RURAL AND REMOTE ABORIGINAL MENTAL HEALTH – MEETING THE CHALLENGES

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ABSTRACT
Recent aggregated statistics confirm our experience as Aboriginal health service providers and researchers that Aboriginal people in the Eyre Peninsula region of SA are living with many challenges to their health and wellbeing. Mental health disorders are prevalent and complex, and include substance misuse, grief and loss, and diagnosed mental illnesses, often complicated by other physical health problems, trouble with the law, and social support needs. The effects on individuals are profound, and extend to families/carers and communities. Services are inadequate, under-resourced, often inaccessible or inappropriate, and struggling to meet the complex needs of their clients. Issues identified at Ceduna-Koonibba Aboriginal Health Service and Port Lincoln Aboriginal Health Service include: cultural respect, workforce recruitment and retention, professional development, confidentiality, communication, and coordination of care. Practice innovations and strategies being developed through participatory action research include: using traditional and modern approaches side by side, psychiatrist visits communities and works closely with families, flexible short courses based on local workforce training needs, training that brings together workers from different sectors and encourages collaboration, mental health promotion, case management approach, advocacy for policy and legislative change, effective and agreed referral documentation, protocols to ensure sharing of information critical to patient safety while safeguarding confidentiality.

INTRODUCTION
This paper outlines the background and progress to date with a project to improve the coordination of care for Aboriginal people with mental health problems living in the Eyre Peninsula region of South Australia. The project is called Coordinated Aboriginal Mental Health Care (CAMHC) and is a partnership of Flinders University, Port Lincoln Aboriginal Health Service (PLAHS), Ceduna-Koonibba Aboriginal Health Service (CKAHS) and Eyre Peninsula Division of General Practice. The CAMHC project builds on our previous research and responds directly to recommendations formulated in consultation with Aboriginal clients and service providers. The presentation at TheMHS 2006 was given by our colleagues from CKAHS, Colleen Prideaux and Lourdes Ordasi, on behalf of the research collaboration.

BACKGROUND
Aboriginal Australians generally view health in a holistic way incorporating cultural, social, spiritual, physical and emotional wellbeing. Individual health and wellbeing is closely linked to family and community health and wellbeing (Australian Government Department of Health and Ageing 1989; Brown 2001; Australian Government Department of Health and Ageing 2003). Recent aggregated statistics (South Australian Aboriginal Health Partnership 2005) and other research, eg (Kreger and Hunter 2005; Mental Health Council of Australia 2005) confirm that Aboriginal Australians carry a higher burden of social and emotional distress than their non-indigenous peers. National hospital separation data indicate that diagnosed mental and behavioral disorders are 1.5 and 2.1 times more likely among Aboriginal people (males, females respectively) than their non-indigenous peers, and that mental disorders due to psychoactive substance use is 4.4 and 3.3 times more frequent (Trewin and Madden 2005). Our own research confirmed the high prevalence of mental health problems among Aboriginal people in the Eyre Peninsula region, and frequent co-morbidity of diagnosed mental illnesses with substance misuse, preventable injury and chronic physical health problems (Kowanko and De Crespigny 2004).
Our previous SA-wide research on medication management for Aboriginal people with mental health disorders, their carers and other family members revealed that they must access a complex maze of Aboriginal and mainstream health and community services in an attempt to meet their needs, and that there is poor integration of and communication between these service providers, clients and carers (Kowanko, de Crespigny et al. 2003; Kowanko, De Crespigny et al. 2004; de Crespigny, Kowanko et al. 2005; Emden, Kowanko et al. 2005). As a result care may be inadequate, and potentially dangerous situations may occur. Our research showed that this is a major issue in metropolitan, regional, rural and remote areas, but the problem is particularly acute for people from country areas who need to be admitted to an Adelaide mental health facility for urgent treatment (Kowanko, de Crespigny et al. 2003). Our previous research showed that it was common for Aboriginal health services, and in particular their social and emotional well-being teams, not to be told by the local hospital or GP when clients are sent to the city for emergency treatment. Similarly, there is inadequate communication between the metropolitan Adelaide mental health facilities and the local mainstream and Aboriginal health and community services. When country people are sent to Adelaide for emergency treatment, beds are allocated by the SA Mental Health Rural and Remote Service, but information is very slow to filter back to the client’s family/carers, GPs, Aboriginal Social and Emotional Wellbeing teams, and other health/community workers who are often involved in the ongoing care of these clients. For example, it can take up to 8 weeks for a discharge summary/letter to be sent from a metropolitan Adelaide mental health facility to the local GP. Meanwhile clients may be discharged, with no arrangements made for follow-up support and monitoring in the community, and families uninformed. The research group was told that it was not unusual for clients to be discharged with a bag of medication and simply put on a bus without an escort or someone to meet them at journey’s end. Similar problems with poorly coordinated services occur for Aboriginal people with mental disorders and involvement with the criminal justice system, especially in regards to continuity of health care and medication management support on release from detention, indicated from our own and others’ research (de Crespigny 2002; Krieg 2006). Not surprisingly, such situations cause great distress to the clients and put them at unnecessary risk; and the families/carers as well as local health providers feel uninformed and frustrated that they cannot provide the timely care and support that is required for these vulnerable people (Kowanko, de Crespigny et al. 2003).

