

Aboriginal and Torres Strait Islander Bridging Policy (2021)

Explanatory Note on Formatting

To avoid excessive length, we have tried to keep the amount of the unchanged existing policies included as small as possible while also providing context to place the amendments. The parts in light grey are the surrounding sections of the existing policy, and where these have been struck through, the amendment includes the removal of that content. Any text in black is a suggested addition or alteration to the policy.

A: Medical School Programs

Aboriginal and Torres Strait Islander Medical Student Recruitment and Retention (2019)

Background

Australia's medical students are primarily represented through the Australian Medical Students Association (AMSA), advocating on their behalf to ensure that their concerns are heard and respected. As such, AMSA takes strong stances on Aboriginal and Torres Strait Islander health outcomes - in particular, the recruitment and retention of Indigenous medical students into the health workforce. **This policy addresses areas of improvement that should be made to maximise the admittance and completion of medical programs by Aboriginal and Torres Strait Islander Students.** These include recommendations made in the Australian Indigenous Doctors' Association Healthy Futures Report (2005), namely in admission pathways and provide cultural and financial support to Indigenous medical students.

Policy

AMSA calls upon:

1. Medical Schools, Universities and Institutions to:
 - a. Identify and provide appropriate support to Aboriginal and Torres Strait Islander people who are interested in entering medical school, through mentoring, alternative pathways programs, and other university entry programs.
 - b. Develop effective recruitment and retention strategies via:
 - i. Providing **and effectively advertising** alternate entry requirements and processes for Aboriginal and Torres Strait Islander students.
 - ii. Involving community and Indigenous staff in the recruitment and retention of Aboriginal and Torres Strait Islander medical students.

- iii. Alternate entry processes which should be culturally safe and include a community-based interview utilising local Aboriginal and Torres Strait Islander community members.
- iv. Fostering a culturally safe approach in the recruitment and retention of medical students, whereby individual guidance, preferably through an Indigenous staff member, is given to students throughout the recruitment process, as well as during the course.
- v. Establish population parity minimum entry targets and ensure that equitable support and retention schemes are in place to maintain population parity graduation number.
- c. Invest resources in maintaining Indigenous Engagement and Support Units at each university to provide collegiate support for Aboriginal and Torres Strait Islander students. This may be through linking Aboriginal and Torres Strait Islander medical students with academics, local Indigenous doctors, and the Australian Indigenous Doctors Association (AIDA).

.Universities should maintain relationships with their local Indigenous communities via Indigenous engagement units.

- i. All study spaces, including on university campuses and in teaching hospitals, should be culturally safe environments.
- ii. Universities should provide dedicated, culturally safe, study spaces for the sole use of Aboriginal and Torres Strait Islander medical students in medical school buildings.
- iii. Universities need to recognise inherent variation in learning styles and provide resources to Indigenous Engagement Units to assist in the transition to university teaching.
- iv. Aim to increase the consistency and transparency of statistical data on Aboriginal and Torres Strait Islander medical student numbers and progress, particularly in regards to student retention to allow for better understanding of the needs of Indigenous students.

B: Medical Education

Interprofessional Education (2018)

Background

Amendment 1: page 1, paragraph 1:

The Australian Medical Students' Association is the peak representative body of Australia's medical students. Accordingly, AMSA is uniquely placed to advocate on issues of medical education and the appropriate integration of the teaching of various other health disciplines, including nursing, midwifery, pharmacy, **Aboriginal and Torres Strait Islander Health Workers**, and allied health, into the core medical school curricula.

Quality Clinical Placements (2019)

Policy Points

AMSA calls upon

1. All medical schools and clinical schools to:
 - f. Ensure students are exposed to clinical experiences in a variety of different settings, which may include exposure to different medical specialties, rural

settings, Indigenous health settings, general practice, and community facilities, in order to:

- i. Encourage students to consider undersubscribed specialties;
- ii. Allow students to explore the educational experiences afforded by a wide range of specialties;
- iii. **Provide the opportunity to demonstrate culturally safe care for Aboriginal and Torres Strait Islander patients;**
- iv. Engage in upskilling medical students for their future role in teaching and encourage students to participate in peer learning;

Rural Health and the Medical Curriculum (2019)

Policy Points

AMSA calls upon

1. All Australian medical schools to:
 - a. Provide students with a vertically and horizontally integrated rural health curriculum that includes a Rural Health focus;
 - b. Tailor a compulsory rural health curriculum to their most relevant or appropriate regional setting, including a public health curriculum;
 - c. Provide a curriculum that equips medical students with the tools to deal with the unique challenges of rural health by:
 - i. Providing exposure to rural health settings, most likely in the University's state, but further afield opportunities should be encouraged and supported;
 - ii. Forming relationships with rural communities through extended rural placements;
 - iii. **Providing opportunities for exposure to rural Indigenous health practices and remote Indigenous communities;**
 - iv. Investigating reasons for and rectify common misconceptions concerning rural health;
 - v. Regularly evaluating the experiences of medical students in the rural setting and collaborate with medical student societies and rural health clubs to address any issues.
2. AMSA to:
 - a) Advocate for more opportunities for students to improve engagement with rural health;
 - b) Liaise with medical student councils to form stronger relationships with rural medical organisations, **Aboriginal land councils**, colleges and organisations;
 - c) Continue to advocate for the interests of students on rural placements;
 - d) Extend students' engagement with rural health beyond the medical curriculum by continuing to hold events such as the Rural Health Summit;
 - e) To continue to promote the career opportunities available to students in rural health settings.

Background

Amendment 1: page 2, paragraph 1:

Rural health is the interdisciplinary field of health and healthcare delivery outside of urban environments. One third of Australians live in regional, rural, and remote areas **including 65% of Indigenous Australians [1]**. Compared to metropolitan residents, people living in smaller towns and non-urban areas generally experience higher levels of satisfaction with life [2]. However, there are several major issues faced by rural health in Australia today. Two such issues are the inequalities in health outcomes of

rural populations compared to their urban counterparts, and the disproportionate distribution of the medical workforce across the country.

References

1. National Rural Health Alliance. Demography [Internet]. ruralhealth.org.au. 2011 [cited 18 May 2021]. Available from: <https://www.ruralhealth.org.au/book/demography>

C: Supporting Students

Mental Health and Wellbeing (2018)

Policy Points

AMSA calls upon:

2. Federal, State and Territory Governments:

- d. To support and/or conduct research investigating student mental health/illness.
- e. To support Aboriginal and Torres Strait Islander communities to design and develop mental health plans aligned with their needs and culture;

AMSA calls upon, in relation specifically to medical students and junior doctors:

8. Medical student societies

- a. To establish and support initiatives that promote mental health and wellbeing among medical students and the broader student community such as mentorship, tutoring, and awareness projects.
- b. To promote involvement in Aboriginal and Torres Strait Islander events of cultural or community significance, including but not limited to: Invasion Day, NAIDOC week and Mabo Day;
- c. To appoint an Aboriginal and Torres Strait Islander Health Officer position, separate to the Australian Indigenous Doctors' Association (AIDA) Student Representative, to advocate for the welfare of Indigenous students.
 - i. The position of Aboriginal and Torres Strait Islander Health Officer should be preferentially appointed to an Indigenous medical student. Where this is not possible, a non-Indigenous medical student may be appointed with demonstrated experience and passion in Aboriginal and Torres Strait Islander health. If there are no suitable, willing candidates the position may be left open.

