RAISE Wellbeing

Regional Aboriginal Integrated Social & Emotional Wellbeing Program

Pika Wiya Health Service Inc.

Northern & Far Western Regional Health Service

NORTHERN RIVERS
University Department of Rural Health

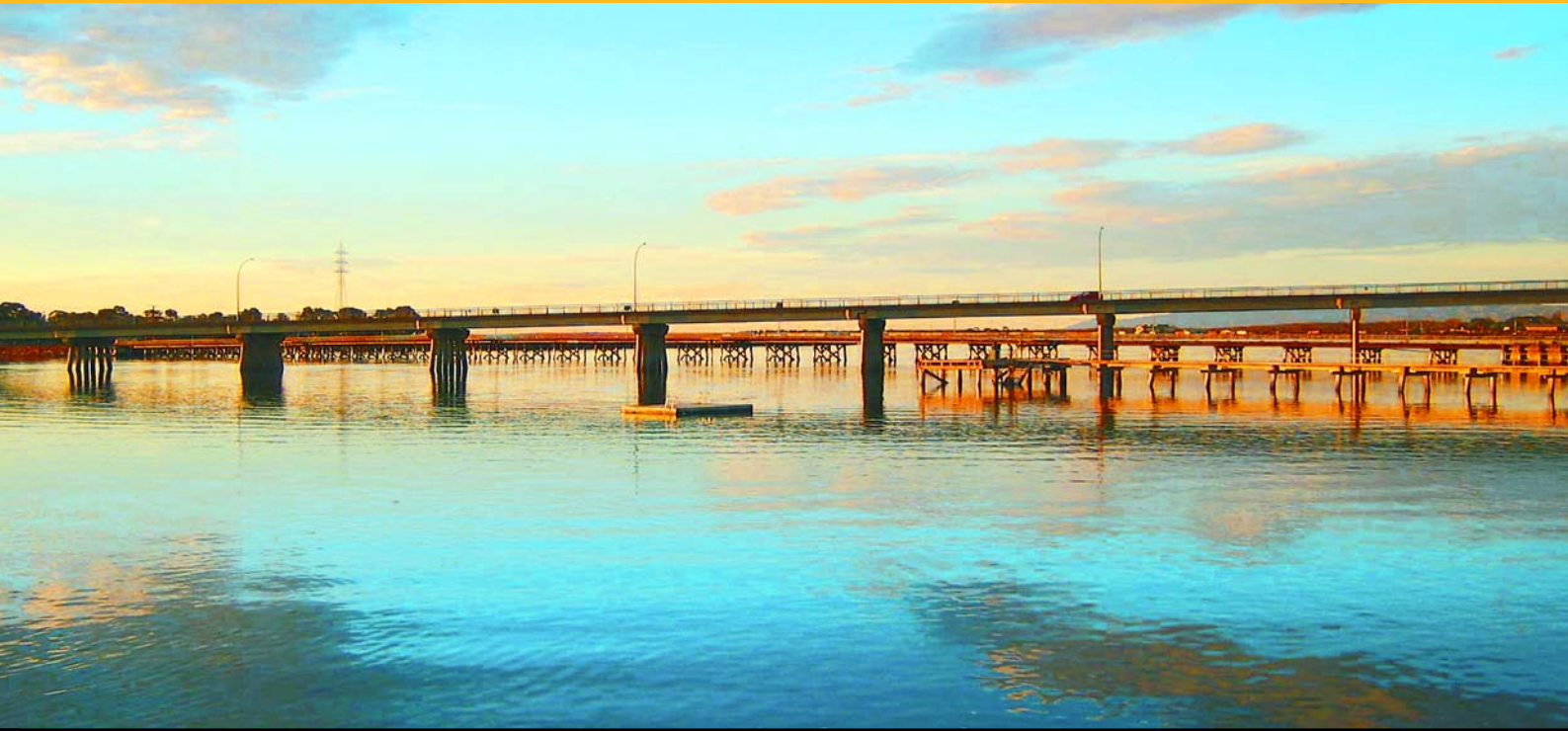## A case study in Aboriginal primary mental health care linkages

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Acknowledgements

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Executive summary

This report documents the primary health care linkages identified through a case study of the RAISE Wellbeing program in the Northern & Far Western Health Region of South Australia. RAISE Wellbeing is a mental health service partnership of one Aboriginal and three mainstream health care organisations. These organisations are the Pika Wiya Health Service, the Pt Augusta Mental Health Team, the Pt Augusta Hospital and the Flinders & Outback Regional Health Service. Data for the study came from (1) a literature and document review, (2) 23 key informant interviews and (3) a group discussion with the staff from the four organisations using case vignettes.

Drivers

The drivers for the partnership were found to be local demand, a conducive policy context and, in recent times, the availability of some additional resources for mental health. Against these drivers is a national background of attempts to improve mental health services that have been limited by inadequate integration of Aboriginal health policy with mainstream policy, insufficient mainstream links with centres of expertise, a low priority on mental health data collection and underestimation of the developmental tasks required in Aboriginal mental health.

Impact

The impact of the RAISE Wellbeing program on the partners to date has been the development of teamwork relationships, greater responsiveness from the Mental Health Team and improved mental health care processes in the Pika Wiya Health Service. Teamwork has seen an increased willingness across the four organisations to share workload as well as share knowledge and skills by learning on the job.

Teamwork relationships

Two foundations to the teamwork partnership were the formal processes (eg MOUs, committee meetings etc) and the important personal relationships between the people involved. The relationship between the organisations' chief executive officers has provided 'stability at the top', there is positive regard between the team leaders in the four partner organisations and team members are getting to know each other through meetings.

Although it was recognised that the current four organisation partnership needs to eventually include other related organisations, particularly in response to significant alcohol and drug related problems, the consensus was to first consolidate the existing relationships.

Factors that initially slowed the relationship development were unclear goals, different views about the program focus, a challenging style of the first RAISE Wellbeing project officer and staffing changes. In particular, a focus on service delivery leadership in Pika Wiya slowed attention to cross-organisational linkages. This has been addressed in the appointment of the most recent RAISE Wellbeing project officer to focus specifically on linkages.

To fully develop the partnership structures and processes a dedicated linkages project officer is still required to move these forward and capitalise on the conducive relationships that have been established.

Workforce capacity

The insufficient base of Aboriginal staff with expertise in mental health was seen to limit the progress of the RAISE Wellbeing program. As a positive, however, the region was reported to have the best staffing level in mental health that it has had for years and so it is well placed to further develop an Aboriginal mental health partnership. The preferred approach to skills development was on the job training by bringing Aboriginal and mainstream staff together to learn from each other. This is a form of organisational learning for innovation and responsiveness that does require considerable input and oversight from skilled team managers, who themselves will need learning and ongoing support for this.

Organisational capacity

As well as workforce capacity, organisational capacity was identified as important, including the provision of infrastructure (cramped facilities in Pika Wiya) and the development of culturally informed mental health care processes. To date formal processes between the four partner organisations for communicating about client mental health care have been absent.

Given the lack of readily available training, the lack of mental health tools for use with Aboriginal people and expert advice about these resources, key staff across the partnership might work together to source and adapt resources for local use. Expert assistance would still be needed and could cover resources for cross cultural team development, mental health training, and culturally appropriate mental health assessment and care management processes.

Program governance

With the intention to pool Aboriginal mental health funds between the Regional Mental Health Program and Pika Wiya, and with Pika Wiya taking a regional Aboriginal mental health responsibility, the role of the program management committee will be important. This will be important to ensure that the needs of the four partner organisations are considered when decisions are to be made about how the pooled funds will be spent.

Communication strategy

To ensure sustainability of RAISE Wellbeing, a communication plan to stakeholders will help to convey program effectiveness and canvass political support as well as demonstrate the need to put regional Aboriginal mental health on a more secure base of recurrent funding.

Achievement expectations

Based on informant expectation over the next two years, the achievements of RAISE Wellbeing might be to: (1) fully determine the required communication and planning processes for a cross-cultural organisational partnership in Aboriginal mental health; (2) have developed teamwork processes for Aboriginal health and community mental health staff to work together; (3) have conducted some work on culturally appropriate assessment and care management tools. It was stressed that expectations should be realistic, given the low base from which Aboriginal mental health partnerships commenced and in light of the time that it will take to develop resources nationally.

Conclusion

The study concludes that against a low capacity starting base and interruptions to the implementation of program strategies, RAISE Wellbeing has established good organisational relationships and improvements in mental health response to Aboriginal clients. These relationships are essential for program development and sustainability. Hence, the program is now well positioned to move into an active stage of sourcing, adapting and piloting service developments in Aboriginal primary mental health care in the region, such as training and care management tools.

Recommendations

Goal area 1: Workforce capacity building

1.1. Training in mental health and cross-cultural competencies be sourced for staff of the four organisations and to cover both on the job & off the job approaches.

1.2. For sustainability: (1) Linkages be established to external 'expert' assistance for the development of Aboriginal mental health service processes and tools. This could include linkage to the relevant South Australian Aboriginal Health Partnership (SAAHP) and also Office for Aboriginal & Torres Strait Islander Health (OATSIH) Social & Emotional Wellbeing action plans, particularly for assistance with workforce development and the development of a data system. (2) Infrastructure required to support the delivery of mental health care (eg office and counselling space) be established to the level possible according to national mental health standards.

Goal area 2: Health services delivery

2.1. The process of developing and signing off of Memoranda of Understanding (MOU) be completed so that the expectations and responsibilities of the four organisations in the partnership be clearly established.