One of the recommendations informed by our previous research findings and formulated in consultation with Aboriginal clients and service providers in Port Lincoln and elsewhere, was to develop better coordinated systems of care (Kowanko, de Crespigny et al. 2003; Kowanko, de Crespigny et al. 2003; de Crespigny, Kowanko et al. 2004). The current project, known as the Coordinated Aboriginal Mental Health Care (CAMHC) project, responds directly to this recommendation, and was designed in consultation with Aboriginal colleagues (Kowanko, De Crespigny et al. 2004; Kowanko 2005). It draws on expertise in developing such systems within Flinders University and collaborating institutions. In recent years Flinders University researchers have been active in developing and trialing systems for coordinated health care eg the SA Healthplus and COAG trials, and studies in the Eyre Peninsula region have demonstrated effective and sustainable systems of coordinated chronic disease management, which have informed this project (Ah Kit, Prideaux et al. 2003; Battersby 2005; Battersby, Harvey et al. 2007). Some of these projects are ongoing and focus on developing systems of shared care with Aboriginal people who have chronic diseases, eg diabetes. The national evaluation of early Aboriginal and Torres Strait Islander coordinated care trials suggested great promise in this approach (Office for Aboriginal and Torres Strait Islander Health 2001).

**AIM, RESEARCH APPROACH AND METHODS**

The aim of the CAMHC project is to improve coordination of care for Aboriginal people with mental health disorders who live in the Eyre Peninsula region, by developing pathways and protocols of care that are client-focused and holistic, culturally appropriate and sustainable, and embedded in systems rather than dependent on personalities or individual relationships. For this project mental health disorders are defined broadly, ranging from social/emotional distress through to diagnosed mental illness, and includes problems with drug and alcohol use.

The research was planned as 5 overlapping phases:
• Exploration: Identify barriers and enablers to coordinated care and find examples of effective strategies, through interviews with a range of key informants from all relevant services and organisations, and analysis of existing policies and protocols.

• Development: informed by the exploratory phase, collaboratively develop detailed pathways of care and agreed protocols for coordinating service from multiple providers.

• Implementation: put agreed protocols and coordinated care pathways into practice, and support organisational change with staff training.

• Evaluation: qualitative outcome and process evaluation.

• Reporting: disseminate information about the project in a variety of formats.

We are using a participatory action research design and multiple methods. Participatory action research classically involves a collaborative cyclic process of planning, acting, observing, reflecting and re-planning, and is well suited to Aboriginal health research due to its action orientation, and empowerment of participants as co-researchers working to effect change (Henry, Dunbar et al. 2002). We have used an action research design in previous work (Kowanko, de Crespigny et al. 2003), and found that the process is not neat or sequential, as the reality includes coping with changing priorities, opportunistic interventions, shifting context, and chronically limited resources. Our research approach emphasizes respect, collaboration, participation and meeting needs (de Crespigny, Emden et al. 2004; de Crespigny, Kowanko et al. 2006).

The project utilizes multiple methods, including:

• Interviews: Semi-structured interviews were conducted with a wide range of health, social and human service providers that are involved in the care or support of Aboriginal people from the Eyre Peninsula region who have mental health (including drug and alcohol) problems. We used an interview guide to explore with participants their professional understanding of what helps or hinders coordination of Aboriginal mental health care, potential solutions to problems and examples of effective practices, and knowledge and compliance with relevant guidelines or policies where they existed. Written notes made during the interviews and reflections afterwards, and these data were analysed for thematically.