Background:

Amendment 2: page 2, paragraph 5:

Rates of mental illness vary among different medical student demographics. Female medical students report higher levels of distress than male students (26% compared to 18%). Higher levels of mental health problems for females was consistent across various measures [16]. Other student populations including international, Indigenous, LGBTIQ+ students, and students with disabilities face unique challenges which can compound the existing stressors of medical school, leading to higher prevalence of mental illness and suicide in these groups [27- 28]. Challenges can include struggling to establish social support networks, financial issues, difficulty obtaining placements, cultural barriers, and additional levels of stigma. See AMSA's 'Medical Students with

Disabilities Policy' (2016), 'International Students Policy' (2017) [29-30], and "Aboriginal and Torres Strait Islander Health Policy" (2019).

D: Graduations & Internships

Internships (2020)

Position Statement

The Australian Medical Students Association (AMSA) is the peak representative body for 17,000 medical students nationwide. AMSA recognises that internships are an important transition period between medical school and medical workforce, which provide an opportunity for supervised practice with educational and developmental support. AMSA supports the provision of Aboriginal and Torres Strait Islander Internship Pathways that provide support and assistance to Aboriginal and Torres Strait Islander interns so they are able to practice in a culturally safe space. AMSA supports the work of AIDA in providing Aboriginal and Torres Strait Islander students with guidance and assistance in navigating and applying for internship opportunities.

Policy Points

AMSA calls upon:

1. The Federal and State Governments to:
 - a. Monitor and regulate the number of medical students, including Commonwealth-supported, full-fee paying and international students;
 - b. Ensure such regulation adequately fulfills projected workforce and population demand in conjunction with recruitment of international medical graduates.
 - c. Continue to fund AIDA to support their work regarding providing assistance and guidance to Aboriginal and Torres Strait Islander students in applying for internships, and supporting Aboriginal and Torres Strait Islander interns.
4. Internship providers to:
 - d. Communicate up to date data regarding present and projected graduating student numbers and internship availability.
 - e. Provide high quality internship pathways tailored for Aboriginal and Torres Strait Islander applicants by:
 - i. Reflecting on current support for Aboriginal and Torres Strait Islander interns;
 - ii. Providing preference for Aboriginal and Torres Strait Islander applicants to stay close to community or work on Country.
5. Australian Medical Schools to:
 - c. Ensure ethical recruitment of international students by ensuring they are aware of the current and projected internship and workforce status.
 - d. Support and assist Aboriginal and Torres Strait Islander students with the internship application process by:
 - i. Advertising AIDA internship guidance;
 - ii. Providing assistance for Aboriginal and Torres Strait Islander students in their Internship application process.

Background

Increasing representation of Aboriginal and Torres Strait Islander people in Australia's workforce has been identified as an integral strategy in improving healthcare delivery to Aboriginal and Torres Strait Islander people [1, 2]. Central to the retention of

Aboriginal healthcare staff is the provision of supportive and flexible training programs [3].

Currently there is inconsistency in the type of internship programs each state provides for Aboriginal and Torres Strait Islander students. Currently, Queensland and New South Wales are the only states and territories that provide specific internship pathways for Aboriginal and Torres Strait Islander students [4]. The Australian Indigenous Doctors Association (AIDA) Internship Guide acts as the key communicator of internship opportunities for Aboriginal and Torres Strait Islander Students.

References

1. Australian Government. Closing The Gap. 2020; 2021 p. 1-108. <<https://ctgreport.niaa.gov.au/sites/default/files/pdf/closing-the-gap-report-2020.pdf>>
2. Deroy S, Schütze H. Factors supporting retention of aboriginal health and wellbeing staff in Aboriginal health services: a comprehensive review of the literature. International Journal for Equity in Health. 2019;18(1).
3. Gwynne K, Lincoln M. Developing the rural health workforce to improve Australian Aboriginal and Torres Strait Islander health outcomes: a systematic review. Australian Health Review. 2017;41(2):234-238.
4. Australian Indigenous Doctors' Association. AIDA Internship Guide. 2021 p.1-18 <https://www.aida.org.au/wp-content/uploads/2021/03/AIDA-Internship-Guide_v4.pdf>

E: Medical Workforce

Rural Clinical Schools (2016)

Position Statement

AMSA believes that Rural Clinical Schools have a vital role in clinical education and as a gateway to future rural practice. In particular, Rural Clinical Schools often provide students with invaluable experience working in Aboriginal and Torres Strait Islander Health. AMSA believes placements should be facilitated in consultation with local Aboriginal and Torres Strait Islander communities and health services so as to not cause any harm to these communities. Efforts must be made to ensure that students placed within Rural Clinical Schools are adequately supported.

Policy Points

AMSA calls upon:

2. Australian Medical Schools to:

- l. Support, in collaboration with government, the allocation of international students to rural clinical schools by ensuring funding and opportunities for rural placement are equal for domestic and international students;
- m. Ensure rural placements are conducted in a culturally safe way of which minimises any potential harm to Aboriginal and Torres Strait Islander communities by:
 - i. Providing culturally sensitive training specific to the history, environment, culture of the Aboriginal and Torres Strait Islander community at the clinical school location;

- ii. Ensuring adequate consultation with Aboriginal and Torres Strait Islander communities and Aboriginal Community-Controlled Health Organisations (ACCHOs) about the placement of medical students in their communities to ensure they are able to facilitate students and that these placements are sustainable;
- iii. Being flexible in their clinical school options for Aboriginal and Torres Strait Islander Students who may want to gain experience in specific rural communities with which they may have a connection.

Background

Amendment 1: page 1, new paragraph 4:

The proportion of the population that is Aboriginal or Torres Strait Islander is also substantially higher in rural and remote Australia [2]. These populations often have complex health issues and higher rates of chronic illness, of which demands holistic and high quality care [1,2,3]. Exposure as a student to placements in Aboriginal and Torres Strait Islander health in rural and remote settings can influence career choice [3]. Often Aboriginal Community-Controlled Health Centres (ACCHS) are central in delivering healthcare services to regional, rural and remote Aboriginal communities, and often act as placement settings for medical students.

