Mental health and Aboriginal people and communities

10-year mental health plan technical paper

Contents

Background

Victoria's Aboriginal population is estimated to be 47,333 people, and forms 0.86 per cent of the total Victorian population. The Aboriginal Victorian population is young. Just under half (47 per cent) are under 19 years of age (Australian Bureau of Statistics 2011). The Aboriginal Victorian population is growing, and growing much faster than the non-Aboriginal population. Just over half of Victoria's Aboriginal population lives in rural and regional areas (53 per cent) (cited in VicHealth 2011).

Victoria's first peoples draw on shared culture that extends tens of thousands of years in the past, and continues to be practiced now. This culture sees health as not simply the physical wellbeing of an individual, but the social, emotional and cultural wellbeing of the whole community.

Victoria's first peoples also share a more recent history of colonisation, dispossession and cultural dislocation and separation from family and community through removal and denial of political power.

Within living memory, Aboriginal Victorians were forcibly removed from their families under Stolen Generation policies, with 47 per cent of Aboriginal Victorians having a relative that was removed under these policies. In itself this represents trauma that is experienced across generations. This intergenerational trauma is a compounded by increased rates of incarceration and child protection intervention, which replicate institutionalised family separation.

The history of Aboriginal Victorians is also a history of resistance, reclamation of rights, and community and personal resilience. It is a history that seeks to re-establish self-determination, in all aspects of community and including the ways in which Aboriginal people and community access and interact with government.

As a result many Aboriginal people enjoy excellent social and emotional wellbeing. Many Aboriginal families and communities thrive. But some do not. Aboriginal people and communities are more likely to face risk factors for poor mental health and barriers to emotional and social wellbeing than the general population. This paper examines the experience of poor social and emotional wellbeing and mental health in Aboriginal communities, and the role that social, economic and cultural determinants of mental health have in contributing to this experience of poor mental health.

Mental illness is estimated to contribute to 15 per cent of the burden of disease for Aboriginal Australians (compared with 13 per cent of total Australian population). This is second only to cardiovascular

disease, which accounts for 17 per cent of the burden of disease for Aboriginal Australians (Vos et al. 2007).

Aboriginal communities and the experience of poor mental health

Aboriginal Victorians report higher rates of psychological distress, and have higher rates of suicide and self-harm than the general population. Aboriginal Victorians are also more likely to experience social and economic circumstances that contribute to and exacerbate the experience of poor mental health.

In a 2012–13 survey, 30 per cent of Aboriginal people surveyed reported high or very high psychological distress levels, which was nearly three times the rate reported by non-Aboriginal people (Australian Bureau of Statistics 2014).

The national rate of suicide in the Aboriginal population is estimated to be between two and three times higher than the rate in the non-Aboriginal population (Department of Health 2010). Suicide was the most common cause of alcohol-related deaths among Aboriginal males and the fourth most common cause among Aboriginal females (cited in Wilkes et al. 2010).

Rates of intentional self-harm among young Aboriginal people aged 15–24 years are 5.2 times the rate of non-Aboriginal young people (Australian Bureau of Statistics 2014).

In 2013–14, a total of 1,308 people who identified as Aboriginal or Torres Strait Islander received treatment and care from a public clinical mental health service. This equated to 2 per cent of all clients (Department of Health & Human Services 2014).

The majority of Aboriginal people receiving treatment in a public clinical mental health service were aged 18–64 years (77 per cent, compared with 71 per cent of non-Aboriginal clients in that age group). For children and young people, 20 per cent were Aboriginal (compared with 14 per of non-Aboriginal clients in that age group) and for older people, 3 per cent were Aboriginal (compared with 15 per cent of non-Aboriginal clients in that age group) (Department of Health and Human Services 2014).

The most prevalent disorders experienced by Aboriginal people who were clients of a public clinical mental health service were schizophrenia and delusional disorders (21 per cent); mood (affective) disorders (19 per cent); stress-related disorders (18 per cent), followed by substance abuse related disorders (8 per cent) (Department of Health and Human Services 2013–14).

