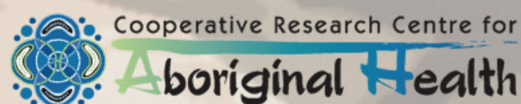
Aboriginal Mental Health Worker Program

Final Evaluation Report



G. Robinson & A. Harris

School for Social and Policy Research
Institute of Advanced Studies

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Acknowledgements

The evaluation team would like to thank all practitioners in the participating communities who kindly contributed their thoughts and opinions to the evaluation. Thanks in particular to AMHWs who introduced the team to their clients and their work, and to the AMHW Program's staff who have been generous with advice and support. This research was made possible by funding from b*eyondblue: the national depression initiative.*

Dr Amanda Harris led fieldwork for this report, developed the analysis and much of the discussion. Charlie Ward carried out fieldwork, conducted interviews, compiled data and contributed to development of the interim report. Dr Gary Robinson is responsible for the overall design and final execution of the project. The project was conducted under approval by the NTU Human Research Ethics Committee, approval number H02027, and Top End Human Research Ethics Committee, approval number 03/47.

Dr Gary Robinson, School for Social and Policy Research, Charles Darwin University
Dr Amanda Harris, School for Social and Policy Research, Charles Darwin University

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ISBN no 0 9757614 0 4

Cover photography by Donna Mulholland.
Cover Graphics by uniprintgraphics. Printed by Uniprint NT Charles Darwin University, Casuarina

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List of Abbreviations

A&OD	Alcohol and Other Drugs
AERF	Alcohol Decuation and Rehabilitation Foundation
AHW	Aboriginal Health Worker
AMHW	Aboriginal Mental Health Worker
AMSANT	Aboriginal Medical Services Alliance of the NT
ASIST	Applied Suicide Intervention Skills Training
BIITE	Batchelor Institute of Indigenous Tertiary Education
CAAPS	Council for Aboriginal Alcohol Programs
CCIS	Community Care Information System
CCTIS	Co-ordinated Care Trial Information System
CDEP	Community Development and Employment Program
CDU	Charles Darwin University (formerly NTU)
CMO	Community Management Order
CNAAR	Centre for North Australian and Asian Research
DHCS	Department of Health and Community Services
DMO	District Medical Officer
EAMHS	East Arnhem Mental Health Services
EBA	Enterprise Bargaining Agreement
FORWAARD	Foundation for Rehabilitation with Aboriginal Alcohol Related Difficulties
GP	General Practitioner
JRU	The Joan Ridley Unit in Cowdy Ward, Royal Darwin Hospital
KWHB	Katherine West Health Board
KMHS	Katherine Mental Health Services
MAHS	More Allied Health Service
MBS	Medical Benefits Scheme
MHN	Mental Health Nurse
MHS	Mental Health Service (Includes Katherine, Top End & East Arnhem)
NACCHO	National Aboriginal Community Controlled Health Organisation
NT	Northern Territory
NTU	Northern Territory University
PBS	Pharmaceuticals Benefit Scheme
RDH	Royal Darwin Hospital
RN	Registered Nurse
TEDGP	Top End Division of General Practice
TEMHS	Top End Mental Health Services
THB	Tiwi Health Board
TIHS	Tiwi Islands Health Service

Final Evaluation Report, Aboriginal Mental Health Worker Program
Executive Summary and Recommendations

This is the final report of the evaluation of the Aboriginal Mental Health Worker Program of the Top End Division of General Practice, prepared by the evaluation team at the School for Social and Policy Research, Charles Darwin University. This final report contains most of the content and recommendations of the draft mid-term report which was issued for comment at the beginning of 2004. It updates the conclusions and recommendations to take into account developments in 2004 and incorporates some of the preliminary findings of the baseline report issued by the evaluation team in 2003 (Robinson, et al. 2003). There has been some response to earlier recommendations by the Top End Division of General Practice and its partners, as the Program moves into a new phase of funding. One or two of these most recent changes may not be captured here.

Program Objectives

In 2001, the Top End Division of General Practice (TEDGP) gained funding under the Australian Government's *More Allied Health Services* (MAHS) program to fund the employment of Aboriginal Mental Health Workers (AMHWs) to work alongside General Practitioners in five remote health centres. In 2002, *beyondblue inc.* joined the Program, both extending Program funding to two further centres and providing funds for the present external evaluation. More recently, the Alcohol Education and Rehabilitation Foundation (AERF) has provided funding for two new AMHW positions (at Yirrkala) and two new Alcohol and Other Drugs (AOD) positions (at Angurugu). These positions do not appear to contribute directly to the current AMHW Program.

The involvement of *beyondblue* also saw the establishment of a Partnership Agreement between the major institutional contributors to the Program: the Top End Division of General Practice (TEDGP), the NT Department of Health and Community Services (DHCS), Batchelor Institute of Indigenous Tertiary Education (BIITE) and Charles Darwin University (CDU). The Partnership Agreement outlined the commitments of each organisation to provide supports for the Program.

The general objectives of the AMHW Program[1] were:

1. To develop the role of the Aboriginal Mental Health Worker as a member of a community-based mental health team in participating communities,
2. To provide ongoing support, training and mentoring to Aboriginal Mental Health Workers in remote communities,
3. To provide more effective mental health care practice through application of the local cultural knowledge and expertise of AMHWs working in conjunction with and in support of general practitioners,
4. To improve the level and quality of mental health care services accessed by members of participating communities,

[1] As interpreted from source documents.

5. To form an effective partnership between contributing organisations in the delivery and support of mental health care services in remote indigenous communities.

Evaluation Objectives

The evaluation has concentrated on outlining the work of the AMHWs and examining the degree to which they are successfully integrated into clinical practice in each of the communities, with a view to identifying the constraints on development of their role. It focuses on the development of infrastructure, provision of support, coordination between providers and development of basic practices in mental health care and mental health promotion. It identifies those factors which support or appear to detract from the sustainability of the Program.

The evaluation of the AMHW Program did not set out to investigate any improvements in the mental health status of clients which might flow from the work of AMHWs or the community mental health teams. The Program had not set a clear protocol for clinical intervention against which outcomes could be measured, even if valid measurement tools had been available. Many practitioners were hopeful that more effective community-based mental health care would lead to a reduction in emergency hospitalisation, readmission, etc. However, the evidence shows that hospital admissions for mental illness are generally rising for indigenous persons across the NT (Nagel 2004) and it is likely that increased mental health care in the communities will contribute to the net increase. It would therefore be of doubtful value as a measure of effectiveness of the current Program. Nevertheless, data on hospital admissions from participating communities is outlined in this report to highlight current patterns of demand on mental health care.

Mental health problems in the communities

Most clients admitted to hospital and diagnosed with mental health disorders are aged between 30 and 39 years (both for men and for women). Combined, a preliminary analysis of audited hospital separation records and CCIS entries for participating communities suggest that:

- the female to male ratio for people admitted to RDH and diagnosed with a mental illness or disorder across the participating communities is 0.48:1.
- substance abuse disorders comprise the greatest proportion of diagnoses, followed by schizophrenia related disorders, with a high incidence of comorbidity.
- there is a significant male-female difference in identified mental disorders, with both substance related disorders (female to male ratio of 0.31:1) and schizophrenia related disorders (female to male ratio of 0.65:1).

The predominance of substance abuse disorders is consistent across all communities with the highest prevalence as a proportion of total diagnoses for Borroloola. Schizophrenia is the second most common type of diagnosis in three communities: Elcho Island, Numbulwar and Borroloola. In Angurugu, mood disorders are diagnosed more frequently among patients admitted to hospital, followed by neurotic, stress-related disorders. Schizophrenia is less commonly identified among Angurugu clients than other communities. Marijuana, followed by alcohol misuse, is associated with a substantial proportion of hospitalizations for psychosis. In addition to the burden of substance abuse related disorders and psychoses, a number of communities report serious levels of self-harm among young people, frequently associated with smoking of marijuana. On the Tiwi Islands, suicide among young people has reached

epidemic proportions after 1998, while other communities report significant, albeit somewhat lower levels.

The kinds of mental health problems encountered in participating remote communities represent a significant demand on primary health care services, even though they encompass problems for which clinical responses remain at best partially adequate.

Achievements

The AMHW Program has been established in six participating communities: Angurugu, Galiwin'ku, Numbulwar, Nguiu, Borroloola and Kalano. Oenpelli and Gapuwiyak have been unable to proceed with plans to participate. The chief problem in these locations has been difficulty in recruiting and retaining AMHWs. Lajamanu has been unable to function, and it has withdrawn. The regional Health Care Provider for Lajamanu, Katherine West Health Board, was not the applicant for funding under the Program, and had not committed itself to a mental health strategy for the region. Funding to Kalano is currently on hold while a change in management is being finalised.

Table 1 Aboriginal Mental Health Worker Program

Community	***Population***	***Period of participation***	***Current AMHWs***	***Doctors***	***Mental Health Nurses***
Angurugu, Groote Eylandt	754	Nov 2001 - ongoing	2	1 GP	-
Galiwin'ku, Elcho Island	2,200 incl. outstations	Oct 2001 - ongoing	Recruitment under way	1 GP	1
Kalano	1,989 incl. Katherine/ Rockhole	Feb 2002 (temporarily suspended)	1 @ 50%	2 GPs	-
Borroloola	751	Oct 2001 – ongoing	2	1 GP	-
Numbulwar	721	May 2003 - ongoing	1	1 GP	1
Nguiu	2,110 incl. 4 communities	mid 2003 - ongoing	5 (2 only funded by Program)	2 GPs & DMO visits	1
Lajamanu	811	Dec 2001 – Aug 2003	-	1 GP	-
Oenpelli	754	unable to participate	-	1 GP	-
Gapuwiyak	1,000	unable to participate	-	1 GP	-

The Top End Division of General Practice administers the Program, and provides funding to successful applicants for the employment of AMHWs in health services in which there is a resident General Practitioner. With two exceptions, in which the employer has been a local health service, the employers of the AMHWs are Community Government Councils.

In all, eight AMHWs are employed under the Program, (with recruitment under way at Galiwin'ku after the departure of the first AMHW). This has approximately doubled the number of community based AMHWs employed in the Top End of the Northern Territory,

and has provided a basis for the development of a dedicated mental health service in communities in which none at all had existed before the Program.

The level of resources varies considerably across the communities, including both numbers of AMHWs and availability of resident GPs. Some teams need to service a number of communities and outstations, while others are largely restricted to one community of operation. In some contexts, there are a number of language groups resident, complicating the field of operation for the AMHW and mental health team generally.

The AMHWs are engaged in a range of activities in all communities. They have taken on a role in primary health care, assisting GPs and RNs with management and treatment of clients, and engaging in follow-up of clients due for medications. The mix of duties and activities varies from community to community. In some, they are frequently involved in crisis situations, responding to attempted suicides, acute episodes involving threatened violence or other manifestations of distress. In some cases they are engaged in advocacy on behalf of the client, undertaking measures to assist with client welfare, including liaison with courts, prison, community services, providing assistance with food and clothing, or with accommodation and travel following hospitalisation in Darwin. AMHWs also carry out counselling of clients with a range of difficulties, relating to substance misuse or to marital violence and relationship difficulties, and have variously participated in community health promotion and education activities, in the areas of general wellbeing, men's and women's health, youth issues, alcohol abuse, and domestic violence. There is no single model for the community roles of the AMHWs.

In health centres where the role of the AMHWs is most effectively established, GPs and RNs report that they provide valuable service to other health care practitioners, explaining cultural or relationship matters, assisting in management of difficult clients or in resolving often complex matters of client welfare. With variations across the communities, it is reported that AMHWs have significantly contributed to practitioners' ability to understand background issues and cultural themes relating to clients' problems. They often benefit from the mediation skills of AMHWs who assist with managing crisis situations in the health centres. It is clear that the AMHW Program has the potential to contribute to significantly improved Indigenous participation in provision of needed health care services.

The development of appropriate mental health services in remote areas of the Northern Territory faces many challenges. The AMHW Program has reached the end of its major funding period, and renewed *MAHS* funding for two years has commenced in a number of participating communities. Notwithstanding this achievement, it is appropriate to review the challenges and constraints encountered by the Program, in order to establish firm objectives for its sustainable continuation and further development into the future. This may entail ongoing revision of some of the Program's arrangements, establishment of some new or modified objectives and revision of commitments by the major partners to the Program.

Clinical and Non-clinical Roles for AMHWs in Remote Area Practice

It has been suggested by participants in most locations that clarification of expectations of the AMHW role needs to occur. AMHWs work both in the health centres, supporting clinical

mental health practice, and in the communities, not only visiting patients, but conducting various forms of health promotional activity beyond the health centres.

In both clinically oriented activity, and in community mental health promotion, the AMHW Program did not set firm developmental objectives. Outcomes and achievements in both areas have been overwhelmingly shaped by pre-existing resources, practitioner preferences, and programs in each community. Some participants have sought to point out that the AMHW role in community education is inadequately supported. However, based on this investigation, it is equally clear that basic clinical practices have not yet been developed to meaningfully involve the AMHWs as far as might be achieved. In other words, objectives and strategies for development of both the clinically oriented and non-clinical roles of the AMHWs are needed.

The possibility that *some* community mental health workers could primarily work in non-clinical mental health promotion, counselling, or other areas of community services and education without a clinical focus might be considered. Such a role would then need to be supported by a program of community-based public health or social services which is not present in most of the participating communities. GPs or health centre RNs are likely to be able to support this work to only a limited degree.

However, the evaluators consider that the role of the AMHWs in the community should in general not be divorced from the AMHWs' role in clinical mental health care. It is suggested that it is preferable to ground their role in community mental health by strengthening the supports for clinical practice to effectively involve AMHWs both in the health centres and in collaboration with the departmental mental health teams. The capacity to participate in community mental health promotion relating to substance misuse, domestic violence, family support or youth issues should then be built on this basis.

Basic health practices and audit outcomes

The AMHW Program did not adopt or implement a specific set of clinical practices or instruments as a formal objective. It has been left to each health centre to determine its own approach to clinical mental health care.

The evaluation therefore examined basic systems of record keeping and case management, the quality of recorded information and indications of AMHW involvement in current care as reflected in medical records. An audit of a sample of clients' files was conducted in four participating health centres. It examined records of delikvery of clinical services, including mental health assessments, care planning and review, and other aspects of clinical care. It identified evidence of AMHW involvement in clinical consultations and in collaboration with other practitioners as reflected in medical records.

In the following, recommendations are made concerning changes to clinical practice which might be supported by the AMHW Program.

Records and record-keeping

The community health centres use different systems of records, some paper-based only, some a combination of electronic and paper systems. Systems to support the monitoring and planned follow-up of mental health clients are not well developed.

Policies vary, but only in Angurugu do the AMHWs consistently and comprehensively enter consultations in client medical records. At other health centres AMHWs contribute only limited entries to central health centre files if at all, or else keep entirely separate sets of records of their own activity, in some cases including files for their clients. Most AMHWs also keep a field diary. Diaries appear to have varying levels of usage and to be of no clinical relevance and only limited managerial usefulness.

These practices coincide with and partially explain the very low incidence of reference to AMHWs and AMHW services in medical records. As a result, there is very little recorded evidence of AMHW input into medical decision-making or treatment.

1. *It is recommended that keeping of separate sets of mental health records for clients by AMHWs should be abandoned.*
2. *Policies which exclude AMHWs from recording consultations in progress notes should be abandoned; basic training should be provided to ensure that new AMHWs can reach an appropriate standard for entry of agreed consultation information.*
3. *The keeping of field diaries for recording client contact and other activity, or as a record for AMHWs to use in clinical casework, in health promotion or community education, should be maintained. They are to serve as a focus for mentoring and training of AMHWS. However, they should not substitute for recording of consultation activity in clients' records.*

Care plans, care planning and assessment

No health centre in the Program currently uses a standard mental health care plan in either paper or electronic form. Audits of medical records show that consultations entered in the *progress notes* section of clients' medical records are also very sparse in terms of records of formal mental health assessments and of mental health care planning activity. Little if any of the planning which *is* noted in medical records schedules any services to be carried out by AMHWs.

Most records of planning in the *progress notes* concern medications, with few references to other common elements of care planning, such as inquiry and counselling about risk factors or involvement of family members or other service providers in care. AMHWs are being employed to monitor client compliance with medications as their primary clinical responsibility (although even this activity is not well reflected in the records). Case-conferences occur infrequently, and there is little recorded evidence of case-conferences occurring which involve staff of Cowdy Ward or other DHCS staff in consultation with community practitioners, as foreshadowed in the Partnership Agreement.

Although existing planning practices are reported to be adequate by health centres, most acknowledge that time and capacity permitting, more systemized approaches to planning would be beneficial. The absence of consistent records of care planning and the predominance of medication decisions in such records as do exist, mean that the consistency of adherence to comprehensive care plan objectives or goals is impossible to verify or to monitor. Any such activity is unlikely to be systematic because coordination of multiple practitioners to ensure that recall and review of patients occurs when due is not supported by transparent practice

arrangements or records. Informal systems are highly vulnerable to staffing discontinuities of any kind.

4. *A mental health practice strategy – concerning care plans, review, monitoring, assessment protocols, record-keeping and case-conferencing - should be developed for the AMHW Program to provide objectives for mental health practice which mental health services will strive to meet.*
5. *Mental health care plans may be tailored to the needs and capacity of local systems (electronic, paper-based, etc.); however, their implementation should be conducted with regard for evidence and with appropriate supports and evaluation.*

Practitioners have expressed concern that adoption of a care plan protocol in the form of a sheet to be inserted in clients' notes might be cumbersome, need frequent review, and might not be sustainable against the demands of acute and general care. It is evident from the audit of client files that, whether or not a formal care plan protocol is adopted as a standard requirement, care planning activity including assessment, planning, follow-up and review are incompletely and inconsistently recorded (and by many practitioners not at all) in clients' records.

6. *Formal training in mental health assessment, planning and review, accompanied by a standard protocol for recording of consultation information in clients' records, should be provided for GPs & RNs.*

Training and Support for Basic Mental Health Care

Three AMHWs have graduated from the Certificate III in Community Mental Health (Non-Clinical) provided by BIITE under the terms of the Partnership Agreement for the AMHW Program. They have enrolled in the Certificate IV that was commenced in 2004 as a result of demand for further study. These courses do not provide a basis for practice registration. There are consequently constraints on the clinical responsibilities which can be undertaken by AMHWs due to the lack of an accredited clinical program leading to registration.

For the on-the-job training requirements of the AMHW Program, there needs to be a focus on development of basic health centre practices to allow for better targeted support for a role for the AMHWs in mental health care. Improvements in clinical competence should be based on responsibility for record-keeping and accountability for consultations delivered, as is the case for other practitioners. In the view of the evaluators, an important means to develop the health promotional and counselling competencies of AMHWs would be for them to be able to enter these contacts as consultations in client records where they can then become a basis for interaction with other practitioners and inform client care more generally. The recording of consultations in which AMHWs participate, such as case conferences, should be encouraged – albeit the records may be entered by GPs or RNs.

Training should therefore aim to assist AMHWs to participate in consultation activity to enter consultations in patient records, and to participate in decision-making about care. Such training can take the form of inservice workshops accessed through DHCS or through delivery of some Certificate III material at BIITE. *However, the intent behind the training and its*

relationship to AMHW involvement in local health centre practice needs to be understood by other practitioners.

Interviews with practitioners suggest that consideration should also be given to making training available to *all* mental health practitioners in the Program: GPs, RNs and AMHWs. This should include components of assessment, review and care planning, as well as attention to issues in cross-cultural practice.

As part of any new Partnership Agreement, it is recommended that:

7. *Support and training in basic practices of record keeping, monitoring and consultation activity will be made available to AMHWs as inservice or workshops, with components provided by DHCS and BIITE.*

Counselling and inquiry

The audits found that with few exceptions there were scanty records of some important areas of clinical activity. This included many elements of inquiry about a patients' condition, manner of presentation and background circumstances, and other observations about risk and protective factors which should form part of mental health assessment. There was also only very limited record of the interaction of practitioner and client and in particular of counselling and health promotional advice offered by practitioners. Some individual practitioners record none of this activity at all.

This absence from the record suggests that there is a need to assist the development of skills in mental health assessment and counselling for all practitioners. Secondly, given that these are areas within which the AMHWs might make some of their most important contributions to clinical work, it is important that a plan to improve skills in care planning, counselling and inquiry specifically include AMHWs, both as recipients of training and as contributors of knowledge about culturally specific matters.

8. *The development of evidence-based care plans and assessment protocols for the AMHW Program should specify elements of service such as counseling, inquiry and mental health promotion, with appropriate recording of these elements of consultation activity.*

A number of practitioners made strong reference to the need for training in counselling, and for access to expert counsellors able to work in the indigenous context. Some forms of counselling – e.g. about depression, or marital conflict – can be developed as further specializations in addition to the elements of counselling and inquiry which should accompany all clinical consultations.

Management Support

The ongoing development and sustainability of the AMHW Program depends to a significant extent on the level of management support and coordination provided to AMHWs. This support derives from two main sources: centrally, from TEDGP as the Program manager, and in the communities, from the organisations employing the AMHWs.

Two Program Coordinators are employed by TEDGP, one female and one male. They have made a vital contribution to the ongoing maintenance and support of AMHWs in the Program. Both Coordinators have experience in mental health care as AMHWs, and have connections in many areas of the Top End. Their responsibilities include ongoing contact with participants through regular community visits and phone, orientation of new AMHWs, brokerage between stakeholders, forging links between organisations and reporting to funding bodies. The breadth of the contribution of the Coordinators is appreciated by Program participants.

The level of support provided to communities by TEDGP from AMHW Program funding has been criticized by some participants, who argue that the proportion of funding for centrally provided support relative to funding available for AMHW positions should be increased. The current level of support can undertake a range of functions, but appears insufficient to assist with establishment of sustainable initiatives in the communities, or, for example, to assist with substantial review and development of work practices in the health centres.

The AMHW Program commenced with a needs analysis, a basic survey of resources in the communities and negotiation of the terms of employment and practice within existing health center arrangements. The Program did not seek or achieve from participants major commitments of support for development of the AMHW's role, beyond basic support for their recruitment and employment, access to workspace, etc. In effect, the achievement to date has occurred with what could be seen as a minimum level of developmental support.

The requirement for support is to a considerable extent dependent on objectives of the Program. Current levels would not be sufficient to initiate and sustain significant changes in mental health practice in the community health centres (e.g. systematic development of care planning) or substantial development of a community mental health promotion strategy.

9. *There should be consideration of the need to allocate dedicated resources (e.g. a funded or seconded position, or other project-funded resources) to provide community-based support to meet specific developmental objectives adopted by the program. This could focus on:*
    a. *Assistance with startup and initial development of administrative, clinical and other practices in newly participating communities,*
    b. *Development of processes for care planning, assessment, monitoring and review in the form of an elementary protocol for inclusion of AMHWs in consultation monitoring and follow-up activity,*
    c. *Planning for access to training for all practitioners as outlined,*
    d. *Health promotional, public health or counselling strategies for the mental health team, including specific priority areas such as alcohol intervention, domestic violence, suicide prevention youth and community education, etc.*

These resources might be funded partly from outside, partly by partners, and partly from within the AMHW Program's resources. They could, for example, be funded as part of a research program. Many of the functions described are undertaken to a limited extent by the current support team.

Notwithstanding concerns about the level of support provided by TEDGP, it is probably not by itself the most significant determinant of Program outcomes. At the local level, two key factors relating to the level of managerial and administrative support available to AMHWs have determined the level of success of the Program in terms of the capacity of AMHWs to pursue their roles.

These factors are:

a. the availability of practitioners other than GPs (mental health nurses and/or health centre managers) who have been willing to invest time and effort in developing the AMHW's role in each health centre
b. the degree of support for a community mental health program by the local health care organisation.

The performance and integration of AMHWs in mental health care has been most effective where the level of local support in these terms was highest. This includes support for non-clinical activity. Where community organisations have access to an effective AOD service provider, as for example, at Angurugu, this can be a major support to the community health promotion role of the AMHWs.

In some communities, local initiative to solve basic problems has not been sustained, in part because the AMHWs are employed by the local Community Government Councils rather than the local health service provider, or because the institutional support has broken down or has been lacking for other reasons (as at Borroloola with the departure of the local General Practitioner who had established the Program). The original GP-AMHW partnership model anticipated that GPs and AMHWs would work in close partnership, with the GP providing the majority of direct support and guidance to the AMHW. GPs have made it clear that they feel unable to contribute much of the support required. The Program's model is therefore vulnerable in a context where a framework for institutional support through the local health care organisation is lacking, or where other individuals, such as local health centre managers or RNs are not available to assist the AMHWs to establish themselves.

A lack of shared understanding of the role of the AMHW between health centre and other community organisations has been an issue of concern for a number of participants. This lack of local consensus has diminished the clarity of direction provided to AMHWs in a number of communities. These difficulties can in part be addressed by clarifying requirements of organisations employing AMHWs. It is therefore recommended that some basic steps be undertaken as a condition of any new or renewed contracts to fund AMHW positions:

10. *Part of the obligation of the employing organisation should be to develop, in collaboration with the health centre and other community stakeholders, a working position description to be forwarded to the Program Manager no later than six months after commencement (or review of existing positions).*
11. *Local providers and councils should be asked to specify more clearly their ability to provide administrative and professional support to the AMHWs, including outlining arrangements for their integration into existing practice.*

It must be cautioned that Program commencement in many of the participating sites has required considerable effort on the part of the TEDGP's Program manager to achieve agreement about even very basic arrangements to support the AMHWs. There have been considerable differences in the level of commitment at commencement across the communities. The difference in commitment involves not only the capacity of clinical services to provide management support, but also the commitment of community service providers and health promotion services to support the AMHWs' non-clinical roles.

12. *It is suggested that in the process of selection of communities, criteria for entry should refer both to the level of community based support by health services and administration, and the level of support from non-clinical programs and community service organisations*
13. *There should be some indication of inter-organisational cooperation to support the AMHWs: it is recommended that community committees involving health and other community service providers be established to support both clinical and non-clinical activities of the AMHWs and the mental health team.*

Employment conditions

The AMHWs are employed under a variety of conditions: in most communities, salaries have been divided and combined with CDEP income to enable the creation of two (a male and a female) positions. The CDEP contribution is therefore an important component of the Program. Local Councils have applied their own discretion to terms of employment concerning leave, superannuation etc. There is accordingly variation across communities, with the AMHWs in general paid substantially less than other nominally comparable positions (e.g. AMHWs and AHWs employed by DHCS). At a minimum, there is a need to top up the CDEP rate of pay to the same as the rate paid by the AMHW Program, in such a way as to allow for salary increments on the basis of performance and training to be uniformly provided across the participating communities (for example, for those AMHWs who graduate with Certificate III from BIITE). Currently, performance management varies considerably across communities, such that variable expectations concerning attendance and performance appear to exist.

It is recommended that:

14. *A review of contractual requirements of employers should stipulate basic terms and conditions, requiring topping-up of CDEP rates to an equivalent single rate for each employee, with increments available for performance and training applied uniformly across all participating communities.*

It must be cautioned that the level of support and the process of development of the Program at local level cannot be dealt with solely by imposing more onerous conditions on funding recipients: this by itself would not prevent breakdown or deficiencies in implementation from occurring, and might lead some communities to withdraw rather than to work towards appropriate responses. However, somewhat more demanding criteria for entry to the program need to include commitment by the recipient to a framework of objectives for management and support of the AMHWs. The Partnership Agreement and the commitments of major partners to provide support, as well as aspects of Program design, including contracts with communities, should be reconsidered in light of the need to find such a balance. These requirements may entail a revised mix of expenditure (for example, on AMHW positions and support positions), which may in turn need to be explained to funders.

Partnership Agreement Inputs and Program objectives

The Partnership Agreement for the AMHW Program is signed by TEDGP, DHCS, BIITE and CDU. The Agreement sets out the Vision of the Program and specifies the role of each party, including the agreement of each to make contributions to the Program. These include the provision of training including certificate level courses (BIITE) and inservice workshops,

(DHCS), the development of specific forms of communication or consultation between practitioners, such as case-conferences (DHCS), responsibility for Program evaluation (CDU), and provision of general support and guidance through a steering group. The formation of such a Partnership to develop remote mental health services is in itself a significant achievement. It has the potential to provide a robust collaboration to underpin remote mental health service development in the Northern Territory.

The existing Partnership Agreement does not specify responsibility for initiating some inputs (for example, some kinds of training or of communication, case-conferences, etc.), in-kind commitments of resources by the partners, or set particular targets for collaboration in the areas of training, collaboration, practice development, and provision of support. The commitment of DHCS as the major provider of health care in the NT is vague and imprecisely defined in the agreement.

The Agreement does not provide guidance in the form of any developmental targets or objectives to be realised over the duration of the Agreement. As a result, there has been little capacity to initiate some developments on a systematic basis. The lack of developmental objectives in turn reinforces uncertainty about what is being asked of participating community organisations. Arrangements with partners and community organisations have been negotiated on an ad hoc, case-by-case basis.

The Program does not intend that the AMHWs are put into contexts where their work performance is solely determined by local conditions, variable resources, the idiosyncrasy of local appointments and the goodwill of individuals. There is a commitment of the partners to assist in the development of systems and processes and to provide support for the ongoing development of AMHWs and community mental health care as well as a means to monitor whether obligations are being met.

It is recommended in the context of further development of the AMHW Program that:

15. *A revised Partnership Agreement should define both in-kind and funded contributions (personnel, facilities and resources) within a strategic plan which sets out objectives for the Program in the context of developing mental health care in the NT.*
16. *The Partnership Agreement should specify general objectives for provision of support, training and collaboration by partners: these should be costed or resourced, and should be linked to timelines, against which broad progress can be measured. It is recommended that the commitments of DHCS include funds for the community-based support described under recommendation 9.*

The AMHW Program has in many respects been a developing collaboration between communities and partners to the Partnership Agreement. It will be desirable for the partners to continue to focus on development of the terms of that collaboration, its costs, its strategic objectives and its more immediate targets over the coming period.

Currently the major risks to the AMHW Program appear to arise a) in the communities, from major discontinuities in staffing and recruitment, failures in organisational resources, or from lack of institutional support, and b) from Program design and management, to the extent that these are unable to meet demands for support, through both funded and in-kind contributions.

17. *Progress under the Partnership Agreement should be monitored by an appropriate group or steering committee at least six monthly, with a view to reinforcing partner involvement, reviewing objectives and monitoring risks to the Program and its outcome through a Risk Management Strategy; such a group should involve representatives of Program funders.*

Refinement of Program Objectives and Program sustainability

While overall monitoring and steering of the Program is a task for representatives of the partners, it is desirable that there be greater depth of collaboration to further develop objectives for training and support of AMHWs and other practitioners, and for the development of health centre practices to support the work of the mental health teams. As indicated, there is both a lack of research evidence to support remote area mental health practice, and a lack of practical knowledge about what solutions would contribute to better basic organisation and practice at the local health centre level. There is a need to enhance the clarity of responsibilities and roles in collaboration between participants. The current framework for steering and management of the Program has not been able to undertake these important tasks.

18. *The Steering Committee should identify opportunities to provide research and development support for elements of the Program in the context of a review or refinement of Program objectives.*

In the draft mid-term report, it was argued that the working group should explore links with existing research projects or seek the development of new research projects to trial new methods or instruments for care, assessment and treatment, in the health centres. As outlined, in mid 2004, TEDGP had formed a link with the *AIMHI Project*. It may be desirable to align with other evaluative research regarding the effectiveness of community mental health promotion, education and early intervention. Funding for such projects should be sought from appropriate research funding bodies.

There remain wide gaps in the capacity and functionality of infrastructure, and in the capacity of administration to support care planning, monitoring and recall in the health centres. The steering committee should continue to consider a project to define basic processes for record-keeping, consultation, planning and review, as well as case conferencing involving DHCS remote area teams and staff at RDH. Guidelines might be provided for participating communities and service providers. Such a program of development could facilitate the provision of further training for all practitioners around mental health assessment to improve general skills and commitment to improved practices. This may need to be supported by investigation of specific protocols for adoption within the Program.

The sustainability of the AMHW Program depends firstly on its ability to secure recurrent funding, but, almost equally importantly, on the ongoing commitment of the partners to provide support in the form of training, clinical and other services, administrative support, and so on. Further strengthening of the working relationship between DHCS and the AMHW Program, including a commitment to strengthening the articulation of the AMHW Program with larger government programs, is particularly important.

Recurrent and non-recurrent funding and Program objectives

It was recently argued that the Northern Territory needs to shift remote community-based mental health services from current insecure, non-recurrent funding to a secure recurrent funding base (Healthcare Management Advisors, 2003). This will clearly confront the AMHW Program and its funders at the end of the current period. The financial sustainability of the AMHW Program is uncertain. To date the Program has existed on the basis of non-recurrent funding which ends in December 2005. Funding beyond mid 2004 provides for four new salaries only. Discussions are currently underway with the Australian Government to secure recurrent funding or at least funding for a further three years.

A model for future funding needs to resolve a number of concerns about adequacy of arrangements and resources. These include:

1. *Adequacy of funded and in-kind support for Program objectives,*
2. *Appropriate and realistic contractual arrangements with community organisations delineating agreed policies on employment conditions and resources,*
3. *Clear delineation of objectives, responsibilities and of the substantive commitments of in-kind resources under the Partnership Agreement,*
4. *Appropriate agreement on the part of funding bodies (to date, Australian Government, beyondblue and Alcohol Education and Rehabilitation Foundation) about Program objectives and the purpose and mix of expenditure under the Program.*

The continued application of funds for salaries for new positions only, would pose a risk to continuing development of the Program and its capacity to achieve measurable outcomes. It is also necessary to consider the funding implications of any revision or strengthening of Program objectives. *However, such support can only be effective if the level of support from community organisations is sufficient to sustain the Program and its developmental objectives.*

In early discussions, Professor Ian Hickie, the former CEO of *beyondblue* expressed some concerns about the original Program model, the over-reliance on general practitioners to provide direction at community level, and the likely difficulty TEDGP would encounter in managing the Program to clear objectives. These concerns were at least partly warranted. However, as outlined here, Program partners and Program funders alike need to review the present mix of expenditures which limit ability to move beyond employment of AMHWs to implement objectives in the areas of clinical practice and community mental health strategy. Review of the Program's ability to provide ongoing development support, if not to fund a developmental program with objectives in clinical practice and community education, should be a priority.