References

1. Australian Government. Closing The Gap. 2020; 2021 p. 1-108. <https://ctgreport.niaa.gov.au/sites/default/files/pdf/closing-the-gap-report-2020.pdf>
2. Australian Institute of Health and Welfare 2019. Rural & remote health. Cat. no. PHE 255. Canberra: AIHW. <https://www.aihw.gov.au/reports/rural-remote-australians/rural-remote-health>
3. Gwynne K, Lincoln M. Developing the rural health workforce to improve Australian Aboriginal and Torres Strait Islander health outcomes: a systematic review. Australian Health Review. 2017;41(2):234-238.

Rural Training Pathways (2020)

Position Statement

Rural and remote Australians continue to suffer health inequities in comparison to their metropolitan counterparts in part due to ongoing workforce maldistribution. This is of particular importance due to the higher proportion of Aboriginal and Torres Strait Islander Peoples that live in these rural and remote communities and experience poorer health outcomes. AMSA believes that rural training pathways are crucial in attracting and retaining rural doctors, hence addressing shortages in the rural medical workforce. While the components of the Stronger Rural Health Strategy and other workforce initiatives aim to address the shortage by strengthening such pathways, AMSA believes continual improvement, including integration, consolidation and support of rural training should be a priority for all Australian State and Territory Governments. Rural training pathways must run in conjunction with university evidence-based programmes as outlined in the Rural Clinical Schools and Medical School Admissions AMSA policies.

Policy Points

AMSA calls upon

2. Australian Specialist Medical Colleges and specialist training providers to:
 - e. Increase rural specialty training position numbers according to workforce need.

- f. Establish positions that facilitate Aboriginal and Torres Strait Islander doctors who wish to return to Country to practice or work within particular communities.
- 3. State and Territory Governments, Hospitals, and Local Health Districts in rural areas to:
 - e. Increase flexibility of employment by promoting:
 - i. Access to timely and affordable locum support;
 - ii. The single-employer model during training.
 - f. Facilities that care for Aboriginal and Torres Strait Islander communities should have ongoing cultural training and discourse specific and individualised to that community.

Background

Amendment 1: page 2, new paragraph 2:

Additionally, the proportion of the population that is Indigenous is substantially higher in rural and remote Australia [2]. These populations often have complex health issues and higher rates of chronic illness, of which demands holistic and high quality care [1,2]. Adequate cultural support and education for healthcare staff has been identified as integral in catering to the cultural needs of Aboriginal and Torres Strait Islander communities [3].

References

1. Australian Government. Closing The Gap. 2020; 2021 p. 1-108. <<https://ctgreport.niaa.gov.au/sites/default/files/pdf/closing-the-gap-report-2020.pdf>>
2. Australian Institute of Health and Welfare 2019. Rural & remote health. Cat. no. PHE 255. Canberra: AIHW. <<https://www.aihw.gov.au/reports/rural-remote-australians/rural-remote-health>>
3. Deroy S, Schütze H. Factors supporting retention of aboriginal health and wellbeing staff in Aboriginal health services: a comprehensive review of the literature. International Journal for Equity in Health. 2019;18(1).

Vocational Training Pathways (2020)

Policy Points

AMSA call upon

2. Australian Specialist Medical Colleges to:
 - k. Create training positions that address the bottleneck of junior doctors working to enter specialist training programs with respect to projected future workforce demands.
 - l. Create flexible training positions and locations that can cater to Aboriginal and Torres Strait Islander doctors who may wish to continue to work on Country or in particular communities.
3. Hospital and Health Services to:
 - a. Work in collaboration with State and Territory health departments and medical colleges to establish appropriate flexible medical training positions that maintain the delivery of high quality healthcare, and provide high quality clinical training; and
 - b. Create training positions that better account for the needs of the community by:
 - i. Consider the Aboriginal and Torres Strait Islander communities they may serve and create specific training positions for Aboriginal and Torres Strait Islander doctors.

Background

Amendment 1: page 5, "Flexibility in Training", new paragraph:

Central to the retention of Aboriginal healthcare staff is the provision of supportive and flexible training programs [1]. Currently there exists a rigidity to the vocational training programs that may not always adequately cater to Aboriginal and Torres Strait Islander doctors who may hope to return to Country or their communities.

References

1. Gwynne K, Lincoln M. Developing the rural health workforce to improve Australian Aboriginal and Torres Strait Islander health outcomes: a systematic review. *Australian Health Review*. 2017;41(2):234-238.

F: Public Health in Australia

Aboriginal and Torres Strait Islander Health (2019)

Position Statement

AMSA believes that:

1. The health of Aboriginal and Torres Strait Islander people is impacted by underlying social determinants such as historic and ongoing systemic racism, income, education, employment and housing, as well as connection to family, community, culture, and Country;
2. The diversity of Aboriginal and Torres Strait Islander communities means that reducing health inequity will require collaboration between all people in order to realise and tailor strategies that are community specific;
3. Listening and learning through discourse with Aboriginal and Torres Strait Islander peoples is paramount in the process of collaboratively working towards closing the gap of health inequity;
4. Action towards improving Aboriginal and Torres Strait Islander health should aim to empower Aboriginal and Torres Strait Islander communities to support their own needs by improving access to health services, facilitating continued connection to and expression of culture, and increasing employment, housing, transport services and educational opportunities;
5. Strong representation of Aboriginal and Torres Strait Islander people within health professions is essential to improving health outcomes. Support mechanisms should be established for Aboriginal and Torres Strait Islander people in all medical schools, hospitals and specialist training programs, should they require additional support to ensure retention and representation;
6. Reducing the inequity in health will require collaboration between both Indigenous and non-Indigenous health professionals;
7. Aboriginal and Torres Strait Islander health education should be developed and implemented at every level of education and employment.
8. Interactions with government systems relating to the criminal justice system should support Aboriginal and Torres Strait Islander people to improve health behaviours, and improve psychosocial wellbeing in order to increase life expectancy for Aboriginal and Torres Strait Islander people in custody.

Policy Points

AMSA calls upon:

1. Australian Government to:

- a. Actively seek and follow guidance from Aboriginal and Torres Strait Islander communities and organisations regarding all policy decisions that affect them, and to:
 - i. Ensure that policy is created in collaboration with Aboriginal and Torres Strait Islander Communities throughout the process and is based upon strengths based research
 - ii. Recognise the life expectancy for Aboriginal and Torres Strait Islander is substantially lower with incarceration within the Criminal Justice system
 - iii. Work within the Criminal Justice system to support Aboriginal and Torres Strait Islanders in custody, to prevent deaths in custody or the immediate decline in health whilst caring for their custodians.
- b. Support the continuation of research by Aboriginal and Torres Strait Islander led organisations to facilitate an evidence-based policy approach to improving the health and wellbeing of Aboriginal and Torres Strait Islander people;

4. Health Professionals

- e. To recognise that children who are separated from their families and placed in out of home care today suffer through the loss of cultural identity and exacerbation of intergenerational trauma;
- f. To recognise how implicit bias, power dynamics and subconscious discrimination lead to poorer health outcomes for Aboriginal and Torres Strait Islander people and understand the importance of actively taking steps to overcome this and achieve culturally safe practise.