While separate MOUs may be signed off between the four organisations for management expediency, one overall partnership agreement/ statement of intent would be useful so that the goals and direction of the program are clearly and unambiguously communicated.

2.2. A minimum common core platform for the management of mental health care (eg care planning) be considered to cover risk assessment, treatments and referral processes (pathways of care). This will facilitate agreement about mental health care goals and responsibilities and would establish cross-cultural care protocols around matters such as home visiting, crisis management plans and the use of traditional healers etc.

2.3. Processes be developed for communicating client care between partners (eg through case notes, referral and feedback letters etc).

2.4. Interorganisation case conferences be held as an ongoing strategy to improve care processes thereby contributing to service quality and staff skills sharing.

2.5. Aboriginal client and community education materials about mental disorders be developed.

2.6. When the partnership processes are well established between the current four organisations, then care management processes be widened to include other agencies such as the Rural & Remote Mental Health Service, housing, drug & alcohol services, police etc.

Goal area 3: Linkages and coordination

3.1. The Management Committee maintain shared decision-making over the business plan to which the program resources are applied. This is to reflect the intent of the program as service improvement through an organisational partnership. This may mean that the committee manage the budget.

3.2. The Linkages Group involve service providers of the four organisations as the vehicle for communicating the partnership at the workforce level on service delivery matters. These meetings be convened regularly and involve all staff across the partnership at lease 2 to 3 times per year.

3.3. The role of the linkage project officer be maintained on the development of organisational capacity. Although much of the focus of this role will be on building organisational capacity in Pika Wiya (necessary for collaboration), for fully responsive Aboriginal mental health care attention is also required on the cross-cultural capacity of mainstream health workers in the other organisations of the partnership.

   Given the still early stage of program development (organisational relationship process are established) it is recommended that further funds be sought to maintain the role of the linkages project officer to at least the end of 2006 to operationalise both staff training and a minimum common platform for client assessment and referral.

3.4. Data system for monitoring be established so that there can be (1) informed decision making by all parties to the management committee and (2) to reinforce the value of the partnership to the teams. Data could include reports on service processes and summated service use and client outcome data to show change in access and outcomes over time. Relevant data should be regularly provided to both the Management Committee and the Linkages Group.

3.5. A communication strategy be developed to the staff involved in the program as well as to local, regional and state health decision makers. Communication could include regular updates about the progress of the program and ongoing program development needs. In particular, keeping the local Aboriginal community and advocacy organisations informed (eg the Aboriginal Health Council) is important to facilitate political support.

Goal area 4: Community and consumer involvement

4.1. Mechanisms be established for consumer and community input and feedback to the four organisations on mental health service delivery. A consumer and community-focussed approach will provide the point of reference for quality improvements, help to achieve increased acceptance of mental health in the community and also create a local political constituency.

Background

This report describes a case study of primary health care linkages in the RAISE Wellbeing Program. RAISE Wellbeing is a partnership between one Aboriginal health service and three mainstream health services that aims to improve mental health care to Aboriginal people. The case study is one of five projects around Australia funded under the Australian Primary Health Care Research Institute to examine organisational linkages in existing primary health care programs.

Because the focus of the research is on organisational linkages, the emphasis of the findings is on teamwork and partnership structure and processes.

The problem

The National Mental Health Strategy consultation 'Ways Forward' indicates that health care for Aboriginal people needs to encompass a mix of services, be provided through their own communities and that links services for major mental disorders with services for co-morbidities related to trauma and grief, substance abuse and family violence.[1] Hence, there is a need to link specialist mental health service provision with Aboriginal health services that capitalises on the respective workforce skills.[2] The Office for Aboriginal and Torres Strait Islander (OATSIH) Emotional and Social Wellbeing Framework, the National Mental Health Plan (2003-2008), the South Australian Mental Health Implementation Plan and other state and local reports seek more appropriate and effective mental health care from both mainstream mental health organisations and Aboriginal and Torres Strait Islander primary health care services. This requires (1) a broadening of mental health care to increase mental health literacy in Aboriginal communities, (2) the incorporation of culturally relevant practices along with high quality community based psychiatric methods delivered through Aboriginal and mainstream service partnerships and (3) capacity building of Aboriginal health workers.[3,4,5,6,7,8]

Evaluation of past initiatives at the national level indicate the following program difficulties:[9]

- Inadequate integration of Aboriginal mental health planning with other Commonwealth policy.

- Centres of expertise established to support mental health capacity building had not approached cross-agency linkages.

- Where local service partnership had been successful then they tended to have inclusive cross agency linkages.

- The development of Aboriginal mental health data collection & information systems had been a low priority.

- The original outcomes envisaged under the national mental health action plan underestimated the developmental tasks involved.

The drivers

Current national and state policies all provide direction towards Aboriginal health and mainstream mental health service linkages, workforce development, and improved data collection for planning.[7,10,11]

The recent 2004-2009 OATSIH Social & Emotional Wellbeing (SEWB) framework proposes the development of national SEWB competencies, mental health management protocols for Aboriginal Community Controlled Health Services, in-service training for non-Aboriginal & Torres Strait Islander (ATSI) mental health workers and increasing the number of ATSI mental health worker positions in mental health services. However the timeframes for this recent framework will not see resources in the short term for use in current local mental health programs. For implementation the OATSIH framework does propose various levels of organisation that at the regional and local level should include local implementation groups as well as articulated responsibilities for Area Health Services and Aboriginal Community Controlled Health Services.

At the regional level in the north of South Australia a series of consultative and research activities have documented over a number of years the following dissatisfaction with Aboriginal people's access to mental health services.[7,8,12,13]

- Lack of mental health staff in the Aboriginal health service.

- Inflexibility in the approach by the mainstream Mental Health Team.

- Need for better coordination between organisations including discharge planning with the local hospital.

In addition to these policy factors there are now greater mental health resources (albeit still inadequate) in the Northern & Far Western Health Region. State expansion money for mental health has provided leverage for service linking. New regional mental health positions have created systematic development of capacity, through the Regional Mental Health Program Manager, the RAISE Wellbeing positions, the regional principal mental health clinician and regional staff psychiatrist. Additional resources have also come from the Commonwealth for the Flinders and Outback Regional Health Service that has a focus on mental health. Hence there is now a greater critical service mass in the region that makes service improvement possible.

At the national, state and regional levels the drivers for service linkages in Aboriginal mental health can be considered as policy, local demand and also in the last few years some additional mental health resources.

The program

The Regional Aboriginal Integrated Social & Emotional Wellbeing Program (RAISE Wellbeing) is located in the Northern & Far Western Health Region of South Australia. The program is an attempt to improve primary mental health care servicing to Aboriginal people through linkages within the primary mental health care sector. The linkages are between the Pika Wiya Health Service, the Pt Augusta Mental Health Team, the Pt Augusta Hospital and the Flinders and Outback Regional Health Service. The program objectives are to:

- Build capacity of Aboriginal health workers to respond to Aboriginal people with mental illness.

- Build capacity of non-Aboriginal social and emotional wellbeing / mental health workers to work in a culturally sensitive manner.

- Build capacity of mainstream and Aboriginal community controlled health services to respond to Aboriginal people living with a mental illness.

- Facilitate linkages and relationships between Aboriginal community controlled health services and mainstream health services.

- Increase community participation in the development of social and emotional wellbeing services.

RAISE Wellbeing has been running since February 2003 and has established a project management committee from the Pika Wiya Health Service, the Regional Mental Health Program and the Regional Aboriginal Health Advisory Council. A business plan has been developed. Memoranda of Understanding (MOU) are being developed to formalise working relationships. The Program has obtained some recurrent state mental health expansion funding through the Country Division, South Australian Department of Health and also a one-off allocation from the Mental Health Unit of the same Department.

A specialist senior mental health worker has been employed by the Regional Mental Health Program and who is currently working in the Pika Wiya Health Service to lead the Social & Emotional Wellbeing Team. A further project officer commenced in 2005 on a short-term contract to develop linkage processes that will facilitate the partnership.

Fig 1: *Current location of the RAISE Wellbeing program (Pt Augusta, Quorn, Hawker, Leigh Creek, Copley & Nepabunna)*

Method

We used a participatory action research (PAR) approach with a case study in which key staff from stakeholder organizations were involved in all aspects of the research through a Research Advisory Committee (RAC). This involvement provided the essential links between Aboriginal community, specialist mental health, regional programming and health policy, in order to understand what will facilitate the sustainability of the program.

The purpose of the case study was to answer the following questions:

- What factors led to the establishment of the program?

- What linkage and coordination processes are informing program development?

- What will sustain the program?

The following three major strategies comprised the data collection.

DOCUMENT ANALYSIS & LITERATURE REVIEW

Relevant policy documents and research literature were reviewed. This established the context within which the RAISE Wellbeing program has been developed and enabled findings about organisational linkages in primary health care to relate to and inform program development.

KEY INFORMANT INTERVIEWS

Interviews were conducted with 23 key informants across service providers, service managers and health policy officers who had involvement with the program or who held key positions relevant to Aboriginal mental health servicing in South Australia. Selection of the informants was on the advice of the Research Advisory Committee. Interviews covered policy processes, setting, implementation processes, impacts, financial & resource issues, sustainability and transferability.

CASE VIGNETTES

Case vignettes constructed with the assistance of team managers were used in focus groups with program staff to identify critical, successful and problematic pathways in the identification, assessment, treatment and referral processes.