The Alcohol Education and Rehabilitation Foundation provided funding for *Alcohol and Other Drug* Health Promotion workers for two communities (of whom only one is within the AMHW Program). This funding option has proven largely inconsequential for the AMHW Program as the funded positions do not contribute to the Program's consolidation, much less expansion. In short, funding too stringently tied by requirements of the funding body will not provide the flexibility needed to consolidate a differentiated community-based, multi-practitioner mental health strategy. In this context, the task for a funding body such as *beyondblue* may be to work with stakeholders to leverage both further funding and stronger

organisational commitments of participants to the Program, and at the same time to provide incentives to the revision and development of program objectives.

If the NT Government and its partners wish to move towards strengthened recurrent funding for community-based mental health, the question may arise as to what role should be played by the current Program. The Program may continue to aim at set-up of basic mental health resources in communities, but not necessarily commit to a) full funding of comprehensive community-based services in any communities; or b) provision of recurrent funding for participating communities in perpetuity. Communities where resources can be consolidated and funded on a stronger basis might not qualify for the support of this Program. Conversely, this Program might come to represent a more narrowly specified element of funding within a broader strategy to build community services. Resolution of these questions is a prerequisite to clarification of the developmental objectives of the Program for the longer term.

Research and development

Community health centres and program managers, including TEDGP and DHCS, are continually subjected to exigency caused by staff turnover, mild to severe institutional failure, funding shortfalls and insufficient investment in human and technical capacity. Further, clinical and non-clinical practice alike in remote communities is driven by reactive styles of response to acute care needs. These pressures are likely to undermine attempts to develop new systems of practice and organisation. Assuming recurrent funding for the base Program, attempts to overcome these problems should be supported by some investment in development projects accompanied by well-focused research and evaluation.

The current evaluation has focused largely on process and support for the development and sustainability of the AMHW Program. It has not been able to focus on the effectiveness of mental health strategies including clinical interventions and counselling, education and health promotion in terms of their outcomes for clients and communities. If consolidation of the Program can be achieved, a shift of evaluation emphasis to effectiveness and client outcomes, including the development of preventive, rather than reactive strategies would be warranted.

The area of Indigenous mental health, particularly in remote Northern Australia is not well understood and can draw on little in the way of an evidence base to support practice in a context of cross-cultural uncertainty and complex social and cultural change. It is therefore not a straightforward matter for the AMHW Program to adopt specific methodologies and practice objectives – for example, evidence based protocols or care plans, or specific mental health assessment tools – where the validity and effectiveness of these instruments have not been established through research trials among Indigenous populations.

These considerations apply not only for clinical practice, but also for many areas of public health and related intervention – for example in areas such as suicide prevention, mental health promotion for youth, domestic violence or substance abuse. Similarly, strategies for counselling specifically developed for Indigenous settings are not widely available, and those reported or marketed by NGOs do not appear to have been evaluated regarding their effectiveness. Beyond the AMHW Program itself, a relevant program of research and development would be of considerable interest to NT DHCS, if not nationally, for the contribution it could make for establishing effective models for community mental health service delivery.

Chapter 1. The Aboriginal Mental Health Worker Program

1.1 Background and Context

This report is the final report of the evaluation of the Aboriginal Mental Health Worker Program of the Top End Division of General Practice by a team located at the School for Social and Policy Research, Institute of Advanced Studies, Charles Darwin University. The evaluation project was funded by *beyondblue,* and conducted as an in kind research project within the *Cooperative Research Centre for Aboriginal Health (CRCAH).* The final evaluation report comes at a point at which the Program has moved into a new round of funding. Earlier drafts of the report have contributed to discussion and negotiation between TEDGP, funding bodies and other stakeholders about the management of the Program beyond June 2004, the end of the original period funded by the Commonwealth Government's *More Allied Health Services* program and *beyondblue.* This report aims to comprehensively summarize and update the findings of both baseline and mid-term reports, including questions for discussion and review of the Program's ongoing development, and discussion of its processes and outcomes to date.

In the Northern Territory, approximately 29% of the population are of Indigenous descent, of whom the majority live in rural and remote communities. It has been generally established that regional and remote health services are under-developed through lack of funds and infrastructure in regional NT. A lack of General Practitioners in the bush has compounded these difficulties, and has in turn contributed to a failure of remote Territorians to access health care funding through the national Medical Benefits Scheme (MBS) and Pharmaceutical Benefits Scheme (PBS). It has been argued that the significantly higher rates of hospitalisation of Aboriginal people compared with the general population is in part a reflection of the under-development of primary health care services in remote areas. Aboriginal clients remain overwhelmingly oriented to acute health services, with relatively little *preventive* use of primary health care services (McDermott, 1995).

The movement of mental health care from a traditional institutional setting to community based services with a push to greater integration between all levels of service is a global trend (eg., Russel & Potter 2002, Squire et al. 2002, Sweeney & Kisely 2003, WHO 2001). As Hickie and Groom note, the policies and initiatives of the Australian Government since the early 1990s have addressed 'the need for the development of collaborative and integrated ways of delivering mental health care, and an increasing emphasis on the central role of primary health care' (2002:377).

The Australian Government's *National Mental Health Plan 2003-2008* outlines an extensive list of 'key directions' for mental health care in Australia. Broadly these cover the need for greater linkages between services in order to ensure greater continuity of care and the need to strengthen the capacity of professionals and services at the community level according to appropriate workforce standards and service delivery benchmarks. Further, States and Territories are directed to undertake evidence-based planning and to establish ways to track and measure service outputs and outcomes.

The National Plan emphasizes the need to increase the proportion of Aboriginal and Torres Strait Islander mental health workers in the mental health workforce along with appropriate support and career structures (Australian Government 2002:27). This emphasis is supported by the *Northern Territory Aboriginal Emotional and Social Wellbeing Strategic Plan* that was released in July 2003.

The AMHW Program takes place in the context of changes in health service delivery in the Northern Territory. Among the most important changes are moves towards regionalisation of health service organisation funded under the Primary Health Care Access Program (PHCAP). PHCAP aims to address the under-funding of regional and remote health care services and in the NT is intended to achieve the expansion of comprehensive primary health care services within regional organisations under Indigenous community control (AMSANT 2002). The extension of PHCAP underpins the NT Government's plan to form health zones, each with its own regional Health Board. These initiatives promise to devolve greater resources to community-based services and infrastructure and to achieve much higher levels of Indigenous community participation in health service decision-making and in the delivery of services through community-based teams. At present only one of the health services to participate in the TEDGP AMHW Program (Lajamanu) is part of such a regional structure (the Katherine West Health Board). At Borroloola, processes are underway to establish a health service for the Gulf Region, while a Tiwi Health Service administered by NT DHCS has replaced the Tiwi Health Board as the regional provider to the Tiwi Islands. Overall the progress towards regionalization of health service delivery is an uneven one with significant differences in resources across regions of the NT. The AMHW Program is a potentially significant element of mental health service delivery in a context of unevenly developed resources and infrastructure available to primary health care in the NT.

In 2003, the Northern Territory Government announced the injection of $7.2M into mental health. A further $5.5M was announced in December 2003, taking the total amount to $12.7 million for three years (2003-2006). Scant detail on the expenditure of the initial $7.2M was provided by the then Minister for Health and Community Services in a statement to Parliament in October 2003. Of direct relevance to the Division's AMHW Program, however, was the announcement of two new positions for senior AMHWs, one in the Top End and one in Central Australia. These positions would be administered by DHCS and, according to the Minister, are intended to contribute to the AMHW Program's Partnership Agreement between TEMHS, TEDGP, CDU and BIITE. Details on how these positions will contribute to the Program were not available at the time of writing.

The additional $5.5M for mental health care is to be allocated to support community based services through the NGO sector (Community Controlled Health Services) and specialist psychiatric services including those at RDH. The funds will also be used to expand mobile TEMHS services and the employment of AMHWs in Tennant Creek and East Arnhem Land. They are therefore being split between central institutional support, community based primary mental health care, and the provision of specialist services at the local level.

1.2 The AMHW Program

The AMH Program funds and supports the employment of community-based Aboriginal Mental Health Workers (AMHWs) to work in partnership with general practitioners and other

health care workers in remote community health centres. As at June 2004, AMHW Program funded the employment of 12 AMHWs. This represented the first steps towards any form of dedicated community mental health service in some of the participating communities and had, at that point, approximately doubled the number of persons employed as AMHWs in the Top End. Since then the number of AMHWs employed (either fully or partly funded) under the Program has fallen to seven in six communities[2].

The TEDGP Program is based on recognition that local knowledge must underpin the management of mental health problems. It aims to establish collaborative partnerships and processes of inquiry between local people and health professionals (Adams 1996, Bolton & Bolton 1994), and between major providers. The Program follows a small number of earlier AMHW initiatives in the Top End, notably in the Tiwi Islands, Belyuen and Daly River. (Tipungwuti et al. 1996, Roman et al. undated). Lack of funding and infrastructure meant that these earlier attempts to develop a role for community based AMHWs were not sustained. A direct precursor to the current Program was developed in Maningrida, where an AMHW, Albert Mileran, was employed by DHCS to work in partnership with the community's General Practitioner, Dr Meredith Arnold, to address the specific mental health issues and problems occurring in that community. A number of participants in these earlier initiatives were active in establishing the present AMHW Program.

After discussions between AMHWs, GPs and mental health staff at BIITE, a series of 'Learning Both Ways' workshops were held in Batchelor in 2000 facilitated by John Maher and Meredith Arnold. As a result of these discussions, TEDGP applied to the Australian Government *More Allied Health Services* (MAHS) initiative for funding. This was granted in February 2001, and a Working Group consisting of the same parties, with the addition of TEMHS managers and TEDGP staff, was formed. By April of that year TEDGP advertised for 'Expressions of Interest', distributing information to 68 communities in the Top End. Fifteen applications were received from community councils interested in employing an AMHW. TEDGP employed a senior AMHW, Henry Sambono, to identify community resources and capability to identify and support an AMHW position. In September 2001 the first four communities: Lajamanu, Angurugu, Borroloola and Galiwin'ku, were identified and entered the Program.

TEDGP produced a *Needs Assessment Report* in September 2001. This reported on the processes used to identify the most suitable communities from amongst the applicants and explored the need more generally for remote AMHWs in the Top End. Community consultations were performed by Henry Sambono and the extent, nature and efficacy of TEMHS services (and service use) already being provided to remote communities were also explored. The Needs Assessment Report indicated the need for further considration of clinical and training support requirements, employment contracts, evaluation protocols, monitoring processes and associated ethical issues (TEDGP 2001).

[2] The position funded at Nguiu was one of five AMHWs in the Nguiu clinic on the Tiwi Islands. As at other locations these funds were combined with CDEP funding to employ two persons within the team. Remaining funds for the Tiwi MHT were received from 9 different sources: ATSIC, Australian Government Department of Health and Aging, Australian Government Department of Health and Aging, FACS Community Services Coordinator, FACS Community Worker, Top End Mental Health, Australian Government FACS, TEDGP.

Funding and duration

Initial funding of $267,000 was received from the Australian Government through the MAHS initiative for a four-year period. A further $345,000 was committed by *beyondblue,* contingent on the commissioning of an external evaluation project, which *beyondblue* also funded. This had not been allowed for in the original project planning. Both MAHS and *beyondblue* funds were fully expended by June 2004.

The Alcohol Rehabilitation and Education Foundation (AERF) has now contributed $175,000 over two years; this grant is being administered through *beyondblue,* and, according to the Program manager, TEDGP, was earmarked by the funders to support two new AMHW positions in Yirrkala and two new A & OD (not AMHW) positions in Angurugu. Thus only half of this funding was being used within the AMHW Program. Funding commenced in January 2004 and will continue until December 2005. According to TEDGP, *beyondblue* specified that its funding be used to support increased awareness of depression and anxiety issues while the AERF requested that accredited drug and alcohol training be made available to the AMHWs.

As at June 2004, an additional two years of funding from the Commonwealth was secured through the MAHS Program. This second phase of funding will continue at the same level as previously and will end 30 June 2006. At the time of writing discussions continue with the Australian Government Department of Health and Aging regarding additional funding to replace the initial *beyondblue* funds that ended on 30 June 2004.

Funding of the AMHW Program is non-recurrent. The continuation, development and future direction of the Program is closely tied to securing further sources of funding. This uncertain financial future has had a limiting effect on the way the Program could be developed in 2003/4.

Table 2: Timelines of AMHW Program Development

Apr & Dec 2000	Education workshops held at BIITE
December 2000	MAHS funding submission developed
February 2001	Commencement of Program
Mar-Apr 2001	Development of Working Group and preparation of Expression of Interest and Senior AMHW materials for communities.
May-Jul 2001	Assessment of Expression of Interest applications and selection of four participating communities.
Sep-Nov 2001	Recruitment and commencement of AMHWs on Angurugu, Borroloola, Galiwin'ku, Lajamanu
December 2001	GP-AMHW orientation workshops at BIITE
February 2002	AMHW orientation week in Darwin
February 2002	Selection of fifth participating community and commencement of AMHW at Kalano

April 2002	GP-AMHW forum at BIITE
May 2002	AMHW presentation at WONCA conference, Alice Springs
June 2002	Training at Yuendemu/Mt Theo Substance Misuse Program
June 2002	Commencement of external evaluation by CDU – baseline
July 2002	Program funding received from *beyondblue.,*
Jul-Oct 2002	Community visits undertaken as part of baseline evaluation
September 2002	AMHW meeting at TEDGP, Darwin
March 2003	Numbulwar enters Program
April 2003	Funding for additional communities received via *beyondblue,* from AERF
June 2003	Orientation for new AMHWs, Darwin
August 2003	Lajamanu leaves the Program
October 2003	AMHWs plan to begin in Oenpelli in early 2004
November 2003	TEDGP Training Workshop for AMHWs, Nhulunbuy
Jul-Dec 2003	Community visits and audit conducted for Mid-Term Evaluation Report by CDU
January 2004	Oenpelli unable to proceed with plans to enter the Program
March 2004	Mid-Term Evaluation Report circulated to stakeholders
May 2004	TEDGP Training Workshop, Nhulunbuy
October 2004	Draft Final Evaluation Report released

Agreements with communities

The TEDGP enters into contractual arrangements with community government councils and, in one case, a regional Health Board, as the organisations employing the AMHWs. Funds to cover salaries (including superannuation, insurance, holiday and sick pay etc.) are forwarded to these organisations quarterly upon receipt of an invoice and acquittal of funds for the previous quarter. The amount for one salary is $9,500 quarterly and funds are not to be used for other purposes as specified in the contract. In several communities this amount is split between two AMHWs and topped up with additional funding from CDEP.

Initially, a Quarterly Progress Report was required from employers and required the employing bodies to provide the following:

1. Statement of date, organisation and person compiling this report.
2. Description of service and a summary of activities since the AMHW position started.
3. Evaluation plans (to be developed for each AMHW position to assist with the collection of information to monitor the results of this program. Appropriate indicators were to be discussed and agreed upon at a workshop between AMHWs and the GPs involved in the Program in September 2001. Indicators were to be based upon the five parts of the overall goal – to improve the mental health status of Indigenous people living in remote communities – stated in the contract.
4. A list of agencies that the AMHW has liaised with, and the reason for collaboration.
5. A work plan for the next quarter.
6. Financial expenditure statement.

The majority of these requirements were eventually removed from the contract. The five indicators under the goals set out by the MAHS program were subsequently dropped from the requirements for community reporting.[3] Neither did they inform the reporting of the TEDGP to the Commonwealth. TEDGP reports that requirements for reporting to the Australian Government on the MAHS program against these indicators has not been required.

A generic job description was supplied to communities as a Supplement to the Contract. This was not intended to be prescriptive but as an outline of 'the scope of the tasks that may be undertaken by the AMHWs and 'to be used to inform another version' which each community was required to then forward to TEDGP.

Objectives and scope at commencement

The AMHW Program was designed and implemented across significantly diverse health service environments in diverse community demographic and political contexts. Management structures and approaches vary from community to community, as do the number of support services and resource levels. The minimal requirements for commencement allowed for flexibility to ensure that Program start-up could occur. However, this also meant that the Program has lacked firm benchmarks for development of the AMHW role across participating communities.

When the Program commenced in the communities of Angurugu, Galiwin'ku, Lajamanu and Borroloola under MAHS funding there was no Partnership Agreement. The Partnership Agreement was finalised in August 2002, a year into the Program (TEDGP 2002:3) and signed by TEDGP, BIITE, TEMHS and CDU. The Agreement set out areas for collaboration between these partner organisations while avoiding prescription of roles and responsibilities for each partner. It thus allowed for the same flexibility in responding to the diversity of community contexts, needs and capacities, while providing at least some indicative parameters for guiding

[3] Under the MAHS initiative, five *Required Outcomes* were specified by the Australian Government. These fall under the overall goal 'to improve the mental health status of Indigenous people living in remote communities'. 1: the Aboriginal Mental Health Worker is part of the remote health clinic team. 2: suitable ways to monitor changes to the mental health status of the people in the community as a result of the Aboriginal Mental Health Worker has been identified. 3: Suitable ways to record and report on service data has been identified. 4: Ongoing support, training and mentoring is available to Aboriginal Mental Health Workers in remote communities. 5: Record of EPC (Enhanced Primary Care) Care Plans and/or Case Conferences is maintained.

Program establishment and development. Yet this has also meant that the Agreement lacked clear objectives and timelines for achievement of objectives in clinical practice, training or other areas of collaboration.

In summary, the Program has five general objectives.

1. To develop the role of the Aboriginal Mental Health Worker as a member of a community-based mental health team in participating communities,
2. To provide ongoing support, training and mentoring to Aboriginal Mental Health Workers in remote communities,
3. To provide more effective mental health care practice through application of the local cultural knowledge and expertise of AMHWs working in conjunction with and in support of medical practitioners,
4. To improve the level and quality of mental health care services accessed by members of participating communities,
5. To form an effective partnership between contributing organisations in the delivery and support of mental health care services in remote Indigenous communities.

These objectives are a synthesis and interpretation of objectives set out variously in the Partnership Agreement, the submission for funding from the TEDGP to the MAHS program and the "Community Health Education Package" provided to participating health centres by the TEDGP.The Partnership Agreement is based on the following Vision (TEDGP 2002:3).

Table 3: Partnership Vision

- Vision -

- Aboriginal Mental Health Workers are the experts in Indigenous primary mental health care in remote communities. They are the key stakeholders in the delivery of culturally appropriate services to Indigenous people living in remote communities.

- Primary mental health care services in remote communities are delivered in the context of 'learning both ways'. This means that all parties recognise the essential knowledge held by AMHWs around culture, family and traditional ways of working in mental health, and will work to facilitate shared primary mental health care between AMHWs, GPs and the visiting mental health team in an environment of cross cultural learning.

- There are local Indigenous people in all remote communities across the top end of the Northern Territory who are engaged by the community as Aboriginal Mental Health Workers and supported to provide appropriate mental health care through training, education and integration with other health services.

- There is a sustainable model of mental health service delivery based on this vision.

The TEDGP's original submission to the Australian Government's MAHS program set out a number of goals to be achieved and indicators for measuring progress. These related primarily to establishment and implementation issues but were not translated into objectives and responsibilities set out in the Partnership Agreement. The submission's goals and requirements were:

1. Implementation plans are well prepared and operational,
2. Community contracts are in place,
3. Local qualified Indigenous Mental Health Workers are available to be placed in remote communities,
4. Suitable infrastructure is available to enable Indigenous Mental Health Workers to be placed in communities,
5. Indigenous Mental Health Workers are part of the remote health clinic teams, and
6. Ongoing support, training and mentoring is available to Indigenous Mental Health Workers in remote communities.

The "Community Mental Health Education Package" outlined a general objectives for the Program, provides extensive tips for GPs, identifies communication about mental health as a priority. It describes the strengths of the project and sets out priorities for building strong community mental health teams.

Strengths include:

1. That the Program is community-based and controlled,
2. Builds up local mental health teams and creates a working relationship between GPs and AMHWs,
3. Senior AMHWs advise the project,
4. The expertise and skills of local community members is recognized and supported through formal training and qualifications,
5. Partnerships are built in the area of mental health services across the Top End.

Priorities for a strong community team include:

1. AMHW leadership and decision making,
2. Aboriginal ownership of the team,
3. Decision making is informed by planning involving AMHWs, local Boards or Councils and other services with a planning role,
4. Cultural appropriateness of services and education of providers by AMHWs and community members,
5. Development of career structure training and support for AMHWs,
6. Development of data on mental health, consultations, activity,
7. Capacity to set objectives, and manage performance is to be developed.

The strategy adopted by the Evaluators of the Aboriginal Mental Health Worker Program, as set out in the following chapter, focused on investigation of the extent to which these objectives have been achieved.

Chapter 2. Evaluation: Aims and Methods

2.1 Aims of the Evaluation

A baseline evaluation study was carried out in 2002/3. Five communities were already participating in the Program at that time: Angurugu on Groote Eylandt; Kalano near Katherine; Lajamanu; Borroloola and Galiwin'ku on Elcho Island (Robinson et al. 2003). Since then the Program expanded to three additional communities: the Tiwi Islands (based in Nguiu), Oenpelli and Numbulwar. These communities were included in the draft mid-term report, circulated among stakeholders in March 2004. By July 2004, Oenpelli and Lajamanu had decided not to participate in the Program leaving a total of 6 participating communities: Angurugu, Nguiu, Borroloola, Kalano, Galiwin'ku and Numbulwar.

The baseline report examined establishment issues, resources available in communities, the priorities of the mental health care providers during 2002 and the experiences and views of the AMHWs working within the Program. Both baseline and mid-term reports focused on a number of issues which are re-examined in this report.

- **Practice objectives**
  The baseline study noted that the Program had committed itself to developing mental health care practices in the form of mental health care plans, assessment and review, involving AMHWs, GPs and DHCS practitioners. The report found that: "given the wide variations in infrastructure and processes within the participating communities, there are likely to be substantial difficulties with implementation of a common care plan process within the life of the current Program. However, further consultation between Program participants concerning adoption of a care plan-based approach concentrating on coordinating processes of assessment, follow-up and review is recommended." As foreshadowed in the baseline study, this report presents outcomes of an audit of files. This audit examines practices in participating centres including the involvement of AMHWs in record-keeping, assessment and planning as well as records of mental health assessment, planning and review as recorded by all practitioners in patient records.AMHW Program

- **Training**
  The Partnership Agreement indicates that training will be available to support the professional development of the AMHWs. AMHWs are able to enrol in the Certificate III in Community Mental Health (non-Clinical) at BITTE. After two AMHWs completed this course, a Certificate IV was developed by John Maher at BIITE .AMHW Program Other forms of training (through inservice arrangements, etc.) were foreshadowed in the Agreement.

- **Collaboration**
  As indicated the Partnership Agreement mapped out desirable forms of collaboration between partners without defining specific objectives. This report considers the need for further specification of Program objectives and responsibilities of participants, including community organisations, government providers and others in any future extension of the AMHW Program.

- **Sustainability**
  The sustainability of the Program depends in the first instance on secure future funding to support further development of resources, infrastructure and processes underpinning the

AMHW's role in community-based mental health practice. This includes the consolidation of resources and practices by Community Government Councils and health centres, as well as reaffirmation of commitments by the parties to the Partnership Agreement.

- **Outcomes**
  The baseline report noted that the area of Indigenous mental health is not characterised by a strong evidence base to inform either clinical mental health care or other relevant forms of culturally grounded psycho-social intervention. Future planning should proceed on the basis that further development of the Program beyond the current period would be greatly enhanced if it were conducted in conjunction with research into outcomes of intervention and practice. This might include trials of care plan methodologies and other interventions. In addition to intervention-level research, improvements to data entry and availability of systemic data should be considered an integral part of development of community mental health systems.

The mid-term report also re-examined the Partnership Agreement and the original Program design.

2.2 Approach and Methods

The main activities of the evaluation in 2003/04 included

- interviews with stakeholders;
- site visits to communities for the following purposes:
  - identification of community and health centre processes
  - audits of patients' files;
  - interviews with health centre staff, including AMHWs
  - interview with mental health clients
- extraction of health service data from hospital and other databases.

Evaluators have tried to ensure that the perspectives of all stakeholders are represented in the evaluation: mental health clients, mental health workers, other health centre staff including GPs, nurses, Aboriginal Health Workers and clinic managers, other support service providers in the community, council and health board members as well as secondary and tertiary care providers of mental health care and policy-makers. All have been consulted through a range of qualitative research practices, predominantly semi-structured interviews that have focused on participants' experiences since the baseline study. Most of these, including all interviews with AMHWs, have taken place in communities. Participatory Rural Appraisal methods (Chambers 1994) were also used in some communities with AMHWs.

In conjunction with audits of files, brief semi-structured interviews were undertaken with a limited number of clients, with consent, to establish the views of some users of mental health services. This was supplemented by participant observation of mental health work in the company of AMHWs. For these purposes, a small non-random sample of clients was selected with assistance of AMHWs. Written consents for interviews were obtained from clients in the company of AMHWs (Consent Forms are at Appendix III). The files of patients interviewed were audited as described below.

Audit of health centre records

The baseline report presented the outcome of a pilot audit of a small number of files in some communities. That audit revealed that mental health care plans are not in use, that formal diagnoses or assessments are not common, that there is likely to be an unknown level of non-recording of routine monitoring, although in some communities AMHWs had been recording follow-up consultations in patient records from 2001.

The audited subsequently conducted examined files of six persons in each community. Although comprising a small cohort, it was felt that this would sufficiently illustrate matters most relevant to the current developmental needs of the AMHW Program. Health centres servicing remote communities operate under a heterogeneous range of conditions, generally lacking resources and with varying levels of infrastructure and support. They also vary in specific arrangements for incorporation of AMHWs in health care activity.

The aims of the mid-term evaluation audit of client files can be summarised as follows:

- To examine record keeping practices and systems in regard to mental health care,
- To identify records indicating involvement of the AMHWs in delivery of services,
- To identify records indicating coordination between practitioners and referrals between practitioners and other related community services,
- To identify the frequency of mental health assessments undertaken and the practitioners undertaking any assessments,
- To examine records for evidence indicating that mental health care planning is being carried out: 1) to identify content of recorded planning activity; 2) to identify scheduled services including reviews of care and/or diagnosis; 3) to identify practitioners, providers, clients and family members involved in any care planning activity,
- To characterise communication and coordination between community mental health workers and between community mental health workers and other agencies as evidenced by record keeping practices and written protocols,
- To identify issues related to records of services that may indicate potential constraints on development of the role of the AMHWs as described in the Partnership Agreement.

Three audit instruments were developed (contained in Appendix III) for gathering data from each file. These record the following information:

1. Mental health services received in the last twelve months and recorded in primary health centre records,
2. Details of mental health assessments that have taken place during the last twelve months, the existence of a mental health care plan and diagnosis,
3. Mental health care plan details including dates, by whom, record of AMHW presence, evidence of client consulted, patient signature, treatment goals, services dues, provider and frequency, plans for review, evidence of case-conferencing and teleconferencing.

Further detail of audit methods is provided in Chapter 4.

The developmental objectives of the Program are to involve AMHWs in delivery of mental health care; to improve coordination of care between providers, and to move towards improved care planning (even in the absence of a standardized care plan). The audits seek to provide a snapshot of mental health practices during the life of the Program which can assist in identifying appropriate steps in this direction.

These aims are consistent with the Partnership Agreement between the Top End Division of General Practice, Top End Mental Health Services, Batchelor Institute of Indigenous Tertiary Education and Charles Darwin University.

Table 4: Practice Objectives in the Partnership Agreement

4.1 The TEDGP and the TEMHS agree to work together in a model of shared primary health mental health care encompassing:

- written or verbal pre/post briefings between the visiting mental health team, AMHWs and GPs to optimise client care;
- Development of team based case conferencing and care plans for each individual;
- Shared access to mutual client notes.

4.2 The parties recognise the unique role of the AMHW as the community's first point of contact to access primary health care services. As such:

- Whenever practical, the AMHW will be present for all assessments and follow up of mental health clients;
- Whenever practical, clients in the community will be assessed by the AMHW and then referred to the GP or visiting mental health team;
- Referrals wherever possible guided by the AMHW and the GP in the community.

4.5 The parties will collaborate to develop locally based written protocols where appropriate.

5.2 The [TEDGP and the Institute] will collaborate to provide appropriate orientation for AMHWs in their communities. This will include:

- The Institute to assist the TEDGP's AMHW Coordinator where-ever necessary to establish the use of the AMHW diary, assessment tools and other operational processes within the remote Health Centre.

The audits aim to draw attention both to record keeping practices, the degree to which recorded services reflect at least the clinical component of the AMHW role and, importantly, the degree to which AMHW activities may *not* be reflected in these records.

This investigation is intended to contribute to a discussion regarding the potential for developing shared guidelines or a common approach to effective record keeping, coordination of roles, and care planning amongst mental health service providers in participating communities. Improved data recording and a transparent record system can contribute to ongoing improvement of mental health care delivered in communities. It is also an important focus for AMHW training. It is strongly cautioned, however, that there may be limits to adoption of standardised approaches to record keeping as to any other aspect of clinical care. Diversity of culture, geography and resources across communities means that there is a need to be sensitive to the issues confronting clinicians at a local level when developing protocols for assessment, treatment and referral of mental health problems in primary care (Russell & Potter 2002).

Mental health data from hospital and CCIS records

The evaluation has undertaken an exploratory investigation of data obtained from hospital service records and the Community Care Information System (CCIS) for audited clients. The aims of examination of hospital records and records of consultations in CCIS are:

- To provide information on diagnoses and services utilised since the introduction of the mental health module into CCIS,
- To obtain health morbidity data from hospital; admission rates, length of stay, diagnoses, etc. from Cowdy Ward and other wards in RDH for patients from participating communities over the last six years.

Data from both hospital admissions records and CCIS were collected through the Corporate Information Services Section of the Northern Territory Department of Health and Community Services.

CCIS data are not extensive but include all entries for the populations investigated. The mental health module of the CCIS has only been in operation since 1998, and some categories of service have only been introduced in the last twelve months. The hospital admissions data (CARESYS) covers all admissions to RDH from communities investigated for six years (1998-2003). The hospital data and the CCIS data do not include information gathered by practitioners in private practice, in Aboriginal Medical Services or in other contexts. To that extent, while accurately reflecting hospital admissions and some related follow-up activity, neither the hospital data nor the CCIS data, accurately reflect even *recorded* morbidity.

Table 5: Evaluation Activity & Timelines, 2003

Event	Evaluation Team Members	Date
AMHW Orientation, TEDGP, Darwin	Charlie Ward	1-2 July 03
THB MH Staff Interview, Darwin	Gary Robinson, Charlie Ward	14 July 03
TEDGP AMHW Program Steering Group Meeting	Gary Robinson, Charlie Ward	17 July 03
Community Visit, Interviews and Audit, Nguiu	Gary Robinson, Charlie Ward	23-24, 29-30 July 27, Aug. 03
Visit and Interviews, BIITE	Charlie Ward	13 Aug. 03
TEDGP AMHWs teleconference	Gary Robinson, Charlie Ward	27 Aug. 03
Community Visit, Interviews and Audit, Angurugu	Amanda Harris, Charlie Ward	15- 19 Sept. 03
Community Visit, Interviews and Audit, Borroloola	Charlie Ward	6-10 Oct. 03
Community Visit, Interviews and Audit, Numbulwar	Charlie Ward	13-16 Oct. 03
Community Visit, Interviews and Audit, Galiwin'ku	Amanda Harris	21-24 Oct. 03
Meet TEDGP Staff, Darwin	Amanda Harris, Charlie Ward	31 Oct. 03
Meeting with Cheryl Furner, TEMHS.	Gary Robinson, Amanda Harris	3 Nov. 03
Interview Dr Hung Nguyen, ex KWHB	Amanda Harris, Charlie Ward	1 Dec. 03

Interview Sue Ellis, Oenpelli Clinic Manager	Amanda Harris, Charlie Ward	2 Dec. 03
Interview, Cowdy Ward AMHWs	Amanda Harris, Charlie Ward	3 Dec. 03
Community Visit, Interviews and Audit, Kalano	Amanda Harris, Charlie Ward	16-18 Dec. 03
Community Visit, Audit, Nguiu	Charlie Ward	19 Dec. 03
Interview John Maher, BIITE	Amanda Harris	19 Dec. 03
TEDGP AMHW training inservice	Charlie Ward	22-23 Jan. 04
TEDGP AMHW/GP Training Workshop, Gove	Amanda Harris	28 May 04

To date no rigorous surveys of the incidence and prevalence of psychiatric morbidity in Indigenous populations have been undertaken in the Northern Territory (Robinson 2002:24), and the data from hospitals, CCIS and community file audits presented here must be interpreted with caution. Combined however, they help create a picture of mental health service provision and mental health disorders in the participating communities which may serve as base-line information for future investigation.

Chapter 3. AMHWs and Community Mental Health Care

3.1 Introduction

This chapter begins with an overview of the AMHW Program in participating communities and summarizes key issues in the success or failure of the implementation of the Program in each site. It then briefly examines practitioners' views of the mental health problems they encounter, highlighting both the significant burden of chronic mental illness and an apparent escalation of youth problems related to marijuana use in addition to established patterns of alcohol misuse and domestic violence. It reviews basic arrangements for AMHWs, their roles in the community health centres and their links with other primarily community-based service providers.

Brief vignettes illustrate some of the work performed by the AMHWs in two communities. These are intended to illustrate some of the needs met by AMHWs and the mental health teams. They were gathered under varied circumstances, so that the material does not represent the full spectrum of work done in all communities. However, a number of these brief case descriptions give a sense of the AMHW's importance in delivery of care, and contextualize some of the uncertainties of practitioners concerning the relationship between the AMHWs' clinical and non-clinical work.