5. AMSA Executive:

- d. Continue support for the AMSA Indigenous Health Project as a permanent collaborative endeavour between Indigenous and non-Indigenous AMSA volunteers and the Australian Indigenous Doctors Association, specifically collaborating with the Student Representative Council and the Student Director.
- e. To formally endorse the 2017 Uluru Statement from the Heart.
- f. To endorse the following key Aboriginal and Torres Strait Islander Health Policies, including any key recommendations.
 - The National Strategic Framework - for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023 (2017)
 - The Gayaa Dhuwi (Proud Spirit) Declaration (2015)
 - The National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2023 (2017)
 - The National Aboriginal and Torres Strait Islander Health Plan 2013–2023 (2013)
 - The National Agreement on Closing the Gap (2020)

6. Medical Student Societies:

- a. To promote involvement in Aboriginal and Torres Strait Islander events of cultural or community significance, including but not limited to: Invasion Day², NAIDOC week and Mabo Day³;
- b. To appoint an **Aboriginal and/or Torres Strait Islander Health Officer**, separate to the AIDA Student Representative, to advocate for the welfare of Aboriginal and Torres Strait Islander students.
 - i. The position should be preferentially appointed to an Aboriginal and/or Torres Strait Islander medical student. Where this is not possible, a non-Aboriginal and/or Torres Strait Islander medical student may be appointed, provided they demonstrate experience with and passion for Aboriginal and Torres Strait Islander health.

New Stakeholder:

8. State and Federal Police, Correctional Services and Prison Operators to:

- a. To mandate that all personnel working in rural, remote and very remote locations are specifically trained in responding to catastrophic injury events, and be trained to and supplied with the necessary medical mobile equipment that can be utilised to prevent catastrophic injury.
- b. To mandate all personnel taking people in police or prison custody to participate to recognise and respond to the disease symptoms and signs relating to systemic long term comorbidities experienced by Aboriginal and Torres Strait Islander people;
- c. Recognise the social constructs of trauma and the wellbeing aspects relating to control, trust, isolation, loss and grief, and provide adequate trauma therapy and mental health support for Aboriginal and Torres Strait Islanders in custody;
- d. Produce policies and procedures which ensure that all Aboriginal and Torres Strait Islander people taken in custody have a full health review, including their physical, social, emotional, health and wellbeing;
- e. Effectively implement all recommendations previously made in previous and current inquests into Indigenous Deaths in Custody

Background

Amendment 1: page 3, new paragraph 2: Defining Cultural Safety

Whilst understandings of cultural safety is varied AMSA endorses the APRA definition which states that cultural safety is:

“Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities. Culturally safe practise is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism” [1].

Amendment 2: page 3, paragraph 3

Australia’s medical students are primarily represented through the Australian Medical Students Association (AMSA). AMSA believes that all individuals within Australia should be able to access culturally safe and equitable healthcare. Aboriginal and Torres Strait Islander people are members of the longest continuing culture and are the First Nations people of Australia. Today, Aboriginal and Torres Strait Islander people account for 3.1% of the Australian population - almost 800,000 people [1]. Within Indigenous communities, 91% identify as Aboriginal, 5% as Torres Strait Islander and 4% identify as both Aboriginal and Torres Strait Islander [1]. **As**

Aboriginal and Torres Strait Islander people are valued members of the Australian community, AMSA must prioritise Aboriginal and Torres Strait Islander health.

Amendment 3: page 4, paragraph 5

Aboriginal people were removed from their traditional Country and relocated to reserves or missions. In every state and territory, with the notable exception of Tasmania, a “Chief Protector of Aborigines” was appointed who had extensive power of Aboriginal peoples lives including their ability to move off missions, seek employment or marry [11]. In the 1950’s Australia adopted an assimilation policy, aiming to eradicate Indigenous culture from Australia [11]. Children were forcibly removed from their communities and families, being placed into foster homes or institutions and often told that their families have given them up as they were unwanted and unloved [11]. The traumatic impacts of legislation during this period are still being felt experienced today by survivors and their descendants [10]. The details of this widespread devastation is documented in the Human Rights and Equal Opportunity Commission’s Bringing them Home Report published in 1997, a document which details the stories of survival and described the extent of harm and burden suffered by this discriminatory legislation of both Stolen Generations members and their descendants [4].

Amendment 4: New Section

Health whilst in Police and Prison Custody

Aboriginal and Torres Strait Islander health whilst in custody has been a significant area of concern since prior to the 1991 Royal Commission into Aboriginal Deaths in Custody. This commission analysed 99 deaths in custody in a nine year period, resulting in 339 recommendations of changes to policies and procedures [2]. Not only have the recommendations not been implemented effectively but 474 deaths have occurred in custody (current as of 9th April 2021) [3]. Although the full data to date relating to deaths is acknowledged and mentioned above, the below analysis has been sourced from 1989-90 to 2018-19, to ensure that any discrepancies relating to Covid-19 statistics do not distort the overall figures captured.

Records from 1989-90 and 2018-19, show that there have been 3003 deaths in custody in total with 455 of those deaths being Aboriginal or Torres Strait Islander people [4]. From those deaths 156 were in police custody, and 295 were in prison custody and 4 were in youth custody. Statistics relating to Police Custody have been considered and discussed separately to Prison or Youth Detention Custody, as Police Custody deaths are often in an acute setting, whereby Prison Custody and Youth Detention deaths are as a result of longer-term incarceration.

Aboriginal and Torres Strait Islander people are 16.5x more likely to die in custody compared to non-Aboriginal and Torres Islander people. The average age of Aboriginal people who die in custody is 29.2 years compared to 35 years for non-Aboriginal people. This represents a statistically significant difference in years of life lost [4].

External trauma such as gunshot wounds, motor vehicle accidents and head injury were identified as the cause of 33% of Aboriginal and Torres Strait Islander deaths that occurred in police custody.

As of May 2021, no police force within Australia undertakes training in the management of major trauma, supplies members with adequate medical treatment or provides pursuit training in remote or very remote conditions. This lack of training and supplies may contribute to deaths from external trauma.

In relation to the medical causes for deaths in police custody, heart disease or related cardiac ailments are the leading cause, followed by stroke, cancer and respiratory conditions [6]. Despite this, reviews of all current police training within Australia do not show any police force instigating training to educate the members of the pertinent signs and symptoms relating to these life threatening health conditions experienced by Aboriginal and Torres Strait Islander people. In addition Aboriginal and Torres Strait Islanders taken into custody in remote and very remote locations that may not have access to professionally trained medical staff, and do not have the ability to access quick and relevant telehealth services. As such, patient medical histories are not explored and red flags to indicate an acute health crisis occurring are not being identified to police officers for attention or action.

The lack of training, lack of provisions of necessary medical supplies, and limitations of policy and procedure surrounding police management and care for Aboriginal and Torres Strait Islander people in police custody are all factors contributing to the high rates of death in custody. The 155 deaths of Aboriginal and Torres Strait Islander people in custody could have been avoided with appropriate training in underlying health conditions and red flag warning of impending critical illness, appropriate training in acute trauma specific to catastrophic injury, and with the provision of appropriate medical supplies.