Nationally, Aboriginal men are over four times more likely, and Aboriginal women over three times more likely, than expected for their proportion of the population to be hospitalised for ‘mental disorders attributable to psychoactive substance misuse’ than their non-Aboriginal counterparts (Purdie et al. 2010).

Many Aboriginal people and communities face continuing social and economic inequity. This includes higher rates social exclusion, institutionalised racism and discrimination, as well as high rates of unemployment, lower income, poorer housing and traumatic experience. These factors are closely linked to physical and mental health and increase the probability of psychological distress and mental health problems. We also know that these conditions have a particular and lasting effect on the future social and emotional wellbeing of children, and that Aboriginal children by extension have an increased likelihood of vulnerability to poor mental health.

A survey undertaken by VicHealth of 755 Aboriginal Victorians in two rural and two metropolitan areas in Victoria found that 97 per cent of those surveyed has experienced racism in the previous 12 months. Evidence indicates racism is associated with poorer mental health and reducing incidents of racism can reduce the risk of a person developing a mental illness, particularly depression and anxiety. Individual coping strategies, however, did not appear to provide adequate protection from harm, indicating the need for organisational and community interventions are needed to reduce racism (VicHealth 2012).

Research indicates that people who lack job security or experience frequent or extended periods of unemployment report the lowest levels of self-rated health and subjective wellbeing. In respect to economic disadvantage, Aboriginal people of working age experience a high level of unemployment – 15.8 per cent of Aboriginal Victorian’s in the labour market were unemployed in 2006, compared with 5.4 per cent of the overall Victorian population (Department of Human Services 2008).

Aboriginal Australians experience homelessness at four times the rate of non-Aboriginal Australians (Australian Institute of Health and Welfare 2011). We know that homeless and housing instability contributes to an

increased risk of mental illness and makes it harder to manage existing poor mental health.

We know that adverse conditions in early life are associated with higher risk of mental disorders. Social and economic disadvantage (including intergenerational poverty) places children and young Aboriginal people at greater risk of behavioural and environmental problems (for example, exposure to racism and family and household factors such as exposure to violence, poor-quality parenting and having lived in five or more homes) that affect mental health as well as physical health and encourage self-harm and self-destructive tendencies. Available data shows an overall picture of pronounced and increasingly poor mental health and social and emotional wellbeing of children and young Aboriginal people (Parker and Milroy 2014).

Aboriginal people comprise 7.8 per cent of the Victorian prison population, despite accounting for less than 1 per cent of the Victorian population. Young Aboriginal people are disproportionally represented in the juvenile justice system (Justice Health and Corrections Victoria 2015).

A study into Aboriginal prisoner mental health and cognitive function found that across their lives Aboriginal prisoners, particularly female prisoners, are exposed to high rates of social adversity, trauma and health problems. The study found that 72 per cent of men and 92 per cent of women had received a lifetime diagnosis of mental illness, compared with a lifetime prevalence of 45 per cent in the general population. The rates of all disorder, including psychotic illnesses, were dramatically higher than those found in the general community in Victoria. For both males and females, the most prevalent illnesses included major depressive episodes and post-traumatic stress disorder (Ogloff et al. 2013).

Policy and program options

Mental health for Aboriginal people and communities is not just about individual wellbeing and effective health care. Addressing entrenched disadvantage and inequity is equally significant to improve the disproportionate experience of poor mental health among Aboriginal people. And given the legacy of institutional injustice, **how** governments work with Aboriginal communities is as important as **what** actions governments take to improve mental health outcomes for Aboriginal people and communities.

Improve access to culturally responsive mainstream clinical treatment and support services

This option focuses on how the different parts of the specialist mental health service system can work with Aboriginal Community Controlled Health Organisations and other key stakeholders towards a common set of priorities, and how resources can be targeted towards activities proven to result in improved access and the best mental health outcomes for Aboriginal people.