3.2 Program Implementation: Recruitment and retention

The AMHW Program has been established in six participating communities: Angurugu, Galiwin'ku, Numbulwar, Nguiu, Borroloola and Kalano. Oenpelli and Gapuwiyak have been unable to proceed with plans to participate. The chief problem in these locations has been difficulty in recruiting and retaining AMHWs. Lajamanu has been unable to function, and its participation has been reconsidered. The regional Health Care Provider for Lajamanu, Katherine West Health Board, was not the applicant for funding under the Program, and has not yet committed itself to a mental health strategy for the region. Funding to Kalano is currently on hold while a change in management is being finalised.

The Top End Division of General Practice is the manager of the Program, and provides funding to successful applicants for the employment of AMHWs in health services in which there is a resident General Practitioner. With two exceptions, in which the employer has been a local health service, the employers of the AMHWs are Community Government Councils.

In all, ten AMHWs are employed under the Program, (with recruitment under way at Galiwin'ku after the departure of the first AMHW). This is a considerable achievement, against startup difficulties commonly encountered. As indicated in the table, the recruitment and retention of AMHWs to the Program is not a straightforward matter. There have been a number of departures and a number of instances in which the arrangements to recruit and support AMHWs to work in the communities could not be established or maintained. Reasons for the breakdown of arrangements may involve uncertainty of commitment on the aprt of the individual AMHW, perceptions of a lack of support in the health centre, perceptions of a lack of community support, difficulties integrating and supporting the AMHW in the context of

demands of general primary health care, and so on. Some of these reasons are discussed below.

Table 6: Aboriginal Mental Health Worker Program and mental health services in participating communities

Community	***Population***	***Period of participation***	***Current AMHWs***	***Doctors***	***Mental Health Nurses***	***Visiting***
Angurugu, Groote Eylandt	754	Nov 2001 - ongoing	Muriel Jaragba Leonard Amugala	1 GP	-	EAMHT **5/6 weeks**
Galiwin'ku, Elcho Island	2,200 incl. outstations	Oct 2001 - ongoing	Recruitment of new AMHWs underway	1 GP	1	EAMHT **5/6 weeks**
Kalano	1989 incl. Katherine/ Rockhole	Feb 2002 – ongoing (temporarily suspended)	Robert Broom	2 GPs	-	KMHT 6/7 weeks
Borroloola	751	Oct 2001 – ongoing	Warren Timothy Jillian Friday	1 GP	-	KMHT **6/7 weeks**
Numbulwar	721	May 2003 - ongoing	Clinton Ngalmi	1 GP	1	EAMHT 5/6 weeks
Nguiu, Tiwi Islands	2,110 incl. four communities	mid 2003 - ongoing	Fabian Kantilla John Tiparui Anna Apuatimi Boniface Alimankinni	2 GPs & DMO visits	1	
Lajamanu	811	Dec 2001 – Aug 2003	No longer participating	1 GP	-	-
Oenpelli	754	Unable to participate	-	1 GP	-	DRMHT **5/6 weeks**
Gapuwiyak	1,000	Unable to participate	-	1 GP	-	EAMHT **5/6 weeks**

At Galiwin'ku, on Elcho Island, Judy Djanumbi had been employed as an AMHW from the inception of the Program in 2001. A second female AMHW, Guymun, was employed from late 2003. Both resigned in 2004. According to TEDGP the resignations concerned family commitments, although erratic attendance and performance of the AMHW had been noted as a problem for some time. Djanumbi had also expressed concerns about her pay and conditions and about lack of support on a number of occasions. Concern was expressed about the lack of general managerial support of and commitment to the AMHW in the health centre. Some aspects of the community activity of the AMHW did not appear to be highly valued by medical staff and managers. Later there had been a need to negotiate role changes with the appointment of a mental health nurse to the health centre, possibly leading to new demands on the AMHWs.

The themes encountered at Galiwin'ku are not uncommon – with variations, they attend the recruitment and retention of AMHWs in most communities. Startup difficulties, indeed failures, in other communities also relate to recruitment of appropriate personnel, adequacy of resources or supports and the degree of commitment of local organisations and healthc entre management. At Oenpelli, despite extensive attempts over 6 months in 2003 to establish the

Program, a husband and wife team due to commence early in 2004 withdrew due to family illnesses. The community felt that it would not be possible to find suitable alternative candidates at that time. Note that the mental health manager had earlier felt that mental health issues were a serious and worsening crisis for the community. It is possible that the community itself is unable to mobilize around mental health related issues and to give support to the establishment of the AMHW Program.

Dr Hung Nguyen similarly found a lack of concern with and ability to mobilize around mental health issues at Lajamanu. However, at Lajamanu, the health service was not strongly committed to the AMHW Program, which had been entered into by the Lajamanu LCGC. The inability to recruit suitable personnel appears to have been exacerbated by these uncertainties of commitment and support.

At Gapuwiyak, substantial efforts to implement the Program were unsuccessful due to a number of factors: no applicants came forward despite advertising widely in the community; there were staff changes in the local community government council and loss of contracts for personnel; clinic staff considered that they did not have the resources to properly monitor and train new mental health workers, given current commitments.

The level of available resources and capacity varies considerably across the communities, including both numbers of AMHWs and availability of resident GPs. Some teams need to service a number of communities and outstations, while others are largely restricted to one community of operation. In some contexts, there are a number of language groups resident, complicating the field of operation for the AMHW and mental health team generally and/or posing particular demands on the qualities, the standing, and the skills of the AMHW. As outlined, below, Borroloola provides one of the clearest examples of these issues. Borroloola is home to a number of Indigenous language groups, who predominantly reside in separate "camps" or suburbs. It is striking that Warren Timothy has sufficient standing in the community work with members of all groups, and, as described below, at times to mediate between them when their members are in conflict. He has continued in his role, despite considerable instability in the level of institutional support for him. This is an indication that exceptional individual qualities may account for a great deal in terms of the sustainability of the Program.

The evaluation has concluded that the successful establishment of the Program in specific locations depends on at least two sets of factors:

1. the level of institutional support for the AMHWs and commitment to the Program by agencies (Councils, Health Centres) and to some extent by the community itself; this support also needs to be direct and personal, in the sense that some key personnel (GP, Health Centre Manager, others) need to be committed to working with and supporting the AMHWs,
2. the recruitment of appropriate personnel, that is, persons of sufficient standing that give confidence to others regarding the integrity of their work, and who have the confidence to establish themselves in their role.

3.3 Key Mental Health Problems

This study does not aim to establish the incidence of particular problems with epidemiological accuracy or to identify trends in mental health outcomes in the communities. Changing diagnostic practices of practitioners, cultural acceptance of mental illness as a legitimate problem, changed patterns of conflict and conflict resolution which have illness and the sick role as an outcome, all influence the recorded incidence of problems. This section reports the perceptions of mental health problems encountered by health centre practitioners, as a means of highlighting perceived priorities for mental health care in the communities.

In all communities, the health centres report a number of clients diagnosed as having a chronic mental illness monitored and in receipt of regular medications. These are most frequently cases of psychosis related to substance misuse, but include depression and other disorders. The mental health teams also confront a high incidence of self-harmful behaviours, suicide and family violence, alcohol and drug misuse, including petrol sniffing and marijuana or "ganja" smoking.

There is an ambiguity about some of the problems encountered which is a source of subtle controversy in the views of practitioners in the AMHW Program. To what extent are these the problems of societies in transition or problems of disordered or stressed relationships, rather than indices of mental illness per se? Correspondingly, to what extent should the emphasis be on a clinical response rather than on community development, promotion of healthy relationships and lifestyles, improved education, family support, and childcare? At the level of government policy, there may be a lack of confidence that increased spending on mental health care is the most appropriate long term response, even though the crisis-demands on the health centres for a medical response continue to grow. The non-Indigenous practitioners interviewed in the health centres were somewhat divided about these issues, with implications for the way they viewed the significance of the AMHWs' contribution to mental health care.

The Mental Health Nurse at **Nalkanbuy Health Centre** in **Galiwin'ku** reports that the mental health problems most frequently seen by the health centre are schizophrenia and psychosis rather than depression, in contrast to trends in predominantly non-Aboriginal southern Australia. Health centre staff suggest that a significant amount of the psychosis and some schizophrenia seen is *ganja*-induced, usually among younger people. However, these individuals comprise only a small proportion of the youth on the island. Nevertheless, they state that the biggest youth problems are *ganja* use and petrol sniffing; the latter is said to vary with availability of fuel. Problems associated with kava drinking exist but are said to be less common that *ganja* and petrol sniffing problems. The island is on 'high alert' on occasions such as a funeral that draw many young people back to the island from the mainland. In contrast to substance use related problems, most of the people in the community with chronic schizophrenia are in their 40s and 50s and have been long term sufferers.

According to the mental health nurse, in the six months preceding the evaluation audit, the health centre had only seen one case of intentional self-harm: this was related to a domestic issue and involved superficial cutting of the forearms. The community has had no suicides for two years with only one attempted suicide by hanging and a small number of ineffective drug overdoses. This is reported to be the longest period suicide free for the community for over a decade. Prior to this there had reportedly been one suicide every 12-18 months since 1991.

There has also been only one case in the last six months of someone drunk in the community. As a “dry” community, people generally come back to Galiwin’ku to “dry out. RDH liaises with the health centre regularly in order to get some of their chronically ill patients back there. The nurse reports that depression is not often seen. The degree to which this represents a lack of recognition of depression in this cultural context is unclear.

At the time of the audits, 24 clients were in receipt of psychotropic medications, 10 females and 14 males, according to the health center-generated spreadsheet. (The list included one recently deceased client and two clients who had recently ceased medication.) The AMHW, Djanumbi, had about 17 clients on her list the year before, and reported that there had not been a lot of change since then. Most of the clients she saw received medications; they included some cases of short-term *ganja* induced psychosis.

The GP at **Angurugu Health Centre** reported that psychosis and depression remain the main mental health problems being treated by the clinic with no obvious change over the previous year. She estimated that about 20% of clients present with depression or psychosis and another 10% ‘present with physical problems but there is really stuff happening at home that’s causing the problems’. This represented a change since she began in the position about ten years ago when, she said, most of the mental health clients were schizophrenics. There were also an increasing number of younger people presenting with mental health disorders that she attributed to increased *ganja* use, unemployment and general lack of direction. *Ganja* misuse appeared to be associated with an increase in the number of psychosis cases. The AMHWs in Angurugu report the same trend towards increasing *ganja* use, particularly among younger people, which they say is overtaking problems associated with petrol sniffing and alcohol misuse. The AMHWs have also observed a decrease in overt violence and fewer public displays of threatening behaviour (such as wielding machetes).

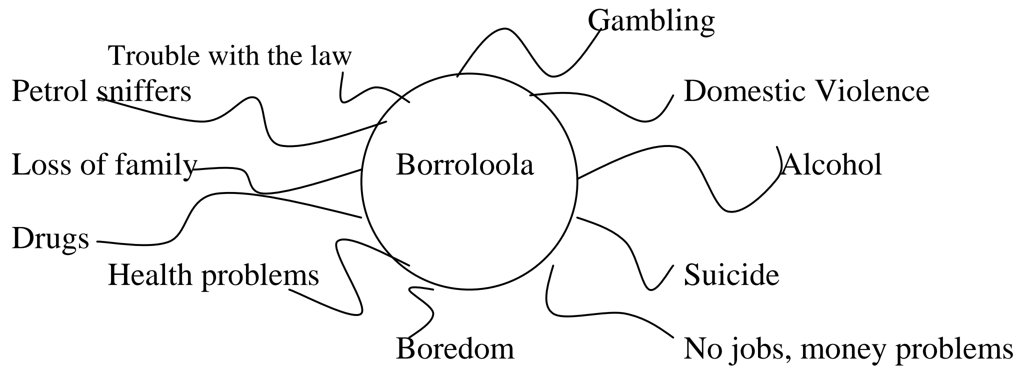
The AMHWs and other service providers in the community maintain that the community has changed significantly over recent years in terms of demographics, poorer employment prospects, a decrease in the standard of education available, lower literacy levels, fewer community activities and substantial cultural change. They also report increasing boredom, stress and depression, particularly among younger people.

On the **Tiwi Islands,** mental health workers report a very high rate of completed suicides and frequent acts of self harm. The suicide rate appears to be significantly higher than other Program communities. A considerable amount of effort on the part of the community mental health team is devoted to responses to crises of this kind. In 1999 the Tiwi Health Board sought to opportunities by installing steel guards to stop young people climbing power poles to attempt suicide by electrocution, which had resulted in numerous emergency evacuations. However, most completed suicides have been a result of hanging.

The Tiwi health centres cope with a high frequency of incidents associated with alcohol abuse, and, increasingly with outcomes of high levels of *ganja* use among people from 10-12 years to young adulthood. Clients with psychosis are managed by the health centre staff and the mental health team. In addition, practitioners suggest that there exists a significant burden of depression and related conditions among both older and younger Tiwi. This is less well recognized and often remains untreated in part due to the preoccupation with acute crisis care.

At the time of the baseline audit, the AMHWs who have been working in association with the **Borroloola Surgery** identified the factors that impact on mental health in the above diagram. In 2004, Warren Timothy commented that sniffing and suicide had in the preceding year fallen somewhat. However, youth boredom and ongoing alcohol related problems were more of a problem than ever, especially in adults. According to Warren this was associated with domestic violence and failure to look after children. Problems with different drugs such as *ganja* and petrol sniffing seem to come and go with availability.

Figure 1: Factors Impacting on Mental Health at Borroloola



> 'Domestic violence, depression, low esteem. They don't feel good about themselves. That's the main problem you see . . . in this town they drink. In this place, the problem now is drinking and smoking, they have domestic, they have arguments with their family of their wife, or mother or father over money, and these things can lead up to bigger problems, to maybe suicide' (Warren Timothy, October 2003).

Attempts to determine with any accuracy the number of mental health clients and the range of mental health disorders utilising Borroloola health services was hampered by the fragmentation of health services in the community and the recent closure of the Borroloola Surgery. KMHS have not been to Borroloola since June 2003 due to staff shortages, and are unable to report on the profile of mental health clients.

At the time of the evaluation audits, the AMHWs were monitoring around 10 clients**.** For the six Borroloola clients whose files were examined there was a range of physical and social problems related to long-term substance misuse, such as liver damage and and injuries caused by alcohol-related accidents and violence, depression and suicidal ideation. One client had no history of significant substance abuse; her presenting problems arose as a result of physical, sexual and emotional violence at the hands of other community members with alcohol-related behavioural problems. Psychoses, including schizophrenia, were not found in the sample. All of the files audited except one belong to 'past' clients of Warren's. These are clients who entered a period of acute symptomatology between one and three years ago.

At **Numbulwar** there appears to be a general consensus, including the view of the Health Council, that the most pressing mental health issue is *ganja* use by young people. Petrol sniffing has ceased at the present time in Numbulwar, and many former sniffers are using *ganja* as their drug of choice. The AMHWs, Samuel Ngalmi and Mary Wurramurra make the

point that the people who use *ganja* have in the past used aspirin and even Vicks chest rub to 'hypnotise' themselves when *ganja* isn't available. Community practitioners and residents concur that it is not the availability of *ganja* per se which fuels the current rate of substance misuse, but possibly wider issues of boredom and lack of opportunity (McMullen et al. 2003). It is not unusual, they say, for *ganja* smoking to trigger delusional and psychotic episodes and cause conflicts over money and scarce resources within families.

Threatened suicide occurs on a regular basis, though there have been no completed suicides in the year preceding the audit. It is noted by the AMHWs that the situation in the town has 'steadied down' compared to that of two or three years ago. They maintain that there are less fights, assaults, suicides, instances of property damage and evacuations than there used to be. Possible reasons for this perceived decline were not given. Like Lajamanu and Galiwin'ku, Numbulwar is a 'dry' community, whose facilities for recreational or vocational use by the young population are limited to a rough football ground, basketball courts, a CDEP program, and a weekly dancing session.

At the time of the audit and the evaluator's visit, several months after the community's inclusion in the Program, there were 24 clients receiving psychiatric medication, a figure close to that at Galiwin'ku health centre. Twelve of these clients had been identified by an RN as receiving 'chronic' medication, or fortnightly injections of *Zuclopenthixol Decoanate*. Ten of these twelve are male, and two female. The remaining twelve clients also receive medications, mostly anti-depressants.

Mental health in **Kalano**, according to health workers, is particularly under-serviced, with the result that it is difficult to know the nature and prevalence of mental health problems and illnesses. Although, according to KMHS, 'mental health, drugs and alcohol are the three main priorities that the community members are expressing', it seems that relatively few people present with mental health problems. Over the last year *Wurli Wurlinjang Health Service* in Katherine has seen only a few mental health clients. This may in part represent a tendency to recognize alcohol problems over mental health problems on the part of practitioners and service providers.

Lajamanu is no longer participating in the Program. The last AMHW, Jenny Johnson, was employed by the KWHB to work out of the Lajamanu Health Centre. She left her position in August 2003. A new resident GP commenced at Lajamanu in mid 2003, and has not engaged with the Program. The current clinic manager reports very few mental health clients on the health centre files. By the time Jenny left she was actively monitoring only three to four patients.

This overview of mental health problems derives from the former GP at the community, Dr Hung Nguyen, who left Lajamanu in August 2003 after two years in the position. According to Dr Hung mental health is not recognised by the community as a problem:

> 'the community is absolutely aware of chronic disease and other issues, childhood and maternal health and all that stuff, they're acutely aware of those so they're holding those as a bigger priority than mental health.'

Contributing to the invisibility of mental health in the community, says Dr Hung, is the form it most commonly takes - depression - in contrast to other parts of the Top End where psychosis appears to predominate:

> ‘the community can say “yes, there’s a lot of alcohol” but they’re not saying its mental health or there’s a lot of depression. They’re not saying there’s a lot of anxiety disorders, they’re only saying there’s a lot of alcohol here. Marijuana is starting to increase, and that’s it.’

In the GP’s experience, there is also more violence in Lajamanu than elsewhere in the Top End, but this causes less concern to people than overt psychosis. Health care staff are not faced with the need to sedate and evacuate mentally ill patients to Darwin. He says that as a result of the lack of a sense of need to do something about mental illness in the community, attempts to recruit someone as an AMHW who understands mental health or who would be interested in working in the area is difficult. It also means that an approach to mental health care on an individual level is unlikely to succeed. The GP explains:

> ‘mental health is a problem and we [the GP and Jenny] both agreed we had to approach [mental health care] at a public health promotion level, basically increasing awareness of mental health. In terms of community awareness that’s what we were wanting to focus on, for people to understand what it was all about. Compare Lajamanu to Numbulwar. Numbulwar is highly aware of mental health because the health issue is related to psychotic episodes and very obvious stuff whereas in Lajamanu its all depression, all hidden.’

The low rates of identification of mental health problems in Lajamanu appear to be the result of two key factors, lack of health promotion activity that would raise awareness, reduce stigmatisation and increase community mental health literacy, and poor recognition of problems by health centre staff pointing to the absence of training in mental health available to primary care providers. The Medical Director of KWHB indicated an interest in undertaking a mental health needs assessment in the region as a basis for developing an approach to mental health care for all eight communities serviced by the Board, including Lajamanu. This will now occur independently of participation in the AMHW Program, which has ceased.

Despite apparent need and substantial attempts to commence the Program in Oenpelli by early 2004, efforts were, as reported, unsuccessful. Contributing factors include growing family commitments of the AMHWs and changes in council staff. According to the manager of the **Oenpelli Health Centre**, mental health is one of the leading health crises in the community yet psychiatric patients rarely present at the health center. The resources of the health centre are stretched. This has meant that the focus on managing acute conditions has been at the cost of being able to deal with more chronic mental health issues or with prevention. She predicts that, ‘mental health issues are going to grow; you have an enormous number of young kids coming through with parents that have an enormous amount of substance abuse and you have to be a pretty strong kid to break the cycle.’ She suggests that this ‘cycle’ is related in particular to poor standards of Indigenous education.

Summary

There are both differences and common themes among the mental health problems reported by practitioners at the health centres in the AMHW Program. There is a predominance of concern

about substance misuse, in particular marijuana use among young people, and a clear identification of wider problems of boredom, unemployment, lack of educational progress, perhaps with a generalized theme of cultural modernity affecting youth. Confirming practitioner reports, Clough et al. (2002:395) report rising cannabis use in N.E. Arnhem Land and evidence of expanding supply links. Suicide is a serious problem in a number of communities and, as on the Tiwi Islands, occurs among young people at a rate many times the Australian national rates.

Against this, there are apparent variations in problems identified: there appears to be a difference in recognition of and capacity to diagnose depression, and, following Dr Hung's comments, differences in community readiness to accept this as a mental health matter amenable to medical assistance. There appear to be some differences between communities in the kinds of acute care required, and among these, of the prevalence of substance misuse-related psychoses. The latter is likely to be lower in the "dry" communities, while marijuana use cuts across all, with some variation due to access. There may well be some ambiguity in the trend towards diagnosis of psychosis related to marijuana misuse. Just as communities vary in their recognition of mental illness or readiness to interpret serious difficulty in terms of mental health, so health service providers vary in the degree of recognition of mental illness among the problems confronted by them.

The comments from all communities suggest that in addition to chronic recurring mental illnesses, many substantial problems should be regarded less as matters for clinical treatment than as matters for psycho-social intervention to promote community wellbeing. The question that remains is whether or how this activity might be supported in conjunction with development of clinical roles for AMHWs.

3.4 AMHW Program Service Arrangements and Supports

This section describes the specific arrangements for the Aboriginal Mental Health Workers funded by the current Program as at July 2004; it also sketches the ways that AMHWs are able to work with other community organisations. Changes in communities during 2003 and 2004 include movements of health staff and, as reported above, turnover of AMHWs in several communities.

Galiwin'ku

The mental health services available through the Nalkanbuy Health Centre in Galiwin'ku, Elcho Island expanded during 2003. Judy Djanumbi was joined by two additional Aboriginal Mental Health Workers, Elaine Guymun, and Len Burarrapuy. Guymun commenced in her position in September 2003 and was described by health centre staff as 'a philosopher with plenty of ideas', 'a very strong, motivated person with a holistic vision' and a strong interest in translating into practice a 'Yolgnu driven approach to wellbeing'. While they worked closely with Djanumbi, Guymun and Len were not employed under the TEDGP Program. They were employed by the clinic and received a combination of CDEP and health centre funds.

As a reliable senior woman Guymun was a valuable support to Djanumbi. Djanumbi's background as a former Aboriginal Health Worker and her interest in bridging western based psychology and Indigenous knowledge had the potential to combine well with Guymun's

cultural knowledge. Djanumbi explains: 'Guymun has the cultural knowledge, she explains it to me, and then I use that to help fit in the western with the cultural.' The health centre GP at the time, David Peris, saw potential in Guymun's position, with the possibility of strengthening her clinical role and nurturing her already strong vision for mental health care.

Len had been in his position for some months more than Guymun but family problems have kept him away from the job for much of that time. He had only recommenced his role as an AMHW in the month prior to the evaluator's main visit in late 2003. Len's role was primarily to pick up patients who needed medications. There is a clear need for a male AMHW with clinical skills who is able to communicate well with both Indigenous and *balanda* people. Djanumbi completed her Certificate III in Community Services (mental health non-clinical) at BIITE, while Guymun had commenced the same course.

Judy Djanumbi's position was administered through the Galiwin'ku Community Council. However, she resigned from her position as the AMHW under the TEDGP Program in early 2004. The other two AMHWs resigned soon thereafter. After two years in the position, having commenced in October 2001, Djanumbi felt that her skills had increased over that period: 'the longer you stay on the job the better you understand mental illness and people and the more you can help.'

In mid 2003, an RN with psychiatric training commenced at the Ngalkanbuy Health Centre making Galiwin'ku and Numbulwar the only two communities participating in the Program with a health care provider with psychiatric training based in the community. The MHN at Galiwin'ku initially was responsible for general men's health and sexual health as well as mental health. This has taken up some of the load off the GP who was then more able to focus on chronic diseases such as diabetes and kidney disease. Despite the breadth of his responsibilities, the new RN had been able to work closely with the AMHWs in formalizing systems to monitor and track clients receiving medications and assisting with the integration of the AMHWs into the health centre. He was also able to deal with some of the male clients that Djanumbi and Guymun are not able to see. The improvements in monitoring and review of clients were achieved largely by the new MHN. Unfortunately, this achievement was offset by the resignation of the AMHWs.

By mid 2003 the AMHWs had secured office space with computers located next door to the MHN at the healthc entre. Although its location on a busy corner of a health centre building meant it was not ideal for quiet and confidential consultations, or as a place for people to sit while waiting to receive their medications, the AMHWs preferred to be located in the health centre rather than away from it.

The AMHWs worked only around Galiwin'ku community. The Marthakal Homelands Resource Centre provides homeland health care. Marthakal staff bring patients to the NalkanbuyHealth Centre or contact its staff for advice on a patient – this has not yet occurred specifically for mental health clients. The GP sometimes visits distant homelands but to date has not been accompanied by an AMHW. In summary, mental health services to the homeland communities are minimal, and demand apparently low.

Elcho Island has no ASIST (Suicide Prevention) Program. A drug and alcohol worker visits every few months from Gove District Hospital. In 2004, a drug and alcohol worker was in the about commence program delivery. At the time of writing, clients with alcohol problems were

referred to Gove. There are few community-based programs which can provide assistance to the AMHWs to support or give structure to a health promotional role, the acquisition of counselling or other skills, and so on.

Borroloola

In early 2004, Rachel McDinny was replaced by Jillian Friday as the AMHW to work alongside Warren Timothy. Rachel McDinny had taken the position previously held by Kathy Roberts at the time of the baseline evaluation report. Health services, including mental health services in Borroloola are currently undergoing substantial change. A regional coordinated health service named Gulf Health Service (GHS) is being established under PHCAP. GHS will service the entire population of the region extending from the Stuart Highway to the Queensland border (see Appendix II). It is intended that GHS will employ a number of AHWs and AMHWs to administer programs in chronic disease outreach, mental health, nutrition and substance "abuse", as well as a Program Manager with nursing experience in a support role. Warren and Jillian are working from temporary housing at Gulf Health Services.

For the past ten years there has been both a DHCS run clinic and a private GP surgery in the town. The GP, Dr Peter Fitzpatrick, initiated the entry of Borroloola into the AMHW Program. The AMHWs were working out of Dr Fitzpatrick's surgery, until its recent closure in July 2003 with his departure. These two health centres were located in separate buildings, approximately one kilometre apart. At the time of writing the GP is visiting the town and seeing patients on a fortnightly basis. A new resident GP has been employed by *Wurli Wurlinjang* to service the region. This GP is currently working from the DHCS clinic. The GP practice may be integrated into the GHS establishment when a building becomes available.

There has been a longstanding agreement that the GP surgery deals with chronic conditions and the DHCS clinic deals with acute problems. This arrangement essentially reflected the fact of the existence of a private GP practice at Borroloola, and is not likely to be retained with the formation of GHS. GHS will administer a range of programs to cover chronic health problems. At the time of writing it is unknown how relations been the GP practice and GHS will develop.

Both Jillian's and Warrens' positions are administered through the *Mabunji Resource Association* (which is affiliated with the town council). Both AMHWs have a driver's licence and have access to a GHS troop carrier, provided by a local business. Mabunji Resource Association makes a second vehicle available to the AMHWs.

Numbulwar

In early 2003 the Numbulwar Nurumbindi council received funding for a community-based AMHW position. Two AMHWs were employed in May of that year, Samuel Ngalmi and Mary Wurramurra, a husband and wife team who were well-respected in their community. Both AMHWs were well experienced in community work, having been performing many of the duties of their current role in an unofficial capacity for many years. Samuel is a senior man who is active on behalf of his community as a local council member and as a Northern Land Council representative. However ongoing commitments elsewhere in the community have impinged on their ability to devote adequate time to their positions as AMHWs. In early 2004

a mutually agreed decision was reached between themselves and the clinic that they would not continue. The couple has been replaced by Clinton Ngalmi.

Community-based mental health expertise has improved substantially at Numbulwar in the last twelve months with the work of Sue McMullen at the clinic. Sue McMullen has a degree in psychology and is an experienced mental health nurse. She treats mental health clients and chronic disease patients at the health centre and by all accounts has played a significant role in supporting the Program's successful integration with health services in Numbulwar. As noted elsewhere, there had not been a GP resident in Numbulwar for several months preceding the evaluator's visit. In the absence of a GP, Sue's employment on a one-year contract has been fortuitous.

Sue is recognised by community members as having mental health expertise and is often a first point of contact for the family members of someone experiencing a social, emotional or psychiatric crisis. On such occasions she is often the only service provider to intervene, spending up to 36 hours with a client and their family until the air evacuation service arrives.

Despite substantial efforts by Sue to integrate the services provided by the clinic with the work of Samuel and Mary continued absences by the AMHWs undermined any hope of success. However, both Clinton and Sue are keen to develop Clinton's role as the new AMHW. Clinton's work will include regular communication regarding mental health case management with other health workers and recording client visits/consultations directly into primary client files.

Sue has also taken a special interest in the medication uptake of chronic mental health clients. Soon after arriving in the clinic she consulted the EAMHS team to identify non-compliant patients. Accompanied by Samuel and Mary, newly inducted in their roles, Sue consulted the clients identified by EAMHS. Several of them agreed to trial the medication and self-presented at the clinic for their next doses.

Due to its small size and isolation, Numbulwar lacks even the low levels of access to services enjoyed by some other communities, in terms of both externally provided services and local programs. Numbulwar doesn't receive any life promotion, anti-suicide, men's health or young people's mental health services, training or initiatives. Although there are many people in Numbulwar living with the issues raised by THC dependence, rehabilitation services are not accessed by Numbulwar people. A child welfare worker and a respite worker are based in Numbulwar, while an alcohol and other drugs worker based in Gove visits the community. At the time of writing this position had been only recently filled. The services received to date were described by clinic staff as inconsequential.

Angurugu

Muriel Jaragba and her husband Leonard Amagula continue in their positions as AMHWs working from the Angurugu Health Centre. Dorothea Lalara and Mark Wurramara moved to Groote Eylandt from Numbulwar Health Centre to work as trainees under the guidance of Muriel and Leonard in late 2003, but have since decided not to continue. TEDGP ARF funds support two A&OD positions in the community from early 2004, and although not part of the AMHW Program, these personnel complement the work of Muriel and Leonard.

By the end of 2003, the AMHWs at Angurugu had their own office space conveniently located in the health centre building but with enough separation from the clinic to provide mental health clients with privacy and a place to talk. The room is the outcome of the efforts of the health centre manager, Jenny Langrill, who is strongly committed to supporting the mental health workers and the AMHW Program. The advent of their own office has contributed significantly to the AMHWs sense of professional identity and is an appropriate mirror of the AMHWs own commitment to their work. The AMHWs continue to see clients outside under a tree at the back of the health centre or in people's homes or the community. The health centre has plans to eventually improve the outdoor consultation area in terms of greater privacy and comfort.

Muriel and Leonard continue to expand the work they do and the areas of the community they work in. Their area of operation is not limited to Angurugu, as both attend to clients in Umbakumba and on Bickerton Island, usually travelling in the company of the GP.

Both AMHWs successfully completed the BIITE Certificate III in Community Mental Health in 2003. In recognition of these qualifications both have received a pay rise as arranged between TEDGP and the Angurugu Community Government Council who administer their positions. Both Muriel and Leonard would like to continue their studies and enrol in the Certificate IV at BIITE. Eventually Muriel intends to enrol in a Master's degree to strengthen her understanding of western psychiatry and mental health care. In the meantime, she is working on a dictionary of Anandilyakwa and western mental health terminology.

Other organisations or fora that support mental health care around Angurugu include the Substance Misuse Program run by Michele Clark; Sport and Recreation; Youth Development Forum meetings; a monthly Youth Diversionary Scheme; the Aged Care Facility; the local police, schools, Town Council and Land Council and the visiting Domestic Violence Officer from DHCS in Gove.

Nguiu, Tiwi Islands

The Tiwi Aboriginal Mental Health Workers are based at the Julanimawu Health Centre in Nguiu, Bathurst Island, and at the time of the evaluation visits and audits, were managed by the Tiwi Health Board which had been established in the context of a Coordinated Care Trial (CCT) on the Islands from 1997-2001. In 2003, the Tiwi Health Board was replaced by the "Tiwi Islands Health Service" (TIHS), run by NT DHCS as a semi-autonomous division. The TEDGP AMHW Program provided funding for one AMHW position that was directed by the THB into the pool of funds for the existing mental health team, which already included four AMHW positions overseen by a mental health nurse.

At the time of the evaluation visits the team included five AMHWs: John Tiparui, Nelson Mungatopi, Boniface 'Tiger' Alimankinni, Jane Puatjimmi and Cynthia Portaminni. John and Nelson were supervisors of the team and Cynthia a trainee. By July 2004, Jane had resigned and Anacleta Apuatimi and Fabian Kantilla had commenced as new AMHWs. Together this group comprises *Ngawuniwani*, the Tiwi Mental Health Team (MHT). It is the largest Indigenous community-based mental health team working in the Top End. The AMHWs work with Glenn Norris, an experienced non-Indigenous psychiatric nurse. Glenn is employed by TIHS as the mental health coordinator. Based in Darwin, he makes regular trips to the Islands in addition to conducting follow-up and liaison work in Darwin.

The AMHWs have an office with a telephone, fax and computer, located not far from the Julanimawu Health Centre in Nguiu. The building is one of several old buildings that were given by the Catholic Mission to the Nguiu Council and in turn to the Tiwi Land Council. The construction of a new Julanimawu Health Centre in Nguiu includes space for the mental health team. Most client consultations by the MHT occur in the community or, if other service providers are involved, at the health centre. The team has access to a TIHS vehicle. Competing demands for use of the vehicle by health centre staff leaves the team often without transport, occasionally having to respond to critical incidents on foot. Often such incidents occur after hours and the work tends to fall to the team members with home telephones.