In relation to deaths in prison custody, a review of all Aboriginal and Torres Strait Islander deaths between 1989-90 and 2018-19, show that there have been 295 deaths in Prison Custody, and that the leading causes of those deaths have been natural causes and hanging death. It is understood that all prisons across Australia do have medical staff present in all settings. However, the medical settings in prisons are not equipped to address critical medical emergencies, and prisoners are moved off site to hospitals for critical medical intervention. No information is currently available to identify whether the time taken to move the medically critically unwell Prisoner patient to medical facilities is a mitigating factor in the deaths in custody. Similar to police, prison officers do not get medical training to identify signs, symptoms and red flags in unwell and critically ill Aboriginal and Torres Strait Islander inmate which also contributes to deaths in custody

In relation to deaths in custody relating to suicide within the prison, in Australia, there is no known professionally structured trauma therapy endorsed by any state or territory government to resolve psychological trauma in Aboriginal and Torres Strait Islander people. Aboriginal and Torres Strait Islander people were thirteen times more likely to acknowledge high levels of trauma and psychological distress as opposed to non Aboriginal and Torres Strait Islander people [7]. As such, the 12 month prevalence to have PTSD was high for both males and females in incarceration. Despite this, consultation has shown that priorities with correctional facilities revolve primarily around physical health, and mental health strategies are often left unresolved to any great extent.

Amendment 5: New Section

Health of Youth in custody

Aboriginal and Torres Strait Islander children and young people are 25 times more likely to be incarcerated than non-Indigenous youth [8]. This is the highest rate since the release of the Royal Commission into Aboriginal Deaths in Custody in 1991 [9]. This increasing trajectory is occurring despite previous reviews, reports and recommendations to the youth justice system. Continued high incarceration rates therefore demonstrates both a lack of action and a failure to address the underlying causes and socio-economic factors contributing to Aboriginal and Torres Strait Islander youth coming into contact with the justice system [8].

Furthermore, Aboriginal and Torres Strait Islander youth in custody experience poorer health outcomes than non-Indigenous youth. In particular 81% of Aboriginal and Torres Strait Islander youth experienced mental health problems in custody, compared to 75% of non-Indigenous youth [8].

Drivers of Aboriginal and Torres Strait Islander youth incarceration are present throughout all elements of society including education, disability, housing, intergenerational trauma, family violence and sexual abuse, employment, health, social exclusion, and racism; all of which have been founded and perpetuated by the continuing consequences of colonisation [8]

As with adult correctional facilities, no youth detention facilities are known to run programs that actively address trauma experienced by youth as a result of their previous experiences or incarceration. There have been successful youth detention programs run through remote locations around the country in the past, however since the 2017 Royal Commission into the Protection and Detention of Children in Northern Territory was presented, research indicates that there have been no new programs implemented.

Amendment 6: page 3, paragraph 5

The Stolen Generations are the most disadvantaged groups within the Aboriginal and Torres Strait Islander population, due to the forced removal and assimilation legislation which lead to disconnection from culture, family, community and Country [10]. In 2015, Stolen Generations members represented 13.5% of the Indigenous population aged 42 and over, with 56% being women and 44% being men [10]. Among Stolen Generations members, 79% live in non-remote areas with three quarters living in either New South Wales, Western Australia or Queensland [10]. Likewise, 84% of descendants lived in non-remote areas and represented 33% of the Aboriginal and Torres Strait Islander community who are older than 18 [10]. The Bringing them Home report estimated that between 1 in 3 and 1 in 10 Indigenous children were forcibly removed from their families and communities, stating that “in that time not one Indigenous family has escaped the effects of forcible removal” [4]. In 2018, statistics revealed that with all Aboriginal and Torres Strait Islander people born before 1972 (when the removal policies ceased), 11% were reported to have been removed from families [10]. It was estimated that approximately 17,000 original Stolen Generations are still alive. Of these Stolen Generations 56% were female, and 79% currently live off-country in non-remote areas. Approximately 15% are aged under 50 years of age, 65% are between 50 and 65, and 20% are aged 65 and over.

In 2014-15, 115,000 Aboriginal and Torres Strait Islander descendants from the Stolen Generations were estimated, including a further 15,000 who themselves were again removed from families [10]. The descendants of Stolen Generations reported a loss of culture with the descendants twice as likely not to speak an Indigenous language, and almost twice as likely to experience violence relating to the intergenerational trauma of removal.

Amendment 7: page 5, paragraph 7

The continuation of child removal from Aboriginal and Torres Strait Islander families is an ongoing problem, with the number of Aboriginal and Torres Strait Islander children in out-of-home care increasing since the Bringing Them Home report was published [19]. Whilst the intention behind the child removal practices today can be perceived to be different, the outcome is inevitably the same, with loss of cultural identity and exacerbation of intergenerational trauma [19]. The recognition of the safety of children is paramount, whereby collaborative and culturally safe legislation regarding the child safety is a necessary element of addressing intergenerational trauma. It is necessary that legislation reflect that once a child has been removed

from the custody of their immediate family, if the child is unable to be placed with extended family and continue cultural growth, substantial efforts should be made by the relevant government institutions, to retain the connection to family, community and culture, and participate in continual and repetitious cultural development on a regular basis.

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LGBTQIA+ Health (2019)

Policy Points

AMSA calls upon:

1. Australian Governments to:

f. Conduct themselves in a culturally safe and sensitive manner, especially in regards to new or changing legislation such as doing so with consultation with relevant LGBTQIA+ stakeholders;

g. Recognise the diversity of culture within the LGBTQIA+ community and the role of intersectionality in this space, in particular Aboriginal and Torres Strait Islander peoples and to:

1. Understand the unique health challenges faced by LGBTQIA+ Aboriginal and Torres Strait Islander communities

2. Integrate strategies to address health gaps of LGBTQIA+ Aboriginal and Torres Strait Islander peoples into Close the Gap legislation in consultation with said communities.

h. Implement legislation to categorically outlaw LGBTQIA+ conversion practices as per recommendations in the 'Preventing Harm, Promoting Justice: Responding to LGBT conversion therapy in Australia' report;

4. Australian medical schools to:

d. Address the health of minority groups within LGBTQIA+ communities within the medical curriculum, this includes, but is not limited to, Aboriginal and Torres Strait Islander people, migrant and refugee populations, culturally and linguistically diverse (CALD) individuals, those from low socioeconomic backgrounds, and people with disabilities;

e. Ensure that relevant teaching contains up to date terminology that inclusively reflects the diversity of various cultures and backgrounds of the LGBTQIA community;

f. Develop strategies for competent engagement with LGBTQIA+ populations, including:...