• Document review: Policy documents, guidelines and protocols were obtained from requests to our research participants and by non-exhaustive bibliographic searching for years 2000-2005. Inclusion criteria were that content pertains to Aboriginal mental health (very broadly defined), the Eyre Peninsula and/or metropolitan Adelaide regions. A content analysis was performed by scanning the headings, captions or other emphasised text in these documents to determine in what way and to what extent they specifically and substantially addressed coordination of health/social care and/or integration of health/social services and/or pathways of care for Aboriginal people with mental health problems.

• Collaborative development of practical solutions to meet local needs: The research team and participants from PLAHS, CKAHS and EPDGP, together considered the combined findings from the exploratory phase with a view to developing achievable and sustainable local strategies to coordinate care. Decisions about potential strategies to implement, how and in what time frame, and how to evaluate them were made by participating organisations according to their needs, priorities and resources.

Initially the geographic scope of the project was restricted to the Port Lincoln area (building on research relationships and activities in the area established during our previous projects), with invitations to other Eyre Peninsula services and communities to become involved according to their capabilities and priorities. Soon after securing seed funds, and supported by collaborative ties through the Centre for Clinical Research Excellence in Aboriginal Health (CCRE) (Giles, Malin et al. 2006), CKAHS asked to join the project as well, because its clients are frequently from the same family and kinship groups as those attending PLAHS, often mobile, and as many of the issues they experience and services they access are similar.

**PROGRESS TO DATE**
The project has been making slow but steady progress since it began in 2004. Flexibility and accommodation of our partner-community timeframes is essential in conducting Aboriginal health
research, particularly when using participatory action research methodology, as in this project. Therefore
the pace of our research is set by our Aboriginal partner organisations - both PLAHS and CKAHS have had
other priorities and many challenges. They include ongoing ramifications of the 2005 bushfires, chronic
staff shortfalls (especially severe in CKAHS), high staff turnover, and increasing number of clients from
outside the Eyre region. Other challenges that have slowed the project include reluctance of organisations
to work together; lack of understanding and confidence between and within services regarding individuals’
roles and skills; shifting policy and governance structures at State, regional and local level; and the demise
of ATSIC. Despite these competing demands and external challenges, all the research partners have
confirmed their commitment to the project.

All documents reviewed (9 national, 5 state, 15 regional) showed an intense need and willingness to
improve Aboriginal health but few documents followed stated policies through to reporting or evaluating
any actions taken. A notable exception is the SA Partnering Agreement (Department for Aboriginal Affairs
and Reconciliation and the ATSIC 2003). ‘Integration’ is referred to extensively; ‘coordination’
ocasionally and ‘pathways’ rarely. The resource package 'Aboriginal health - everybody's business'
specifies coordination responsibilities at state, regional & organisation levels (South Australian Aboriginal
Health Partnership 2004), and the National Mental Health Plan 2003-2008 refers to care pathways
(National Mental Health Plan Steering Committee 2003). Overall, the documents call for integration and
coordination between a very wide range of health and human services and key players. Importantly, this
CAMHC project includes them all.

We have formally interviewed a wide range of health, social and human service providers that are involved
in the care or support of Aboriginal people from the Eyre Peninsula region who have mental health
(including drug and alcohol) problems. This includes managers and workers from Aboriginal community-
controlled and mainstream organizations at community and Eyre Peninsula regional level and in Adelaide,
such as mental health services, community health, Drug and Alcohol Services SA, police, corrections,
housing, public advocate, Royal Flying Doctor Service, SA Ambulance, Division of GPs, visiting
psychiatrists, support groups, Child Youth and Family Services, government policy makers, and more. The
main issues affecting PLAHS and CKAHS that were identified from interviews include: cultural
competence, workforce recruitment and retention, professional development, confidentiality,
communication, and coordination of care.