The Tiwi Islands Health Service employs two GPs, Dr Penny Roberts-Thompson and Dr Peter Chilcott who also regularly visit the community of Pirlangimpi on Melville Island, with departmental District Medical Officers visiting Milikpaiti. The Nguiu GPs and the nurses in the men's and women's clinics all work with the mental health team from time to time. The team may bring a patient to see them in an emergency or in order to address a relatively acute need, or they may accompany a doctor on a visit or follow-up patients concerning medications. The male nurse in the men's clinic is a key respondent at most mental health incidents and presentations at the clinic involving males. He provides the AMHWs with lists of persons requiring follow-up for medications (based on search for medication items in the clinic database, CCTIS).

The Team is based at Nguiu on Bathurst Island. The AMHWs and Glenn travel and provide services to clients in the other Tiwi communities: Milikapiti, Pirlangimpi (Melville Island) and Wurankuwu (an outstation community on Western Bathurst Island). These other communities are relatively under-serviced. Whereas the AMHWs can drive or walk through the Nguiu community, access to other communities is less regular and less immediate in crisis situations. Work done there tends to follow crisis situations, and is therefore not always attuned to ongoing counselling needs or preventive work. The male nurse stationed at Milikapiti is responsible for the greater proportion of direct clinical mental health care, at Milikapiti and when visiting at Pirlangimpi.

There are a number of other organisations and groups that provide support to mental health clients on the Tiwi Islands. These include Strong Men's and Women's Clubs, sexual health, drug and alcohol, counselling, self-harm, suicide training (ASIST) and money management workshops. At Nguiu there is a youth diversionary program and an early intervention program for children and families.

Kalano

At the time of writing Robert Broome was the AMHW for Kalano community, near the major rural centre of Katherine. Robert replaced Darren Smith at the end of July 2003, some months after Darren Smith resigned. Robert has maintained an office at the Kalano Community Association and Council building where he keeps his own files on clients and has access to a phone and computer. Kalano Community Council is Robert's employer and the council administers his position with funds received from TEDGP with additional funding through CDEP. Other mental health services in Katherine include the Emotional and Social Wellbeing Centre associated with the Wurli Wurlinjang Aboriginal Medical Service and the EAS

Katherine Alcohol and other Drug Program. EAS Katherine is funded by NT DHCS and provides counselling, training, mediation and consulting services.

Robert has completed his Certificate III in Community Services (mental health non-clinical at BIITE). Robert's role has differed from that of AMHWs in other locations in that he has not been located at a health centre. Rather he has split his time between Rockhole Rehabilitation Centre and Wurli Wurlinjang Health Service in Katherine, in addition to undertaking community and home visits. The submission to join the AMHW Program was made by Rockhole Rehabilitation Centre which later entered into an MOU with Wurli Wurlinjang setting out how Robert's time and services would be shared between the organisations. It has subsequently become clear that this situation involving multiple parties has been problematic in a number of respects and has prevented development of the AMHW role. In particular, Robert has been unable to engage fully with the clinic or KMHS. Despite these difficulties Robert has proven to be extremely focused on his work and has responded to this situation by organising his time down to the hour between his various responsibilities Management arrangements for Kalano have recently been under review. For this reason a more detailed summation of the Program in Kalano are not included in this report.

Lajamanu

Initially three AMHWs were employed by the KWHB under the Program and based at the Lajamanu Health Centre. Their employment continued for about two months. In late 2002 Jenny Johnson commenced as an AMHW some time after the initial recruits had departed. Jenny continued in the position until about August 2003. She came into the position with no background in mental health care and for the duration of her employment was undergoing training by the then GP, Dr Hung, and other health centre staff when time was available. Jenny's departure coincided with that of Dr Hung. There is currently no AMHW in Lajamanu, where there are in effect no dedicated mental health services, only those services provided by RN's AHWs and GP as part of their normal clinical activity**.**

As already indicated an important consideration is that entry into the AMHW Program was initiated by the Lajamanu Community Government Council, rather than by the Katherine West Health Board. KWHB is yet to formulate its mental health strategy and has shown only limited interest in supporting the AMHW Program.

Summary

A number of issues arise from these accounts of current arrangements. The first is that where managerial support for the AMHW positions cannot be created, the prospects for effective and more systematic development of their role in and outside of the clinic are diminished. This may be exacerbated where there is a lack of clear sense of need either in the community or on the part of the major health care provider, as at Lajamanu. At Kalano, despite the dedication of the AMHW, ambiguities about the AMHW's responsibilities have arisen from lack of consensus between the two interested organisations, Rockhole Rehabilitation Centre and Wurli Wurlinjang Aboriginal Medical Service. Moves are being taken to address this situation. At Borroloola, the partial breakdown of arrangements after the departure of the GP and his wife placed the mental health service in a state of uncertain transition with diminished support for the AMHWs. The issues encountered there exposed the fragility of the original GP-

oriented model in a context where a framework for institutional support through a larger health care organisation was lacking.

While the development of adequate support and employment arrangements is significant, recruitment of AMHWs is in itself an important dimension of the consolidation of an effective program in any community. In a number of the participating communities, turnover of AMHWs has severely limited Program impact and have stretched under-resourced support structures. In only three communities, has there been successful identification of appropriate persons from the outset, while at a fourth, the initial appointment terminated with changes in circumstances. Recruitment difficulties cannot always be overcome by provision of additional managerial support alone. In some contexts there may need to be testing of arrangements and personalities over time to find individuals who have the appropriate skills and understandings, and standing in the community to undertake the work required. This in turn may be less likely to occur where there are significant uncertainties of commitment on the part of community organisations or indeed on the part of the community itself. Without this commitment, otherwise highly appropriate personnel may lack the confidence to assert themselves in the AMHW position.

3.5 The Community Role of the AMHWs

The baseline evaluation report suggested that the AMHW role can be thought of in terms of three main areas: clinical; counselling; health promotion and education (Robinson et al, 2003). To these might be added client welfare, in the sense that some AMHW work is concerned with providing supports for individual patients relating to food, money management and dealing with family issues. In some locations, 2003 saw a greater clarification of the mental health services provided by AMHWs. However, a greater degree of variation also emerged as the Program adapted to the particularities of each remote community.

The AMHWs are engaged in a range of activities in all communities. They assist GPs and RNs with management and treatment of clients, and engage in follow-up of clients due for medications. The mix of duties and activities varies from community to community. In some, they are frequently involved in crisis situations, responding to attempted suicides, acute episodes involving threatened violence or other manifestations of distress. In some cases they are engaged in advocacy on behalf of the client, undertaking measures to assist with client welfare, including liaison with courts, prison, community services, providing assistance with food and clothing, or with accommodation and travel following hospitalisation in Darwin. AMHWs also carry out counselling of clients with a range of difficulties, relating to substance misuse or to marital violence and relationship difficulties, and have variously participated in community health promotion and education programs in the areas of general wellbeing, men's and women's health, youth issues, alcohol abuse, and domestic violence. There is no single model for the non-clinical roles of the AMHWs. In many communities, there has been a lack of support for development of educational, health promotional activity.

Where the role of the AMHWs is well established, GPs and RNs report that they provide an invaluable service to other health care practitioners, assisting in management of difficult clients or in resolving complex matters of client welfare. With variations across the communities, it is reported that AMHWs have significantly contributed to other practitioners' ability to understand background issues and cultural themes relating to clients' problems. They

often benefit from the mediation skills of AMHWs who assist with managing crisis situations in the health centres. It is clear that the AMHW Program has contributed to improved Indigenous participation in provision of needed services, although, as will be seen, much of this work is not formally recorded in central health centre medical records.

Many of those interviewed spoke of a need for greater role clarification for the AMHWs, particularly in respect of their non-clinical work. Problems related to the clarity of mental health care roles is not a peculiarity of the AMHW Program. Russell and Potter (2002) and Sweeney and Kisley (2003) report that role confusion and role conflict regarding mental health work is common in primary mental health care generally. Russell and Potter predict that this is likely to grow as mental health moves out of the traditional institutional setting to communities. At this point, it is important to consider the kinds of support and management needed to reduce the risk of confusion of expectations and roles. In part, this means consideration of how collaboration between services and levels of mental health care might result in improved support for AMHWs in their various activities.

The contract between the Program manager, TEDGP, and the employing organisation for the AMHWs in each community includes, as a *Supplement to the Contract*, a *Generic Position Description*. The description is not intended to be prescriptive: rather, as it states it ‘May be used to inform another version’. As also stated on the Description, the TEDGP required the employing body to forward ‘a copy of the AMHW Position Description adopted for use’. *This requirement has not been fulfilled by employing organisations or enforced by the TEDGP.* The diversity of socio-cultural contexts, mental health needs, health centre capacities and infrastructure in participating communities necessitate a flexible approach to role development. While such flexibility may help the Program meet the needs of participants and communities, it also carries risks, in that it invites evasion of the need to set standards and goals for practice and can lead to confusion about the AMHW role among other providers thereby hindering role development.

An issue that continues to elicit a range of often quite contrary views is the extent to which the AMHWs should focus on clinical service provision or work primarily outside the clinical arena in health promotion or general counselling, or indeed whether the two can be successfully combined. Drawing on the words of health centre GPs, the baseline report suggested that the clinical and non-clinical facets of the role “need development in relation to each other, in order that one not undermine or displace the other, or in order that the AMHW Programs are not burdened with unrealistic expectations” (Robinson et al. 2003:85). In the following, the development of AMHW roles will be examined in relation to health centre capacity, inter-organisational cooperation and Program support in the participating communities. Although the situation varies considerably between communities, some key factors emerge as impacting on Program success.

Galiwin’ku

Recent changes in the mental health care services at Nulkunbuy Health Centre in Galiwin’ku have been outlined above. The effects of those changes on development of the Program at Galiwin’ku will be outlined here. These include the eventual departure of Judy Djanumbi from her position.

The work of the former AMHW Judy Djanumbi at the health centre was predominantly clinically oriented. Djanumbi's registration as an AHW meant that she was able to administer some medications. She administered some depots to women and to some men, depending on family and "poison" (avoidance) relationships, and refilled dosette boxes for patients requiring regular medication. With the arrival of the MHN and with access to a vehicle she and the other AMHWs brought patients in for the MHN to administer injections. Djanumbi continued to play an important role in the medications program by transcribing into her diary when clients are due and actively seeking people out in the community to either deliver their dosette boxes or to bring them into the clinic. Of the three AMHWs employed at that time, Djanumbi had the most advanced clinical skills.

The workload of remote health centre GPs limits their capacity to provide support and training to AMHWs. According to the GP the mental health program at the health centre has the potential to add more value than it currently does. This is partly due to institutional factors and partly to individual factors. With the arrival of the RN with psychiatric training in Galiwin'ku in mid 2003 the GP was able to work through the RN to ensure that the AMHWs received additional support.

The GP says that because of the RN,

> 'we're reviewing our patients more regularly . . . our depot rates are much better than they've ever been [and] our rates of acute exacerbations of chronic mental illness within the group that we already known to me has gone down quite a lot in the last 6 months compared to last year. In fact a few we've reviewed more intensively. We've taken them off depot and they seem to be going quite well.'

However, he also sees difficulties in developing the role of the AMHWs:

> 'We can provide good clinical care and support and training, but our strengths are not in wellbeing' explains the GP. It is, he adds, 'the emotional and spiritual wellbeing element which is where the AMHWs' strengths are, and our strengths are not'; this area has not yet 'taken off', he says.

However, although Djanumbi was more enthusiastic about these arrangements, the achievements of the MHN in improving the organisation of medications displaced her own way of "doing the depots". As the GP explains:

> 'We were in this process of transition to a spreadsheet and doing the depots all on the computer – its user independent – she was getting into that system three months ago or maybe a little longer and she was actually doing the data entry herself and updating the records on the spreadsheet and it wouldn't have taken much further to get her running that on her own.'

Irregular work attendance particularly around the time the new RN commenced, and the need to develop a reliable system for delivering clinical mental health care limited options. The GP explains:

> 'she hasn't been around consistently, it's back to square one now and unfortunately the power has been taken out of her hands. She probably doesn't feel a sense of ownership of the depot program at all now because [the RN] has been running it. So you get all those

> issues of a paternalistic health service delivery where that *Yolngu* co-worker is marginalised.'

The RN identifies several areas where the AMHWs add value: 'They are invaluable in that they a source of insight into the culture, can work out who's related to who, know how to find people and know what's happening within the family.' The AMHWs also assist with translation and 'explaining auditory and visual hallucinations, and trying to get something back from the family about whether anything like that has been happening – it's just invaluable, otherwise we can't get a lot of that information'.

Establishing a professional identity is a concern to many of the AMHWs. Both AMHWs and health centre staff report that the AMHWs in Galiwin'ku had an identity distinct from that of the AHWs. The specialised nature of their work and the fact that much of it goes on in the community rather than the health centre distinguished them from their AHW colleagues. Other health centres, such as Angurugu, report along similar lines, adding that this distinction is helps define the AMHW role and fosters their own sense of professionalism.

The AMHWs also engage in some mental health promotion and education, counselling and youth work. The GP and RN felt hampered in their ability to support the AMHWs in this work, where, as a result, the AMHWs' potential remains unexploited and their energy, ideas and vision untapped. According to the RN:

> 'One of the problems we find at the clinic is that we're so caught up in doing acute work that we don't get the time to do prevention work. If people were a bit more aware of what's happening with their mental health [they could] take a bit better control over their life and what's happening. So yeah, I'd love to see more of that [health promotion, education] happening . . . the level here of acute mental illness is much lower than down south where you can have a team of people doing it constantly, whereas here there is a big opportunity to do more community based education and yet still have that clinical component of reviewing patients here and seeing them at home. Community education is really important, and particularly if it can be done by the *Yolngu* people without a *balanda* standing up in front and saying what the mental health problems are without really understanding the culture.'

At the time of the evaluators' visit, Djanumbi had just returned from Groote Eylandt where she was doing some work in schools alongside the Angurugu-based AMHWs. The TEDGP had organised to do the same work on Elcho Island during the Healthy Lifestyles Week later in October 2003. The plan was for Djanumbi to talk to primary school children, to have them draw examples of 'good mental health' and 'bad mental health', to help them understand 'what's going on in their own bodies', 'what's happening when they feel angry or sad', and to give them skills to 'deal with their feelings'. Djanumbi had been instrumental in raising the needs of children in joint meetings leading up to Healthy Lifestyles Week. Her work in this regard was particularly important considering the shortage of other organisations working with youth in the community. A youth worker position has been funded by the Galiwin'ku council but was then not filled. A police-supervised diversionary program in the community may be a focus for future collaboration.

The RN at Galiwin'ku was not aware of any community education or mental health promotion component to the AMHW training at BIITE. 'Certainly', he suggests, 'if they had a bit more education in that and felt more confident in addressing small groups or working with other

organisations in the community such as the Yalu Women's Centre.' However training would not obviate the need for community-based support to sustain a health promotional role.

The GP identified a number of under-explored areas where he feels the AMHWs could work effectively. The Healthy Lifestyle Festival is part one of an attempt to develop a Healthy Lifestyles Committee to help overcome the ongoing lack of coordination between community organisations. This is contingent upon council approval, but if it goes ahead it will involve three *Yolngu* people to form, a capacity building coordinator group. The idea will be that a representative from each department will work together to support these three people in any community development activity. As he explains,

> 'say Djanumbi is working with Yalu and they want to start up a program for revitalising a women's ceremony which hasn't been performed for a while then rather than do it on their own and find the funding on their own, they'll bring it to these three coordinators who will then look at what's available from every department and whether the other department want to get in on supporting this idea, not just supporting by personnel but by money, and then develop a more coordinated approach to it. That's where I see if you could shift the AMHW position into other areas, but they wouldn't end up working independent of Nalkanbuy necessarily.'

The GP further identifies a role for the AMHW in promoting improved cross-cultural communication between *Yolngu* and *balanda* in the health centre:

> 'There are so many obstacles for Yolngu in this community because of the inherited colonial history and because of the kind of baggage that comes into the interaction between Yolngu and balanda and there's so much room for interesting workshops to improve the relationship between the two. . . Why Djanumbi's a great person for this job is that she can put a foot in both camps. Djanumbi is a person who presents herself incredibly well outside her community with her ideas she's a really strong thinker, really assertive, good literacy skills. She's one of the few people in a meeting who will stand up and talk what ever the meeting is.'

Health centre staff feel that they are unable to provide support for the community role of the AMHWs, and hold a perception that "community politics" hinder inter-organisational communication and collaboration. According to the GP:

> 'in some respects the Yalu Women's Centre is better situated for doing wellbeing work than we are because we get caught up in all the chaos of the day and in a way a different model where an AMHW position was purely community development work and non-clinical may be the way to go. Having said that though, if you shifted it into Yalu or an equivalent organisation you are undermining the Program that was set up where it's supposed to be a GP-AMHW partnership.'

The GP also sees the continuation of the AMHW position in the clinic as an inevitable continuation of Yolgnu subservience to a *balanda* driven paradigm.

> 'Our AMHWs juggle millions of roles. Being the culture broker, the interpreter, the social worker and the go between is a huge responsibility but I think it puts them in a secondary role and I think that's always going to be problematic within the health centre. So I think getting out of the health centre is really – with good support – and moving it into a non-clinical position – [the best option]. A health worker can give depots and fill depot boxes,

> you don't need to be specialised in mental health to do that, anyone can do that. But to set up a good wellbeing program with good support, I think probably this health centre can't do it. It would need to be separate but coordinated.'

The GP also acknowledges that his training as a clinician has equipped him poorly with community development skills and the ability to conceive of clinical work as within the realm of 'wellbeing':

> 'There have been a few half-arsed attempts to get some things going, regular excursions and hunting programs shifted away from the clinical paradigm, and I think we have to take some blame for that, but we are clinicians . . . and clinicians aren't very good at community development work. So we don't really know, we don't have good ideas on how to do this stuff and we don't have the experience. That's why I think we're not really the right people to support someone like Djanumbi. I think she's someone that if she had a really good co-worker . . . a fairly easy going co-worker who can juggle the inconsistencies and absences and go with that a little bit, no *Yolngu* like to work in isolation. Her getting Guymun on board is probably a good reflection of that.'

The baseline evaluation study noted that there was uncertainty, even debate about whether the AMHW positions would be more appropriately located outside the health centre. A year later the debate continues and does not appear to be approaching any resolution. It appears to be a relfection of the uncertainty of non-indigenous practitioners about the limits of their responsibility and about how mental health work might more actively engage with the community beyond a busy health centre. The key issue in this respect may be that the RN with mental health experience is, with current duties, circumscribed in his capacity to take the lead in supporting work beyond the health centre.

Numbulwar

In Numbulwar, the majority of Samuel and Mary's work was performed with mental health clients and other community members outside the clinic, and related to *ganja*-induced psychosis or to domestic violence. Consistently and informally Samuel and Mary educated users about the potential effects of drug use, usually in their own homes or at the community meeting-place, the town shop. Samuel is regarded as a 'funny man' in the community, and has a dress sense that puts him at home amongst younger community members. He exploited this special rapport with younger people as he and Mary pursued a harm minimisation strategy relating to misuse of *ganja* and other substances.

Aboriginal Health Workers and others reported the occurrence of assaults or other critical incidents directly to Samuel and Mary. Some assault victims came directly to Samuel's and Mary's residence seeking protection and/or medical treatment. In situations where domestic violence or child abuse was occurring, Samuel would directly intervene and talk with the perpetrator in their home or in the community. If the matter appeared psychiatric-related, the AMHWs escorted the person to the clinic, often with family members in attendance. If the matter was criminal, the police were called from Groote (an hour by air) or Ngukurr (2-3 hours by road). Samuel has been physically assaulted, but states that this does not concern him. He believes that he has the support of the council should any serious allegations about his conduct be made. He explains,

> '. . . some of the young boys, you know when they get angry or sometimes after a while they think and they come back and say sorry to me. I tell them I'm doing my job for your good, or for your daughter's good, for her health.'

As in all communities, critical incidents are more than likely to happen after hours. Although like most homes in Numbulwar Samuel and Mary have no telephone, they are often the first point of contact and may work hours each week outside of the clinic's opening hours.

As a senior man with ceremonial responsibilities, Samuel contributed to the social and emotional wellbeing of his community in other ways. During circumcision, funerals and other ceremonies he played a leading role as a dancer and song man, encouraging young people to become involved in the Nungubuyyu culture. Samuel and Mary valued these activities as also serving a preventive function by providing participatory activity for the community and wished to see more invested in establishing other activities for community youth:

> 'Something for them to do, yeah with young people, enjoy themselves. Every Friday they do corroboree dancing, they make something for ceremony, then they can dance too. Like last night I got heaps of young boys dancing.'

The AMHWs travelled on foot to the homes of clients to consult with them regarding their general wellbeing and medication uptake. Access to a vehicle has been an ongoing point of contention and a contributing factor, it appears, in their departure. Differences seemed to centre on who was responsible for supply of a vehicle.

> 'Sometimes we walk, you know, or see them in the shop there. They come in and we talk to them there or we might see them in the clinic here. . . . We don't use a vehicle here. Even the council vehicle they won't let us use. It's hot here, too hot to walk around', says Samuel.

Borroloola

Warren Timothy has developed an extensive workload in mental health-related services in Borroloola. This includes counselling, referral and follow up, as well as work in domestic violence, related legal matters, substance misuse and related support groups, as well as work with youth. However, at the present time, the focus of Warren's work is non-clinical and, since the GP surgery has closed, largely unintegrated with the mental health work of other providers.

Warren has initiated a number of activities and programs since commencing as an AMHW. These include a *Stay Sober Support Group* and a *Mental Health Awareness Week*. The *Stay Sober Support Group* involved about six individuals who had given up drinking of their own accord. The group met every fortnight or so as a source of support for each other and also as a means to encourage others in the community to give up drinking. Unfortunately, the group was inactive in 2004 due to a lack of funding. Warren has spoken to individuals who are currently drinking but state that they would join any such group immediately if the opportunity arose.

Part of the breadth of Warren's work and his prominent role in the community is a product of an association that many hold of Warren with his father. Warren's father was an important

figure in the community, acting as a mediator, pastor, and general community leader. There is an expectation among many that Warren should continue his father's work.

Warren is a counsellor, with many different strands of knowledge informing his approach. He combines his knowledge of mental health from BIITE with ASIST related skills, and cultural knowledge. Many people come to see Warren in his office to talk to somebody about their problems or to ask Warren to mediate in matters involving 'outside' organisations, such as legal and rehabilitation services. Warren has long standing connections with many Borroloola residents, having grown up in the town. Many people want to talk with Warren after work hours.

Most of Warren's current clients entered a period of acute symptomatology between one and three years ago. During phases of psycho-social crisis, the AMHWs played pivotal roles in providing support and counselling, provided cultural brokerage between their clients and psychiatric services, as well as co-coordinating access to the services of other providers, such as FACS and Legal Aid. In recent times, these clients are being monitored through Warren's network of community surveillance.

Warren is called by people who feel suicidal, or who know others who do. In counselling them, Warren emphasises the person's family connections and how much family members would be affected if a suicide occurred. Warren believes that the number of suicides has dropped in Borroloola in the last two years. Victims of domestic violence also come to Warren for assistance. He has supported women wanting to press charges by accompanying them to the police station as well as providing advice on their legal situation.

Community members will also approach Warren for assistance with managing their alcohol use. Sometimes Warren will work with people in the community on these issues, or refer them to rehabilitation services such as Rockhole near Katherine. As well as counselling and referring clients, organising groups and activities, Warren also has the skills to be a community leader and skilful facilitator. Damian Vincent, a former employee of GHS, describes a serious conflict, which 'split Borroloola in two'. As the community polarised over the issue and an increasing number of assaults and fights began to occur, Warren (who like many had family on both sides of the conflict) diplomatically spoke to the people most directly involved on both sides of the dispute. He then organised and facilitated a town meeting on the issue. 'If it wasn't for Warren', says Damian, 'the streets would be red with blood.'

As so many of Borroloola's social problems and mental health issues are alcohol related, Warren has been involved in a long process of negotiation with the owners of the Borroloola Hotel to reduce its opening hours. This work has been partially rewarded. Instead of staying open from 10am to midnight every day, the Hotel now has reduced hours to between 11am and 10pm on Thursdays and Fridays, days which were previously renowned for 'big trouble' because they coincided with *Centrelink* payments. Warren would ideally like the pub to be gone 'because I can see what [drinking] is doing to my people.'

Warren also works with young people in the community. He has been asked to talk to primary age children at the school, explaining the importance of education and that education can be fun. The principal of the secondary school approached Warren to hold talks with students at risk. In these sessions Warren provides anger management training and education on

substance misuse. He uses a range of educational pictures and videos to explain the physical effects of using drugs and advocates harm minimisation practices, such as drinking only on a full stomach.

When clients are displaying ‘crazy’ behaviour, Warren pursues a range of approaches. With some clients, particularly those that are younger, and those whom he knows well, he is able to pick when they are seriously disturbed, or just ‘playing games’. If he suspects the latter, he will give them ‘a little fright’ by suggesting that he send them to Cowdy Ward, a ‘place where they find out if you’re really crazy’. Warren emphasises that all his activities are done within the context of gaining the trust of community members. He believes he has made significant progress in this regard, but that it will be another year or so before he has the trust he envisages. Confidentiality is the primary issue in this regard - clients find it hard to accept that their personal information can be trusted with a community member. Warren states that women, in particular, are wary of disclosing their issues to him, and will sometimes chose to go to the DHCS health centre where they can talk with female practitioners. Warren describes a feeling that many in the community are sitting back and watching, waiting to see if he can be trusted. He also believes that there is a common perception that a person must have mental health issues if they are seen talking with him.

The AMHWs work separately with female and male clients for cultural reasons, although they are able to work together with young people vulnerable to petrol sniffing and other drug use. When a client’s issues are family-based, Warren works with the whole family, attempting to negotiate ‘different ways to do things.’ On occasion the AMHWs have assisted family members to come to Borroloola from Arnhem Land and other areas to help work on a client’s problems. At other times though, when family and other issues appear too complex, Warren used to ask for advice from the Surgery GP with whom he had enjoyed a close working relationship.

The Surgery GP was the source of most referrals to the AMHWs. With difficult cases, Warren would often consult the GP as a kind of cultural reference point, to establish a ‘whitefella’ way of responding to the problem. According to Warren this process was a reciprocal one; one of ‘learning both ways.’ Usually the ‘whitefella’ way would be tried first, such as medication. If this didn't work, the client would be reviewed, and a ‘blackfella’ approach would be employed. This occasionally includes the use of local traditional healers, either at the client's request or Warren's suggestion. The earlier relationship between Warren and the GP played an important role in cultivating Warren's confidence and professional development.

By comparison, the working relationship between Warren and the DHCS clinic is amicable but largely unintegrated, lacking regular or substantive collaborative protocols, communication, or complementary planning of service provision, despite attempts by TEDGP and BIITE to strengthen the working relationship between the AMHWs and the clinic. Although communication between the DHCS clinic and Warren is rare, occasionally the staff at the clinic will contact Warren for assistance. DHCS will refer Indigenous mental health clients to the AMHWs who will then decide if a client should then be referred to the GP or KMHS. However, it is not clear to what extent this is acted upon. The DHCS clinic manager sees the potential for DHCS staff to learn about mental health issues from the AMHWs through a knowledge sharing process.

Nguiu, Tiwi Islands

The Tiwi MHT focuses on service provision that addresses what they regard as the breadth of psychosocial needs of the Tiwi people, and as such undertakes a broad range of activities. Six areas had been prioritised for the attention and intervention of the Tiwi Health Service. They were:

- Child protection
- Domestic violence
- Suicide
- Alcohol and other drug issues
- Mental Illness

The development of the Tiwi MHT was a key strategy for achieving outcomes in these priority areas. Specific strategies have included the Strong Men and Women's groups, education programs, jail programs, Cowdy Ward visits and the Suicide Response Group. The work of the MHT also entails involvement in these activities through organisation, participation and facilitation, encouraging attendance and providing support to participants.

Conducting social health promotions such as Strong Men's and Women's Clubs and workshops on sexual health, drugs and alcohol, counselling, self-harm, suicide prevention (ASIST) and money management, have been an important part of the Team's activity. More than thirty participants attended both Men's and Women's groups regularly. The Strong Men's Club (*Pukupuwi Wawurriwi*) met fortnightly for over two years. The objectives of the groups were to share knowledge and life skills, provide role models of leadership and healthy living, pass on traditional culture and develop social models for the future. The activity of these groups has not been reported in detail or specifically evaluated.

One of the key contributions made by the Tiwi AMHWs is their capacity for early intervention in potentially critical incidents. The AMHW field diaries (discussed in Chapter 4) contain, for example, records of attempted suicides in which family members have been able to call upon the AMHWs to intervene, often after hours. In such cases the AMHWs have been able to defuse the situation and/or ensure that the individual in need of help attends the clinic to talk to the GP. They are also able to monitor the individual concerned and liaise with his or her family as part of their regular work in the community.

The Team provides debriefing and counselling services for those affected most directly by traumatic incidents on the Islands. The AMHWs are often the first point of contact in critical incidents and provide support and follow-up to clients in several communities. Over a six-week period after a community has experienced a major traumatic event such as a suicide or a murder, the team will facilitate debriefing sessions for the affected people or "skin group". These sessions provide a forum for people to discuss physical, mental, emotional, and spiritual after-effects. They also enable the Team to assess the families affected for possible referrals.

The clinic manager reports that the AMHWs work well as a team and have a good range of skills. There is confidence in their work and other staff work well with them. Furthermore, the AMHWs have the confidence to make their own decisions and can obtain information that other practitioners are not able to access. 'They think proactively, they don't wait for the

whitefella to come along.' The MHN has spoken highly of the team's capacity to respond to urgent needs independently, in his absence.

It was suggested that by attending consultations and occasional case-conferences, bringing clients into the clinic and providing cultural interpretations, the AMHWs frequently collaborate with healthc entre staff to ensure medication uptake and monitoring. The AMHWs have expressed a desire to increase their clinical skills.

When Tiwi Islanders are admitted to Cowdy Ward, the AMHWs or the MHN try to intervene as soon as possible to support their clients, offer assistance in assessment, and negotiate appropriate discharge planning. The AMHWs help to organise family visits to Tiwi people in both Berrimah Prison and RDH Cowdy Ward, as well as provide news and connections with home via photographs through regular visits themselves. As the case of 'Levi' (below) illustrates, the AMHWs are uniquely positioned to draw on their knowledge of community kinship to facilitate communication between the client and family members to ease a client's return to his or her community and take action that may reduce the risk of future problems.

"Levi", 25 years[4]

As a child Levi largely 'grew himself up' while living in his mother's community. His father was absent during his younger years and while still a young boy, Levi's mother was diagnosed as mentally ill and had found it difficult to care for either Levi or herself.

As Levi grew into a young man without family support or occupation, he engaged in ongoing disruptive behaviour around the community, (often in the company of a particular cousin) so that Levi spent two years in Berrimah Prison with a series of charges including thefts and sexual assault.

During his time in prison Levi was diagnosed as requiring psychiatric care. He was visited by the Tiwi AMHWs in prison. Upon release the Berrimah staff prison authorities contacted the Tiwi MHT to let them know that Levi was being transferred to the Joan Ridley Unit (secure section of Cowdy Ward) at the Royal Darwin Hospital. While at RDH the MHT decided that it would be beneficial to Levi if he and his father could spend some time together and negotiated for Levi to be flown to his father's community upon release. This arrangement also aimed to separate him from his cousin with the intended effect that chances of re-offending by either would be reduced. When Levi was flown back home one of the AMHWs went out to Levi's father's community to meet Levi and help see him settle into the community. While this did not have an enduring effect, (Levi soon returned to his mother's community) it demonstrated that the awareness of the AMHWs is an asset in the development of strategies for individuals.

The MHWs provide a link between clients, the health centre and other supporting services. They refer clients to services such as FACS and rehabilitation services, and identify potential clients within the community that may need assistance from drug and rehabilitation services or ASIST. Under Glenn Norris' oversight, the AMHWs may assist clients in legal matters by providing input into court reports and providing support and translation during hearings at Darwin Magistrate's Court. Glen Norris provides formal reports to the courts or to NAALAS. As indicated, the MHT calls on the Aged Care Facility, school and youth groups, CAAPS, ASIST and FORWAARD in dealing with client welfare or specific sources of risk.

[4] Names of all cases are pseudonyms.

The AMHWs have also fostered and developed links with the Nguiu police, who now occasionally call upon the services of the AMHWs. Nguiu Health Centre staff report that over the last year the police have developed a less 'heavy-handed' approach to clients displaying disturbed and/or violent behaviour. It was claimed that police now more often contact the AMHWs seeking their intervention, rather than placing people in detention. This has helped to increase the confidence and capacity of the AMHWs to manage critical incidents.

The AMHW role is a balance between personal relationships connecting them with their client base, and professional intervention in their clients' lives. The AMHWs may act as mediators between clients and their families and a range of other health workers and government and non-government bodies. As bearers of particularly private and personal information on individuals, the AMHWs need to be able to balance their roles as sources of information on community members at risk of mental health problems or illness, and protectors of the privacy of community members. The standards expected from the team by the community in terms of their relationships and personal behaviour are high: it is reported that some MH trainees were shunned by clients because their drinking and gambling were inconsistent with their professional role, and left the team.

As emphasised by Nguiu health centre staff, without community goodwill, clients are unlikely to respond to the interventions of the AMHWs, and the community is unlikely to involve them in matters involving their families. However, the ability to keep up close and regular contact with clients and their families outside the clinic context while maintaining people's trust is one of the AMHWs greatest assets. In situations where mentally ill community members are at risk of being exploited sexually and financially, the interventions of the AMHWs can be especially valuable. The case of Julie (below) shows how a client at risk of abuse and substance misuse is assisted by the AMHWs.

"Julie", 29 years

Julie has been a Tiwi mental health client for five years. The AMHWs believe that Julie suffered some abuse as a child. Her father passed away when she was quite young, and her mother died only recently. Her husband is sometimes violent and has stabbed her in the past. The AMHWs regularly check on Julie who now lives with family members in her community, monitor her substance use and support her to go to the clinic to receive medication.

Prior to the onset of her mental health problems Julie was a heavy smoker of *ganja* and had a poor appetite. When she was about twenty-four Julie was diagnosed by health centre staff with severe depression and eventually went to Cowdy Ward, accompanied by her young daughter. Julie was prescribed anti-depressant medication, but lacked the motivation to stay on it after returning to the community.