Organ and Tissue Donation (2019)

Policy

AMSA calls upon:

1. Australian governments to:

a. Adopt a soft 'opt-out' model of consent;

i. Ensure roll out is inclusive of all patient demographics

b. Continue to support the efforts of DonateLife in:

. Increasing awareness of the benefits of organ donation for individuals and the community;

i. Encouraging people to consider their willingness to register for organ, tissue and bone marrow donation;

ii. Encouraging family discussions of relatives' intentions regarding organ and tissue donation;

iii. Targeting these campaigns towards a diverse range of populations, including older adults, **Aboriginal and Torres Strait Islander Peoples** and culturally and linguistically diverse subpopulations;

iv. Addressing the disparity between intent and legally valid consent registration

c. Institute a simplified, easily accessible way for individuals to electronically register their wishes, and notify family and/or loved ones of these wishes.

2. Medical students to:

. Consider their willingness to register as an organ and tissue donor and to discuss this with their families; and

- a. Promote organ, tissue and bone marrow donation in a respectful and culturally aware manner.
- 3. Medical Student Societies to:
 - . Support and participate in educational and promotional campaigns that advocate for organ donation, such as DonateLife week
 - a. Educate students of the ethical issues in organ and tissue donation and its cultural significance in other communities, including Aboriginal and Torres Strait Islander Peoples
 - 4. Australian medical schools to:
 - . Provide appropriate training of medical students in:
 - . Understanding the ethical issues of organ donation, including the need to promote organ donation while ensuring informed and voluntary consent and the need to provide a culturally safe manner in which these issues are discussed;
 - i. Discussing organ and tissue donation with their patients and other stakeholders involved; and
 - ii. Making donation requests in a sensitive and timely manner.

Background

Amendment 1: page 2, paragraph 6:

Role of Education in Organ Donation

The education of health professionals and medical students on the issue of organ and tissue donation is vital for its efficiency and effectiveness. Lack of educational programs on organ donation and transplantation has been shown to be one of the reasons for the shortage of organ donations [29]. The International Federation of Medical Students' Associations (IFMSA) calls upon medical associations to 'support physician training on donation' and to 'promote donation awareness among the local population through physician initiatives' [30] to partly address the issues surrounding organ donation. Data from DonateLife also support that training of health professionals in organ donation increases family consent rates: in 2018, 75% of families consented to organ donation when a trained doctor or nurse was involved in the process, compared to 45% of families consenting when a trained doctor or nurse was not involved [3]. Furthermore, including education on organ donation and transplantation in medical curriculums **and the current discrepancies in the organ donation system** would allow medical students to disseminate information on organ and tissue donation to their family and friends [29], and counsel future patients.

In regards to Aboriginal and Torres Strait Islander Peoples, the Australian Medical Association (AMA) states that Indigenous patients are 10 times less likely than non-Indigenous patients to be added to the waiting list for kidney donation transplant. While 13% of patients receiving dialysis treatment are Indigenous, only 2% of patients with a functioning kidney transplant are Indigenous [1]. Overall, Indigenous people represent only 2.4% of total organ donations in Australia and due to lack of trust and communication within the medical fields, Indigenous families are far less likely to consent for deceased donation than non-Indigenous families [2]. This education would help foster a positive attitude towards the issue in the general public, and thus, lead to higher rates of organ and tissue donation. In addition, awareness and education around the differences in organ transplant and donation in Indigenous and non-Indigenous peoples will allow medical professionals to close the gap and mend these issues.

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Intimate Partner Violence and Abuse (2018)

Policy Points

AMSA calls upon medical schools to:

1. Educate students on the socio-cultural bases of IPVA, how to recognise IPVA, and appropriate ways to respond, **especially on doing so in a culturally safe manner, and** including mandatory reporting guidelines.
2. Liaise with clinical schools to ensure students have adequate support in dealing with IPVA amongst patients or in their own personal lives.
3. Support students who require leave from studies due to IPVA and liaise with the student to facilitate their return to study.
4. Include specific education about reproductive coercion in relevant pre-existing teaching around contraception and reproductive health.

AMSA calls upon medical students and/or practitioners to

1. Commit to ongoing personal development, training, and education in IPVA.
2. Familiarise themselves with available avenues of support for both patients and themselves, including women's refuges, and financial, counselling, **Aboriginal and Torres Strait Islander Health Services** and legal advice services.
3. Engage with victims of IPVA and offer acute and ongoing support, where appropriate, and within their clinical training and expertise.
4. Medical professionals to assess the acute risk to a patient and help to formulate an acute and ongoing plan of action that prioritises patient autonomy and wellbeing.

G: Global Health

Access to Safe Termination (2021)

Amendment 1: page 11, paragraph 6

Limited data is available regarding TOP specific to the Indigenous community. However, it is recognised that Indigenous Australians suffer poorer baseline health outcomes and have a lower life expectancy (all-cause mortality) than their non-Indigenous counterparts. ~~They experience a burden of disease 2.3 times higher than non-Indigenous Australians, 64% of which is attributable to chronic conditions [68]. Sexual health outcomes are likewise poorer, with studies recording up to 50 times more cases of sexually transmitted infections (chlamydia, gonorrhoea and syphilis) in remote Indigenous communities than in non-Indigenous Australians [69].~~ These disparities are a result of past and present discrimination, racism, intergenerational trauma and differences in the social-determinants of health. Aboriginal teenagers have a double the pregnancy rate of non-Aboriginal teenagers but a smaller proportion of these pregnancies are terminated. This is likely due to barriers to health education surrounding safe sex, contraception and access to termination services [1]. Maternal mortality is also higher in Indigenous communities: between 2012-2018, the maternal mortality ratio for Aboriginal and Torres Strait Islander women was 4 times higher than for non-Indigenous women (20.2 and 5.5 per

100,000 women respectively) [70]. As such, Indigenous Australians are placed at greater risk of poor health outcomes when prevented from accessing safe TOP, relative to the general population.

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Maternal and Infant Health (2018)

Policy Points

AMSA calls upon:

5. With respect to Aboriginal and Torres Strait Islander Health:

- a. Increase funding of accessible, culturally appropriate and sensitive Aboriginal and Torres Strait Islander maternal and infant health initiatives that address the social, economic and cultural determinants of the health discrepancies between Indigenous and non-Indigenous populations **including Birthing on Country services;**
- b. Continue to re-evaluate and fund successful Aboriginal and Torres Strait Islander maternal and infant health services;
- c. Address the ways in which colonialism impacts on the gap between maternal and child health outcomes in Indigenous and non-Indigenous populations;
- d. ~~Promote active involvement of~~ **Involve Indigenous communities in the design and deliverance of** maternal and infant health program development;
- e. ~~Invest in training of more Aboriginal and Torres Strait Islander maternal and infant health workers~~ **Support the training of Aboriginal and Torres Strait Islander health workers through the provision of scholarships and cultural support**
- f. Improve outreach services for Aboriginal and Torres Strait Islander women and infants for increased access to maternal and infant health care, including quality antenatal care.