First meeting of the Research Advisory Committee: November 2004

Lee Martinez (Regional Mental Health Program Manager), Dana Shen (Manager, Indigenous Programs, Country Division, South Australian Department of Health), Harold Stewart (Senior Policy Officer, Aboriginal Services Division, South Australian Department of Health), Kathryn Cronin (Mental Health Liaison Nurse, Pt Augusta Hospital), Cephas Stanley (Chief Executive Officer, Pika Wiya Health Service), Kathy Verran (Regional Social & Emotional Wellbeing Program Manager), Ruth Klee (Team Leader, Pt Augusta Mental Health Team), Jeffrey Fuller (Research Leader, University of Sydney), Alwyn Chong (Research & Ethics Officer, Aboriginal Health Council of South Australia).

Absent: Daniel MacKenzie (Coordinator, Flinders & Outback Regional Health Service), Bronwyn Ryan and Kuda Muyambi (Project Officers, RAISE Wellbeing), James Stanley (Research Assistant, RAISE Wellbeing).

Findings

As this report is designed to aid program development, the findings are reported against the program goal areas rather than against the research questions that are being reported through the academic literature.

Impact on partners

Teamwork relationships

Given the focus of the case study on primary health care linkages and the early stage of program development, discussion about impact focussed mainly on changes in teamwork relationships. Examples of these changes included flexibility from the Mental Health Team in not always requiring an appointment and the mental health service improvement processes in Pika Wiya. The improved relationships between the teams was seen to have shared the workload and responsibilities for care, as one service manager described:

> *The benefit to [our community outreach team] is receiving support and not having the sole responsibility as the carer … having the collaboration means that you are not alone and you are supported; two people are stronger than one. Because we are on the ground we relieve [the other team] from the burden of having to come up here and do all the work. If we weren't here and they relied solely on the health service for referrals then there would be a lot less, because there are more feelers going out into the community.*

Sharing of the workload also led to some sharing of knowledge and skills and hence learning on the job from other team members. Service provider informants wanted to work alongside staff from the other teams so that both clinical and cultural knowledge was shared. This would help mainstream workers to understand how cultural issues relate to mental health and how to approach mental health care delivery with Aboriginal clients. For Aboriginal health workers this would help them to see how mental health workers perform their clinical role. In one of these situations (that was described) a mental health nurse instituted the process of detaining a client who had verbalised suicidal thoughts, a process that was in accordance with the nurse's professional duty of care. This led to disagreement with the Aboriginal health worker who did not view the client's suicidal intent in the same way. The relevant point here is not about who was correct, but rather that the client's situation had brought to the fore differences about care in a cross-cultural mental health context. The important outcome was that these two workers talked through their professional and cultural perspectives of mental illness and duty of care. The impact on the teams has been to get issues like this onto the table for discussion.

A policy officer made a similar point, that the program could bring practitioners together to help clarify roles, develop the trust and confidence to work together and to develop referral protocols and networks. Working together and sharing ideas was seen to improve mental health care, presumably because there would then be more practitioner input.

CASE EXAMPLE: NEED FOR PARTNERSHIP INPUT

The following case illustrates this need for input from both mainstream mental health and Aboriginal health workers for optimum access to care.

A depressed Aboriginal woman was referred for a psychiatric review because the GP was not happy with her medication. The client was willing to see a psychiatrist but did not want to attend at the Pika Wiya Health Service or Pt Augusta Mental Health Team because she might be seen. The family did not support her seeking mental health care but were trying to cure her using traditional methods. The psychiatrist arranged to see the client at the hospital but she still did not attend the appointment. The hospital rang the client's home, but because the mother answered they were unable to say who they were. In hindsight the psychiatrist felt that more needed to be done to work with Pika Wiya and increase acceptance of mental illness in the community so that families can be 'got on board'.

There were two foundations to the change in teamwork relationships through the RAISE Wellbeing program:

- The important personal relationships between people.

- The formal processes for collaboration, such as the MOUs and the Linkages Meetings.

Three levels of personal relationship were described. First, the respect that had developed between the chief executives of the Regional Health Service and Pika Wiya who had both been in their positions for a number of years. This time had enabled them to develop a good working relationship thereby providing 'stability at the top'. The second beneficial relationship was the support and regard between the four service managers who were all *'passionate about addressing the needs of Aboriginal people'*. The third beneficial relationship between service staff had come through informal meetings and more opportunities for team members to meet were requested, especially for workers in the Flinders and Outback Regional Health Service who were the most isolated.

A few informants described the downs and ups in the relationship between staff in the Pika Wiya and Mental Health Teams that were initially strained because:

- The goals of the program were unclear.

- Difference in views about the program focus. The Mental Health Team were concerned that the focus was on the development of a mental health service in Pika Wiya rather than on collaboration with them.

- The style and actions of the first RAISE Wellbeing project officer in criticising the Mental Health Team that led to conflict with them. The importance of relationships and hence the dependence on personalities was demonstrated here. While this project officer's challenging style created some energy and got Aboriginal health servicing onto the team agenda, this also caused some tension about the partnership moving forward. A challenging style was useful at the start to establish what was needed (capacity building in Pika Wiya) but

for continued developments a more facilitative style of the subsequent project officers has been useful to enable the partnership to move ahead. Hence, different styles of operating were beneficial for different stages of the partnership.

The following processes were helping to formalise productive relationships:

- The development of memoranda of understanding (MOU) - Although relationships were built on trust, the MOUs made it clear what was to happen.

- Team linkages meetings, even though these had been held infrequently until recently.

Some changes in the organisational relationships were attributed also to the following wider changes in the region that had put mental health programs generally on a more strategic and secure course:

- The region now had a regional manager of mental health, a senior mental health clinician and a staff psychiatrist.

- Expansion funds had included the development of a mental health liaison nurse position at the hospital with the addition of a facility in the emergency department to accommodate people in distress.

Limiting relationship developments has been the large staffing changes in both the Mental Health Team and Pika Wiya that has meant the following:

- Tension around workload in small teams. When there is team instability and insufficient resources for the work then it is harder to take the extra time to collaborate.

- Staff who are new to the area take time to get to the first stage of a relationship (simply getting to know other staff).

- Difficulty in arranging continuity of care between the organisations.

- Moving the RAISE Wellbeing focus into service management in Pika Wiya, prior to the employment of the most recent project officer, limited the capacity to focus on linkage activities and so this slowed things down.

What achievements might be expected?

There was a desire from the Regional Health Service that Aboriginal mental health-servicing take on a regional approach beyond Pt Augusta where it is presently located, so that the program provided a consultancy and support service to other locations within the region. However some caution was expressed about what could realistically be achieved, as a senior manager described:

> *Establishing a regional partnership approach to Aboriginal mental health servicing will take a few years. Relationships are key with linkages. [I expect to see] Aboriginal mental health care for the whole region being provided or supported by Pika Wiya and that brings together professional mental health training and mental health knowledge.*

Policy officers also mentioned this need to be realistic over the immediate timeframe with what they saw as a project with a relatively small amount of funds. They were of the view that Aboriginal health services were at times too ambitious with their goals and without the funds for adequately trained staff or infrastructure. Realistic expectations were as follows:

- That communication and planning processes are tried out for organisations to work together cross culturally in Aboriginal mental health.

- That teamwork is established between Aboriginal health workers and mainstream community mental health workers.

- That some work may have occurred on what tools are useful for assessment and treatment in Aboriginal mental health.

Goal area 1: Workforce capacity building

When asked about the workforce to sustain a mental health service partnership, informants talked about the current capacity in the Aboriginal and mainstream mental health workforce and also training.

There was wide agreement that the region had the best staffing level in mental health that it has had for years although mental health staffing in Pika Wiya was still considered inadequate. This improvement in mainstream mental health staffing may be because of the structures and positions that have been put in place and the willingness of the Regional Management to innovate in how it recruited to key positions. There was now a strategic regional approach to mental health servicing, with a regional program manager, a regional senior clinician, team leaders in both the Aboriginal and mainstream 'mental health' services, a project officer position in the RAISE Wellbeing Program, a mental health liaison position in the hospital, a regional staff psychiatrist with cross cultural experience and a community outreach service that was funded by the Commonwealth with mental health as one of it's priorities. With this improved staffing position and with what one senior service provider described as a culture of innovation, the region was well placed for an Aboriginal mental health service partnership. Although the staffing levels in both the Aboriginal and mainstream teams were improved, retaining these staff was the critical and most difficult challenge and it was this issue of staffing levels in health services across the country regions that informants thought would limit the transfer of the mental health partnership to other locations.

While Aboriginal health workers have been established as the base of Aboriginal health services, there are insufficient Aboriginal staff in specialist areas such as mental health. This is a factor that informants indicated would limit how readily the RAISE Wellbeing Program could rest on a solid staffing base and how easily it could be transferred to other locations.

The preferred approach to training was knowledge and skills development that was gained on the job by bringing Aboriginal and mainstream staff together to learn from each other. Two informants suggested that some structure could be added to this on the job learning by setting up mentoring for staff. The rationale seemed to be the immediate relevance of on the job training that can be responsive to and supportive of staff as they work through events as they occur, thereby minimizing burnout. However, on its own, on the job training could be ad hoc and would require considerable input and oversight from skilled team managers.

Regarding content for Aboriginal health workers, one informant was of the view that specific training was required in identification, medication management and worker response to mental illness. For cross-cultural awareness of all staff, it was suggested that the use of local community members would localise content to specific issues. This would also provide an opportunity for the local community and mental health workers to get to know each other.