People in the community became worried that she did not take proper care of her children and her troubles came to a head when she attempted to stab her two children and then hang herself, upon which she was readmitted to Cowdy Ward where she was diagnosed with psychosis. FACS intervened and arranged for Julie's two children to be sent to live with her sister in a mainland community.

Since returning to her community from RDH for the second time Julie has been banned a few times from the local club and has undertaken a drug rehabilitation course in Darwin.

> Currently she is complying with anti-psychotic medications (zuclo and olanzapine) and a benztropine, to mask the side-effects of these medicines (tardive dyskinesia which manifests as uncontrollable shaking of the body).

The AMHWs undertake a diverse array of activities that directly impact on the priority areas of the Tiwi community: child protection, domestic violence, suicide, alcohol and other drugs, mental illness and health. The diversity of forms of assistance provided to a client and his or her community is illustrated by the case of 'Harold', a 30 year-old male who has been a client of mental health services in Nguiu for several years.

"Harold", 30 years

> Harold was diagnosed psychotic by psychiatrists at Cowdy Ward in 1998 and 1999. More recently the diagnosis was revised to include conduct disorder. Severe malnutrition during childhood is thought to have affected Harold's mental ability and he is regarded around his community, and by MHT staff, as being 'a bit simple'. At the present time the MHT try to check up on Harold on a regular basis, transport and time allowing. Since he is frequently distressed and getting into trouble, he is often bought to the clinic by police or other community members, and the AMHWs see him more often than most clients.
>
> Harold likes to smoke *ganja* and often spends his fortnightly pension cheque very soon after it arrives, which means that he usually has no money for food. Harold also enjoys spending time at the club in Nguiu, however he often drinks too much and gets involved in fighting or other trouble. Harold's family are exhausted from catering to his needs and find it difficult to provide him with the care his condition demands, although his brother routinely comes to his aid him when he is in trouble or distressed.
>
> To help Harold cope with the symptoms of his illness, the MHT try to ensure he takes his medication when due and comes to the clinic for regular check-ups. They have also organised that a part of Harold's pension is given to the Aged Care Facility, so that they can provide him with a daily meal. Harold's medication is also kept at the Facility so that he doesn't miss any of his tablets. Occasionally the AMHWs will use some MHT money to buy him bread, chicken and smokes. Sometimes, for example when Harold visits the GP at the clinic, the AMHWs give Harold clean second-hand clothes (obtained from a charity) and assist him to wash. Other counselling and education work by staff has aimed to reinforce the idea of drinking low alcohol beer, since it was thought he could not be expected to stay away from the club. This reportedly had some success.
>
> Although these efforts have had a positive effect on Harold, his problems will remain. He is still usually without money, in search of *ganja* and has little supportive contact with family, apart from his brothers.

The evaluators accompanied John Bernard Tiparui in responding to an incident at the shop. Harold was 'upset and running amok', accusing family members of failing to give him money for cigarettes and ganja. Female relatives were in retreat with Harold shouting abuse at people, walking around, waving a stick. John Bernard drove up, called out gently from the van and then continued to back the van up and down, following Harold as Harold's brothers began to try to talk him down. They were, said John Bernard, the only family members who worried

about Harold. After much shouting and pacing up and down by Harold, the brothers edge him closer to the van and then coax him in. Harold's brother and friends calm him during the drive to the clinic, where he is offered a smoke and further calmed while he sees the male nurse and John Bernard, with the GP looking on. John Bernard's intervention with the van assisted the brothers to take charge without confrontation. His minimally interventionist style draws on Indigenous Tiwi methods of dispute resolution and containment of conflict.

In 2003, the then Services Director of the Tiwi Health Board, Jeremy Smith, indicated that he believed that there is a need to improve the clinical skills of the AMHWs. This should including encouraging them to conduct consultations and enter those consultations in clinical records. This is currently not the case, with the AMHWs only responding to lists provided by Glen or the RN, and entering no consultation information in any patient's records. Jeremy was of the view that the field diaries illustrated their capacity to contribute to the clinical record. At the same time he noted that there is a risk of over-medicalisation of their role in mental health with 'pills and injections constituting the only interest of the clinic'. However he said that overall, integration of the AMHWs more into the clinic and increasing their understanding of biomedically based psychiatric care would be to their advantage and assist the health centre in providing mental health care. He believed that the AMHWs' more "holistic" approach to mental health would not be overwhelmed by the biomedical paradigm.

While capable of independent intervention, the AMHWs work is also structured by the inputs of the other health centre staff and in particular, of the Mental Health Nurse. The Tiwi Islands Health Service, at least at Nguiu, is in this respect well resourced in terms of RNs and GPs who are able to make use of the assistance of the AMHWs and in turn assist with structuring and perhaps limiting demands on them. A more systematic evaluation might consider how mental health services are rationed according the preferences of the system established at the health centre – in addition to the specific constraints on provision of services to communities other than Nguiu.

Angurugu

The work of Leonard and Muriel is well integrated into the Angurugu Health Centre. The approach and energy of the health centre manager has been seen as the chief contributing factor to their integration into primary health care delivery, as the GP at the time, Dr Wendy Williams[5], explained:

> 'I don't really see them as working differently to anyone else here [and] we have a health centre manager who supports the integration of their role into the clinic. I think it's really vital that they've become a part of the clinic. We all work together or it doesn't work because all the problems overlap. Mental health care is like another chronic disease. It's all intertwined. The domestic issues for example all impact on health.'

The non-Indigenous health staff, says the GP, share knowledge with the AMHWs and the AMHWs share relevant cultural information, and this enhances patient care. She feels confident that she and the Health Centre staff are informally but regularly kept up to date on clients.

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[5] Dr Wendy Williams has held this position for the last ten years. She resigned in early 2004. A permanent replacement for her has yet to be found.

Clinic staff interviewed are generally of the opinion that in most cases, clients who present with a mental health problem are best referred to Muriel and Leonard in the first instance. Muriel and Leonard may then refer them on to an RN or AHW for help with medications, or to the GP. Thus clinic staff effectively utilise Muriel and Leonard as the first point of contact for mental health problems that would otherwise be dealt with by other staff or may not present at all. Non-Indigenous staff report that over the last year their own views on the role played by the AMHWs have become more positive and supportive.

For a substantial proportion of the estimated 10% of patients who present with a complaint which clinic staff assess as possibly involving a mental health or social or family issue, the AMHWs are called upon to visit the client at home with their permission. The GP reports that patients rarely object to these visits. The GP also says that over the last year the community has come to understand more the role that the AMHWs play, are better able to recognise their problems as more appropriately dealt with by them, and are more likely to approach the AMHWs first before coming to other clinic staff than previously.

Early help is delivered by an AMHW of appropriate gender, and usually includes counselling. If more than counselling is required, the AMHWs accompany the patient to the GP and provide a cultural bridge during the consultation. They may also encourage and support the use of medication when this is indicated and ensure that the patients receive regular follow–up.

By all reports from the community, the presence of the AMHWS has meant that mental health literacy is improving in the community and people are seeing the clinic as a place that deals not only with conditions of the body but mental health issues as well. According to the GP, by having Muriel and Leonard around they are dealing with problems earlier. Community members are more willing to report the early signs of psychosis to the clinic enabling clinic staff to treat a condition in its early stages. ‘They're so good at it' says the GP, ‘they have taken a load off me.'

The GP reports that emergency evacuations from Angurugu are down dramatically and attributes this to the work of the AMHWs and their role in assisting the early recognition of problems:

> ‘…we had one medical evacuation a month, one every two months, at least six a year. Now one or two a year if we're lucky. We haven't had any for about a year now . . . people are recognising that when they're mentally ill, or when their relatives are mentally ill they can actually come to the clinic and get something done for it to alleviate the symptoms.'

The AMHWs are involved in psychiatric evacuations in Angurugu or in Alyangula and make themselves available late into the night as their guidance is considered valuable by clinic staff. In such instances the clinic manager ensures that they have time off in lieu, as compensation for such after hours work is not addressed in their employment conditions through the town council. The clinic manager fills in the time sheets for the AMHWs and so is able to ensure that they receive adequate rest, a practice that is greatly appreciated by both AMHWs

As confidence in the AMHWs and knowledge of their work grows in the community, Muriel and Leonard are finding that they are called upon to perform an ever broadening array of tasks.

The case of "Tim" below illustrates the type of intervention in relationship problems that the AMHWs are able to provide and which other clinic staff were unable to deal with effectively.

"Tim", 40 years

Tim lives by himself in a small East Arnhem Land community. Until several years ago it was not apparent to either health centre staff or his family that Tim had any significant mental health issues. For much of his adult life, Tim had held a responsible position in his community with a number of people under his supervision. Tim was also married with several children. According to the AMHWs, his mental health problems were precipitated by his wife's decision to leave him.

Since living alone, Tim started to withdraw socially and remained isolated at home for days at a time. Tim began copying out phrases from the Bible and attempted to communicate to his family by writing them notes that became increasingly cryptic and impossible to understand. One theme that did emerge from his communications more clearly was an overpowering sense of loss relating to his former wife.

Concern for Tim among staff at the Health Centre was high, but his behaviour made it difficult to know how best to help him. Tim seemed to be taking reasonable care of himself, eating and sleeping enough, and for the health centre staff there was no obvious diagnosis they could make regarding Tim's condition. The local GP eventually rang a psychiatrist in Darwin who, according to the AMHWs, was unable to offer much assistance. Later a visiting psychiatrist came to the community and diagnosed Tim as psychotic and prescribed him anti-psychotic drugs. As Tim did not consider himself ill, he was not compliant with the medication. Neither was it possible to evacuate him to Cowdy Ward as he did not appear to be a threat either to himself or anyone else.

At about this time the two AMHWs from Tim's community took up their positions at the health centre. Little had been done to assist Tim at that point, and the AMHWs shared the concern of health centre staff. Tim's wife had by this time found a new partner which caused Tim even more grief. The new AMHWs were aware that Tim's aunt was probably the only person who would have some understanding of Tim's experience so they approached her to explore ways of assisting Tim.

The AMHWs decided to intervene by asking Tim's wife to join one of them and Tim's aunt in visiting him. The female AMHW arranged to meet with Tim's wife. Tim's wife expressed fears that Tim would be angry if he saw her and may try to belt her. However, after several hours of talking with the AMHW, she agreed that it could be of benefit to all concerned, and a few days later the meeting took place at Tim's house. After initial discomfort between them all, the AMHW and Tim's aunt went outside and left the couple alone. Half an hour later Tim emerged smiling and said to the AMHW, 'You make me a happy man now, Mum!'

This approach appears to have been consistent with the traditional system, according to which, if a man loses his wife or she is taken, then his rights have been denied. Traditionally, such a thing should be acknowledged and recognised by relevant people in the kinship structure. This need for acknowledgement usually extends to a wife's new spouse.

Later Tim felt that he needed to speak with his wife's new *balanda* boy friend as well. The AMHW contacted the man's boss and explained the situation to him. Shortly afterwards, the *balanda* came around in his four-wheel drive to pick up the AMHW on

> his way to Tim's. Again, the AMHW left the two alone inside the house until they had finished. Afterwards Tim came out and gave the *balanda* a big hug.
>
> Some eighteen months later Tim continues to take medication prescribed for depression and has gone to a neighbouring community where his brothers live. The AMHWs use their visits to the other community with TEMHS staff as well as news from inter-community travellers to keep updated with how Tim is going. According to the AMHWs, Tim is much happier, goes out fishing with his brothers and interacts socially with other people in the community.

Leonard's and Muriel's role includes the referral of clients who need medications to other practitioners for administration, bringing clients into the health centre for medications or delivery refilled dosette boxes to people's homes and following up on compliance in the community. Problems with compliance are ongoing and the GP reports that Muriel and Leonard play a significant role in recent improvements.

The clinic manager believes that a greater clinical role in terms of administering medications would strengthen the work they do and further support the health centre:

> 'Down the track what I can see as beneficial for them is that they also have a clinical role. That might be a little way away, but I certainly think that would be helpful, would empower them more and it would give them more autonomy, if that's the way they wanted to go . . . they may be able to take on more total patient care for those people who are just on a maintenance program, rather than having to bring them in for a zuclo injection and getting one of the nurses to help. If they could just do that it would make it more holistic, maybe more private, more culturally acceptable. . . . sometimes they need to know about clinical things, and at the moment they don't. I think it would only add to their ability.'

This concurs with the views expressed by the AMHWs themselves; Muriel and Leonard would like to increase their knowledge of western psychiatry so they can more effectively bridge western and Indigenous approaches to mental health care.

Over the last year the AMHWs have broadened and strengthened their relationships with other service providers. As Leonard says, 'If we don't work together, we're all stuck in the mud'. Michele Clark, the Social and Community Worker, has had a great impact on the community. There is a good link between the clinic and her position and she is very supportive of the AMHWs who work quite closely with her. Other relevant foci include Sport and Recreation and Youth Development Forum (YDF) meetings, monthly Youth Diversionary Scheme meetings, the Aged Care Facility, the police, schools, Town Council and Land Council and the visiting Domestic Violence Officer from DHCS in Gove. The AMHWs attribute a fall in over night lock-up rates to the impact of the YDF and better communication between the police and the AMHWs.

Networking by the AMHWs is supported by health centre staff. 'I think it's important', says the health centre manager, 'that they move between the community social worker, domestic violence, the different groups, youth development. I'm involved with the youth development and they come with me to the network meeting because a lot of the clients they are dealing with are youth, youth at risk, which is what the group is all about supporting.'

The evaluators were invited by the male AMHW to attend a YDF meeting at the Land Council office in Alyangula. Muriel and Leonard see an important part of their role in these community meetings as ‘ensuring that *balanda* people work well in the community, to translate for them and educate them’. These meetings have arisen out of the Youth Diversionary meetings with the police that commenced in late 2002. The YDF meetings take place monthly and are attended by representatives from several local organisations: the East Arnhem MHS, GEMCO (sponsor of the Youth Rehabilitation Scheme), the Sport and Recreation Officer employed by the Alyangula Council, the Angurugu health centre GP or the health centre manager and one or both of the AMHWs. The target group for YDF activities is youth at risk of court or prison system in the 12 to 28 year old age group. The aim is to establish both short-term and long-term programs through inter-agency planning and collaboration to divert these kids into other activities. Despite Leonard’s and Muriel’s presence and contribution to the meeting among non-Aboriginal participants, there appeared to be little reference to or interest in the contribution of the AMHWs to youth diversion.

Earlier in the year, Muriel and Leonard helped host a suicide prevention workshop and invited many local people to attend. They report that such activity contributes to a general increase in understanding of mental health issues in the community and reduces the stigma attached to mental health issues. This is suggested by the greater ease with which community members will approach them to discuss problems. In terms of general recognition, young people in the community have approached Leonard to ask him to be a football coach, while Leonard is also keen to start up music workshops for kids. His ideas extend well beyond those suggested by others in the YDF meeting.

Like the MHN at Galiwin’ku, the GP at Angurugu would like to see the AMHWs taking on more of a role in health promotion. The main issue to consider at Angurugu however, is the already busy schedule of Leonard and Muriel: ‘ It would be a good idea, but I don’t know whether they would have the time . . .we don’t want to stress them out too much. That’s the other thing [to consider], putting unreasonable workloads on them’. The GP believes they could competently talk about substance abuse and psychosis, how family violence causes depression, the effects of depression and the symptoms of depression so people can recognise it as well. Ideally, she would like to see schools and councils play a greater role in health promotion in collaboration with the health centre.

According to a local school principal, around 45% of children with the potential to be in trouble end up in court. There is a need to avoid early pregnancy, glue and petrol sniffing, *ganja* and illegal activities. Community attitudes are tolerant of *ganja* misuse. With Donna Mulholland’s (TEDGP) visit in October 2003, their work in schools commenced with both AMHWs addressing school groups on the risks of drug and alcohol misuse and general promotion of mental health.

The AMHWs refer clients to a traditional healer if necessary. Usually this is done quite discreetly but Muriel and Leonard can act as mediators or contact points for someone who may need to see such a person. The occurrence of such meetings is unlikely to be shared with other clinic members, particularly *balanda* staff. One such case that is known involved flying a local client to Katherine for two days to get help with a ‘cultural illness’. Muriel and Leonard arranged for funds from mining royalties to pay for the airfares. The client had been on psychotropic medication and anti-depressants for some months without improvement. The AMHWs report that the treatment in Katherine was successful and the client’s condition

disappeared without taking further medication. Similarly, Indigenous people have access to a range of bush medicines that can be used to treat mental health problems, such as depression. Although knowledge of these seems to be widely shared, Muriel and Leonard have on occasions suggested the use of these to some clients. Once again, this is generally kept quiet.

In the future, Muriel and Leonard would like to see the needs of men in the community addressed more to match the services available to women and to more effectively address issues such as domestic violence. The Angurugu GP supports this view:

> 'Everyone helps the women but they don't help the men . . . there's a huge need for behavioural management with anger control. And men want that too, not just women. Most of the men feel ashamed that they beat their wives or that they get angry and don't know how to deal with it otherwise and would really like to'.

According to one health centre staff member, the most effective and sustainable way to address the mental health needs of the community is about "empowerment":

> 'I think empowering the community, in the sense that if more people were gainfully employed, there would be a feeling of increased self worth, and not as much time to smoke *ganja*, not as much desire to smoke *ganja*. People smoke because they are bored, so you stop the boredom – more sport and recreation programs, cultural, music, an art centre, literacy and numeracy programs. Somehow that skill has to become relevant to the community.'

Muriel and Leonard would also like to establish an outstation rehabilitation centre available to youth, married couples or the elderly on land owned by Leonard's grandmother. They would also like to increase their work in schools raising awareness of drugs and alcohol, and establish facilities such as a music studio for young people to use.

Summary

This section has highlighted both the context of the AMHWs' work communities, and some of the breadth of the work they undertake both within and outside the health centres. In two communities the AMHWs' contribution to community health promotion has been substantially developed. In others, the AMHWs' non-clinical roles have remained under-developed for a number of reasons. These include lack of wider community support or inter-organisational cooperation between service providers, and perceptions among clinicians that psycho-social or "wellbeing" work is not within their capacity to support.

The view that clinical practice is necessarily separate from 'wellbeing' work, may be narrow. The experience at Angurugu indicates that AMHWs can combine basic clinical work and a focus on non-clinical community involvement, including relationship counselling and other health promotion, provided there is some support for this activity. There may well be justification for separate housing and development of a community based team responsible for social and emotional wellbeing in some circumstances. This requires community input and support, from both Indigenous and non-Indigenous agencies. The relationship between the health centre and *Yolngu* organisations at Galiwin'ku – as expressed in the comments of a number of GPs and other non-Aboriginal personnel over time - seems to present a particular challenge to the health centre which inhibits its staff from taking the lead in any non-clinical

developments. This may also be a reflection of longstanding priorities of the health centre manager.

It is clear that satisfactory management support cannot be provided by the GPs alone, as some GPs themselves have noted; progress has been made where other sources of support and guidance are available. At Angurugu, supported by the clinic manager and by the community's alcohol and other drugs worker, at Nguiu, and more recently at Galiwin'ku and Numbulwar where nurses with psychiatric training have been employed, the AMHW teams have the prospect of more systematically developing both clinical and non-clinical roles.

3.6 Coordination with Other Mental Health Services

Top End Mental Health Services

The Partnership Agreement o the AMHW Program stipulates that the mental health services of NT DHCS will provide inputs to the Program, in the form of services provided to the community and collaboration and coordination with the AMHWs in the communities. Mental health staff from TEMHS, consisting of the Darwin Rural Team, EAMHS or KMHS, visit participating communities other than Nguiu. However, the records of services provided are patchy. In client file audits conducted by the evaluation, the only recorded services detected were by EAMHS. These are entered into a separate Mental Health section in each client file. Nguiu files contained the occasional entry by a visiting psychiatrist in the *progress notes* but regular visits by TEMHS did not occur. No files were audited in Kalano and there were no entries from KMHS in Borroloola files for the audit period.

Elcho Island comprises the biggest client base for the Nhulunbuy-based EAMHS. Other Program communities visited are Angurugu and Numbulwar. An EAMHS mental health nurse visits each community once every five to eight weeks. On occasions when a psychiatric registrar comes to Gove, EAMHS either sends him or her to a community in particular need or arrange for clients to be seen locally. Overall, visits by a registrar to a community are rare (about once or twice a year). As discussed in Chapter 4, formal diagnoses of clients rarely take place in a community and are generally made only when a client is referred to Cowdy Ward at Royal Darwin Hospital.

When the Mental Health Teams are able to visit a community they generally consult with the AMHWs who may also accompany them on house visits, participate in clinic consultation or informal 'case-conferencing' with the GP and other clinic staff. However, EAMHS staff have expressed frustration at being unable to direct other health providers to participate in a case conference or teleconference between visits, due in part to the lack of clear stipulation of responsibility for ensuring these processes take place in the Partnership Agreement.

EAMHS see clients in Galiwin'ku and undertake assessments and reviews that the health centre do not have time to do. Often this is in the company of one of the AMHWs. '[EAMHS] provide more than we could but in the ideal world it would be good if we could do assessments and reviews and it would be better if supplied locally,' says the GP.

On visits to Numbulwar, the clinic will provide the EAMHT with a vehicle and a driver. The visiting team will pick up clients for consultation at the clinic, or review them in their homes.

Local staff -AMHWs, an AHW, or a driver - usually accompany EAMHS staff on their visits. A MHN from EAMHS consults Leonard and Muriel about the list of clients to review or see prior to visiting Angurugu, and is frequently accompanied by an AMHW when seeing clients. The audit of client files from Angurugu Health Centre reflects this vertical integration and communication, with the AMHWs having considerable input into clinical case notes.

Occasionally a psychiatrist visits the Tiwi Islands from Darwin and records of these visits can be found in both primary client records and AMHW field diaries. However TEMHS staff do not regularly visit the islands. While clinic staff at Nguiu report that access to TEMHS psychiatric services and specialist knowledge is adequate there are said to be communication issues which currently undermine the provision of optimal mental health care. According to other sources, the working relationship between TEMHS and clients on Bathurst and Melville Islands had diminished considerably from the levels reported in the mid 1990s (HealthCare Pty. Ltd., 2003). There was a belief amongst THB staff that 'we don't need more psychiatric services, we need better communication between them [psychiatrists] and our GPs.' The main perceived value of psychiatric visits to the Islands among staff is that they establish familiarity between clients and the visiting practitioners, particularly valuable for clients who may find themselves in Cowdy Ward at a later date.

Katherine Mental Health Services operate across 350,000 square kms and for the last two years has been operating with a reduced compliment of staff. KMHS indicated that fortnightly community visits would be possible if staffing levels were improved. This would include an overnight trip or longer at least once a month, and day trips to several closer communities. Ideally they would see one community every six weeks. However staff shortages have meant that this has not been possible for at least two years. Among the Program communities this has affected Borroloola and Kalano.

The Program's Vision for primary mental health services in remote communities embraces the ideal of 'learning both ways': that all participants recognise the essential knowledge held by the AMHWs around culture, family and traditional ways of working in mental health, and work to facilitate shared primary mental health care between AMHWs, GPs and the visiting mental health team in an environment of cross cultural learning (TEDGP 2002: 3). AMHWs and staff at EAMHS report that their working relationship has strengthened over the last year. Communication has improved and understanding of the scope of the work, the skills and knowledge of each party has increased on both sides. AMHWs and EAMHS have reached a mutual understanding of common goals and appear keen to strengthen their working relationship. GPs also report a good working relationship with EAMHS. They generally see EAMHS as providing oversight, adjusting medications as needed and monitoring and reviewing clients where resident health centre staff lack the time. Besides the fact that visits are infrequent and short, the only problem identified, that could undermine all gains made, is the high rate of staff turnover. Even with some consistency of staff, the decision of EAMHS to alternate visits to different communities between staff makes it extremely difficult to establish any rapport with clients.

Promoting mental health literacy on communities is part of the mandate for EAMHS. One route by which they hope to achieve this is by allocating time for talking with community members. EAMHS see this as an opportunity to also hear community members' views on how mental health services could best meet their needs. The perception of EAMHS by the AMHWs appears to have shifted from an early view of EAMHS staff overstepping their

mandate in communities and lacking the cultural skills to be effective educators, to one where the AMHWs see value in the complementary approaches of both Indigenous and non-Indigenous approaches to mental health care. Several of the AMHWs are keen to learn about western psychiatry and to have EAMHS explain terms such as psychosis and neurosis during informal discussions when they visit. GPs and RNs also find EAMHS staff a valuable resource in this regard and most comment that they would like to see this explored more.

EAMHS staff would like to see support for the development of AMHW skills in their ability to bridge the perceptual/knowledge/cultural barrier, such as the gap between western and Indigenous approaches to mental or psycho-social health and their ability to play a role in educating western mental health workers. EAMHS say that the AMHWs have helped them to communicate more effectively with Indigenous clients and that their presence during consultations has proved invaluable. However, any culturally attuned communication with clients is not being reflected in EAMHS entries in primary client files - these stick rigidly to mainstream categories of assessment and contain little other information.

It has been reported here that two AMHWs are working on dictionaries of western psychiatric categories and Indigenous concepts pertaining to mental health. As their knowledge of mental health care has increased, AMHWs have taken on an educative role within their communities by endeavouring to convey to people that mental health does not only deal with 'the crazy ones'. It may be appropriate for the AMHW Program to identify resources to assist such projects.

There is scope for communication between the AMHWs and EAMHS staff to be more open. AMHWs could make contact with EAMHS staff for advice on a client, rather than keeping a problem localised as tends to be the case at the moment, and EAMHS staff could benefit from calling AMHWs in the communities between visits to monitor clients. Such contact between visits occurs with other health centre practitioners and is something that is likely to develop over time with AMHWs as trust and understanding on both parts increases. EAMHS currently contact AMHWs regarding people from their communities who are in crisis care in Gove.

Cowdy Ward, Royal Darwin Hospital

In a study of the Aerial Medical Service evacuations records, Fung (2003) reports that while all medical evacuations have decreased, psychiatric evacuations from Top End communities have *increased* in number for 2002 and 2003 compared to all years between and including 1994 and 1998. The most common referrals are reported as substance-induced psychosis and 'situational crisis' (such as attempted suicide without depression). Trends for individual communities over the years are not currently available.

A total of twelve hospital admissions occurred for Angurugu, Nguiu, Numbulwar and Galiwin'ku for the twenty four clients whose files were audited over twelve months. Most of these admissions were to Cowdy Ward at the Royal Darwin Hospital. Some health centres suggest that emergency evacuations for mental illness may have decreased over recent years. However, for the 744 patients admitted to RDH and diagnosed with a mental health condition, for five participating communities from 1998 to 2003, hospital admission rates show an increase each year from 1998 to 2002 for females and an increase for men over the same period except for 2000 and 2001. For total patients the number of admissions has increased

from 65 in 1998 to 177 in 2002, with a slight decrease in 2000 and 2001 (see Table 28, below).

Contact and communication between Cowdy Ward and remote health centres is an important element of mental health practice which is at times reportedly problematic. Problems surrounding communication protocols and legislation regarding evacuees from other remote communities have been identified in the larger Northern Territory context (Healthcare Pty. Ltd., 2003). Program participants identify problems concerning: a) evacuations from communities that the hospital considers inappropriate, b) lack of consultation with communities upon assessment for admission, c) early discharge or discharge without adequate support or supervision. Practitioners report a general difficulty in establishing reliable communication protocols with hospital staff, including contact between AMHWs based at Cowdy Ward and remote community-based AMHWs.

However, experiences working with Cowdy Ward vary across communities. Galiwin'ku Health Centre staff report that communications, as with EAMHS, are good and that when the health centre has had to ring up the ward to request follow up on a client, the process has been unproblematic. Similarly, discharge summaries are forwarded to the health centre promptly. For Angurugu, contact with Cowdy is 'sometimes good' and 'they are usually reasonable with their discharge summaries', but there have been two or three occasions when psychiatric patients have been evacuated out without then being admitted to hospital:

> 'They've been admitted here and they get to Darwin A&E and they sit there for a while and then they assess them and they decide that they're not as psychotic as when we've sent them out. It hasn't happened a lot . . . certainly when we've sedated, gone through the whole rigmarole, it's very concerning for families . . . we evacuate them because they're beyond community management. If they get to Darwin and then they're discharged, with no family support . . . Beyond community management for us and RDH are two very different things.'

Separation from the triggers in the community including availability of substances affects how a client presents. However, putting them out into the communities again without being admitted, says this RN, also causes families concern, while clinic staff feel that it reflects poorly on them. This problem is noted by several participating communities: Angurugu, Nguiu and Katherine/Kalano. In 2002, the Nguiu GPs had a number of exchanges with DHCS personnel over similar matters, in particular over policies regarding admission and subsequent return of clients to communities of origin.

A manager from another health centre related their experiences:

> 'That's been a real heartbreak, sending patients in. One client we sent in and his wife followed him in the car and he was discharged before she even got there. I have a real problem with psychiatric services. They discharge too early without a doubt and there's no consultation with us before they discharge them. They get them, they review them and they see how they present at the time. The clinic is not brought into the equation at all and the family circumstances aren't brought into the equation either. I feel very sad for families when they put up with a heap of crappy behaviour and it's actually discounted when they get to town. It makes me so angry. I think that's an issue that every clinic has with Cowdy. It sounds like they just don't have the resources. I think all staff in those services need to spend time on a community.'

Cowdy Ward staff suggest that there are problems with the selection of patients in communities: 'We do have a lot of air meds coming here that shouldn't be sent here . . . Clients are not selected out properly at point of origin . . . These are instances of a social problem.'

Numbulwar health centre reports that mental health-related evacuations were occurring monthly throughout late 2003. The relationship between the clinic and Cowdy Ward is described as good and perceptions of services provided by Cowdy as positive. However, the former AMHWs at Numbulwar did not communicate with Cowdy Ward staff. Staff reported surprise at the rapid discharge of some Numbulwar residents from Cowdy Ward. Overall, staff aim to be realistic about the priorities of the evacuation service, noting that physical emergencies such as heart attacks or trauma may take precedence over psychiatrically-related evacuations.

There is a perception among Nguiu Health Centre staff and the MHT that RDH secondary care staff are often unaware of the scope and complexity of mental health work that is undertaken on the islands. Nguiu staff state that the quality of care delivered to Tiwi people using RDH inpatient services varies with the attitudes of individual members of the RDH psychiatric team. There is also a perception amongst Nguiu service providers that not all the psychiatric specialists employed by Cowdy Ward appreciate the value of the Tiwi AMHWs' knowledge, and that they have not consistently demonstrated an interest in collaborative care and inter-agency communication between the islands and Darwin. A member of the Nguiu MHT stated that some Cowdy Ward psychiatrists are reluctant to take client histories from Tiwi AMHWs, and will only speak to medical personnel.

When Tiwi Islanders are admitted to Cowdy Ward, the Tiwi MHT endeavours to provide support and cultural brokerage. The MHT believes that in some cases it is more beneficial to Tiwi clients to have access to a Tiwi AMHW who can provide a link to family and community. Although the MHT is able to visit and support clients admitted to RDH, this could be rendered more effective with improved communication between RDH and the THB MHT. Overall, the AMHWs at Nguiu feel that they are under-informed about Tiwi clients once they are in the care of Cowdy Ward. They report that RDH staff often do not contact them about Tiwi clients, either at admission or discharge.

As has been noted elsewhere (Hudson 2001), discharge summaries from RDH often arrive at the community health clinic well after the return of a patient, (as noted above, some communities report no significant delays). The Tiwi Team believes that clients are sometimes discharged from Cowdy without travel arrangements. There is also a perception amongst clinic staff that Tiwi clients are sometimes prematurely released from Cowdy Ward after involuntary evacuation from the Islands. These evacuations occasionally occur because current legislation dictates that formal psychiatric assessments may only be conducted by staff in Darwin or Alice Springs.

According to health centre staff Cowdy staff do not consult with the community health centre over the decision to admit or not to admit the patient. Nor does Cowdy Ward inform the health centre that the client has not been admitted. Health centre staff usually find out 'via the grapevine', when they may hear from the family that the patient is out in the long grass or somewhere else in Darwin. If a discharged patient is booked in to return to their community

by the Patient Assisted Travel Scheme (PATS), this does not always ensure that the client returns to the community. Patients are not monitored after discharge. This reportedly causes great frustration to health centre staff who have had the client under high surveillance to ensure their safe arrival at RDH. Through the PATS system clients are entitled to a return fare. Clients defaulting on PATS bookings commonly have no means of getting back to their community. If clients do not wish to return to their community, Cowdy Ward staff try to find accommodation in Darwin but point out that clients often 'burn their own bridges' with accommodation services by, for instance, leaving without paying. This is felt to reflect badly on Cowdy Ward. Staff may also assign a case manager through the Tamarind Centre for clients discharged into Darwin.

Summary

Community based mental health services in most remote communities are undeveloped. The intermittent visits of traveling Mental Health Teams do not engage consistently or extensively with clients in the communities, and do not yet articulate fully with the community based teams developing within the AMHW Program. The AMHW Program has the potential to strengthen the vertical links between primary and secondary mental health services.

The issues outlined in regard to Cowdy Ward are complex, and might ultimately only be addressed through strategies to fill the gaps in services between a secure psychiatric facility and the under-developed and under-utilized outpatients' and respite services in the major centres. These services might attend to many clients who would benefit from treatment outside the community. For the purposes of the AMHW Program, attention might be given to development of a project to trial protocols for general communication between community teams and RDH, with appropriate case conferencing after discharge of patients.

Clinical and non-clinical roles for AMHWs in remote area practice

AMHWs work both in the health centres, supporting clinical mental health practice, and in the communities, not only visiting patients, but conducting various forms of non-clinical health promotional activity. It has been suggested by participants in most locations that clarification of role expectations needs to occur. There is great diversity in the work done, and, probably, some inconsistency in the way in which it is done over time. The non-clinical, health promotional work of the AMHWs lacks formal support and appears to have evolved in each location according to the preferences and skills of AMHWs, the preferences of local health staff, and the degree of support and collaboration available from other community agencies.