Background

Amendment 1: page 6; paragraph 5:

Successful strategies recognised by both the RANZCOG and the Close the Gap campaign have a focus on cultural competency and community engagement. This involves a holistic approach that acknowledges Indigenous cultural and spiritual beliefs and practices as well as involving community controlled health services with trained Aboriginal and Torres Strait Islander staff [18, 72]. **This was further highlighted by the 2010-2015 national Maternity Services Plan, which detailed three core strategies to closing the health gap: increasing the Indigenous workforce; increasing culturally competent maternity care; and developing dedicated programs for Birthing on Country [1].** However this goal was not met within the five year deadline for 2015 and little progress has been made since. Indigenous health workers are employed throughout Australia in government and non-government health services to help support primary health care delivery for First Nations people [73]. In 2011 however, approximately 1.6% of the Aboriginal and Torres Strait Islander population were employed in health related areas. This was half the rate of the non-indigenous health workforce [74].

Amendment 2: page 6; paragraph 6:

A number of key areas for intervention have been identified to improve the health of Aboriginal and Torres Strait Islander women and children and decrease rates of child mortality. Improving the accessibility of healthcare services for Aboriginal and Torres Strait Islanders is a priority for the Federal government [75]. Geographical distance, fear, **past and present discrimination, and lack of cultural sensitivity** are significant barriers to access [76, 77]. Improved access to antenatal care services and training of Aboriginal and Torres Strait Islander health workers will promote ~~on Country births, thus helping to maintain connection to country~~ [72]. Birthing on Country, which has been recognised to improve health through the integrated connection between birthing, land, and place of belonging [1]. It is a new phenomenon for Aboriginal and Torres Strait Islander people to not be unable to give birth on country, which is another fundamental consequence of colonisation. Birthing on Country is considered vital to maternal, infant, and community health and has been described as 'a metaphor for the best start in life for Aboriginal and Torres Strait Islander babies and their families'. [1]. In order to be effective these services must provide continuity of care, have Aboriginal and Torres Strait Islander Health workers and be culturally safe [1, 2]. It will also provide women with support during and after pregnancy and lower the associated risks of poor antenatal care such as having a preterm birth or low birth weight baby [72]. Furthermore, smoking and alcohol consumption during pregnancy are more prevalent amongst Aboriginal and Torres Strait Islander women [18] and are among the major risk factors for poor pregnancy outcomes such as foetal growth restriction [78]. RANZCOG identified that 45% of Aboriginal and Torres Strait Islander women smoked during pregnancy as compared to 13% of non- Aboriginal and Torres Strait Islanders [72]. ~~Initiatives to improve health behaviours during pregnancy, such as smoking and drinking, are in place, however knowledge about the associated risks is ineffective in reducing these behaviours that are exacerbated by the stressful social environments experienced by Aboriginal and Torres Strait Islander women [78].~~ The disparity in the rates of these risk factors is largely as a result of colonialism including intergenerational trauma. For example, a study found that over half of Aboriginal women who were pregnant had more than three significant social stressors including death of a family member (sorry business) or housing difficulties [3] therefore any interventions must address these socio-cultural and economic factors in order to be successful.

Amendment 3: new section, page 7, "Indigenous Infant Health":

Aboriginal children are more likely to be born premature (11.7% vs 7.2%) and low birth weight (LBW) (11.1% vs 6.5%) and are twice as likely to die in infancy than non-Aboriginal children [4, 5]. Similar inequalities exist in terms of increased rates of congenital conditions and infections resulting in longer hospitalizations and higher mortality rates in preschool years [6, 7, 8]. Poor health in early childhood translates to increased risk of disease in school aged children [9].

Across all age groups, Aboriginal children are more likely to be hospitalized than non-Aboriginal children [10, 11]. There is a significant disparity between avoidable hospitalization between Aboriginal and non-Aboriginal children. This suggests that targeting risk factors for avoidable hospitalization could reduce inequity between these populations [12]. Equitable access to community-based health services, such as Aboriginal Community Controlled Health Services (ACCHS), have been shown to increase health service use by Aboriginal people [13].

Successes for Aboriginal infant health include early childhood vaccination with 5 year old Aboriginal children being more likely to be fully vaccinated than non-Aboriginal children [14]. Between 2010 to 2018 the number of infants receiving health assessments has tripled.

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Non-Communicable Diseases (2018)

Position Statement

AMSA believes that:

1. NCDs pose a significant health threat globally and include mental ill health, which has particular relevance to the medical students who AMSA represents.
2. NCDs are not uniformly distributed among the Australian population, with higher representation among lower socioeconomic groups and Indigenous Australians.
3. Preventative and tertiary health-care should be directed towards vulnerable groups in order to reduce health inequity in non-communicable diseases, in particular Aboriginal and Torres Strait Islanders.
4. Australia requires a comprehensive plan to address the increase in incidence of NCDs and associated risk factors, acknowledging that equitable access to primary, secondary and tertiary prevention and treatment is essential.
5. There is a need for a substantially greater focus on evidence-based preventative health care within Australia, at the individual, community and wider systems levels (e.g. addressing the issue of an obesogenic environment).

Background

Amendment 1: new section, page 4, "Aboriginal and Torres Strait Islander Health":

A significant disparity in life expectancy exists between Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander Australians, which can be attributed to past and present discriminatory policies, racism and gaps in the social determinants of health [1]. Non-communicable disease (NCD) is the largest contributor to this gap, accounting for 80% of the difference of the years of life lost between the two populations [1]. The leading causes of NCDs in Indigenous populations are substance use and mental disorders, cardiovascular diseases (CVD), cancer and chronic respiratory diseases [1]. The largest contributors to the mortality gap between Aboriginal and non-Aboriginal Australians are ischaemic heart disease (22%), diabetes (12%), liver disease (11%), other heart disease (6%), chronic respiratory disease (6%) and cerebrovascular disease (5%) [1]. Non-fatal disease burden was largely due to mental health and substance use disorders (39%), musculoskeletal conditions (14%) and respiratory disease (12%) [1]. Aboriginal and Torres Strait Islander people living in NSW were 2.6 times more likely to experience more than one non-communicable disease (multi-morbidity) and as a result were 2.4x more likely to die than non-Aboriginal people [2].

This mortality disparity is largely due to differences in the social determinants of health, in particular differences in the rate of smoking, alcohol use, poor nutrition, hypercholesterolemia lack of exercise and being overweight or obese. These risk factors themselves are largely due to social and economic barriers that prevent improvement of health including lower health literacy, educational attainment, income and employment, and poor access to culturally safe health services. Perinatal risk factors including prematurity and low birth weight occur more frequently in Aboriginal Australians and similarly contribute to poor health in later life. Of all risk factors tobacco use is the most significant causing 23% of the disease burden gap. Barriers to preventative health also contribute to this mortality gap; for example, rates of cervical cancer screening are lower in Aboriginal compared to non-Aboriginal women. Furthermore, failure of secondary healthcare also plays a role; for example chronic kidney disease contributes to the mortality gap which is largely due to diabetic nephropathy, which is preventable if diabetes is well controlled.