Not only was capacity in terms of staff required, but also the capacity of organisations to provide mental health services in a culturally responsive manner. From a low capacity workforce base, it is unrealistic to expect that organisational change and service improvement would simply come about by partnering mainstream and Aboriginal health workers as a policy officer described:

> *You cant expect this to happen by osmosis … we are starting to understand now that we have to take an advocacy role … You do have to deal with training issues and so on … that is a recommendation that we want to have identified.*

For the Aboriginal health service this meant the development of mental health care processes, such as assessment and care management (eg case review meetings), as well as the provision of infrastructure, such as adequate workspace and administrative support. For the mainstream mental health team this meant creating an expectation amongst new staff (as they were employed) that working in partnership with the Aboriginal health service was the norm.

Given the improved staffing position in the region it would be useful to consider the role of key staff in the following three areas of organisational capacity building: (1) the processes required to promote and maintain teamwork across the partner organisations; (2) the type of training that would be accessible and useful for Aboriginal health workers and the mainstream mental health team in working with Aboriginal clients; and (3) the use of mental health assessment and care management processes appropriate for Aboriginal people. Having key regional staff work together to source expertise related to training and assessment and treatment tools could be useful, given that there appears to be very little training or tools readily available in South Australia or expert advice on these.

The support and expertise that these key staff might draw upon is at present unclear as the resources proposed in the recent 2004-2009 OATSIH SEWB Framework are not yet operational, there are no specific mental health resources identified in the South Australian Aboriginal Health Partnership (SAAHP) SEWB Strategy and the Aboriginal mental health portfolio in the South Australian Mental Health unit is vacant.

Recommendations

1.1. Training in mental health and cross-cultural competencies be sourced for staff of the four organisations and to cover both on the job & off the job approaches.

1.2. For sustainability: (1) Linkages be established to external 'expert' assistance for the development of Aboriginal mental health service processes and tools. This could include linkage to the relevant South Australian Aboriginal Health Partnership (SAAHP) and also Office for Aboriginal & Torres Strait Islander Health (OATSIH) Social & Emotional Wellbeing action plans, particularly for assistance with workforce development and the development of a data system. (2) Infrastructure required to support the delivery of mental health care (eg office and counselling space) be established to the level possible according to national mental health standards.

Goal area 2: Health service delivery

What has been the program focus?

Although the major focus was first on the development of capacity in Pika Wiya, this focus was not at first equally understood across the teams. Lack of agreement about the program focus became evident in the February 2004 evaluation report, some 12 months after the program commenced.[14] This report described the expectation from the mainstream mental health team that the project perform a link role, but that this role changed as the project took on a clinical focus in crisis intervention. In severely traumatised communities, human services can be driven by response to crises around immediate needs that are not often predictable. Hence, medium and longer term planning (even daily plans) can be put on hold as crises are dealt with.

At this 12 month stage Pika Wiya informants wanted the project to take a greater case management role and felt that it was obvious that an Aboriginal specific mental health approach was required. Some anger was evident from the mainstream mental health team about their perception of this change in focus, as was illustrated in the following comment:

> *Within a few months the project became quite frustrating … few meaningful efforts were being made to create linkages … Interactions with the project officer regarding the project reduced to near zero … In December 2003 at the first linkages meeting my understanding of the project was clarified and that the project officer was not actually supposed to be spending all their time on developing linkages … which was quite distinct from how it had been explained to me from the beginning.*

Early in 2004 a funding proposal for the continuation of the program was developed by the project officer, in collaboration with two respective service managers in the mainstream and Aboriginal health services. The funding proposal was for the development of a mental health team in Pika Wiya. Although not fully funded, the creation of a mental health team in Pika Wiya seemed to hold as the focal direction over time. This was particularly evident as the program took on a service management function in Pika Wiya in response to clinical demand and with the resignation of SEWB staff. Hence linkage developments fell by the wayside until 2005 when an additional project officer was employed to work specifically on these.

Over time then, there has been a tension between the focus on linkages, that involves working with all the four teams, and the focus on mental health capacity building in the Aboriginal health service. The focus that has taken precedence has been the development of capacity in the Aboriginal health service and the rationale for this seemed to be that without effective capacity in the Aboriginal health service then there could be no effective service partnership. The management group resolution of this problem was to realise that the two foci required two people and so the project position was split with the second person brought on in 2005 specifically for the linkages development.

Literature on partnerships indicates that teams work best when they have agreement about service goals and that this agreement is easier to negotiate when the following factors are in place:[15,16]

- Clarity about who has primary responsibilities for a client
- A commonly accepted approach/ shared philosophy
- Practice is interdisciplinary
- Managers have a good relationship
- A single organizational unit
- Care costs are predictable

Although these factors may not all be possible in RAISE Wellbeing (points 5& 6) the first four points can be worked on. However, two overarching threats related to these factors do seem to stand out for the RAISE Wellbeing partnership: (1) clarity and maintenance of focus that has already been described and; (2) legitimacy amongst the partners towards the program goal and towards each other (collective efficacy).

The term collective efficacy has been used to describe team members' belief that their collective efforts are necessary to solve the problem and that each member has confidence in the other members of the team.[15] In RAISE Wellbeing there are four teams each with a potentially different mandate and approach, from acute to community care and from Aboriginal to mainstream. Hence, a threat to collective efficacy would first be the inability to reach agreement about common goals. The second threat to collective efficacy is to do with confidence between staff in the partner organizations. In work with marginalised communities (such as in Aboriginal communities) health staff often include community workers employed because they come from the target community. They are often employed as 'cultural consultants' because of their knowledge of and skills in relating to that community. They come with a different set of skills and level of training than discipline based health workers.[17,18] These differences can include different views about the legitimacy of each other's knowledge and skill base for health care practice. Early in RAISE Wellbeing there was criticism from Pika Wiya that the Mental Health Team (discipline based health workers) were inflexible and conversely there was concern from the Mental Health Team, about the mental health knowledge and skills of the Aboriginal Health Workers (cultural consultants).

With these findings, some attention is warranted on the structure and processes of the partnership. While Memoranda of Understanding are being developed to guide the relationships between the four organisations, as at February 2005, only one of these was fully signed off. The reason for this lack of progress seemed tied up with the focussing of the RAISE Wellbeing program for a while towards the leadership of the Pika Wiya Social and Emotional Wellbeing Team. With the creation of the additional project officer dedicated to linkages work, these partnership structures and processes should now be progressed.

Care management processes

From the perspective of the Aboriginal health service informants the development of a best practice model would respond to Aboriginal people's preferences, such as about how an assessment was conducted. Three service providers described a less formalised conversational assessment process in which observations were made over the course a few sessions, rather than as a structured assessment using a proforma. A set of direct questions about a person's family life and relationships were not considered appropriate as '*you would then lose the person and they wouldn't use the service again*'. Rather, it was seen to be the health worker's role to structure an assessment into mental health domains from the conversation and from what they had observed of the client, as the following service provider described:

> *Questioning needs to be done slowly so as not to drive people away. I usually let people tell their story and find the answers to my questions through the story.*

In addition, the conduct of an assessment was also found to rely on 'collateral information' from staff who have worked with the client. Hence a partnership between Aboriginal health workers and the mental health workers was a big part of this assessment.

This use of a narrative was also mentioned by others as the way for the client to tell themselves what the problem was and what needs to be done[i] and to 'check out' that the worker could be trusted and would be helpful. A service provider described this as follows:

> *If we want to get indigenous people to attend and to understand what we are offering them, we have to change the way that we are looking at things and not from the [current model that we have] … Much illness is psychosomatic so if you deal with the psychic component the somatic component goes off … We need to present in a fashion like the traditional healers use, to talk about issues in the way that the patient does. If the patient complains of a stomach ache, then deal with the problem in terms of that symptom and not label it as anxiety … You have to join them in their story to form a part of whatever they are and then if they feel OK they may come out and ask the question that they came for.*

Regarding care management, there did not appear to be a formal process across the four organisations for communication about clients, for developing and managing care plans or for case reviews for quality assurance.

Prior to the employment of a mental health liaison position at the hospital, two informants indicated that the goals of hospital admission for some Aboriginal clients were often unclear and that this had led to negative attitudes from hospital staff towards these admissions. According to one of these informants, clearly articulated and realistic goals around such admissions can minimise staff anger about repeated admissions for self-harming and risk taking behaviour. The suggested ideal was a short admission in which the short term crisis response goals were separated from the long term rehabilitation goals and with the relevant organisational responsibilities for these identified.

Although there was a general positive regard articulated about the informal relationships across the four organisations, for one service provider the benefit sought in formal discussions was the development of treatment guidelines that would evolve because service providers would be communicating in a more structured and regular manner.

At both the State and Commonwealth level, policy officers were keen for this type of material, as they were faced with the task of funding Aboriginal mental health service developments within the frameworks of current mental health policy, but with only a limited evidence base about what works. Hence, the experiential learning from this program was for them useful if this could be applied to ongoing policy development and the funding agreements with services elsewhere.

One policy officer wanted the program to map the care pathway from the earliest opportunity that a mental health problem could have been identified, then through the sources of referral and subsequent care decisions. Through mapping the care pathway the points of care deficit could be identified and worked through for any client group. Even though the care solutions for groups may be different the common factor was to have a process for mapping the mental health care pathway so that an appropriate care solution could be devised. This care mapping process was conducted for the first time at a staff workshop based around two case vignettes (see appendix 1).

How wide should the partnership go?

A few informants commented that 'other' visiting services should be included in the partnership and this is consistent with the literature that indicates linkages work best in mental health when they are inclusive.

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[i]The term for this is abreaction, which is the therapeutic value in telling one's own story as a means of gaining self understanding or self insight.