The evaluators consider that the role of the AMHW in the community should not be divorced from the AMHW's role in clinical mental health care, although the possibility that some community health workers could primarily work in non-clinical mental health promotion, counselling or other areas of community education without a clinical focus should be considered. However, such a role would then need to be supported by a community-based public health or social services. It may not be within the capacity of GPs or health centre RNs alone to support this work.

Considering the specific role of the AMHW within the current Program, it is suggested that for pragmatic reasons alone, it is necessary to ground their role in community mental health by strengthening the supports for clinical practice and by involving AMHWs in collaboration between practitioners both in the community and in the centrally located facilities. Links with

other agencies with responsibilities in public health, substance misuse, domestic violence or community education can be built on this basis.

While the lack of support for the AMHWs' role in community education has been emphasize by practitioners in some contexts, it is also clear that basic clinical practices have not yet been developed to meaningfully involve the AMHWs as far as might be achieved. This area of development is pursued in the following chapters.

Chapter 4. Systems of Delivery of Mental Health Care

4.1 Introduction

This chapter examines key aspects of the systems of health care in participating health centres, with particular reference to elements of organisation and infrastructure which may influence the development of the AMHW's role in community-based mental health care.

International literature indicates that clinical practice needs to be supported by effective leadership, management support, protocols, training, information technology and feedback to practitioners about performance (Shediac-Rizkalla 1998; Steckler 1989). As has already been observed, the specific arrangements to support the AMHWs vary considerably across the communities. The evaluators consider that improvement of systems and infrastructure, and processes of management and collaboration are needed both to underpin the sustainable development of community based mental health care and to adequately support the role of AMHWs and other providers. In this section, the evaluation looks at systems of record keeping, processes for monitoring and review of patients, care planning activity, with particular reference to the place of AMHWs in these processes.

Our intention in focusing on records of activity is not to try to measure mental health outcomes for clients. This is not possible within the resources of the current evaluation and the quality and completeness of medical information. Rather it is to assess the degree to which systems of practice as reflected in the records are able to include and support the work of AMHWs in mental health practice. In one sense, this part of the investigation tests whether indeed 'the care is in the *progress notes*' as was asserted by the RN cited above.

In focusing on the health care record, we make a number of assumptions:

a) that not all, and in some areas of practice, very few services actually conducted are recorded,
b) that the quality of recorded information is an indication the capacity to coordinate, plan and review the provision of services to any given standard or set of outcomes,
c) that the system of medical records is necessarily a key underpinning of organised practice, an important focus of training for professional practice, and a key underpinning of sustainability and continuity of clinical care.

It is evident from the material presented here that (with the exception of one community) the greater proportion of records are kept or entered by non-Indigenous practitioners (GPs, RNs) and very few by AMHWs. The quality of recorded information and the degree of reference to AMHW activity is therefore largely a reflection of pre-existing habits and preferences of these practitioners, and the limitations of the systems available to them; however, it is also an indicator of the degree to which these practitioners have endeavoured to incorporate AMHWs into clinical work.

Concerning practitioner habits and preferences, medical records usually emphasize records of clinical measures and medications rather than counselling or health promotional inquiries.

Whether or not the latter have been carried out, they are less likely to be recorded (Robinson & Bailie, 2002). This can take an extreme form. For example, the consultation information recorded by one General Practitioner in the files audited for this study did not contain any information other than the numerical value of blood pressure, or other clinical measure such as weight or pathology result, or the name and dosage of medication prescribed. Auditors were unable to find a single instance of qualitative information about interaction with the client, or about the clients' manner of presentation or circumstances recorded by this practitioner in the twelve months audited.

Therefore, if steps are to be taken to improve the integration of AMHWs in systems of clinical practice, it must be understood that this will require not merely encouragement of AMHWs to record their activity, but considerable change of recording practice and consensus about objectives on the part of *all* practitioners.

4.2 Health Centre Systems: Records of referral, assessment and review

Overview of record keeping practices

Across the communities, including those where audits were conducted, a range of systems was in use or being developed to track mental health clients. Some health centres are able to generate lists for various purposes. At the time of the audits no health centre maintained a complete list of patients receiving *both* psychotropic drugs *and* other forms of mental health care. The Tiwi system can generate client lists according to medication item for those who have been entered on CCTIS; Nalkanbuy Health Centre in Galiwin'ku and Numbulwar Health Centre maintain up to date spreadsheets of mental health clients in receipt of medications. However, these systems are not reliable in that they generally do not capture clients who are not or have not recently been on medications. How this impacts on service delivery and patient care is difficult to assess without further investigation. It is certainly an indication of limited resources and financial support available to remote health centres, and of the fact that in most centres, practice has evolved unsystematically, without clear institutional planning and support. The lack of purpose-built mental health data systems limits availability of reliable information concerning numbers of clients, services due, planning, consultation and treatment. As a result, coordination of services and follow-up of clients is not well supported in any location.

Communities have joined the Program at different times, and as a consequence, the time they have had to develop their systems of support varies considerably. In general, the situation in participating health centres simply reflects the uneven development of data and recording to support mental health care across the NT. In addition, turnover and re-recruitment of staff also heavily influence the sustainability of systems in each site.

Borroloola

While functioning, the Borroloola Surgery maintained its own electronic client files. The AMHWs maintained separate paper records on each client, while the DHCS clinic maintains hard copy records for all attending clients. The multiple systems in use at Borroloola are in themselves problematic from the standpoint of transparency and continuity and coordination of care between providers. This is not a tenable basis for a future regional health service, and

is ill suited to promote the work of the AMHWs within the health care system. Gulf Health Service does not plan to continue with the electronic system set up by the departing Surgery GP, but will consider other proven options.

The electronic files at the Surgery were not made available to the evaluators by the departing GP, but were accessed by proxy through a mental health nurse visiting from an East Arnhem Land health centre who had access to some information from these records. Before the surgery closed, the GP had been sending the DHCS clinic monthly patient updates and the clinic had access to the GP's electronic database. The DHCS clinic itself does not currently have an electronic database, but is working towards developing one through a community health network program. The Katherine Mental Health Services (KMHS) visiting team includes its client records in the DHCS clinic files only. The AMHWs are entitled to access both sets of files although access to the DHCS files is relatively recent, a result of talks between the DHCS clinic, BIITE and TEDGP. AMHWs do not, however, enter consultations in DHCS clinic files.

DHCS files contain reasonably comprehensive *progress notes*, KMHS consults, pathology test results and specialist reports. Indigenous mental health clients' files at the DHCS clinic are in part a repository of information generated elsewhere. This is because chronic conditions, including mental illness, have been treated through the GP surgery, as well as the fact that Indigenous clients have also tended to use the AMHW/GP services for acute mental health problems. The DHCS files are the primary location of records of mental health consultations undertaken by KMHS. The majority of these derive from referrals to KMHS from the DHCS health centre, with a number referred from the GP Surgery since the commencement on the AMHWs.

The AMHWs keep their own paper records for clients seen by them. These are stored in the AMHW office in no discernible order. The AMHW files record the development and aetiology of the psycho-social crises of clients. Details of these events are recorded in the form of fairly minimal notes by the AMHWs, and include some correspondence between agencies regarding each client. These include some discharge summaries from Cowdy Ward, correspondence between health services and police on legal matters, and correspondence from FACS and similar agencies. These files do not appear to contain records of ongoing follow-up and monitoring work; such activity had been generated by lists provided by the GP, and there is no correspondence between the AMHW records and any information available from the GP database. These records are an incomplete mental health record for many if not all clients, since each client will have records elsewhere.

Many of the people included in the AMHW files are not clients of the visiting KMHS team. Rather, some of the names are of people who the AMHWs 'keep an eye on'.
Their files also record the names of people who have passed away and whether these deaths were alcohol related. In creating such records, the AMHWs have built up a partial profile of their community with regard to its past and recent alcohol related problems. They might be a useful resource to inform health promotional and educational work about the links between alcohol use and community deaths.

During the evaluator's visit Warren made it clear that only one of the six clients for whom he had records was an 'active' client, receiving care for a schizophrenic condition with acute

ongoing symptomatology.[6] None of the other clients had received documented care for mental health, or social and emotional wellbeing related conditions in the last twelve months.

The decentralised nature of mental health care in Borroloola, the fragmentation of records, lack of access to the Borroloola Surgery electronic files, and the fact that the AMHW had only one ‘active’ client, meant that there was little to be gained from a thorough audit of files. The situation in Borroloola should be re-examined once Gulf Health Services have become established in the region.

Files examined by the evaluators at Borroloola thus reflected the then current caseload of the AMHWs in records held by them. Generally speaking, the Borroloola clients whose files were examined had a range of physical and social problems related to long-term substance misuse, such as liver damage and other health problems, depression, suicidal ideation, and injuries caused by alcohol-related accidents and violence. One of the clients had no history of significant substance abuse; her presenting problems arose as a result of physical, sexual and emotional violence at the hands of other community members with alcohol-related behavioural problems. Psychosis and schizophrenia were not evident in the sample. The information obtained on these clients is presented in Appendix I.

The situation at Borroloola illustrates the challenge of providing adequate systems to support mental health care. Data is incomplete and fragmentary in each of its many locations; there are at best poorly supported systems for referral and monitoring and recall; the AMHWs do not contribute to records of consultations and do not have access to a common system to source patient information. Such records of their health promotional work as do exist are excluded from all other records, and they receive no support to independently develop these records. Future development of the AMHW Program at Borroloola must be linked to a strategy to overcome these deficiencies over time.

Galiwin’ku

At the Nalkanbuy Health Centre in Galiwin’ku, electronic lists of patients receiving medications for a mental health disorder are maintained by the GP and passed regularly to the MHN and former AMHWs. They monitor these patients and either bring medications to the client in the community or the client to the clinic. The AMHWs transcribed lists provided into their own work diaries. This system appeared to work well and to enable care providers to reliably track mental health patients receiving medications. It also meant that an historical record of follow-up activity was being developed. The lists detail the type of medication (oral or depot), dosage, frequency of administration, date last given, date next due and any comments that identify a client travelling, recent changes in medications, the need to review, or particular signs or symptoms to monitor.

However, only clients receiving medications are monitored by this system, as it does not include clients receiving other forms of mental health care. This narrow clinical emphasis reflects the priorities of and resources available to this particular health centre. Although the

[6] It is of interest that at the time of writing there is only one community resident in Borroloola displaying florid delusional behaviour and/or receiving anti-psychotic medication in contact with the community’s AMHW. It is unknown if there are other individuals who may be accessing the services of KMHS.

stated desire of the GP and MHN is to be able to support a broader range of mental health care options, the system does not currently support this.

'Not a lot has happened in terms of incorporating AMHW comments into centralised records', explains the MHN. 'When we're interviewing they actually do all the interviewing and interpreting and feed the information back to me and I document it and when they've been seeing people at other times they come back and tell us the story but they haven't actually documented it in the notes.' Although the *progress notes* do contain some entries by the AMHW, the nurse agrees that some AMHW-provided mental health services are not recorded in the client files. He feels that it 'is certainly something that [they] could work at.'

The files of Galiwin'ku mental health clients are divided into three sections. Section A contains the general *progress notes*. These are preceded by summary data on client health status, a summary of medications received on a form titled 'Regular Depot Injections for Psychiatric Conditions' and a 'Medication Profile' sheet. Section B is the Mental Health Section that is seen in all three communities serviced by EAMHS. It contains copies of the electronic file entries prepared by EAMHS after each visit and details of each review or attempt to consult with a client on their visits to a community. Section C contains letters and correspondence from specialists similar to that found at other clinics such as Angurugu and Numbulwar. It is in this section that official diagnoses are found.

Numbulwar

Systems to support mental health practice at Numbulwar are clearly at an early stage of development. Numbulwar Health Clinic uses a paper files system. At the time of the audit, the AMHWs had only been contributing to patient files for two months, and entries by them in clients' *progress notes* seen by the evaluation team were minimal. Although scant in detail, these entries nevertheless represent records of contact between mental health service providers and clients. They contain generalised and informal assessments of the relative wellbeing of clients, and notes on medication uptake. Regardless of medically or psychiatrically useful content, the AMHW entries record monitoring of and contact with clients for whom clinical attendance may be minimal and infrequent.

An RN employed by the clinic deals with mental health issues; she has inserted a 'chronic medication' sheet into the files of clients who have been receiving medication to treat psychiatric conditions on an ongoing basis. This sheet contains the date that medication is due to be administered, and the date on which it is actually given. The files of identified mental health clients contain a Mental Health Section, which contains notes from EAMHS).

There is as yet no established pattern of referral between practitioners in the clinic. Clients may nominate whom they wish to see upon arrival. Clinic staff receive information from community members regarding behavioural changes of clients and others whom the concerned party believe warrants attention. Samuel and Mary were also a channel for information between the community and clinic staff.

Angurugu

At Angurugu Health Centre a list of mental health clients who received medication was formerly maintained by the clinic manager. This has been abandoned since the AMHWs have

developed their own diary-based system to monitor clients and ensure that they receive medication when due. For reasons of confidentiality, the clients and service events recorded in these are not entered into the central client files. Given that this does mean that some information is excluded from patient records consideration could perhaps be given to some minimal recording of these events in the central client files in a way which does not compromise client confidentiality.

> The clinic manager: 'That's what we wanted, for Muriel and Leonard to write in the notes, how can we provide best practice of care if we don't all know what's happening? Say there's someone who's been through the system here today and maybe we or they go up town for the nights, so the nurse on call, and it may not be any of our staff, it may be the nurse from town, and the GP from town, so they at least know what's going on. That's just done without question.'

Entries pertaining to mental health care in the Angurugu Health Centre records appear in the general *progress notes*, the separate Mental Health Section, the Correspondence Section and a Prescription Section. The format is a standard one and close to that used at the Galiwin'ku health centre. All providers at the health centre contribute to the general *progress notes* which include regular and comprehensive entries from the AMHWs. The Prescription Section includes a list for current medications on a 'chronic medication' sheet that is included for long-term users of psychotropic medications. Although there is no formal referral system between clinic staff, any referrals are recorded in the main clinic files. All staff, including the AMHWs, record any both consultations and referrals.

The system of monitoring clients probably encompasses a broader range of clients and mental health issues than the previous lists. On request, the AMHWs were not able to convey how many clients they monitored, a breakdown of conditions or types of medications being administered. To that extent, the system probably warrants some improvement to provide a record of activity transparent to all. Overall, the AMHWs at this clinic contribute significantly to central client files and a great deal of their work at the clinic and in the community is recorded here.

Nguiu, Tiwi Islands

The Tiwi Health Board (and now the Tiwi Islands Health Services) keeps a set of numerically ordered paper files in a standardized format for all clients, in which the majority of client information is stored. The system was redeveloped and standardised in order to meet requirements for AGPAL accreditation of the Tiwi Health Centres. At Nguiu, patient files are kept in a password-locked secure central records room.

The service also uses the CCTIS electronic system in all health centres. This system was introduced during the Coordinated Care Trials in 1997/1998. CCTIS includes standard care plan protocols to enter diary items for the management of a number of diseases, which ensures that due care plan diary items can be seen whenever a client's record is accessed. However no standard care plans for mental illness exist. A number of items in the system, such as psychiatric nurse consultations and psychotropic medications, do enable CCTIS to be used in a limited way as a search engine to identify clients due for a specific mental health service.

Table 7: Number and source of mental health services for audit sample over 12 months

Client	Total Recorded MH Services*	Number entered in CCTIS	Number entered in Paper File	Entered in both CCTIS & Paper File
Ngu 1	23	15	18	10
Ngu 2	10	5	7	2
Ngu 3	38	22	30	14
Ngu 4	16	8	14	6
Ngu 5	11	6	10	5
Ngu 6	3	0	3	0
Totals	101	56	82	37
% of Total	-	55%	81%	37%

* Mental Health Services include all entries in the filing systems which include a mental health component: eg., consultation at the clinic or in the community, evacuation to Cowdy Ward, RDH or case-conference with other service providers.

Nevertheless, given that the majority of clinical service provision is recorded elsewhere, in the paper files, this is a very limited capacity. A GP or a registered nurse working in the clinic usually records the provision of psychiatric medication in both systems. Together these two record systems comprise the official client record of the Tiwi Islands Health Service.

Although intended to be the main repository of client data in the Tiwi Health Centres, the CCTIS database appears to be less used than the paper file system, and the CCTIS record of each client usually contains a less detailed version of consultations recorded in the *progress notes*. Since the introduction of MBS (Medicare) bulk-billing in 2002, the CCTIS system has seen more frequent use to record MBS items to ensure payment of benefits. Thus medication histories are more readily available on CCTIS, while the majority of information describing client assessment and much routine service activity is not entered into this system.[7]

Table 7 shows that there is no one complete record of service provision at Nguiu Health Centre. Only 37% of service events are entered into both paper and CCTIS files. Fifty five per cent of services are recorded in CCTIS electronic database and 81% of services are recorded in paper files. Of the three methods of recording mental health service provision at Nguiu, the paper *progress notes* were the most widely utilised and provide the main record of client

[7] Staff using CCTIS complained of useless data retention, limiting categories of service type, an unnecessarily difficult 'front end', and difficulty in accessing current medication schedules. Users comment that the CCTIS system is unwieldy and ineffective, particularly because the client diary is inundated with automatically scheduled services. Training in use of the system was also said to have been insufficient. CCTIS had been the subject of protracted negotiation between DHCS and the Tiwi Health Board, and was to be replaced by PHCIS, the next-generation *Primary Health Care Information System*.

contact with the clinic; however, they are not the basis for monitoring, follow-up and recall of clients.[8]

The data recorded in Table 7 is incomplete in that neither paper nor CCTIS files record AMHW service provision. A large part of AMHW activity does not occur at the clinic and is not recorded in these systems, other than the rare mention of AMHW attendance at a consultation recorded in the *progress notes* by an RN or GP. AMHWs do not enter their consultation activity in the *progress notes* and are required to maintain separate field diaries. These comprise the only written record of services provided by the AMHWs. They are stored separately from other central health centre files in their own building adjacent to the health centre and originals or copies are made available to the Mental Health Nurse. The diaries of the Nguiu AMHWs are discussed further below.

Records of consultations are recorded in the *progress notes* by GPs, RNs and AHWs and the occasional visiting psychiatrist. Diagnoses, pathology reports, MBS services and documentation from health and allied service organisations are also stored in the client file. The *progress notes* represent an accessible central record that can be easily supplemented with additional notes.

Consultations recorded by visiting TEMHS psychiatrists are usually marked with the practitioner's signature, which doesn't readily identify role or identity. The AMHW journals record the date of a visit and the MH clients due for a consultation with the specialist. The only other evidence of the visits is on CCTIS, although consultations appear here only if medication was dispensed and entered as a GP consultation. Cowdy Ward staff maintain their own records of the visit.

The use of three separate systems between the health centre and the AMHWs to record the history, service provision and case management of mental health clients at Nguiu appears far from ideal. Evaluation of the Coordinated Care Trial noted inconsistency of data entry such that there may be no certainty for users where a client's most recent contact is recorded and the electronic system has limitations as a recall system (Tiwi CCT Evaluation Team, 2001). This characterises the situation of mental health services as much as any of the chronic conditions for which the system was ostensibly developed.

It is unknown to the evaluators what percentage of services remains unrecorded at Nguiu (as in any other centre). Medications dispensed on call-outs are not reliably entered in CCTIS, according to staff. Staff at Nguiu stated that service provision (particular acute care) must often take priority over data recording. One of the GPs stated that this was particularly true in mental health, because they felt that some of the non-clinical services delivered are relatively intangible. The significance of the 'human' element of service delivery to mental health clients on the islands remains unknown. As one GP joked, ' I dispensed six smiles today'. Other

[8] At the time of evaluation audits, the Tiwi Health Board's services director was considering the development of an 'active' and 'passive' list of mental health clients. Those on the active list have recurrent problems and on are psychotropic medications. Those on the passive list continue to be monitored, but have not presented or been treated recently and are not currently taking psychotropic medications. Clients on both lists would be regularly followed up by the AMHWs. Many of the clients would be seen by the AMHWs in the community, but those with psychosis or dangerous depression would be brought into the clinic. Following a review and/or case conferencing the two lists of clients would be adjusted as necessary. Given the replacement of the Tiwi Health Board by a DHCS-run Tiwi Health Service this development may not be pursued.

services provided during mental health-focussed consultations such as counselling and education are more readily transcribable, but are not systematically recorded (cf Robinson et al., 2002).

There is very little sharing of *recorded* data between the MHT and other service health workers at Nguiu health centre. Clinical staff do not access AMHW records, and AMHWs do not access either CCTIS or paper files. The RN or MHN provide lists of clients due for follow up and medication, either printed out from CCTIS or handwritten. A referral sheet also exists for referral of a client to the AMHWs by a nurse (although these were not found in those files audited).

Policies and practices regarding mental health data recording at Julanimawu Health Centre have varied since the early development of mental health services there, before the commencement of the CCT. In 2000-2001, the then MHT co-ordinator, a Mental Health Nurse, initiated a separate system of files for mental health clients. During this period regular clients of the Team had two paper record systems, one of which was specifically for mental health care in which the AMHWs made written entries. The mental health files from this time comprise a more comprehensive single record of client history and service provision than the current parallel systems of client records. MHT documentation and DHCS assessment, diagnoses and discharge summaries are all more commonly found in the mental health files from this period. However, the two-file system was abandoned in 2002 due to confidentiality requirements of clinic accreditation.

There is a largely informal chain of verbal communication between the MHT and clinical staff, mostly unrecorded and premised on the view that it is more important that AMHW services be provided than recorded. This undoubtedly constraints further development of the contribution of the AMHWs to clinical care. A shortcoming of informal systems is their vulnerability to turnover of staff and other systemic change. Furthermore, as identified, the existence of separate paper records and electronic records, each incomplete and each with distinct limitations in terms of ability to support client recall, care planning and coordination between providers, is a constraint on development of the mental health service generally. In particular, the exclusion of AMHWs (as at Borroloola) from recording of consultation activity is a deficiency which should be overcome, for reasons discussed more fully below. At the time of the file audit, the THB Services Director expressed the view that trained AMHWs should access and enter consultations in the main health centre files, citing as evidence, the quality of their entries in the AMHW Field Diaries. These are discussed in some detail here to illustrate issues relevant to development of AMHW roles in mental health care.

AMHW field diaries

As stated in the Partnership Agreement, the establishment of AMHW field diaries was intended to be the outcome of a cooperative effort between the TEDGP AMHW coordinator and BIITE (TEDGP 2002). Field diaries are used by AMHWs in most locations although the way they are used and their content varies considerably. The intention of BIITE was to train the AMHWs to use their diaries as reliable records of their client base, the services they were delivering, and the mental health problems and illnesses they were seeing. The diaries were also intended as a record of activity that could be used by the TEDGP in reporting on the Program to funders. Although in use, their intended purpose has not been fully realised. In some instances they are used purely to monitor medications (eg. Galiwin'ku), in others they

contain minimal notes on clients seen (eg. Numbulwar) and in others they contain confidential information on clients and are not normally viewed by other health centre staff (eg. Angurugu). The most comprehensive entries in diaries were found at Nguiu. They will be discussed in a little more depth to illustrate implications for AMHW record keeping.

The original intended purpose of the Tiwi diaries was as a means of documentation of AMHW activity. The content of the diaries does not enter the client files nor are the diaries consulted by health centre staff. The use of the diaries by the AMHWs at Nguiu has been supported by the manager of the Tiwi Mental Health Team, Glenn Norriss who uses them primarily for managerial purposes. Once viewed by Glenn, the diaries are not used for any other purpose.

The diaries provide an interesting picture of the range of activities of the AMHWs and evidence an extensive amount of mental health care activity outside the clinical context that is not recorded elsewhere. The diaries document the role that the AMHWs play in critical incidents involving harm or self-harm, often with a substance misuse component, in the ongoing monitoring of clients receiving medication, clients at risk of violent behaviour or simply in responding to those whom the AMHWs know to have been involved in some form of conflict in the community. They document numerous incidents wherein the AMHWs provide a first port of call outside the clinic for people after hours. In such situations, the AMHWs have been able to provide immediate care and protection, counselling, or intervene to moderate a potentially critical situation or ensure the attendance of those involved at the clinic the following day. The majority of this activity and their effectiveness derives from the position and status the AMHWs hold within their community. In this sense, they are able to provide a service that other mental health professionals have not been able to fulfil.

In addition to the above, the diaries contain a record of AMHW activity in:

- Substance misuse counselling and management strategies,
- Routine client follow-up and wellbeing assessment,
- Visits to clients and other Tiwi people in Berrimah Prison or RDH,
- Psychosocial health promotion activity (e.g. Strong Men's and Women's Club meetings),
- Specialist psychiatrist visits to the Islands (by either TEMHS or RDH) and clients seen,
- Client consultations with the GP facilitated by the AMHW, [often in greater detail than recorded by the GP in the *progress notes*],
- Collaboration with the police in critical incidents.

Diary entries reflect how the AMHWs understand their role as community workers and interlocutors between the community and other providers of mental health care and related services. English fluency levels among the THB AMHWs varies considerably, and record keeping skills could be improved. The AMHWs could also benefit from further training in relation to psychiatric concepts and terminology as they and a number of other providers have suggested. Motivation among several of the Nguiu AMHWs to improve their skills in a range of areas is high. One of the Nguiu AMHWs (already qualified in non-clinical mental health care) is currently taking tuition in English literacy skills. Jeremy Smith, the then services director emphasized the need for the AMHWs to improve their skills in basic literacy, computer training and mental health to assist them in accessing both CCTIS and paper files and to improve their general capacity in clinical context.

Most of the Tiwi AMHW diary entries are predominantly descriptive, containing details of family situations, relationship problems, and relevant past events. Client behaviour is described, as well as people's perceptions of, and reactions to, that behaviour. Hence they describe aspects of the socio-cultural context for mental health problems and illnesses, and motives for behaviour, that generally receive less attention in other clinical records. They contain some Indigenous analysis of current client behaviour and emotional state in light of risk factors related to community and family events, medication uptake, substance misuse and past mental health problems. The diaries could arguably stand as a powerful source of information relevant to preventive care for individual clients.

As they are presently organised, the AMHW journals are of limited use for other service providers. Each journal is a record of one AMHW's activity, and as such will include mention of scores of clients. One page of entries can skip between up to five clients and a particular client might have contact with a number of AMHWs. They are the AMHW's record, first and foremost.

Consideration might be given to the further development of the field diaries, both to assist managers to manage and develop performance, and to help structure AMHW input into collaborative care planning by service providers involved in primary care or allied services (eg., rehabilitation, FACS). AMHWs could consult their own diary records in the course of case conference discussions and meetings, note down planning decisions for the coming period, and so on. The use of field diaries by AMHWs should be supported as part of a strategy to further support both the clinical and the non-clinical roles of AMHWs in community mental health care, health promotion and prevention.

Summary

Both the clinical and the non-clinical work of AMHWs could be better supported if there were specific training for AMHWs to participate in consultation activity and to enter consultations in patient records (as has long been the case for AHWs). Certificate Level III at BIITE potentially covers some of this ground. However, training needs to be backed by appropriate policies at the clinic level. Policies and systems which exclude AMHWs from entering consultation data should be abandoned and provision should be made for appropriate training to assist AMHWs to undertake this basic activity. Improvements in clinical competence should be based on responsibility for record-keeping and accountability for consultations delivered, as for all other practitioners. It is further suggested that one of the most important supports for the supposedly "non-clinical" health promotional and counselling activities of AMHWs would be for them to be able to enter these in client records where they can then become a basis for interaction with other practitioners and inform client care more generally.

The baseline report commented on problems associated with creating parallel sets of records used by AMHWs only: 'there would be only limited value in recording consultations on activity sheets, if the information in these sheets had no linkage to the information in the patient's primary record and, in theory at least, to the records kept by TEMHS personnel' (Robinson et al. 2003:89). Separate sets of mental health records, as persisted at Borroloola, should be abandoned. The role of parallel records should be reviewed, with a preference to supporting the use of AMHW field diaries not as an alternative to the recording of consultations in clients' health records, but in order to assist AMHWs to keep records which may be of use both in clinical casework and in health promotion or community education.

The emphasis on clinical record-keeping should not lead us to forget the considerable amount of informal work which AMHWs do and will continue to do: work based on their local cultural knowledge and expertise. This may not ever be the subject of formal records. It was stated in Angurugu that some activity concerning cultural, family or personal business is not to be entered into the AMHW diaries. Or at Nguiu: 'Clients tell stuff to the AMHW that they don't want to go further, that they don't want to have written down . . . 'Tiwi first', that's the way everyone is taught.' However, this is no argument for exclusion of AMHWs from learning to work with clients' records as a part of their health centre work.

4.3 Audits of Patient Files

Written consent was obtained from six clients in each of five communities - Galiwin'ku, Angurugu, Numbulwar, Nguiu and Borroloola – for the evaluators to access their individual medical records held in each health centre for the purposes of the evaluation audit. An audit of files was carried out in four of these communities. The circumstances in the fifth, Borroloola, as outlined, meant that a thorough audit of files would not be productive at the time. The audit period for each community was the twelve month period immediately prior to the evaluators' visit. The tables presented in this Section summarise data collected from the community health centres. Complete community data is in Appendix I.

The audit examines the mental health services undertaken by remote community health centres. It examines the:

a) frequency of services events and the extent to which AMHWs are recorded as contributing towards care provided,
b) the frequency of assessments and diagnoses and practitioners conducting these,
c) existence of standard assessment protocols and whether standardized care plans are in use,
d) the frequency and nature of unstandardized 'care planning activity',
e) the role that AMHWs are recorded as playing in such activity, and
f) the frequency of case-conferencing between multiple providers for mental health clients.

Findings are presented in Tables 9-23 below.

For the purposes of the audit, at least six clients on each community currently receiving care from their community mental health team were approached by the evaluators, in the company of an AMHW, to request their participation in the audit. Once written permission was secured, the evaluators examined each client's primary records. Where files existed in both paper and electronic form, such as at Nguiu Health Centre, data from both sources were included in the audit. Field diaries were not consulted for this purpose.

Three audit instruments were developed (see Appendix III) for gathering data from each file. These record the following information:

1. Mental health services received in the last twelve months and recorded in primary health centre records,
2. Details of mental health assessments that have taken place during the last twelve months, the existence of a mental health care plan and diagnosis,

3. Mental health care plan details including dates, by whom, record of AMHW presence, evidence of client consulted, patient signature, treatment goals, services dues, provider and frequency, plans for review, evidence of case conferencing and teleconferencing.

For the purposes of the audit the following operational rules were applied:

- **Assessment:** a service event was defined as an assessment if records included evidence of inquiry about at least two listed assessment elements: appearance, behaviour; mood, affect; thinking; cognition; perception; attention; memory; insight; medical history; family history; social history; conversion; risk factors; protective factor; other (eg. appetite, sleep).

This minimal definition of an assessment is intended to capture instances of assessment conducted by a broad range of mental health care providers, including Aboriginal Mental Health Workers who are in the early stages of training. Examples which barely meet even this definition and those which are more comprehensive examples of assessment are clearly differentiated in the client file audit data (see Appendix I) and discussed below. The assessment elements chosen by the evaluators are based on those found by the evaluators to be used by GPs, RNs, MHNs, psychiatrists and AMHWs themselves, rather than a given template or standard model. Nevertheless, the file audit reveals that practitioners utilise a fairly uniform range of categories when undertaking assessments. The assessment elements chosen for the purposes of the audit include those to which the AMHWs have been exposed through their training at BIITE. This included instructions in the use of a standard assessment pro forma.

- **Mental health care plan:** This was defined as a comprehensive and standardised pro forma (in either paper or electronic form) placed in a patient's file and used to record intended service delivery for an individual client.

Most health centres utilise care plans for at least some other somatic health problems such as heart disease or diabetes. However at the time of the baseline evaluation, no mental health care plans were in use. A sample mental health care plan was provided to all participating health centres in the TEDGP's information package. This care plan was also included in training for AMHW at Batchelor College. A standardized care plan, however, is to be distinguished from *care planning* recorded in a patient's file.

- **Mental health care planning:** The audit process seeks to capture the extent of planning within client care as it was recorded at health centres in the absence of standard mental health care plans. The form this takes, the regularity with which it occurs and the way it is recorded and shared among practitioners varies greatly between communities. The audit process was designed to identify all recorded instances of planning, including the most minimal examples such as a note in a file to review medications in a week, or to discuss a client with the GP, or the AMHWs, in the future. While a medication schedule may be considered the most common basic element of a health care plan, it should be noted that not all mental health clients are prescribed medication and the audit process was designed to capture and identify these and determine their frequency. It was necessary to assume that unless a review period was specified, that the duration of a plan was indefinite and continued until either a new treatment plan was recorded or until the audit cut-off date.

- **Review:** Intention to review was defined by evidence of intention to reconsider a client's treatment, progress or condition either by the same practitioner or in consultation with another practitioner. Ideally, this would be an intention to review care management as set out in a previous mental health care plan. However, the paucity of care plans and formal care planning and the absence of

clear evidence that client review does occur has meant that a minimal definition has been employed (albeit at risk of subsumption in general care planning activity).

Where permission was obtained from the health centre GP and clinic manager, file entries relevant to mental health care were photocopied. As per ethics requirements, all photocopied pages are de-identified, coded and stored in a locked cabinet at the Charles Darwin University. They will be destroyed upon completion of the Program's evaluation.

Table 8: Audit Periods (12 months) for communities audited

Community	Audit Period	
	From	To
Nguiu	31 July 2002	30 July 2003
Angurugu	15 September 2002	14 September 2003
Borroloola	10 October 2002	9 October 2002
Numbulwar	14 October 2002	13 October 2003
Galiwin'ku	22 October 2002	21 October 2003

Audit Results

Table 9 below summarises the age and sex distribution data of the mental health clients from whom written consent was obtained to audit their files. The sample was constructed through consultation with providers with a view to representing the clients of the mental health teams and AMHWs. It shows a predominance of men as clients (female to male ratio 0.76). Most clients are in the 20-39 year old group, with women outnumbering men in the 30-39 year old age group only. It must be remembered that due to the small size and probable biases in selection of the sample of clients audited, comparisons between communities should be treated with caution.

