. 159(16): 1946-52.

World Health Organization: Declaration of Alma-Ata. International Conference on Primary Health Car accessed at www.who.int/hpr/NPH/docs/declaration_almaata.pdf

Wulsin L, Sollner W, Pincus H. (2006). Models of integrated care. *Medical Clinics of North America*. 90(4): 647-77.