At some stage other health units and organisations need to be involved. Some early discussions had been held with the Aboriginal health service in Coober Pedy about inclusion in a regional model. Because of the extent of drug & alcohol problems in the region the inclusion of drug and alcohol agencies was considered a priority. Several informants mentioned the mental health support provided to health workers through the Rural & Remote Mental Health Service at Glenside Hospital and so there is a clear rationale to involve this organisation in the partnership. While an inclusive approach will eventually be required, the consensus seemed to be that it was first important to establish the relationship with the current four partners. Getting this relationship established and understanding the processes that achieved this was important for sustainability and transferability, as a policy officer described:

> *What is important is mapping the journey that you went on and right at the beginning how you cemented the relationships … that is probably the key to rolling it out somewhere else … If I was to go to another place and try to role it out there, what would you do first? You would go and talk to people and find out who the key people are. You would cement a relationship with them, you would try to develop some rapport, you would find out what their current roles are and how these have to change or whether they should change and how they [would] go outside their work culture to work with an Aboriginal organisation.*

While agreeing to focus on the current four partners in the immediate time frame was accepted, the problem in 'staying small', according to a senior service provider, was that it made the program more vulnerable. A larger number of agencies may give the program greater momentum and would open the program up to a wider range of strategies. A wider range of strategies would increase the likelihood that at least some of the strategies will survive and be successful. With a wider range of strategies the program would be less vulnerable to the failure of any one strategy and it would also be more open to increased funding opportunities that can become available from time to time in targeted areas.

How wide to take the program requires a balance between being pragmatic with what is possible and manageable at the local level at this time but also being opportunistic to include those organisations from outside the region that are clearly important to mental health servicing.

Recommendations

2.1. The process of developing and signing off of Memoranda of Understanding (MOU) be completed so that the expectations and responsibilities of the four organisations in the partnership be clearly established.

   While separate MOUs may be signed off between the four organisations for management expediency, one overall partnership agreement/ statement of intent would be useful so that the goals and direction of the program are clearly and unambiguously communicated.

2.2. A minimum common core platform for the management of mental health care (eg care planning) be considered to cover risk assessment, treatments and referral processes (pathways of care). This will facilitate agreement about mental health care goals and responsibilities and would establish cross-cultural care protocols around matters such as home visiting, crisis management plans and the use of traditional healers etc.

2.3. Processes be developed for communicating client care between partners (eg through case notes, referral and feedback letters etc).

2.4. Interorganisation case conferences be held as an ongoing strategy to improve care processes thereby contributing to service quality and staff skills sharing.

2.5. Aboriginal client and community education materials about mental disorders be developed.

2.6. When the partnership processes are well established between the current four organisations, then care management processes be widened to include other agencies such as the Rural & Remote Mental Health Service, housing, drug & alcohol services, police etc.

Goal area 3: Linkages & coordination

Who was involved in the establishment of the program?

Informants responded to the question about involvement by describing three stages:

- The very early stage around securing funds

- The development of the program after initial funding

- Continuation

Early stage

Two types of people were seen as important in the early stage, which were senior service directors in the region (local champions) and the central facilitating policy officers. Early senior management involvement and 'championing' support was important to give the program its legitimacy, so that if personalities changed then the authority for the program was maintained.

As well as the local champions who put together the funding proposal, the following Department of Health policy officers had been directly involved in helping to secure the original $80,000 of recurrent mental health expansion funding for the program:

- The Manager Mental Health, Country Division.

- The Mental Health Unit project officer with the Aboriginal Health portfolio (that is now vacant).

The role of these policy officers was described as creating two way communication into and out of the central department, so that there was central understanding of the local program and so that opportunities and threats emanating from the centre could be made known to the local program staff. That there was now a vacancy in the Aboriginal health portfolio of the Mental Health Unit may well have created a 'slow down' in how the program was able to subsequently communicate to the central bureaucracy. This seemed to be evident in the current uncertainty of the local managers about who in the bureaucracy was their advocate and so who they should use to channel their communications.

Development of the program

The local service delivery managers were mentioned as important in developing the program business plan and in securing additional funding for a 0.5 Aboriginal mental health worker and a further one-off allocation of $80,000.

Continuation

For continuation of the program the RAISE Wellbeing project officer was considered crucial and while this person was to sit in the Aboriginal health service it was recognised that links had to be maintained with all four organisations to ensure collaboration. Given that the current project officer is dedicated to the development of linkages and that this person is on a very short term contract it is unclear how this function will continue and whether the processes that are established could be sustained by the team leaders of the four organisations in the partnership.

The Department of Health policy officers (in Country, Mental Health Unit and the Aboriginal Health Division) and officers in the peak Aboriginal community controlled health service sector were also considered important to translate the findings from this pilot program (if successful) into policy for wider implementation.

It was suggested that for sustainability the program must be dependent on more than just individuals. Certain people and organisations have been important for program establishment and they need to continue to be involved for program development. One policy officer made the point, however, that it was important to see the partnership documented in memoranda of understanding so that the partnering became a part of the organisational culture. Hence, while a critical success factor appears to have been the key role of individuals, for sustainability it needs to have partnership structures in place and a partnership culture maintained. This will be achieved through effective communication processes.

What are the program communication processes?

There are two meeting processes for communication within the program.

Management Committee

The Management Committee comprises the Regional Mental Health Program Manager, the CEO or Business Manager of the Pika Wiya Health Service, the Regional SEWB Program Manager (who is currently focussing on mental health leadership in Pika Wiya) and the RAISE Wellbeing project officer. The committee has developed a program business plan and yearly action plan.

Linkages Group

At the appointment of the first project officer it was decided that a forum for communication was required at the operational or worker level. This Linkages Group first dealt with the confusion amongst the staff of the Pt Augusta Mental Health team & Pika Wiya team about the role of the project officer.

The Linkage Group meetings provide a forum to discuss how services are organised, but does not include the clinical management of cases and until recently has met infrequently. A desire was expressed that this group meet regularly on a monthly basis and include the hospital mental health liaison and staff from the Flinders and Outback Regional Health Service. Distance to travel means that only some staff from the Flinders and Outback team might attend, although tele or video-conferencing could overcome this. The advantage in having all team members attend would be to truly operationalise service links on grass roots matters.

Two issues mentioned during the interviews illustrate how this Linkages Group could be helpful. The first involved the Mental Health Team and the Pika Wiya SEWB Team each servicing the same client through outreach without the other knowing. It was through the Linkages Group that staff from both teams discussed this issue and found a way to resolve the problem. The outcome agreed was that (with the consent of the client) the Mental Health Team would first discuss with Pika Wiya before taking on a new Aboriginal client in an outreach location.

The second issue was around the priority that the Mental Health Team places on staff security that has been criticised by Pika Wiya for limiting the flexibility to make home visits. However, this issue of security was highlighted for Pika Wiya by a recent incident at the clinic that involved threatening behaviour of a Pika Wiya client with a knife and which demonstrated the potential for violence against staff. Although not dealt with in the Linkages Group, this incident could have been used to discuss how clients could be served in a culturally responsive way but that also maximises staff safety.

What data relating to the program are currently being collected?

Our knowledge about the program data came from two sources, first from our own attempt to collect and then collate data on health service use that would give some baseline about Aboriginal mental health servicing and then, second, what we were told during the interviews.

Informant comment about data on health service use reflected our experience, that the number of client presentations, the reason for presentation, the referral source and the treatment provided were collected by each organisation, but that none of the organisations routinely collected data that would quantify the amount of joint work. Furthermore, there was no evident capacity across the partnership to assess the quality of data collected or to analyse that data to see if improved access to mental health care for Aboriginal clients had been demonstrated since the commencement of the program. There did appear to be moves to collect client outcome data using tools such as the National Outcomes for Casemix Classification (NOCC) and the Health of the Nation Outcome Scale (HoNOS), but there was no evidence that these had been used as yet to evaluate population health improvements.

Comment about partnership data was more about what was needed rather than what was currently being used. One informant described this needed data as the descriptive mapping of what was being done, that included how the four organisations had cemented their relationships and how staff had been able (or not able) to work across cultural boundaries in Aboriginal mental health. These data were important, according to this informant, to demonstrate how the partnership improved health service delivery to Aboriginal clients, to show workers that they were doing a good job and for decision makers to decide whether to maintain the program and transfer it elsewhere. Informants did reinforce our experience that there was too little analysed data made routinely available to service managers in a form that was useful for planning, which two managers indicated makes it hard for them to argue their case for program resources.

The situation in RAISE Wellbeing is similar to that found nationally, which was the low priority of Aboriginal mental health data collection under the 1996 OATSIH SEWB Action Plan. Hence, this regional program could not be expected to resolve locally what has not yet been resolved nationally.

The recommendations that came out of the 1996 National Indigenous Mental Health Data Workshop provide a guide about the sort of useful data for partnership planning:

- Population demographics

- Data on intervention effectiveness

- Use of current services

- Service profiles

- Data on resources required and distribution

Is the initiative sustainable and/or transferable under current funding arrangements?

While the mental health expansion money has always been meant for service improvement across the region, to date this has been purposively expended on building mental health capacity in one organisation (Pika Wiya) where it was considered most likely to result in successful partnership outcomes. The intention remains that once capacity is built then the Regional Health Service and Pika Wiya funds will be pooled, with Pika Wiya taking a regional responsibility for Aboriginal mental health. However, the other Aboriginal health services in the region at Coober

Pedy and Whyalla will need to agree and some early discussions have been held about this.