Table 10 examines diagnosis by sex across the same five communities for the 30 clients who gave consent to audit their files. For three of the thirty clients no diagnosis was recorded in clinic files. Overall, substance abuse disorders are the most common diagnosis followed by schizophrenia. There is a predominance among women of identified mood disorders (depression accounts for 45% of female clients) and a predominance among men of identified substance abuse related disorders (47% of male clients). The above figures also suggest a variation in types of mental health conditions being diagnosed between the communities, broadly consistent with reports by community-based GPs.

Table 9: Sex-specific ratios of audited client files from Galiwin'ku, Angurugu, Nguiu, Numbulwar & Borroloola

Age	Persons	Female	Male	Female-Male Ratio
10-19	1	1	0	-
20-29	12	5	7	0.72
30-39	10	6	4	1.5
40-49	6	1	5	0.2
50-59	1	0	1	-
All Ages	30	13	17	0.76

Table 10: Diagnosis by sex, audited client files

Comm.	Diagnosis*							
	Female				male			
	ubstance use related	chizophrenia & related	Mood disorder	other	substance use related	schizophrenia & related	mood disorder	other
Nguiu	0.5	1	1.5		1	1		1
Angurugu	0.5	0.5	1		2	1		
Galiwin'ku	0.5	0.5		1	1	2	1	
Numbulwar			1		2.5	1.5		
Borroloola			1		2	0.5	1.5	
All ommunities	1.5	2	4.5	1	8.5	6	2.5	1

* Where a diagnosis has more than one significant component, such as substance induced psychosis and depression, then 0.5 is recorded under both categories.

4.4 AMHW Involvement in Mental Health Service Delivery

Health centre client files were audited for the total number of mental health service events provided to audited clients by the health centres. Audits examined the twelve month period prior to the evaluators' visit to the community. Service events include all entries into the primary client files that contain a mental health component: a consultation, a review, an evacuation to Cowdy Ward, a case-conference, an assessment, an impression, the dispensing of medications, discussion with another support service or family member, a care plan, a

teleconference or a case conference. They include services by both resident health centre staff as well as those provided by visiting TEMHS staff. That is, all practitioners who have made entries into the primary client record.

Table 11: Total mental health service events provided to audited sample over 12 months

Comm.	Total MH Service Events*	Mental Health Service Component											
		assessment	diagnosis	Impression	meds given	counselling	planning	care plan	teleconf.	case conf.	support # service liaise	family disc	hospital admission
Ngu	106	24	2	4	63	3	26	0	0	5	11	1	4
Ang	238	74	1	18	90	14	36	0	1	1	15	25	1
Gal	175	48	3	24	116	3	50	0	0	0	2	16	3
Num	183	74	4	27	106	4	62	0	0	2	7	14	4
Total	**702**	220	10	73	375	24	174	0	1	8	35	56	12
Average	**175.5**	**55**	**2.5**	**18.3**	**93.8**	**6**	**43.5**	**0**	**0.25**	**2**	**8.8**	**14**	**3**

* A Service Event can include more than one service component, eg., an assessment and a diagnosis. Further, Total Mental Health (MH) Service Events includes some components entered into *progress notes* not found among the listed service types above. Thus Total MH Service Events should not be expected to equal the sum of components in the other columns.

Support Services include: Substance Misuse Program, AOD services, Aged Care Facility, police, CAAPS, FORWAARD, Centrelink, Department of Housing, FACS.

Table 11 shows the total number of mental health service events for the sample for each community. The health problems for which clients are being treated vary in the amount and type of attention they require. Some clients present more frequently for treatment than others, staff capacity for providing services also varies, and the level of recording of some kinds of service may vary from place to place. However the data still indicate variations in practice across communities and point to those components of services most commonly provided and those which are rare or absent.

The most common component of any service event across all four communities is the administration of medications with an average of 93.8 per client over twelve months. These exceed the number of assessments that occur, at an average of 55 per client, even with the minimal definition applied, according to which an assessment must include reference to only two of any of the usual standard assessment elements, such as ‘behaviour’ and ‘mood’.

While client assessments occur at all four health centres, diagnoses are rare and generally only occur outside the community when a client is admitted to Cowdy Ward or another psychiatric institution. The rarity of formal diagnoses perhaps reflects a lack of transfer of records of diagnosis from hospital to health centre file. It is of course also a reflection of the lack of

formal psychiatric assessments conducted in the communities. Except in rare instances, TEMHS staff visiting remote communities are mental health nurses who can only make provisional diagnoses. Visits from a psychiatrist rarely occur more than once a year. Most often the visiting nurse records an 'impression', or 'formulation'. The average frequency for an impression was 18.3 per twelve month period. Thus close to two thirds of those consultations counted in the audit as assessments do not lead to the entry of an impression or a formulation into the primary client record, let alone a diagnosis. For a total of 36 clients whose files were audited there were only ten diagnoses made over the audit period.

Table 12: Length of time between last recorded diagnosis and audit date

	Time since end of audit period (months)			
	Nguiu	Angurugu	Galiwin'ku	Numbulwar
client 1	**15**	**1**	**243**	**1**
client 2	**42**	**no diagnosis**	**180**	**3**
client 3	**14**	**22**	**9**	**46**
client 4	**1**	**15**	**1**	**no diagnosis**
client 5	**48**	**62**	**67**	**22**
client 6	**47**	**4**	**33**	**20**
average	**33.4**	**26**	**106.6**	**23**
all communities average		**47.25 months**		

The average time across all four communities between the last diagnosis and the end of the audit period is, as shown in Table 12, a lengthy 47.25 months. This indicates that there is a significant period where, although the client may be reviewed or monitored fairly closely over the years, this rarely results in a formally updated diagnosis.

Standard mental health care plans have not been adopted in any of the health centres. (As noted a number of centres have adopted standard care plans for other conditions such as diabetes, palliative care and asthma). Recorded instances of 'care planning' according to the minimal definition used by the evaluators, occurred at an average of 43.5 instances for the audited six clients in each community, a frequency approaching that of assessments. The type of practitioners responsible for planning is discussed later in this section.

Case-conferences are rare. Over the audit period one community conducted none for the six clients and another had conducted only one. The highest number for any community was five. The average number of case-conferences for any community was two, compared to the number of times medications were administered which averaged nearly 94 over 12 months. Case-conferences are also discussed in greater detail later in this section.

Table 13: Mental health service events with a record of AMHW involvement

Comm	% Total MH Service Events*	Mental Health Service Component											
		assessment	diagnosis	Impression	meds given	counselling	planning	care plan	teleconf.	case conf.	support # service liaise	family disc	Hospital admission
Ngu	8%	0%	0%	0%	0%	0%	15%	0%	0%	80%	9%	0%	0%
Ang	48%	78%	0%	50%	18%	100%	56%	0%	100%	100%	4%	66%	0%
Gal	17%	23%	0%	25%	6%	33%	10%	0%	0%	0%	100%	25%	0%
Num	6%	9%	0%	19%	2%	0%	11%	0%	0%	50%	0%	8%	0%
Average	19.8%	27.6%	0%	24%	6%	33.3%	23%	0%	20%	57.5%	28.3%	24.8%	0%

* A Service Event can include more than one service component. eg., an assessment and a diagnosis. Further, Total Mental Health (MH) Service Events includes some components entered into *progress notes* not found among the listed service types above. Thus Total MH Service Events should not be expected to equal the sum of components in the other columns.

Support Services include: Substance Misuse Program, AOD services, Aged Care Facility, police, CAAPS, FORWAARD, Centrelink, Department of Housing, FACS.

Written records of counselling provided to clients were also scant: an average of six instances per audited client in each community. Discussions with the family members of a client were more commonly recorded than instances of counselling provided to the client him or herself, at an average of 14 instances per community. A record of liaison with another service provider, such as the Aged Care Facility, FACS, the police or the Department of Housing were not frequent, at an average of 8.8 instances per community. All communities had records of hospital admissions over the audit period, although these were not common with an average of three per six clients in each community.

Table 13 compares the average involvement of AMHWs in mental health service events and service event components across the communities. AMHW involvement includes both instances where AMHWs are solely responsible for the service and instances where they have worked in collaboration with other practitioners or have contributed to the service in some form, where this is clearly recorded in the client's file.

As a proportion of total mental health service events, AMHW involvement is recorded in 48% of events for one community, then drops sharply for the other three communities, to 17%, 8% and 6%. The average for written records of AMHW involvement across the four communities is about 20%. The highest rate of contribution by AMHWs is in case conferences. Thus, although they rarely occur, when they do, AMHWs usually contribute. In Angurugu AMHWs were always involved, while in Numbulwar they were involved in one of the two case conferences recorded. Records of teleconferencing were even less common that case-

conferencing, with only one instance across all communities and was conducted and recorded in the client records in some detail by the AMHW. It should be kept in mind that the AMHWs at Numbulwar had only been contributing to the primary client files for two months at the time of auditing.

Counselling was recorded in all four communities, but AMHW involvement varied significantly. In Angurugu they were involved in all instances where counselling was provided to a mental health client and in 33% of instances in Galiwin'ku, but no AMHW involvement in counselling was recorded in Nguiu or Numbulwar. In the case of Nguiu, this is in stark contrast to the counselling work evidenced by the AMHW field diaries.

Substantial variation across communities was also evident with AMHW involvement in assessments and liaison with support services. In Angurugu, the AMHWs made a significant contribution to records of client assessments (78%). In Galiwin'ku, the AMHWs contributed to 23% of assessments, but in Numbulwar this drops to 9% and in Nguiu to zero. In Galiwin'ku the AMHWs were always involved in recorded liaison with other services in stark contrast to the other three communities which all recorded very little to no AMHW involvement.

There is also significant variation between communities with contributions to impressions or formulations (usually by visiting EAMHS who may incorporate the insights of AMHWs into their assessments), care planning and discussions with family members, with Angurugu showing the highest level of AMHW contribution for all three service components.

The activity of AMHWs is least evident in the administration of medications, the area of mental health care that is recorded with the greatest frequency, usually by GPs. Nguiu AMHWs play no discernable role in this regard, and only very limited input is recorded in other communities. At Galiwin'ku one AMHW had initially taken responsibility for the administration of medications but has ceased to do this in later months. At Angurugu and Numbulwar AMHW involvement, though minimal, takes the form of delivering filled dosette boxes to clients in their homes or advising an RN or AHW on medications due and referring a client to them. While not contributing directly to medication decisions, AMHWs can be an important source of information about compliance and its determinants.

Tables 14 and 15 below disaggregate the figures for AMHW involvement into the percentage of service components where the AMHW was solely responsible for delivery of a service and those in which they made a contribution working in collaboration with another practitioner. The differences between these figures give an indication of the degree of autonomy with which the AMHWs operate and the responsibility that has been handed over to them by other health centre staff.

Table 14: Recorded mental health services conducted by AMHWs alone in preceding 12 months

Comm	% Total MH Service Events*	*Mental Health Service Component*											
		assessment	diagnosis	Impression	meds given	counselling	planning	care plan	teleconf.	case conf.	support # service liaise	family disc	Hospital admission
Ngu	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	9%	0%	0%
Ang	40%	60%	0%	0%	0%	100%	14%	0%	100%	0%	4%	64%	0%
Gal	4%	2%	0%	0%	5%	33%	0%	0%	0%	0%	0%	6%	0%
Num	3%	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Average	11.8%	15.8%	0%	0%	1.3%	33.3%	3.5%	0%	25%	0%	3.3%	17.5%	0%

* A Service Event can include more than one service component. eg., an assessment and a diagnosis. Further, Total Mental Health (MH) Service Events includes some components entered into *progress notes* not found among the listed service types above. Thus Total MH Service Events should not be expected to equal the sum of components in the other columns.

Support Services include: Substance Misuse Program, AOD services, Aged Care Facility, police, CAAPS, FORWAARD, Centrelink, Department of Housing, FACS.

Counselling clients is one area where AMHWs might have more independent responsibility. This is only substantially recorded at Angurugu and to a lesser extent at Galiwin'ku – not at all at the other two communities. This activity can include counselling on relationship, family or marriage problems, or on depression or compliance with medications. Where recorded, 33.3% of counselling events were conducted solely by an AMHW. Assessments, teleconferences and discussion with client's family are areas where the Angurugu AMHWs – in contrast with the other sites - appear to act on their own more commonly than together with another practitioner.

Although the AMHWs have some autonomy in undertaking client assessments, the data presented in Appendix I shows that most assessments conducted independently by AMHWs are not comprehensive. Most instances of collaboration with other practitioners are with EAMHS during their visits to communities.

Independently conducted AMHW assessments never led to recorded impressions or formulations. AMHW contributions to impressions are collaborative only. Similarly, AMHW involvement in recorded care planning was predominantly collaborative. Only in 3.5% of planning instances did AMHWs operate independently.

Table 15: Mental health services involving joint consultation with AMHWs

Comm	% Total MH Service Events*	*Mental Health Service Component*											
		assessment	diagnosis	Impression	meds given	counselling	planning	care plan	teleconf.	case conf.	support[#] service liaise	family disc	hospital admission
Ngu	8%	0%	0%	0%	0%	0%	15%	0%	0%	80%	0%	0%	0%
Ang	8%	18%	0%	50%	18%	0%	42%	0%	0%	100%	0%	2%	0%
Gal	13%	21%	0%	25%	0%	0%	10%	0%	0%	0%	100%	19%	0%
Num	3%	8%	0%	19%	2%	0%	11%	0%	0%	50%	0%	8%	0%
Average	8%	11.8%	0%	23.5%	5%	0%	20.8%	0%	0%	57.5%	25%	7.3%	0%

* A Service Event can include more than one service component. eg., an assessment and a diagnosis. Further, Total Mental Health (MH) Service Events includes some components entered into *progress notes* not found among the listed service types above. Thus Total MH Service Events should not be expected to equal the sum of components in the other columns.

[#] Support Services include: Substance Misuse Program, AOD services, Aged Care Facility, police, CAAPS, FORWAARD, Centrelink, Department of Housing, FACS.

The area where AMHWs potentially operate independently of other practitioners - counselling – is under current arrangements and conditions, not considered to be of sufficient clinical importance to be entered regularly into primary client notes in three of four communities. In the fourth, Angurugu, the non-Indigenous practitioners record almost no counselling activity together with AMHWs. In the area of mental health service that dominates all health centre files - the administration of medications - records of AMHW involvement are peripheral at best. In one area where they could conceivably contribute much more - care planning – records of AMHW involvement are minimal. Yet, as discussed above, the AMHWs are engaged in a diverse and often demanding array of responsibilities much of which is not being reflected in primary client records – except, possibly at Angurugu. This does not favour the establishment of basic processes of coordination between AMHWs and other providers. Records do not indicate that their work is being consistently communicated to other health care staff.

4.5 Mental Health Assessments

Tables 16 and 17 below summarise the data on assessments presented in detail in Appendix I. Table 16 compares the frequency of assessments, (according to the minimal requirement of evidence of just two elements), across the four communities and the practitioner type responsible. Table 17 summaries the breakdown of each assessment in terms of its constituent elements. It provides an overview of those elements which most commonly comprise records

of assessment and those elements given least attention. As discussed, the elements chosen for audit by the evaluators are drawn from those used by practitioners themselves: GPs, RNs, MHNs, psychiatrists and AMHWs.

Table 16: Evidence of mental health assessments in preceding 12 months

Comm.	Number of files audited	Files with Evidence of standard Assessment Protocol	Files with evidence of Assessment written up	Total Number of Assessments	Number of Assessments by or with contribution from					
					GP	**RN**	**AHW**	**AMHW**	**MHS**	**unclear**
Nguiu	6	0	6	24	12	2	1	0	5	4
Anguru	6	0	6	74	1	3	0	53	24	3
Galiwin	6	0	6	48	4	5	0	14	37	1
Numbu	6	0	6	74	5	23	5	7	43	2
Totals	24	0	24	220	22	33	6	74	109	10
Average	**6**	**0**	**6**	**55**	**5.5**	**8.3**	**1.5**	**18.5**	**27.8**	**2.5**

At the time of auditing no participating health centre was using a standard assessment protocol whether an established assessment tool or their own synthesis. As a contribution to the AMHW Program, BIITE and TEDGP collaborated in the development and supply of a suggested Mental Health Assessment proforma. This proforma was used at BIITE for training received by the AMHWs undertaking the Certificate III in Community Services and supplied to all participating community health centres along with a suggested Mental Health Plan and Mental Health Review. Although most AMHW and GPs, when asked, reported knowledge of it, the proforma is not in use at any location. These three tools were intended as part of a '3 Step Mental Health Process' of assessment, mental health care planning and review promoted by ADGP under the *Better Outcomes in Mental Health Care* initiative. The aim of this process is to 'encourage GPs to increase their level of skill in mental health care and to provide increased access to mental health care' and 'to improve the quality of care provided by GPs through encouraging effective and holistic patient assessment, mental health planning and review' (TEDGP 2002).

Table 17: Recorded elements of mental health assessments in preceding 12 months

Comm.	Assessment Elements*																
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	***Total***
Nguiu	4	6	11	5	12	3	17	5	11	9	1	12	0	0	5	5	**106**
% of total	*3.8*	*5.7*	*10.4*	*4.7*	*11.3*	*2.8*	*16*	*4.7*	*10.4*	*8.5*	*0*	*11.3*	*0*	*0*	*4.7*	*4.7*	
Anguru	20	28	50	16	15	8	46	14	38	5	6	23	12	2	31	47	**361**
% of total	*5.5*	*7.8*	*13.9*	*4.4*	*4.2*	*2.2*	*12.7*	*3.9*	*10.5*	*1.4*	*1.7*	*6.4*	*3.3*	*0*	*8.6*	*13*	
Galiwink	18	24	31	31	25	10	27	10	34	10	5	7	3	3	32	22	**292**
% of total	*6.2*	*8.2*	*10.6*	*10.6*	*8.6*	*3.4*	*9.2*	*3.4*	*11.6*	*3.4*	*1.7*	*2.4*	*1*	*1*	*11*	*7.5*	
Numbul	32	27	42	34	40	17	44	19	44	15	14	22	9	1	37	35	**432**
% of total	*7.4*	*6.3*	*9.7*	*7.9*	*9.3*	*3.9*	*10.2*	*4.4*	*10.2*	*3.5*	*3.2*	*5.1*	*2.1*	*0*	*8.6*	*8.1*	
Totals	74	85	134	86	92	38	134	48	127	39	26	64	24	6	105	109	**1191**
% of total	***6.2***	***7.1***	***11.3***	***7.2***	***7.7***	***3.2***	***11.3***	***4***	***10.7***	***3.3***	***2.2***	***5.4***	***2***	***0***	***8.8***	***9.2***	

* Assessment Elements:
A – Appearance; B - Behaviour; C – Mood; D - Affect; E – Thought; F – Cognition; G – Perception;
H – Insight; I – Medical History; J – Family History; K – Social History; L – Risk Factors;
M – Protective Factors; N – Cultural Factors; O – Conversation/Speech ; P – Other (eg., sleep, appetite).

The '3 Step Mental Health Process' was intended to be conducted by the GP thereby enabling claim for costs under the Medicare Benefits Scheme. However, the incentive for uptake of these items and thus for the process as a whole appears to continue to be weak in the NT (cf Robinson, et al., 2003). This is because of the low rates of bulk-billing generally, and because constraints on practice mean that much of the relevant activity is not undertaken by GPs. On average, across the communities assessments are also commonly conducted by visiting DHCS staff, or by RNs and some AMHWs, (mainly at Angurugu). At Nguiu Health Centre, however, where bulk-billing occurs, most assessments are conducted by the two resident GPs, although not in a form which would qualify for the reimbursement as the new MBS mental health care items.

The data in Table 17 show that the most frequent elements of assessment conducted by practitioners are questions or observations concerning *Mood, Perception, Medical History* (which includes current medications), followed by *Conversation* (which includes rapport, eye contact and memory), *Sleep and Appetite*. Together these make up over 51% of all assessment elements. (If *Conversation* were broken down into its elements, the proportion would be even larger.) The least common aspects in any assessment are *Insight, Protective Factors, Cultural Factors* and *Social History*. Together they make up only 8.2% of all assessment elements. Of these, *Cultural Factors* appears with the least frequency. *Cognition* (which includes *Judgement)* and *Family History* are marginally more common. Together these two are 6.5% of

all assessment elements. Falling in between these two broad groups are *Appearance, Behaviour, Affect, Thought* and *Inquiry about Risk Factors*.

An examination of the assessment elements used by AMHWs and entered into primary client files (Appendix I) shows that AMHWs tend to be replicating the emphases of other practitioners, especially those of the visiting MHS staff whom they frequently accompany on home visits or clinic consultations. When AMHWs are conducting and entering assessments into client records autonomously, rather than supplying the cultural input or social history, they record similar information. Thus, despite the claim that AMHWs are proving to be valuable sources of cultural insight and local knowledge to health centre staff and to visiting TEMHS staff in a range of ways, an examination of the main repositories of validated mental health care information in the primary health care setting suggests that something else may be occurring.

Limits on the ability of practitioners to explore the background themes and meanings of a client's condition were discussed in the baseline report (Robinson et al. 2003:80). In order to interpret social and cultural themes when formulating both diagnoses and appropriate treatment, assistance of AMHWs and family members was recognised by GPs as invaluable. Yet, mid-term evaluation audit findings reveal that most health centres have not put in place processes to more systematically support this collaboration. In fact, it appears that AMHWs may feel pressure to conform to a model of practice in which there is little room for their own understanding of their clients and their individually and culturally specific sources of strength and difficulty. In order to realise the 'learning both ways' ideal of the Program, it will be necessary to find more effective ways to promote the envisaged role of the AMHW, to properly acknowledge and foster their skills and to improve their integration into primary mental health care.

Although a range of mental health outcome measures is in use across Australia – including the Health of the Nation Outcome Scale, the Kessler-10 (adopted as a standard instrument by DHCS) and the Life Skills Profile - no one assessment tool is used by any participating health centre. GPs report that any one of these instruments, if strictly applied, would be of little use in the context of their practice, most notably because of their inadequacy for assessing mental health cross culturally. The difficulties in developing an assessment tool or tools which have validity and clinical usefulness in Aboriginal populations have been highlighted by a number of authors in recent years (eg., NACCHO 2003, Sheldon 2001, Westerman & Kowal, 2002). The same has also been said of the diagnostic tools DSMIV and ICD10, both of which are used to diagnose mental health problems in Indigenous clients (Jablensky 1999). The impact of culturally different notions of time have on limiting the applicability of standard assessment procedures has been pointed out by Janca and Bullen (2003). Nevertheless, as indicated, the file audit reveals that practitioners utilise a range of common working categories when undertaking assessments. These draw on mainstream measures and concepts which, as Westerman and Kowal (2002) note, 'have yet to establish their cultural validity' with Aboriginal populations in Australia. The baseline survey found that GPs are aware of the limits to their diagnostic abilities in the cross-cultural context. In particular, some GPs report 'difficulty with diagnosis of depression, or distinguishing categories of depression, along with some uncertainty about deciding on appropriate treatment responses which they believe is resulting in under-diagnosis of some conditions (Robinson et al. 2003: 79).

The turnover of GPs and other health care staff in most remote health centres and even visiting departmental services militates against consolidation of the benefits of informal collaboration with and learning from Aboriginal staff. The practitioners who live outside the communities, including most of the DHCS staff – who presumably have the least direct experience and understanding of local relationships and cultures - are responsible for many and in some communities most of the formal mental health assessments undertaken. This makes the maintenance of AMHW input into clinical work at once more difficult and all the more important to achieve.

4.6 Care Plans and Care Planning

The WHO (1998) recommends that mental health care in the primary health care setting includes a 'treatment plan' and that this plan should be explained to the patient. In the same guidelines the WHO also recommend that the practitioner(s) 'set-up a follow-up visit(s) to review treatment in general, medication, compliance with recommendations and overall progress'. In line with this policy the TEDGP has included in a folder of information to participating GPs, guidelines for Mental Health Plans as part of the '3 Step Mental Health Process' (TEDGP 2002; Robinson et al, 2003). The information provided includes a Process Checklist which advises that Mental Health Plans should be: prepared in consultation with the patient and/or carer; have the approval of the patient; with a copy provided to the patient and/or carer *and* kept as part of the patient's medical records. It should include: a discussion of the diagnosis and/or formulation, a discussion of the treatment options, a written plan for the treatment of the assessed mental health disorder and crisis intervention, the provision of psycho-education, and a plan for relapse prevention, if appropriate. Although not listed under the Checklist, the suggested *proforma* also includes a space for setting a date for review of the Plan.

At the time of audit no formalised care plans that meet any of the above criteria were in use at any of the participating health centres, as Table 18 below shows. Health centre staff were generally sceptical that the addition of care plans would add value to current care of mental health clients. That planning does occur, albeit in a less formal way, has been noted, and is further illustrated in Table 18. Although none of the audited health centres was using care plans, care planning events (as defined above)[9] were recorded in all audited files across all four communities (Table 18). Only at one health centre, Numbulwar, was there any recorded evidence that the client had either been consulted in the planning process or approved of the planning. If this is occurring elsewhere, it is not being reflected in client records.

Data reported in Appendix I show that planning events comprise from 15% to 34% of Mental Health Service Events across the four communities: 25% (26/106) at Nguiu, 15% (35/238) at Angurugu, 29% (50/175) at Galiwin'ku and 34% (62/183) of Service Events at Numbulwar

[9] mental health care planning was included as a category in the audit process to capture the extent of planning of client care management that was occurring at health centres despite the absence of standard mental health care plans. The form this takes, the regularity with which it occurs and the way it is recorded varies greatly between communities. The audit process was designed to identify all recorded instances of planning, including minimal examples such as a note in a file to review medications in a week, or to discuss a client with the GP, or with AMHWs, in the future. A medication schedule may be considered the most common basic element of a health care plan. However, not all mental health clients are prescribed medication, and other elements of service are important elements of care planning.

Health Centre. In most cases they consist of one or two lines at the end of an entry in either the *progress notes* or a Mental Health Section.[10]

Planning events generally address medications, the need to liaise with other support services, or follow-up with the client or with other practitioners. As Table 19 shows, the most common part of any planning instance is the intention to review (66% of planning events). Usually this involves a note by the practitioner of the intention to see the patient on his or her next visit. As community visits in East Arnhem Land are about five weeks apart, the time period specified is recorded here as five weeks (see Appendix I). Responsibility for a review can also be referred to another practitioner if a shorter time period is considered necessary. This can be a GP or, on occasion, an AMHW. Duration for the plan to apply before review was specified in 43% of cases.

Table 18: Evidence of use of standard care plan protocol or of care planning in preceding 12 months

Comm.	**Total files audited**	**% files with Standard Care Plan**	**Total Care Plans**	**% files with Evidence of Care Planning**	**Total Planning Events**	**% AMHW involvement in Planning**	**% with Evidence of client consent***
Nguiu	6	0%	0	100%	26	4%	0%
Angur	6	0%	0	100%	35	57%	0%
Galiw	6	0%	0	100%	50	10%	0%
Numb	6	0%	0	100%	62	5%	8%
Totals/ Average	**24**	**0%**	**0**	**100%**	**43**	**19%**	**2%**

The next most common element of planning after review concerns medications (58% of planning events). In most cases this simply involves a decision to continue with current treatment or to recommend a change. The need to follow-up on the client's condition, compliance, or to provide counselling or hold discussions with family members was a component of 39% of planning events. This is also the area where AMHWs are called upon most frequently. There were no instances of a case-conference being planned as part of a planning event.

[10] Appendix I provides detail on every planning instance, what it consisted of, who was responsible and wherever an AMHW was involved. This information is summarised in Tables 4.11 to 4.14.

Table 19: Elements of recorded care planning

Comm.	Care Plan or Planning Elements					
	duration specified	meds.	liaise with other service	review planned	follow -up	case – conf.
Nguiu	5	17	3	16	8	0
Angur	13	12	7	20	21	0
Galiwin	29	33	3	34	17	0
Numbu	28	39	5	45	22	0
Total	75	101	18	115	68	0
As % of Total Planning Events (174)	**43%**	**58%**	**10.3%**	**66%**	**39%**	**0%**

Table 20: Care plans or care planning with reference to AMHW involvement

Comm.	Care Plan or Planning Elements					
	duration specified	meds.	liaise with other service	review planned	follow -up	case – conf.
Nguiu	0%	0%	33%	19%	75%	0%
Anguru	0%	8%	57%	5%	57%	0%
Galiwin	0%	3%	33%	6%	82%	0%
Numbu	0%	0%	0%	0%	32%	0%
Average	**0%**	**2.8%**	**23.3%**	**7.5%**	**61.5%**	**0%**

Table 20 shows the proportion of planning elements with evidence of AMHW involvement. As noted above, the services of AMHWs are utilised in follow-up after a planning event more than in any other way. AMHWs are called upon to play a follow-up role as an outcome of 61.5% of planning events. They liaise with other support services as an outcome of 23.3% events, and are asked to or plan to review clients as an outcome of 7.5% of planning events. Their involvement in planning medications is minimal and indirect. Ironically, checking on client compliance with medications is the most common follow-up request of AMHWs by other practitioners. This is shown in Table 21 which disaggregates types of planned follow-up services provided by AMHWs.

Table 21 shows that monitoring the signs and symptoms of the client's condition is requested with about the same frequency as monitoring compliance. Talking to a client's family,

providing counselling or liaising account for half or less than either monitoring compliance or condition. These results suggests that resources are directed to management of acute cases through medications with a focus on immediate symptoms, leaving scant resources for investigation or follow-up relating to the social or family circumstances of the client. They also suggest that AMHWs are under-utilized as a consequence of the emphasis of a medicalised and individualised view of illness at the expense of a social and relational view of the clients' condition. AMHWs have spoken of the need to *talk* to clients, and to *listen*. These are taking second place in the broader context of mental health care in remote communities - at least insofar as they are acknowledged at all in records of health worker activity.

Table 21: Type of follow-up provided by AMHW after record of planning

Community	Type of Follow-up provided by AMHW				
	monitoring of signs & symptoms	medication compliance	talk to family	client counsellig	liaise with support service
Nguiu	1	3	1	1	1
Angurugu	4	3	4	1	4
Galiwin'ku	8	10	2	3	1
Numbulwar	6	4	1	1	0
Total	**19**	**20**	**8**	**6**	**6**

Observation of arrangements for planned follow-up and care in the communities revealed a number of informal systems for coordination of care. At the Galiwin'ku Health Centre, every patient receives a drug chart that is reviewed monthly. The MNH explains:

> 'This means that the GP is reviewing medications monthly, and there is a system in place where if a medication chart runs out we put it on the list and the GP goes through it. This system doesn't include referrals, that's more in the *progress notes*. We also have a spreadsheet system where all the depot medications are listed on spreadsheets and patients their details are entered there and if we had to send them away or there was something particularly urgent that they had to be seen about it could be entered there. But no, nothing like a care plan, structured, that we've been using since I've been here.'

According to the GP at Galiwin'ku:

> 'The spreadsheet works well for the depots. We have something simple that works. I'm not convinced care plans actually deliver a better service even though you can get Medicare out of them. They mean more paper work, which can be good in terms of role definition but I can be almost certain that the way we're set up at the moment the roles will be assigned and anything that's not to do with giving drugs will become very grey and won't get done without some other more institutionalised support. ... If there's some way of supporting a hunting program then yes, we can put down it's Djanumbi's role to support this patient, to take this patient out, but there's no point in telling Djanumbi to do that in a care plan situation if there's no way to support it.'

As the GP argues, care plans would be of little use if ‘only a few *balanda* could use it’.

Many care planning systems are dependent on the implementation of systems of electronic medical records (like CCTIS, and similar systems). For example, a goal of the *Aiming High in the Far North: The Indigenous Stream of the Australian Integrated Mental Health Initiative (North Queensland)* is to realise better coordinated mental health care through mental health care plans integrated into the *Ferret* ® system. However, such an approach is unlikely to succeed (without modification) for the present in remote Top End communities due to the challenges of maintaining computerised systems in remote locations. Hudson (2001), points out that among the obstacles to operationalising computer technology in remote locations is the requirement for computer literacy skills among all staff and for computers to be available and working at every work site. In other words, these developments need significant investments both in technical and human resources.

The GP at Angurugu Health Centre argues that a formal system of care plans may be difficult to implement:

> ‘We get [clients] back and see how they’re going or I talk to Muriel and Leonard and see how they’re going. From what I read about care plans and case managements with special item numbers that can be claimed through Medicare is that where that works the best is in practices which have lots of doctors and a practice manager who coordinates it all. So that doesn’t happen here. I just charge the appropriate consultation. That comes back through Medicare because this is a Territory Health run clinic, all our Territory Health has been ‘Medicared’ now.’

Angurugu staff generally felt that ‘at the rate at which things change it would mean that you could have four care plans produced in two days’ for some clients. Rather, ‘the care is in the *progress notes*’ says one RN. Clinic staff feel that the current system works and that efforts at instigating a formalised care plan could be undermined by the divergent views of different family members. This appears to assume that the object of a plan is to formalise family involvement, rather than, for example, to direct or remind practitioners to follow-up with or to consult family members.

These comments notwithstanding, the GP at Angurugu was also of the view that the health centre ‘probably would benefit from having some things happening more systematically’ and cited the example of the two chronic disease nurses employed at the clinic who encourage patients to have their bloods or their blood pressure checked regularly. She points out that ‘you have people on line to do that to make sure that that does happen . . .it’s a matter of people having time to sit down and do it.’

At Nguiu Health Centre an ‘Action Plan’ was included in the AMHW notes that were, during 2001-2002, included in the central client records. However, entries into these show that their purpose may not have been clearly communicated to AMHWs and the information they contained was minimal. In light of the fact that these were not used by other practitioners, they may have justifiably appeared to the AMHWs as a poor use of their time. More importantly for the present situation, Tiwi Islands Health Services Practitioners have direct experience of a system of electronic care plans implemented with CCTIS and the Coordinated Care Trials. This was an ambitious program which which evaluation has shown to be very uneven in its

outcomes for service delivery. Nevertheless, one GP expressed interest in a simple *process* care plan which could encourage the more comprehensive recording of relevant information and serve as a basis for coordinating practitioner responsibilities for individual clients. The key objective would be to support processes of coordination between all practitioners, to improve the quality of recorded information, and to extend it to encompass important elements of care beyond medications and clinical measures.