Data from the interviews and document analyses were combined with notes of strategies put in place during
the project and reflections of the research team. This combined information was taken back to participants
for confirmation and to inform decisions about any further strategies to implement. The major categories
were:

• Alcohol and other drugs
• Communication
• Cultural understanding and acceptance
• Emergency care
• Holistic health issues
• Policies and protocols
• Community education (health promotion)
• Transport
• Workforce planning and development support (education & training)

Within each category, we identified factors that enhance and hinder coordination of care, noted relevant
strategies and interventions (direct and indirect) put in place during/as a result of the project, and
suggestions based on professional experience and the literature. Some strategies that promote inter-agency
collaboration or communication that have already been identified and implemented during the project
include:

• bringing together workers from different agencies for training in response to shared needs, eg mental
  health, drug and alcohol, co-morbidity, safe use of medicines
• advocating for Aboriginal community input into the Review of Mental Health Legislation in SA
• providing health promotion resources
• lobbying for improved out of hours telephone help
• advocacy and training for a methadone clinic at Port Lincoln
• strengthening links between mainstream and Aboriginal health, eg staff from Eyre regional Mental Health Service now work alongside the PLAHS social and emotional wellbeing team several days each week and the Aboriginal advocate role at the Port Lincoln hospital has been extended.

A full account of these findings and strategies is beyond the scope of this paper and will be published elsewhere.

Currently the CAMHC project work at PLAHS is focused on improving intra-agency communication at PLAHS. The need for effective and timely communication within PLAHS, especially concerning clients with multiple and complex needs that require services from different sections of PLAHS and sometimes also from external services, was seen as a priority by PLAHS staff and Board in meeting the organizational goal of quality holistic care. In particular the need for the Social and Emotional Well Being team to work more closely and effectively with the Clinical and other teams at PLAHS has been stressed (Ashe 2005). Consequently the research team and key PLAHS staff have worked together to develop a uniform screening and referral protocol and documentation for all clients. It is hoped that PLAHS will be able to implement the new system soon. A much better computer system (Communicare) is being installed at all PLAHS sites at this time also, and the software can be tailored to include the agreed referral document. Challenges to implementing the new system include reluctance of some staff to record or look up client information, perceived issues around confidentiality and information-sharing within PLAHS, geographical separation of teams at PLAHS (the Social and Emotional Well Being team is at Haigh St and the Clinical and other teams are based at Oxford Terrace), lack of clarity about job descriptions and sharing care of clients in common. These challenges are already being addressed by supporting organisational change through staff training and education, and there are plans for staff rotations, more case conferencing, and handover protocols to address the other issues. PLAHS has also employed a clinical coordinator recently.

Current involvement of CKAHS in the CAMHC project is limited, due to many stressors on the community and chronic staff shortfalls at CKAHS. A wide range of service providers in the Ceduna area contributed significantly to the development of themes and strategies described above, but capacity to implement new strategies is lacking at present. CKAHS is watching developments at PLAHS with the common screening and referral document, and hopes to apply the new system, or elements of it, at a later stage. Meanwhile CKAHS continues to offer a wide range of mental health services including: case conferencing; counseling; well being program; mental health clinic day offering screening, assessments, follow ups and referrals; ‘Bringing Them Home’ program; substance misuse program with drug action week and day trips; and home visits. CKAHS faces many challenges such as: client confidentiality, the wellbeing of its professionals, staff retention and recruitment to such a remote area, limited resources and funding sources, the isolation of Ceduna, lack of access to allied health and specialist services, and staff development.

SIGNIFICANCE
There is a serious absence of coordinated Aboriginal mental health care between designated Aboriginal health services, mainstream mental health and GP services within and beyond regions. This is despite recognition in mainstream health of the need for coordinated care as a keystone and principal of best practice, and significant reports calling for improvements in Aboriginal health and mental health care over the last 10 years (Human Rights and Equal Opportunity Commission 1993; Bidmeade and Government of South Australia 2005) (Australian Government Department of Health and Ageing 1989; Australian Government Department of Health and Ageing 2003). Our requests to the SA Department of Health to provide us with its policies and protocols for Aboriginal mental health care revealed an absence of such, highlighting the urgency of this work. Our previous research revealed that a wide range of health, police and social services have regular and frequent contact with Aboriginal people with mental health problems, yet 'singular services' and poor skills amongst many workers do not promote sound care of these clients. The CAMHC project is an attempt to address this problem, and has already made considerable progress towards the goal of providing coordinated, holistic and culturally appropriate mental health care for Aboriginal people.
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