This could include:

- identifying key gaps, issues and good practice in the provision of treatment and support interventions for Aboriginal people experiencing severe mental illness and their families
- identifying a cohesive set of strategies, including system redesign and service development, needed to improve Aboriginal peoples' access to timely, culturally sensitive and culturally safe clinical mental health treatment, with the focus on early intervention in the illness pathway and episode and suicide prevention. These strategies would take into account government investment in mental health support services for Aboriginal people and opportunities for a more joined up approach with the corrections/justice system and other key social support services
- monitoring and report achievement of Mental Health Community Support Services[1] program in improving outcomes for Aboriginal people aged 16–64 years living with a psychiatric disability, and identifying further action required to optimise outcomes for Aboriginal people with a psychiatric disability in the lead up to the introduction of the National Disability Insurance Scheme
- identifying action required to facilitate participation in the National Disability Insurance Scheme for eligible Aboriginal people
- the need for new culturally appropriate indicators to monitor improved responsiveness, including modification of the planned consumer mental health Your Experience of Service survey to ensure it is culturally appropriate and fit for purpose.

[1] Previously called the Psychiatric Disability Rehabilitation and Support Services (PDRSS) program, this program provides psychosocial rehabilitation support to adults 16–64 years with a mental illness and psychiatric disability.

Particular attention could be given to:

- the needs of children, adolescents and young people, given growth in this demographic group within the Aboriginal population and the heightened vulnerability of these population groups
- Aboriginal people with mental health problems engaged in the criminal justice system (focus on diversion and pre- and post-transition support)
- inter-relationship between poor mental health, family violence and vulnerable children
- inter-relationship between mental health and physical health (for example diabetes and obesity)
- co-occurring alcohol and substance misuse, including impact of growing use of poly-drug misuse within the Aboriginal community
- reducing homelessness among Aboriginal people experiencing mental illness and dual diagnosis, drawing on the findings of National Partnership Agreement on National Mental Health Reform initiatives that prioritised Aboriginal people experiencing homelessness and housing risk
- suicide prevention.

This work should take into account the risk factors that contribute to psychological distress and mental illness (for example adverse childhood experiences and trauma) and the social and economic factors that increase or exacerbate mental health problems and influence overall health and wellbeing (for example poverty and unemployment, homelessness and housing insecurity, family breakdown and disengagement from social supports, engagement with corrections, and co-existing alcohol and drug misuse problems).

Improve mental health of Aboriginal prisoners

Incarceration comes at a high cost through exposure to harsh prison environment, marginalisation, poor health outcomes and impact on employment opportunities. Research has found that a person's contact with or progression through the justice systems can be reduced through diversion programs. However, Aboriginal Australians have lower participation and completion rates of diversion programs – particularly for those who access mainstream programs.

As identified by the Victorian Government's recently released Justice Health and Corrections *Aboriginal social and emotional wellbeing plan*, key areas for consideration include pre- and post-transitional release programs for Aboriginal women and men, and strategies to strengthen the cultural competency of the prison workforce. Consideration should also be given to integrated diversionary strategies for keeping Aboriginal women and men out of prison.

Improve access to stable, appropriate and affordable housing

The impact of unaddressed homelessness and insecure housing among people with a severe mental illness has significant social and economic dimensions that are broader than health. A common policy response across housing, homelessness and mental health portfolios is therefore critical if improved health, social and economic outcomes are to be achieved for people with a severe mental illness. The housing needs of Aboriginal people with a severe mental illness and their families should be given priority, given the disproportionate level of homelessness experienced by this population group.

Questions for consultation

1. Are the key barriers to good mental health and disadvantage associated with poor mental health for Aboriginal communities and people adequately described? How else can this be understood?
2. Are there particular outcomes that we should focus effort on for Aboriginal people and communities?
3. How can we improve these outcomes for Aboriginal people and communities (given what we know about the barriers and harms experienced by Aboriginal people and communities)? What do we know works?
4. Do the options for consideration focus effort where it is most needed and most effective? Are there other options that should also be considered?
5. How do we integrate mental health programs generally or programs focused on Aboriginal people and community in particular into a system of care?

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Where the term 'Aboriginal' is used it refers to both Aboriginal and Torres Strait Islander people. Indigenous is retained when it is part of the title of a report, program or quotation.

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