Informants did not think that there would be any immediate cost savings as a result of the service partnership, but rather that an increase in service quality and access might lead to increased use and hence increased costs, which one policy officer described:

> *Integrated services do not mean cheaper services but more efficient services because the dollars are spent smarter.*

For Pika Wiya, there had been no additional direct costs up to this point, although resource difficulties were being felt such as cramped office space for staff without confidential counselling rooms, safety exists or panic alarms and the sharing of phones.

For the Regional Health Service the cost of providing improved services was described as par for the course, because 'this is what we do' (ie, provide services), especially as Aboriginal health and mental health were regional health priorities. The direct cost so far to the Regional Health Service had been to provide incentives to recruit a project officer and a significant resource cost of time to drive the process and develop the partnership.

The potential resource impact for both the Regional Health Service and Pika Wiya was in the future pooling of funds for mental health, with Pika Wiya using these funds to operationalise services. This would mean that the Regional Health Service might forego the control of these funds on a day-to-day basis, with the agreement that Pika Wiya take on regional responsibility for Aboriginal mental health servicing. Hence, the project management committee might consider how the ongoing needs of all the stakeholders are included in decisions about how the pooled funds are spent. The role of the program management committee could be to maintain shared decision making over the program business plan to which the resources are applied.

Three policy officers with the funding organisations indicated that there was little likelihood of additional large-scale funds to expand Aboriginal mental health servicing. Hence RAISE Wellbeing may have to further develop services through combining current resources within and between the partner organisations.

Other policy officers and also service managers indicated that Aboriginal mental health servicing should be on a secure base of recurrent funding. The problem at present was that funding has come in relatively small amounts and over incremental stages and this has had an effect on the employment of the project officer over a number of short-term contracts.

Is there political support for sustaining and transferring the project?

There was a uniform response from policy officers and managers about the political support for 'shared responsibility arrangements' amongst local agency heads, local government leaders, state health policy officers and with health politicians. One policy officer put this in the following way:

> *The politics is right, as mental health is on the agenda and indigenous is always on the agenda, and so if we can demonstrate effectiveness then the business case is [more] convincing.*

While there was no new dedicated funding the effect of current policy support, according to a policy officer, would be a 'flow-through' to the various 'jurisdiction

implementation plans'. We took this to mean that Commonwealth and State funding of mental health would favour service partnerships and so RAISE Wellbeing would be aligned to this favoured approach.

Despite this optimism, regional service managers appeared frustrated in their attempts to turn rhetorical support into additional resources. The mental health position in the state bureaucracy with the Aboriginal brief was vacant and until this position is filled then RAISE Wellbeing might find it difficult to make the connections and garner more resources.

According to a policy officer, the program needed to get the following four factors right for sustainability, that are much about politics and management and hence external and internal communications.

1. The issues addressed by the program must be put onto the political agenda by creating a sense of resolution urgency. This then leads to political support for the project and its sustainability.

2. The symbolism of the program must be clearly articulated. The message must be communicated that the program is responding to importantly held values in mental health and Aboriginal health, such as respect for human rights, equitable access to treatment and responsiveness to culture.

3. The program should be structured to optimise such things as leadership, management support and follow through and also the articulation of accountability.

4. That staff are supported and can see their successes.

It was evident that the establishment of the program had at various times involved close communication between mental health service managers, regional and Aboriginal health service executives, the regional Aboriginal Health Advisory Council (AHAC) and Health Department policy officers. Despite attempts, however, communication had not been kept up across these stakeholders in a formal and systematised way as was suggested by the following response:

> *The AHAC was involved then but have not been involved since. We are always interested in updates and I think there are plans to have some presentations made soon to the Committee about what's going on with RAISE.*

Given that communication and relationship development would appear to be fundamental requisites to the project success and sustainability then attention to a communication strategy is recommended.

Recommendations

3.1. The Management Committee maintain shared decision-making over the business plan to which the program resources are applied. This is to reflect the intent of the program as service improvement through an organisational partnership. This may mean that the committee manage the budget.

3.2. The Linkages Group involve service providers of the four organisations as the vehicle for communicating the partnership at the workforce level on service delivery matters. These meetings be convened regularly and involve all staff across the partnership at lease 2 to 3 times per year.

3.3. The role of the linkage project officer be maintained on the development of organisational capacity. Although much of the focus of this role will be on building organisational capacity in Pika Wiya (necessary for collaboration), for fully responsive Aboriginal mental health care attention is also required on the cross-cultural capacity of mainstream health workers in the other organisations of the partnership.

Given the still early stage of program development (organisational relationship process are established) it is recommended that further funds be sought to maintain the role of the linkages project officer to at least the end of 2006 to operationalise both staff training and a minimum common platform for client assessment and referral.

3.4. Data system for monitoring be established so that there can be (1) informed decision making by all parties to the management committee and (2) to reinforce the value of the partnership to the teams. Data could include reports on service processes and summated service use and client outcome data to show change in access and outcomes over time. Relevant data should be regularly provided to both the Management Committee and the Linkages Group.

3.5. A communication strategy be developed to the staff involved in the program as well as to local, regional and state health decision makers. Communication could include regular updates about the progress of the program and ongoing program development needs. In particular, keeping the local Aboriginal community and advocacy organisations informed (eg the Aboriginal Health Council) is important to facilitate political support.

Goal area 4: Community & consumer input

The focus of the case study has been on organisational links rather than on community involvement, however some informants made comment about this.

In thinking about what would keep the program sustained and relevant two service providers (one from each of the Mental Health & Pika Wiya teams) mentioned the importance of the community. This was mentioned in two ways. First, it was important that consumers know what is available and what to expect from a mental health service, so as to generate service demand and hence a local political constituency. Second, a focus on what the community wants can provide a common basis around which workers communicate about service delivery. This would require some community input in order to determine these wants.

Recommendation

4.1. Mechanisms be established for consumer and community input and feedback to the four organisations on mental health service delivery. A consumer and community-focussed approach will provide the point of reference for quality improvements, help to achieve increased acceptance of mental health in the community and also create a local political constituency.

Conclusion

Although RAISE Wellbeing has been funded for over 2 years, progress needs to be considered against the low base of capacity from which it started and the interruptions to the implementation of the strategies. Hence, service system changes have yet to be adequately developed, embedded and sustained. Similar partnership projects elsewhere have reported that up to four years are required simply to establish the relationship processes for effective collaboration.[19]

The following factors have influenced progress in RAISE Wellbeing:

- A long recruitment time before the first project officer was employed.

- A change in the project officer.

- Significant staff vacancies in both the Pika Wiya and Mental Health teams that has forced a temporary change of focus in response to crisis demand and a temporary change in the role of the project officer.

- No direct expert or operational policy support to source effective cross-cultural mental health tools or staff training.

- Inadequate data systems from which to negotiate and plan between local organisations and also with the Department of Health.

Despite these factors, RAISE Wellbeing has established good service relationships. The program remains viable, with planning processes, a development framework established and, at present, improved levels of staffing across the four organisations.

Against six factors described by Villeneau et al for joint working in mental health (see table 1), we can see that the RAISE Wellbeing program has made some progress and now needs to operationalise integrated assessment processes and data collection, for which expert assistance will be required. RAISE Wellbeing has established partnership relationships as well as commitment and agreement across these partners and so is now well positioned to move into an active stage of sourcing and adapting training and practice tools in Aboriginal primary mental health care.

Factor	Progress	Comment
Integrated assessment processes	☹	As yet no common assessment processes across the organisations or associated training in cross-cultural mental health. Remains dependent on personalities and goodwill.
Coordination processes for joint working	😐	Management committee established with regular meeting of team members across the partnership recently commenced. MOUs being finalised but no common protocols for assessment, treatment and referral. Regular meeting of staff yet to include case discussions.
Commitment of authority	☺	Organisation executives and service managers committed. Support of Aboriginal community obtained via key Aboriginal service directors as "champions".
Information sharing	😐	No data that describes the extent of collaboration. Regular meetings of staff across the partner organisations recently commenced.
Valuing the role of the other	😐	Team leaders are mutually supportive. Team members appear willing but do not yet have adequate opportunities to form working relationships.
Locality wide joint strategy	☺	Program has a business plan that comes under the overall mental health plan for the region.

Table 1: *Six factors for joint working in mental health*[20]

Appendix 1: Staff workshop

Synopsis

A one-day workshop was conducted on the 13th April 2005 for staff of the organisations involved in the RAISE Wellbeing Program. These were the Pika Wiya Health Service, the Pt Augusta Mental Health Team, the Flinders and Outback Regional Health Service and the Pt Augusta Hospital Mental Health Liaison. Two hypothetical vignettes were used in small group work to discuss Aboriginal mental health issues.

The purpose of the workshop was twofold:

- Identify points of intervention for early identification, treatment and referral of Aboriginal people with social and emotional wellbeing problems.

- Enable staff from the four organisations to meet and help build a sense of partnership from the ground up.

Participants identified a range of possible intervention points over an Aboriginal person's lifetime, such as to do with grief and loss, identity, family relationships, schooling, employment, and contact with health services etc. The complex & chronic nature of some people's history, that were illustrated in the two vignettes led participants to describe the importance of a team based approach to mental health care. The benefits of a team-based approach to care were considered to be an increased range of care options for the client and the sharing of knowledge and skills amongst team members. Barriers to teamwork and service delivery included the time and resources needed to meet and work together and concern about workers operating outside their role.

The process

The four team leaders were asked to provide material for the case vignettes. They drew on real situations (but did not include real names) that described the person's circumstances, their problems and their attempts or otherwise to seek help, who had been involved in providing help, and the outcomes of the situation (both positive and negative). The vignettes were discussed at a Research Advisory Committee to establish the features of each vignette and these were then combined so that two vignettes would be available for the workshop.