However, older Aboriginal people face a substantially higher burden, and from younger ages, in the number of chronic conditions with an impact on quality of life, even as the lifespan gap narrows for these older survivors relative to their non-Indigenous peers [3]. Their data highlight the imperative to change early life trajectories in order to reduce physical and mental multimorbidity, and to improve health and longevity. In other populations, adverse childhood experiences have a clear association with multimorbidity, physical and mental chronic conditions, and the risk of premature death [3].

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Vaccinations (2020)

Position Statement

AMSA believes that:

8. **First Nations** peoples globally experience a disproportionate burden of vaccine preventable diseases.

Background

Amendment 1: page 7, paragraph 3 “Aboriginal and Torres Strait Islander peoples”:

In Australia, addressing the health disparities between Indigenous and non-Indigenous-Australians is an ongoing priority for governments and health providers. Aboriginal and Torres Strait Islander people experience a significantly higher burden of VPDs than non-Indigenous Australians. Despite making up only 3.3% of the population, they account for 10% of the national burden of VPDs in 2015, experiencing a preventable burden 4.1 times that of non-Indigenous Australians [12].

Amendment 2: page 7, paragraph 4 “Aboriginal and Torres Strait Islander peoples”:

This disparity has been attributed to lower standards of living, higher burden of chronic diseases, poorer access to clean water, housing and health care, and social determinants of health such as low education outcomes and intergenerational trauma [16]. Aboriginal and Torres Strait Islander people are also more likely to experience barriers to accessing healthcare and vaccination, including transport, cost, communication difficulties, distrust in government programs, concerns about vaccine effectiveness and safety and, notably, a failure of health practitioners to identify

Indigenous status within a primary healthcare setting [28, 29]. These determinants and barriers are discussed further in the AMSA Aboriginal and Torres Strait Islander Health Policy (2019).

Amendment 3: page 7, paragraph 5 “Aboriginal and Torres Strait Islander peoples”:

For these reasons, Aboriginal and Torres Strait Islander people have been identified within the National Immunisation Program as a group for whom full immunisation coverage is of particular importance [9]. Under the NIP, Aboriginal and Torres Strait Islander people of all ages are eligible for various free and “catch-up” vaccinations, and for children under five years old, there is a tailored immunisation schedule that includes additional vaccines such as Meningococcal B, Pneumococcal, Hepatitis A and Influenza [30, 3]. Furthermore, these vaccines are often recommended for a broader age range for Indigenous versus non-Indigenous people [1]. For example, annual influenza vaccinations are covered for all Indigenous people 6 months and older whereas non-Indigenous people are only eligible if they are 6 months-5 years old, older than 65, pregnant or identified as part of another vulnerable demographic [2].

Amendment 4: page 7, paragraph 6 “Aboriginal and Torres Strait Islander peoples”:

These vaccination schedules have reduced the incidence of many VPDs such as diphtheria, hepatitis A and B, measles, mumps and rubella amongst Aboriginal and Torres Strait Islander people [31]. Haemophilus influenzae Type B (Hib) notification rates have decreased by more than 95% since 1993, and hepatitis A notification rates have been lower than for non-Indigenous people since 2007, following the introduction of specialised programs for Aboriginal and Torres Strait Islander children [24]. Notably, Aboriginal and Torres Strait Islander children aged 5 were the first to reach the 95% immunisation coverage target nationwide, and by as of March 2020 2021 the national coverage rate for Aboriginal and Torres Strait Islander 5-year-olds was 98.86% this demographic remains above the target at 97.26% [9, 32, 4].

Amendment 5: page 7, paragraph 7 “Aboriginal and Torres Strait Islander peoples”:

Although most Aboriginal and Torres Strait Islander children eventually complete the appropriate vaccination schedule, many do not do so in the recommended time frame. ~~In~~ As of March 2020 2021, ~~only 92.92%~~ 93.70% of Indigenous 1-year-olds and ~~89.70%~~ 91.73% of Indigenous 2-year-olds were fully vaccinated, compared to the nationwide average of 94.91% and 92.53% for all 1-year-olds and 2-year-olds respectively ~~compared to 94.37% and 91.46% of non-Indigenous children respectively~~ [11, 32-4, 5]. This delay is significant due to the lower median age of onset for certain VPDs amongst Aboriginal and Torres Strait Islander children compared with non-Indigenous children. For example the median age of onset for Hib is 9.4 months in Indigenous children versus 17.7 months in non-Indigenous children [31].

Amendment 6: page 8, paragraph 1 “Aboriginal and Torres Strait Islander peoples”:

Further, despite improvements brought about by the NIPS, Aboriginal and Torres Strait Islander adults still experience poorer overall vaccine coverage rates, a disproportionate burden of disease and higher rates of severe outcomes associated with such VPDs ~~a disproportionate burden of disease and poorer overall vaccine coverage rates~~ compared to non-Aboriginal and Torres Strait Islander Australians [1]. The majority of this burden can be attributed to HPV. Although HPV vaccination uptake rates are comparable between populations, Aboriginal and Torres Strait Islander women experiences morbidity rates from cervical cancer twice as high and associated mortality rates four times higher than non-Indigenous women ~~women experience much higher rates of morbidity and mortality from cervical cancer~~ [12, 6]. Similarly, despite similar (albeit low) rates of vaccination for influenza across both populations, ~~influenza~~ age-adjusted hospitalisation rates for influenza and pneumonia

were 2.4 3.1 times higher amongst Aboriginal and Torres Strait Islander peoples of all age groups compared with non-Indigenous Australians between 2011-2014-2015 [33, 7]. These disparities highlight the need for more effective, targeted communication with Aboriginal and Torres Strait Islander people regarding the importance of, and their eligibility for, free seasonal influenza vaccinations [28].

Amendment 7: page 8, paragraph 2 “Aboriginal and Torres Strait Islander peoples”:

Improving timeliness and rates of vaccination coverage and lowering the burden of VPDs amongst the Indigenous population will require enhanced collection and utilisation of data and improved efforts to reduce barriers to vaccination for Aboriginal and Torres Strait Islander people. Currently, national vaccination coverage data for Indigenous adults is only reviewed in four-year periods and publication of this data can be delayed. Reviews are needed more regularly to more effectively monitor and target program delivery efforts. A failure of health practitioners to correctly identify Indigenous patients also significantly impedes accurate data collection and delivery of appropriate healthcare [34]. Successful techniques should be continued and these include the development of culturally appropriate resources for Aboriginal and Torres Strait Islander Australians, the creation of follow-up programs to increase rates of vaccine course completion and of receiving opportunistic vaccines, as well as the employment of Aboriginal and Torres Strait Islander health workers in all local health districts [8].

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Policy Details

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