For the first vignette (discussed in the morning) participants were allocated to their respective workplace groups. This enabled them to discuss the issues in the vignette from the perspective of their particular workplace. The focus of the first vignette was on identifying past and current service delivery issues. For the second vignette (discussed in the afternoon) participants were allocated to mixed workplace groups. This enabled them to discuss the issues in the vignette across different workplace perspectives and to build staff relationships from across the four partner organisations. The focus of the second vignette was on identifying realistic service solutions within a timeframe of a few years.

Participants recorded their small group discussion on butcher's paper and this was then fed back in a large group forum. This summary report has been compiled from the butcher's paper and issues that were recorded during large group feedback.

Findings

Vignette 1. Analise

Analise is a 37-year-old Aboriginal woman with two sons aged 8 years and 6 months, both from different fathers who no longer live with her.

Analise was removed from her birth family at the age of 3 months. A family who had 7 children adopted her. They also adopted an older boy, Keith, after Analise. Analise says that her adoptive mother had an Aboriginal and Irish parent, but she is unsure about her adoptive father. She says her adoptive parents taught her good values and skills, especially her adoptive father who died 10 years ago from cancer. Her adoptive mother is still alive and has had an AVO (restraint order for violence) against Analise since 1991.

According to Analise, the main "bad" experience of her childhood was bullying by a sister who was jealous that Analise had replaced her as the baby of the family. She also felt excluded at school and "all I ever wanted was to find out where I came from". Analise left school as soon as she could, and after a few years of odd jobs in supermarkets, she left home to join her adoptive brother in Port Augusta.

In Port Augusta she started training as a nurse but dropped out after 2 years. At this time Analise was a heavy user of marijuana and alcohol as self-medication for her increasing depressive moods about her life that she felt was "going nowhere". She then entered an abusive relationship against the wishes of her brother. Her first female child was born from this relationship. Analise left this relationship because of the abuse when her baby girl was 2 months old.

Analise was first admitted to Glenside Hospital in 1994 after she was found sitting in the sun with her daughter for 2 days, believing this was necessary to stop the sun and the moon from colliding. She was diagnosed with schizoaffective disorder. It was around this time that her daughter was removed from her care to be raised by the birth father.

Analise has had subsequent repeated admissions to the Port Augusta Hospital after being brought in by the police. The staff at the hospital seemed unclear at times about the goal of her care. She is non compliant with medication, particularly when she is pregnant, and says that she knows all that she needs in order to help herself as she has been trained as a nurse. Five years ago she was placed on an Administrative Order due to considerable debts. Analise moves around quite a lot, and in a one 2-year period she shifted her place of residence 10 times.

Analise is currently detained at Glenside. A neighbour found her wandering around her house in an agitated state, complaining that people had broken in and were urinating on the bed. The neighbour called an Aboriginal health worker from the Pika Wiya Health Service who visited the home. Analise's 6-month old baby was in poor physical condition, and was found to be severely underweight. Since this most recent detention, her eldest son is in the care of her brother in Pt Augusta, and the 6-month old is being cared for in the Pt Augusta Hospital; the authorities are considering what care options would be best for this child.

The questions

The health & health service delivery issues

    A. Identify the points in time that assistance could have been provided?

    B. What would have helped and hindered the provision of this assistance?

    C. What assistance does this person need at this point of time & what might be some realistic outcomes from this assistance?

The response

Points of past assistance and barriers to care

One group mapped the following events in Analise's life and an excerpt of this map is provided.
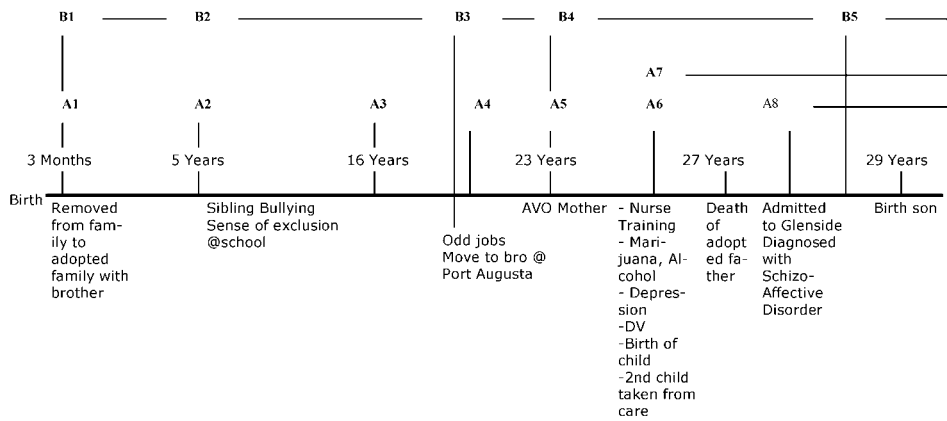
A timeline is provided to which the points at which assistance was or could have been provided are listed at A1-A8. Reference points to discuss helping and hindering factors are labelled at B1-B5. Response from all the groups has been compiled into the following table against the timelines mapped above.

Time	events	assistance provided/needed	time	help/hinder
A1	3 months removed from birth family and adopted by another family.	Family Care, Family Services/family support to adoptive family, church based adoption agency, Indigenous protectors.	B1	Age (intervention then through family), family size, lack of cultural understanding (continue to present day).
A2	Five years old started school/ identity crisis - loss/ grief/ abandonment (continues).	Education/ school welfare, Financial (Abstudy).	B2	School culture, racism, family tension (continued through to 16).
A3	16 years	Career Employment Agencies. Ideal time for early intervention.		
A4	Odd jobs, move to Port Augusta.	Could capitalise on brother support; facilitate friendships & mentoring.	B3	Transient nature (continues).
A5	23 years, AVO from mother.	Courts/ Welfare	B4	Loss of support from mother.
A6	Started nurse training. Sub mood disorder. Birth of second child. Abusive relationship.	Could use educational mentor support via study/ student counsellors. Needs drug & alcohol intervention. Needed domestic violence/ women's health/ victims' support.		
A7		Family Services/ child health nurse (could continue to now).		
A8	Death of adoptive father. Admitted to Glenside. Daughter removed to father's care.	GP/ medical and mental health care (continued to now – Pika Wiya). Could have had a community treatment order. Grief counselling.	B5	First contact with the mental health system, attitude to treatment.
A9	Admin Order. Repeated Pt Augusta Hospital admissions.	Financial counselling/ Centrelink. Possible contact with police/ courts. Would also need housing support.	B6	Unclear goals of care.
			B7	Inconsistent care, financial stress.

Current assistance needs

The following issues were those that participants thought should be addressed. Primarily that Analise needs a case manager to organise the range of services that she could benefit from, such as:

- Counselling/ social and emotional wellbeing support/ deal with identity, grief & loss/ link up

- Stable GP/ identify key worker in Pika Wiya

- Maintenance of medication/ adherence with treatment

- Cultural mentorship (to help with identity crisis)

- Drug & alcohol support

- Supported accommodation

- Family support to deal with relationship issues/ reunite parents & children

- Financial support

- Commonwealth Rehab Services for re-skilling to get back into community life

- Socialisation

Flinders & Outback Regional Health Services Group

This group saw the Pt Augusta Community Mental Health Team as the main provider of care because of the mental health issues. This led to discussion that either the Community Mental Health Team or Pika Wiya might be the main care provider after Analise's discharge from Glenside. The key was thought to be a stable service partnership so that care is coordinated, continuous and deals with issues over the longer term.

Pt Augusta Mental Health Team Group

This group saw Glenside as the <u>current</u> main provider of care to help Analise come up with a discharge care plan. This led to a discussion that the ongoing main provider of care might change, but that at times the main provider of care might be unclear, particularly if Analise is moving around. This would create coordination and continuity of care difficulties. The main provider of care might change dependent on what problems were most significant at the time, eg. cultural support, employment or medication.

Pika Wiya Team Group

This group saw Glenside as the <u>current</u> main provider of care. They noted that Glenside has good communication with Pika Wiya; Glenside staff will ring Pika Wiya to discuss the case when a Pt Augusta Aboriginal person is detained and they usually ring prior to discharge and send a discharge summary. This communication does not occur with other hospitals. It was stated that it helps that Pika Wiya has a GP with a mental health portfolio.

It was suggested that improvements could occur through formal communication arrangements with other hospitals. Pika Wiya staff indicated that they would like to be involved in the design of discharge summaries. It was also suggested that if a case history were sent with the client when detained to Glenside then the context leading up to the detention would be better understood.

Realistic outcomes

Realistic outcomes for Analise where thought to be:

- Stability in housing, finances, relationships and health

- Consistent care

- Medication maintained

- Psychological self-comfort

- Social, mental and cultural identity

Vignette 2. Jack

Jack is an Aboriginal male in his early twenties who lives in a small town 100 km north of Port Augusta. He was recently reported to the police in an intoxicated and aggressive state, in possession of a firearm and threatening family members. When police attended, Jack was hiding in scrub outside of the township and the police could not find him. Upon returning to the community he was persuaded by family to get rid of the firearm and to seek help from the Health Service.

The RN who knew Jack was able to talk with him and help calm him down. He has told his GP that he cannot sleep, is losing weight, and feels there is a devil inside him. He lost the tablets that were given to him. He has stopped his work. He had an altercation with his partner who has gone to live with an auntie, taking their daughter.

The doctor on call referred Jack to Glenside Hospital where he remained for some days. Since at that time Jack had been caring temporarily for his other child, Child and Youth Health were notified of the situation. The RN and the Youth Worker from the Health Service counselled Jack on his return. A custody dispute, which developed between Jack and his now ex partner, was eventually resolved after lengthy negotiations, which also involved the RN and the Youth Worker. Both the mother as well as Jack abuse alcohol, which affects their capacity to support the children.

The RN, often out of hours and outside her job description, provided support and counseling to Jack, as other professional services were unavailable. Jack agreed to be involved in a drug and alcohol program, but the waiting time to entry was 8 weeks, during which time he went back to drinking. He made an appointment with the visiting Community Mental Health worker, but he missed the appointment and so needs to wait another 4 weeks for the next visit. Attempts have been made to refer him to the Aboriginal Health Service, but he refuses this assistance because he knows people who work there and some are his relatives.

A neighbour told him that he was belligerent and loud over the weekend, and he may face a report to the housing authority about this. He cannot remember the events and doesn't know how to defend himself legally.

Jack still remains a concern within the community regarding his relationships with his ex partner and children.

The questions

The solutions we would like and what could be done within 2 years to ensure these solutions happen.

In addition to discussing the issues facing Jack, participants were asked to focus on the following questions:

A. How would a team approach to care help Jack?

B. What might be the barriers to working together on this case?

C. What health system improvements could be realistically implemented in 2 years to improve a team approach on this case?

The response

Benefits

The benefits of a team approach were listed as:

• More coordinated, holistic and continuous care that includes Jack in care planning. If a history is documented and shared then everyone in the team knows this history.

• Increased detection of symptoms & early intervention hence reduction in hospital admissions.

• Increased care options for Jack.

• Increased links between and with other providers. Increases the input of ideas about care. All in the team (including Jack) learn about each other's services.

• Increased team members' mental health & also cross-cultural knowledge.

Service and teamwork barriers

The following service and teamwork barriers were listed:

• A set of barriers to providing service to Jack were identified around his situation, such as the isolation of where he lives, his own attitude, his possible addiction, financial situation etc.

• A possible desire from Jack for his details to remain confidential (hence the denial of consent for client information to be shared) would limit the capacity of staff to work together on his case.

• Concern was expressed about workers' involvement out of hours and beyond the role in their job specification, such as the RN's involvement in the custody dispute. This was a service concern on two points, first the occupational health & safety issues for workers and, second, the appropriateness of operating beyond the skill requirements of the job description leading to uncertainty about the quality of the service that is then provided to the client.

• Turnover of staff would limit the formation of mature working teams.

- Teamwork across four organisations was seen to take resources, particularly in workers' time to communicate through meetings. The different structures, policies and procedures across the organisations, for example about meetings, were considered as potential barriers to teamwork.

Improvements

The following service improvements were suggested. Some are these are within the capacity of the partner organisations, while others, such as a compatible (or common) data system may be reliant on outside decisions and take longer than two years.

- Need to complete the formalisation of the partnership at all levels. This includes the MOUs and policies at the organisational level and partnership roles and expectations written into job descriptions at the workforce level. The need for coordination was emphasised through mechanisms such as the Management and Linkages Meetings.

- Culturally appropriate assessment, management and referral forms that guide a common approach to cross cultural service delivery across the four teams.

- The need to differentiate culturally based behaviours and thought processes from symptoms of mental disorder.

- Use of traditional healers.

- Use of crisis management plans so that workers across the partnership know what to do when clients present in crisis.

- Increase in client education about their illness and treatments as well as community education to reduce the stigma associated with mental disorders.

- Flexibility and timely responsiveness to the mental health needs of Aboriginal people, but with the realisation that current worker caseloads may not enable immediate responses.

- Knowledge of the services available and respective roles of each organisation in the partnership. This could include a directory of services that also covers processes for referral, expected waiting times etc.

- Orientation of workers to the partnership that could include worker peer shadowing across the organisations and also cross-cultural training. Cross-cultural mental health training might involve Aboriginal people from the respective communities so that the information is relevant to that local community and as way of engagement between the local community and mental health staff.

- Increase the number of Aboriginal workers in mainstream mental health and also the availability of gender specific workers.

- Improve workers' ability across the four teams to communicate about client matters through casenotes. One concern was that Pika Wiya staff are unable to write in the Pt Augusta Hospital client casenotes.

- An electronic data system across the partner organisations that facilitates the sharing of information and communication. It was noted that the new version of CME (electronic data system in community health) will include the discharge plan and crisis management plan.

Conclusion

Regarding the second purpose of the workshop (to help build a sense of partnership from the 'ground up') feedback at the end of the day and afterwards indicated that having all staff meet helped to get some partnership issues into the open. Participants indicated that further forums would be useful so that staff would get to know more about each organisation in the partnership and the respective staff. The workshop also identified issues that had been raised elsewhere, such as in key informant interviews. This gives additional credence to these issues and is an indication that addressing these issues will have staff support.

The first purpose of the workshop (to identify points of intervention and referral of clients) was explored through the vignettes. The response to the Analise vignette demonstrated staff understanding of the multiple points at which intervention could occur when a client has a long and complex history. This means that when addressing current health care needs, a worker might deal with what is currently important. Although the worker might recognise the impact of past events, dealing with these impacts over a longer timeframe might require balancing available worker skills and resources with what is now appropriate and currently needed by the client. Dealing with both current and longer-term issues would require a partnership with the client so that goals are relevant and realistic. This would also require effective working relationships with those organisations that can deal with specific issues, such as loss and grief, identity and self esteem work, employment, housing, etc. A theme in the responses was that a realistic outcome for Analise was to achieve some stability in her life and for continuity, effective communication and coordination across her service providers.

Response to the Jack vignette demonstrated participants view about the benefits of a team approach to care. These benefits were both to Jack, in improved care, but also to partnership staff in their increased understanding about each other and about mental health and cross cultural knowledge through sharing. Barriers to service and teamwork were recognised, some related to Jack and his situation, others related to the process of working in teams and others to do with working in a remote setting where specialist services are often non-existent.

References

[1] Swan P and Raphael B (1995). Ways Forward. National consultancy report on Aboriginal and Torres Strait Islander Mental Health. Commonwealth of Australia.

[2] Sheldon M (2001). Psychiatric assessment in remote Aboriginal communities. Australian and New Zealand Journal of Psychiatry. 35: 435-442.

[3] Office for Aboriginal & Torres Strait Islander Health (2004) Draft Social and Emotional Well Being Framework (2004-2009).

[4] Australian Health Ministers (2003). National Mental Health Plan 2003-2008. Canberra, Australian Government.

[5] Mental Health Services (2000). New Millennium - A New Beginning. Mental Health in South Australia. Implementation Plan 2001-2005. Adelaide, South Australian Department of Human Services.

[6] Department of Human Services (2003). First Steps Forward - South Australian Health Reform. Adelaide, Government of South Australia.

[7] Northern & Far Western Regional Health Service (2001). Regional Mental Health Plan 2001-2004. Pt Augusta, Northern & Far Western Regional Health Service.

[8] Clark Y & Stewart T (2000). A focussed step toward wellness and wellbeing in Aboriginal health. A state strategy and action plan for social and emotional wellbeing for Aboriginal people. Adelaide, South Australian Aboriginal Health Partnership.

[9] Urbis Keys Young (2001). Evaluation of the Emotional & Social Wellbeing (Mental Health) Action Plan. Canberra, Office for Aboriginal & Torres Strait Islander Health.

[10] National Aboriginal & Torres Strait Islander Health Council (2004). National Strategic Framework for Aboriginal & Torres Strait Islander Health 2003-2013. Canberra, Commonwealth of Australia.

[11] South Australian Aboriginal Health Partnership (2005). Aboriginal Health - Everybody's Business. Social & Emotional Wellbeing. A South Australian Strategy for Aboriginal & Torres Strait Islander People 2005-2010. Adelaide, Department of Health.

[12] Kowanko I, de Crespigny C et al (2003). Better medication management for Aboriginal people with mental disorders and their carers. Bedford Park, South Australia, Flinders University School of Nursing & Midwifery and Aboriginal Drug & Alcohol Council (SA).

[13] Pika Wiya Health Service (1999). Social & Emotional Wellbeing Seminar Proceedings. Davenport Community Hall, 9-10 August.

[14] Fuller J & Ryan B (2004). Indigenous mental health project: summated response from evaluation questions for stakeholders. Pt Augusta, Northern & Far Western Regional Health Service.

[15] Johnson P, Wistow G et al (2003). Interagency and interprofessional collaboration in community care: the interdependence of structure and values. Journal of Interprofessional Care 17(1): 69-83.

[16] Norman I & Peck W (1999). Working together in adult community mental health services. An interprofessional dialogue. Journal of Mental Health 8(3): 217-30.

[17] Mignore B & Boone M (2002). Realizing potential: improving interdisciplinary professional/ paraprofessional health care teams in Canada's northern aboriginal communities through education. Journal of Interprofessional Care 16(2): 139-47.

[18] Fuller J (1995). Challenging old notions of professionalism: How can nurses work with paraprofessional ethnic health workers? Journal of Advanced Nursing 22: 465-72.

[19] Salisbury C (1998). A health service and Aboriginal & Torres Strait Islander partnership to develop and plan mental health services. Australian Journal of Primary Health Interchange 4(4): 18-30.

[20] Villeneau L, Hill R et al (2001). Establishing process indicators for joint working in mental health: rationale and results from a national survey. Journal of Interprofessional Care 15(4): 329-40.