Standardized, best-practice care plans are comprehensive, evidence-based practice protocols which guide formulation of goals for treatment and the delivery of all services relevant to the client's condition, including clinical examinations and assessment, medication, inquiry about risk and protective factors, provision of counselling and health promotional advice. Care plans should also support the coordination of services between multiple providers. While *care planning* conceivably occurs in all health centres informally to some degree, the absence of complete or consistent records of care planning means that such activity is unlikely to be systematic, that adherence to planning objectives or goals is difficult if not impossible to verify or to monitor, and that coordination of the activity of multiple practitioners to ensure that prompt recall and review of patients occurs is not supported by transparent records and arrangements.

The clear emphasis of care planning in health records audited by the evaluators is on medications. AMHW involvement in even this limited area of planned care – for example, with monitoring of client compliance with medications – is largely unrecorded. The very low levels of recorded inquiry and counselling – areas in which AMHWs are known to have a role both within and outside the health centres – are almost entirely absent from records of care planning. Although existing planning practices are reported to be adequate by health centres, most acknowledge that time and capacity permitting, more systemized approaches to planning would be beneficial.

EAMHS have reported intentions to expand care plans, to make them more comprehensive, to include AMHW and family involvement and to promote goal setting with clients and clinic staff. Their aim is to use plans as a two-way tool that will also play an educational and communicative role. Reviews would be built in and plans would include referral to other services. Plans would include what EAMHS are required to cover under the mental health legislation plus other social and cultural issues. The EAMHS commitment to care plans may provide a starting point for the collaborative development of mental health care plans by Program participants. Without some wider support both at community level and by partners to the AMHW Program Partnership Agreement, it would not by itself address those other areas of mental health care planning undertaken by practitioners in the community-based teams.

In a study of mental health services, Sweeney and Kisely (2003) conclude that poor communication between practitioners and other support services present common barriers to the management of mental health problems. They emphasise the need to move beyond a medicalised model of care through an expansion of counselling services and multi-agency shared care. This is not quite what is required in the AMHW Program, where firmer systemic supports for comprehensive clinical care might be a first prerequisite for better structured complementary counselling and educational activity.

4.7 Case-conferencing for Mental Health Clients

Case-conferencing was not common among the audited files. Only 14% of files had records of a case-conference having occurred during the twelve month audit period. Table 22 shows that the total number of case conferences for the total 24 audited files was eight. GPs are the most regular participants followed by RNs and AMHWs. In fact, participation of AMHWs in case-conferences was high, 100% at Angurugu, 80% at Nguiu and 50% at Numbulwar. No case-conferences had taken place in Galiwin'ku for the audited client files. However, the MHN at Galiwin'ku reports that the AMHWs would participate if there was a need for a case-conference. When EAMHS staff visit Galiwin'ku and other East Arnhem communities they generally spend time with the AMHW, GP and other staff if available discussing clients.

One GP says: 'It's always chaotic and it's always in a corridor somewhere, but we do do it and we have pretty good coordination.' Furthermore, because of these meetings and EAMHS visits, 'quality control has improved dramatically, just even knowing who our client base is has helped enormously because there's some patients who I don't really feel I've got to know very well.' This system is reported to work with the time constraints of all involved, but the adequacy of recorded outcomes of such case-conferencing could be questioned. There is no detailed record of these events, detailing those present, points discussed or decisions made. There is no evidence that the outcome of these meetings was communicated to all relevant care providers.

Table 22: Evidence of case conferencing in preceding 12 months

Comm.	**Number of files audited**	**Files with evidence of Case-Conf.**	**Total Number Case-Conf.**	**Number of Case-Conferences with Participation of**							**% Case-Conf. with AMHW involvement**	**Scheduled as an outcome of a Plan/ Planning event**
				GP	RN/MHN	AMHW	family/ client	MHS/Cowdy	support service	other		
Ngu	6	3	5	5	3	4	0	1	0	2	80%	0
Ang	6	1	1	0	1	1	1	0	1	1	100%	0
Gal	6	0	0	0	0	0	0	0	0	0	(0%)	0
Num	6	1	2	2	2	1	0	2	0	1	50%	0
Totals	24	5	8	7	6	6	1	3	1	4	ave 75%	0

The Angurugu Health Centre undertakes case-conferencing or teleconferencing as needed for clients who are in Cowdy Ward or for those who may be in Berrimah Prison. These usually involve the clinic manager, the GP, the AMHWs and as many family members as they can locate at the time. The health centre manager explains that involving the family is particularly important if the client is young: 'people here, they make family decisions. The family makes decisions for people, not people making decisions for themselves . . . It would be really inappropriate for me to make a decision about young people without involving the family'. These issues were underscored with the suicide of a young man in detention in Darwin two

years ago. The example of case-conferencing found in audited files at Angurugu contained details of all present, including family members and other support services. Also present in the file were letters written as part of the follow-up to that case-conference.

At Nguiu Health Centre case-conferencing for clients occurs but, according both to interviewed practitioners and audit findings, is far from common practice. At the time of the audit, the Services Director wanted to see the current rate of case-conferencing - which he reported as about once every five months - to increase to once every three months. The audit of files over the twelve month audit period suggests that the occurrence of case conferencing may be less frequent than even this, or may involve activity not entered into the *progress notes*. AMHWs were said to be included in case-conferences for those clients specifically monitored by them. Their presence is recorded for two of the three case-conferences documented in audited files.

It is worth noting that clinical nurse manager who supervises the AMHWs at Cowdy Ward, RDH has expressed the wish to start regular (monthly) case-conferencing to link up DHCS-employed AMHWs at Cowdy Ward with the AMHWs in communities, as suggested by TEDGP.

Summary

The development of objectives for clinical practice has been heavily determined by pre-existing systems of practice, and the preferences of specific personnel, health centre by health centre. It is not surprising that the clinical audits conducted as part of this evaluation show that AMHWs are not well integrated into the delivery of clinical care in most sites and that at most health centres some basic practices relating to record-keeping signal the ongoing lack, or at least limitation of collaboration between AMHWs and the practitioners (GPs and RNs) who make the clinical decisions at the highest level of responsibility. Only at Angurugu do the AMHW enter consultations in client records, and actively participate in a significant number recorded consultations between clients and the GP. At the other health centres, these processes are at best informal and for the most part unrecorded.

Numerous elements of clinical consultation activity are both unrecorded and probably considerably under-developed in their execution by all practitioners. Most practitioners lack or have only limited training in clinical mental health assessment and related processes (including planning and review). As has been found for other areas of clinical practice ((Robinson 2001) practitioners do not systematically record information about their inquiries about the patient’s condition and circumstances. By comparison with recording of medication dosage or clinical measures such as blood pressure, they usually do not record the counselling and health promotional activity done as part of clinical consultation to a much lesser and much more inconsistent degree. The lack of development of *recording* of clinical activity inevitably points to the need for more systematic attention to objectives of practice and training to achieve them. In this case, the development of counselling skills for the cross-cultural context, for GPs and RNs as well as for AMHWs is an important area for further development. Practitioners have raised concerns about the lack of counselling training. The AMHW Program has yet to formulate any objectives in this important area.

4.8 CCIS and Hospital Data Audit

Audit of CCIS data

The Mental Health Module of the Community Care Information System (CCIS) was introduced in 1998. Data was extracted from this system for the four participating communities.

Table 23 below shows the extent of use of the system since that time to record mental health diagnoses for five of the Program communities - Tiwi Islands, Angurugu, Elcho Island, Numbulwar and Borroloola – from January 1998 to October 2003 inclusive and was provided by the Corporate Management Section of DHCS. Thus the data for 2003 is two months short of that for other years. The data available for Borroloola include Mara and Garawa tribal groups; the data for Elcho Island includes all clients from Elcho Island beyond Galiwin'ku and the data for the Tiwi Islands includes the three communities of Milikapiti, Nguiu and Pirlangimpi. They also include both non-Indigenous as well as Indigenous clients, although the latter are by far the majority.

A total of 94 diagnoses are recorded for the period, including both principal (75) and provisional diagnoses (19), for a total population of 6,536. The first two years of operation of the Mental Health Module saw few entries from these five communities. However, as Table 23 shows, the number of entries rose sharply in 2000 and 2001 before falling off again slightly in 2002 and again in 2003. It is unlikely that the inclusion of two additional months of data for 2003 will have much impact on these results. The paucity of entries suggest that the system is significantly under utilised, and subject to variation in practitioner activity levels, including some under-recording of services delivered.

Table 23: Total diagnoses recorded in CCIS, all communities

Year	1998	1999	2000	2001	2002	2003	Total
Recorded diagnoses, all locations	8	4	25	26	22	9	94

Table 24 breaks down information on diagnoses by community. The most common diagnoses entered into CCIS are for schizophrenia related conditions (32%), followed by mood disorders (27%). Substance abuse related cases account for 22% of diagnoses. Table 24 also indicates variation between communities, though the numbers are so small as to preclude any substantive conclusions being drawn. Numbulwar shows the highest number of diagnoses for schizophrenia and substance use related disorders, while Elcho shows a more marked predominance of schizophrenia, followed by about equal numbers of identified mood disorders and substance use related disorders.

The greatest number of entries come from Elcho Island (31), followed by Numbulwar (19) and the Tiwi Islands (18), then Angurugu (14) and lastly, Borroloola (12). As a proportion of the populations they cover, however, Table 23 shows that the highest rate of diagnoses entered into CCIS comes from Numbulwar, followed by Angurugu. With this adjustment Elcho Island ranks third. It is likely that these differences reflect a combination of days visited and record

keeping practices of visiting mental health staff. Tiwi data indicate that the Coordinated Care Trial lead to reduced visits by DHCS mental health practitioners. Increases after 1999 may be a result of increased linkage with TEMHS in Darwin at Tamarind Centre and Cowdy Ward, by the Tiwi mental health team.

Table 24: Audit of CCIS files – mental health diagnoses for all clients, 1998-2003

Year	Comm.	All diagnoses		organic F00-09		substance use related F10-19		schizo-phrenia & related F20 – 29		Mood disorder F30-39		neurotic, stress-related F40-48		adult personality & behaviour F60-69		behavioural (childhood onset) F90-98	
		f	m	f	m	f	m	f	m	f	m	f	m	f	m	f	m
	Tiwi Isl	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Angu	2	1	-	-	-	-	-	1	1	-	-	-	1	-	-	-
1998	Elcho	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Numb	1	4	-	-	-	-	-	3	1	1	-	-	-	-	-	-
	Borro	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Tiwi Isl	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Angu	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-
1999	Elcho	1	1	-	-	-	-	1	1	-	-	-	-	-	-	-	-
	Numb	0	2	-	-	-	-	-	2	-	-	-	-	-	-	-	-
	Borro	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Tiwi Isl	1	7	-	1	-	1	1	2	-	1	-	2	-	-	-	-
	Angu	4	3	-	-	-	3	2	-	2	-	-	-	-	-	-	-
2000	Elcho	3	3	-	-	-	1	1	2	1	-	1	-	-	-	-	-
	Numb	0	1	-	-	-	-	-	1	-	-	-	-	-	-	-	-
	Borro	1	2	-	-	-	-	-	-	1	-	-	-	-	2	-	-
	Tiwi Isl	1	6	-	-	-	2	1	1	-	1	-	1	-	1	-	-
	Angu	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-
2001	Elcho	4	7	-	-	-	3	2	4	2	-	-	-	-	-	-	-
	Numb	1	6	-	-	-	4	-	1	-	1	1	-	-	-	-	-
	Borro	1	0	-	-	-	-	-	-	-	-	-	-	-	-	1	-
	Tiwi Isl	0	2	-	-	-	1	-	-	-	1	-	-	-	-	-	-
	Angu	0	2	-	-	-	-	-	-	-	1	-	-	-	1	-	-
2002	Elcho	4	5	-	-	-	2	1	1	1	1	2	1	-	-	-	-
	Numb	0	4	-	-	-	3	-	-	-	1	-	-	-	-	-	-
	Borro	3	2	-	-	-	-	-	2	2	-	1	-	-	-	-	-
	Tiwi Isl	0	1	-	-	-	-	-	-	-	-	-	1	-	-	-	-
	Angu	1	1	-	-	-	1	-	-	-	-	1	-	-	-	-	-
2003	Elcho	1	2	-	-	-	-	-	-	1	2	-	-	-	-	-	-
	Numb	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Borro	2	1	-	-	-	-	-	-	2	1	-	-	-	-	-	-
Total		31	63	0	1	0	21	9	21	14	11	6	5	1	4	1	0

Despite limitations, CCIS data warrant closer examination both in terms of the incidence of diagnoses and events, and in relation to hospital audit data, in order to determine the degree of concurrence between the data sets.

Table 25: CCIS diagnoses per 1000 population

Comm.	Population*	All Diagnoses	No. of diagnoses per 1000
Tiwi Isl	2110	18	8.53
Angu	754	14	18.57
Elcho	2200	31	14.09
Numb	721	19	26.35
Borro	751	12	15.98

* ABS 2001; ABS data are likely to significantly under-enumerate populations; Tiwi Health Board records indicated a population of 2,600 on the Tiwi islands in June 2003.

The CCIS data in Table 24 show an overall female to male ratio of mental health clients of 0.49. That is, in CCIS records, men are twice as likely to be diagnosed with a mental health disorder than women in these remote communities. If this were taken as an indication of the prevalence of mental health disorders between the sexes, then the situation in these communities is in stark contrast to global trends. Overall rates of mental health disorders are almost identical for men and women globally (WHO 2001: 76). Partial explanation may relate to the differential effects that cultural change in Aboriginal communities is having on men and women and gender-specific effects of social and economic policies.

The impact of gender on mental health is compounded by its interrelationship with other social, structural determinants of mental health status, including education, income and employment as well as social roles and rank (WHO 2001: 82). An important difference lies in the higher level of services available to women than men in remote communities. Bias in the detection of mental health disorders in men and women may be another influence. The mental health disorders of Aboriginal woman may be less visible than those of men, particularly given the lack of diagnostic attention to depression, including maternal depression. It is not possible to attribute the gender difference in client populations to underlying levels of psychological disorder in Aboriginal men and women.

The data in Table 24 also suggest that there are significant male-female differences in identified mental disorders. These data suggest that, in contrast to global patterns, men are far more likely to be diagnosed with a schizophrenia related disorder than women. General population studies indicate that no significant gender differences have been reported for schizophrenia (Piccinelli & Homen 1997). Men are predominant in the diagnosis of substance abuse related disorders, which is consistent with patterns identified in other populations (Busfield 1996, WHO 2001). Only in mood and neurotic and stress-related disorders is the reverse the case, although the difference between the sexes in both of these categories is small. However, the gender difference in diagnosis of depression, consistently more commonly diagnosed among women, is one of the most robust psychiatric epidemiological findings. The patterns suggested by the data here clearly need more thorough investigation with larger populations.

The diagnoses presented in Tables 24 and 25 comprise only 3.4% of total contacts with the communities. Table 26 below shows the types of contact that psychiatric services have with community clients. The number of 'diagnosis assessment' events indicated in Table 4.18 is more than twice the number of diagnoses indicated in Table 4.16 (Appendix I). However the contact type 'diagnosis assessment' includes assessments that are not necessarily ICD10 diagnoses which may be made, or entered into the system, by a range of practitioners other than a psychiatrist, such as 'community mental health nurse', 'author', 'case manager', 'designated mental health practitioner' or 'social worker'.

Table 26: Service provision to communities recorded in CCIS, 1998-2003

Comm.	Type of Contact														
	outcome (assessment	authority (order)	case review	casual service	diagnosis assessment	diary entry	group session	meeting	order review	phone contact	referral in	referral out	register report	service event	Total
Tiwi Ils.	0	26	65	1	21	20	19	0	13	7	39	0	2	59	**272**
Angur	1	20	61	0	29	67	28	4	6	25	67	4	5	353	**670**
Elcho	5	53	53	1	57	106	64	12	13	35	103	4	0	589	**1094**
Numb	2	24	50	0	32	64	23	5	8	35	68	1	3	487	**802**
Borro	6	2	40	1	17	22	0	1	0	6	31	0	0	68	**194**
Total	14	125	269	3	156	279	134	22	40	108	308	9	10	1556	**2974**
% of Total	<1%	4.2%	9.1%	<1%	5.3%	9.4%	4.5%	<1%	1.3%	3.6%	10.3%	<1%	<1%	52.3%	-

Table 26 includes all clients for whom a mental health 'event' is recorded in CCIS for the period 1998-2003. These contact events are provided by TEMHS, the East Arnhem Team, Katherine Team, Darwin Rural Team, Inpatient Unit, On-Call Team, Adult Team, Education and Training Team, Forensic Team or the Early Intervention Team. The data do not include those clients for whom the only recorded event is a *referral (not accepted)*. There were only three instances of this from the above communities.

'*Outcome (assessment)*' has only been recently introduced as a category in CCIS in 2003, and indicates administration of an assessment tool, such as the Kessler-10 or Health of the Nation Outcome Scale, for a client. Thus the data here is limited and although mandatory, some MHS staff report that staff and time shortages make it difficult to administer these assessment tools regularly. 'Service events' are the most numerous of all contact types (52%), but cannot be broken down further as the quality of data recorded at this level is not reliable. This category of contact encompasses all instances where the provider sees the client. The Mental Health

Program area of DHCS is currently working on developing a consistent set of codes for reporting to this level of detail.

As Table 27 indicates, 84% of service events occur in the communities. Most commonly these take place at the community health facility (43.6%), followed by the clients usual residence (25.2%), then a mental health community facility (10.8%).[11] That is, the majority of services take place somewhere other than in the client's home. The brevity of visits to communities make it difficult to seek out all clients outside the community health centre, but this could also be posing an obstacle in terms of client access to services. Stigmatisation of mental illness, lack of a suitable place for a confidential and quiet consultation and differing concepts of time (Janca & Bullen 2003) may contribute to lack of attendance at the clinic and utilisation of available services.

Angurugu shows a higher proportion of services occurring in a client's home (30.5%), while the Tiwi Islands have no CCIS-recorded instances of services being provided in a client's home, while nearly 60% of services are provided to clients while in a correctional facility (reflecting that almost all contacts with TEMHS staff are in Darwin, who rarely visit the Islands). The location of other events is not recorded, except for 'meetings', most of which occur in communities.

Audit of hospital data

The data presented in Tables 28 - 30 include the total population for the Tiwi Islands, total population for Elcho Island, Angurugu, Numbulwar and Borroloola. Population data are presented in Table 30. The data for January 1998 to August 2003 inclusive[12] was provided by the Corporate Management Section of DHCS. Data available at the time of writing, for 2003, was significantly less than for other years.

The hospital information captures not only clients who have a principal mental health diagnosis but encompasses all clients for whom a mental health diagnosis has been made. It includes clients admitted to Cowdy Ward and other parts of the hospital. Table 28 shows that the male predominance among mental health clients suggested by the CCIS data is consistent with data on admissions to Royal Darwin Hospital (RDH). Males are more than double the number of females admitted to hospital for clients ten years of age and above. Table 28 indicates that the female to male ratio for RDH hospital admissions among the communities audited is 0.48. This is in contrast to estimates for the general Australian adult population as reported by Andrews et al. (1999:7). The total number of female clients admitted has risen steadily from 1998 to 2002. For men, the years 2000 and 2001 saw a drop in admissions from 1999. Admissions for men rose again in 2002.

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[11] However, a percentage of entries entered into 'MH community facility' may in fact take place in the community health facility, as 'MH community facility' is the default category when entering data into CCIS.

[12] At the time the data was gathered, December 2003, DHCS reported that RDH was experiencing a backlog in clinical coding which means that most cases after August will not appear in the data until sometime in 2004.

Table 27: Location of service events recorded in CCIS, 1998-2003

Community	Venue									
	Client temp. residence	client usual residence	community health facility	MH community facility	correctional facility	MH Inpatient facility	Hospital	telephone contact	other	Total
Tiwi Isls.	2	0	0	15	35	1	1	5	1	**60**
% of Total	*3.3.%*	-	-	*25%*	*58.3%*	*1.7%*	*1.7%*	*8.3%*	*1.7%*	
Angurugu	20	119	108	42	17	5	9	32	2	**354**
% of Total	*5.6%*	*33.6%*	*30.5%*	*11.9%*	*4.8%*	*1.4%*	*2.5%*	*9%*	*<1%*	
Elcho Isl.	23	131	309	36	0	11	14	31	11	**566**
% of Total	*4.1%*	*23.1%*	*54.5%*	*6.4%*	-	*1.9%*	*2.5%*	*5.5%*	*1.9%*	
Numbulwar	29	108	214	23	5	1	7	15	10	**412**
% of Total	*7%*	*26.2%*	*52%*	*5.6%*	*1.2%*	*<1%*	*1.7%*	*3.6%*	*2.4%*	
Borroloola	1	11	8	43	4	0	1	3	3	**74**
% of Total	*1.4%*	*14.9%*	*10.8%*	*58.1%*	*5.4%*	-	*1.4%*	*4.1%*	*4.1%*	
All Comms Total	75	369	639	159	61	18	32	86	27	**1466**
% of All Comms Total	*5.1%*	*25.2%*	*43.6%*	*10.8%*	*4.2%*	*1.2%*	*2.2%*	*5.9%*	*1.8%*	

Table 28: Admissions to RDH of clients with a mental health diagnosis by age and sex

Year	Age (female)							Age (male)						
	10-19	20-29	30-39	40-49	50-59	60+	All ages 10+	10-19	20-29	30-39	40-49	50-59	60+	All ages 10+
1998	3	6	7	1	1	2	20	2	23	6	10	1	3	45
1999	3	15	11	6	6	5	46	9	34	41	29	7	6	126
2000	5	16	15	10	2	4	52	13	31	21	19	13	5	102
2001	2	13	20	5	9	8	57	6	20	27	20	11	7	91
2002	0	16	14	16	6	7	59	6	24	36	29	15	8	118
2003	0	1	3	3	1	2	10	0	3	8	1	5	1	18
Total	13	67	70	41	25	28	244	36	135	139	108	52	30	500

For both men and women the highest proportion of clients fall within the 30-39 year old age group with over half of total admissions for males and females falling in the 20 – 39 years age groups. Again, this is at variance with that reported by Andrews et al (1999:8) in relation to the adult general Australian population, for which the prevalence of mental disorders is greatest in the 18-24 year old group. The RDH admissions data show a slightly higher proportion of female clients (22%) are in the older age groups (50-60+ years) than for male clients (16%). There is negligible difference between men and women in the younger age groups (10-29 years).

Table 29 below shows that mental health diagnoses for the 760 clients from the five locations admitted to RDH total 1000, over six years. As admissions with one or more mental health diagnosis recorded beyond the principal diagnosis have been included in Table 29, the number of diagnoses exceeds the number of clients

Substance use disorders comprise the greatest proportion of diagnoses (68.6%). This needs to be seen in a global context where substance use disorders have grown dramatically world wide in the past three decades. Indigenous people, prisoners, young people and people with a severe psychiatric illness are at particularly high risk(WHO 2001:34). Substance use disorders are also the most common and clinically significant Co-morbid disorder among adults with severe mental illness, such as schizophrenia (Drake et al 2001:469). C-omorbidity data has not been analysed for RDH admissions, however, schizophrenia and related disorders are the second most numerous diagnoses for admissions to RDH from the study populations (9.6%). Compared to the CCIS data discussed above, the hospital admissions data reveal a far higher proportion of substance use disorders. This is partly explained by the fact that substance use disorders are more frequently associated with more than one related diagnosis. A more detailed analysis of the data is required in order to be able to make a direct comparison. The data in Table 29 show the frequency of diagnoses rather than the number of clients with a particular diagnosis.

Neurotic, stress-related disorders, followed by mood disorders are the next most common diagnoses. Among all the mental and neurological disorders, depression accounts for the largest proportion of the mental health burden almost everywhere in the world and the prevalence of depression is almost twice as high among woman as among men (WHO 2001:46). However, the RDH admissions data indicate that for these Top End communities men again predominate, with a female to male ratio of 0.75 for mood disorders.

Table 29 indicates that substance use related diagnoses are most commonly associated with men. The female to male ratio is 0.31, the lowest female to male ratio of all diagnoses, and consistent with the ratio found in CCIS diagnoses. The gender ratio for schizophrenia and related disorders also shows a marked male dominance, but less so than that of the CCIS data. However, at 0.65, this differs significantly from the patterns emerging in global population studies that do not show a significant gender difference in prevalence.

Table 29: Sex-specific admissions to RDH, clients with a mental health diagnosis by disorder and community, 1998-2003

Comm.	all diagnoses		organic F00-09		substance use related F10-19		schizo-phrenia & related F20 – 29		mood disorder F30-39		neurotic, stress-related F40-48		assoc. with physiol/ physical F50-59		Adult personality & behaviour F60-69		mental retard/n F70-79		Psycho-logical develop/t F80-89		behav/l (child. onset) F90-98	
	F	M	F	m	f	m	f	m	f	m	f	m	f	m	f	m	f	m	F	m	f	m
Tiwi Isl	129	338	10	5	81	237	11	29	7	22	11	30	0	2	1	8	2	2	6	3	0	0
% of Total (467)			3.2%		68.1%		8.6%		6.2%		8.8%		<1%		1.9%		<1%		1.9%		0%	
Angur	36	60	1	0	18	49	2	1	7	7	7	2	0	0	0	1	0	0	0	0	1	0
% of Total (96)			1%		67%		3.1%		14.6%		9.4%		0%		1%		0%		0%		1%	
Elcho	50	136	0	4	20	99	17	13	4	1	4	6	2	11	0	0	1	2	1	0	1	0
% of Total (186)			2.2%		64%		16.1%		2.7%		5.4%		7%		0%		1.6%		<1%		<1%	
Numb	13	60	0	0	3	38	0	9	5	1	2	3	0	0	0	0	0	2	3	6	0	1
% of Total (73)			0%		56.2%		12.3%		8.2%		6.8%		0%		0%		2.7%		12.3%		1.4%	
Borro	62	116	6	3	42	99	8	6	2	2	2	4	0	0	1	1	0	0	1	1	0	0
% of Total (178)			5.1%		79.2%		7.9%		2.2%		3.4%		0%		1.1%		0%		1.1%		0%	
All Comm. Total			17	12	164	522	38	58	25	33	28	45	0	13	2	10	3	6	11	10	2	1
% of Total (1000)			2.9%		68.6%		9.6%		5.8%		7.3%		1.3%		1.2%		<1%		2.1%		<1%	

The predominance of substance use disorders is consistent across all communities with the highest prevalence as a proportion of total diagnoses for Borroloola. Schizophrenia is the second most common type of diagnosis in only three communities: Elcho Island, Numbulwar and Borroloola. In Angurugu, mood disorders are diagnosed more frequently, followed by neurotic, stress-related disorders. Schizophrenia is comparatively less commonly identified in Angurugu than in other communities. Among Tiwi Islanders, neurotic stress-related disorders are slightly more commonly identified than schizophrenia, but the difference is negligible.

Table 30 shows the number of diagnoses for each community as a proportion of the population. The data indicate that the highest rate of admissions comes from the Tiwi Islands, followed by Borroloola then Angurugu. The lowest rate of admissions comes from Elcho Island.

Table 30: Diagnosis of community clients admitted to RDH per 1000 population

Community	Population*	All Diagnoses	No. of diagnoses per 1000
Tiwi Isl	2236	467	208.9
Angu	754	96	127.3
Elcho	2200	186	84.5
Numb	721	73	101.2
Borro	751	178	237

* ABS Statistics 2001

In summary, the data available from CCIS is not extensive and is probably not a complete or comprehensive record, but, in terms of diagnostic information, is largely consistent with that indicated by hospital admissions data from RDH. Some indicative patterns are evident. Males comprise the majority of mental health clients in these remote, predominantly Aboriginal communities. The disorders most commonly diagnosed and seen by hospital staff are substance use related disorders, in most cases diagnosed in men.

Fung (2003:7) has identified the most common causes for evacuation from Top End communities as substance-induced psychosis and situational crisis. She also states that these conditions are 'often preventable – better communication and awareness of family dynamics within the community may help to flag up potential problem situations'. Second in frequency is schizophrenia, also predominantly identified as a disorder of Aboriginal men rather than women.

Fung (2003) identifies an increasing number of psychiatric evacuations from the Top End for the period January 2002 to October 2003 compared to numbers between 1994 and 1998. The data for RDH admissions presented here includes a broader category of clients than just those evacuated from communities. The overall rise in admission rates (the small drop in 2001 aside) may support Fung's argument for the potential benefit of primary prevention in mental health for remote communities in the Top End (Fung 2003:1) with training and services that are tailored to meet the mental health needs of these remote communities.

However, one must caution against any facile expectation that there will necessarily be a direct flow-on of reduced hospital admissions and emergency evacuations as a result of improvements in community-based mental health care, and that the investment in community-based services should be justified in these terms. Increasing practitioner activity in the communities is likely to lead to increasing demand for hospital services. Increasing focus on other conditions, such as depression in women or the chronically ill may similarly increase demand for hospital inpatient services. Social change and medicalisation of psycho-social problems more broadly has already and may continue to lead to increased demand for hospital services among community members. All of these may work to outweigh the growing capacity to treat people in communities. However, such trends would not necessarily at all diminish the importance of *appropriate, adequately resourced* community-based care.

A note on gender and mental health care

Gender specific patterns of mental health diagnoses and hospital admissions have been discussed above. The data suggest that the mental health needs of men and women in remote communities are not the same. Nor are they the same as the mental health needs in other populations in Australia and in other countries. There is therefore a need for gender sensitivity in provision of mental health care in remote Australian communities.

The most striking difference is the predominance of men in the identification of mental health disorders among Indigenous people. The reasons behind this need to be examined closely, but the comparative shortage of services that cater to the needs of Indigenous men living in remote communities has been raised by several Program participants, including both AMHWs and GPs, as a priority. Unravelling gender-specific risk factors impacting on mental health - economic and social policies, cultural change, unemployment, education, social capital, social status, rank and role - need to be prioritised in future research.

Of more direct importance in relation to the Program is the need to have both male and female AMHWs available in each community. Wherever this is not the case, AMHWs have stressed that this is a significant obstacle to service provision. Establishing AMHWs in newly participating communities needs to ensure the capacity to sustain a minimum of two AMHW positions.

Gender bias in detection, diagnosis and forms of treatment can be countered to an extent by the provision of education to primary health care practitioners. However, gender issues may cause considerable difficulty and uncertainty in the cross-cultural setting, a fact noted in the baseline report (Robinson et al. 2003). Cross cultural learning and mental health education for GPs and RNs should develop an approach to gender issues in mental health work.

4.9 Discussion: Integration of mental health and primary health care

Increasing recognition of the co-morbidity of physical and mental disorders points to the need for greater integration of care that can be effectively delivered at the primary level. Malnutrition, infectious diseases and chronic diseases, for instance, can be risk factors for mental disorders and can worsen existing mental problems. The WHO (2000) forecast mental health problems to dominate clinical issues in primary care in the next decade (cited in Russell & Porter 2002). In the UK, the Department of Health reports that ‘it will not be possible to promote mental health and reduce morbidity without strengthening the capacity of primary care services to identify, assess and treat those with mental health problems’ (Russell & Potter 2002:119). Writing in regard to Australia, Hickie and Groom (2002:376) argue that, ‘a primary care-based system is the only system that has the potential to reach the broader population, provide access to the right mix of affordable primary and secondary care services and provide the integration and continuity of medical and psychological care that persons with mental disorders require.’
According to criteria proposed by WHO (2001: 17) and by Hickie and Groom (2002), successful integration of mental health into primary health care rests on:

- strategies for ensuring sufficient numbers of adequately trained specialists and primary health care staff,

- an appropriate mix of evidence-based pharmacological and non-pharmacological treatments,
- integration and continuity of medical and psychological care,
- promotion of early intervention in assessment and treatment,
- promotion of the mental health literacy of the community,
- established linkages with specialist care services,
- referral criteria and procedures,
- communication systems between care providers and clients,
- systems for documentation and evaluation of services and mental health outcomes,
- a medical pluralist approach,
- links between primary health care, community and social services.

On the majority of these criteria, mental health services within the AMHW Program, reflecting the broader context of services in the NT, remain substantially underdeveloped. The AMHW Program may nevertheless have laid a basis for important moves in these directions.

According to some, the chief obstacles to the development of community-based mental health care include stigmatisation, a lack of political will and the absence of stable community services. The WHO estimates that at present stigmatisation is a major reason why less than 40% of people experiencing a mood, anxiety or substance use disorder seek assistance in the first year of onset (2001:16).

It is clear that political will to commit to development of infrastructure and supports, and to improve the stability of community services are important ingredients for any further development of community mental health care in the NT. However, it is *not* clear whether stigma is a major inhibiting factor in the communities of the AMHW Program. The GP at Lajamanu, for example, reported that many problems were simply not seen as illnesses amenable to medical treatment but were dealt with through traditional patterns of action. It may be that stigma attached to individualized concern about self (the illness model) is a component of traditional patterns of externalisation in response to distress. In this sense, to the extent that these patterns may be diverted to other forms of help-seeking, gains may be made in de-stigmatising presentation with mental health problems. In some participating communities, the presence of AMHWs may facilitate this change over the medium term. In other communities, however, changes in community understanding and attitudes towards mental health may be occurring more slowly, so that traditional patterns of conflict and responses to distress persist at the expense of new idioms of response - including medicalised ones.

Hickie and Groom speak of the need to improve mental health literacy in the community: ‘If the system simply relies on a relatively ‘illiterate’ community to present their psychological difficulties within a system that does not prioritise their active management . . . then overall improvements in outcomes are unlikely’ (Hickie & Groom 2002:380). On this argument, the AMHWs should be part of a program of pro-active work which does not await community demand for services. However, the evidence to support proactive intervention is somewhat patchy. Where should the focus be? Where is the evidence-base for intervention in indigenous contexts? Is there any risk that a careless advocacy of medical and psychological interventions might have an adverse impact on culturally based patterns of coping with difficulty? Should

the emphasis be on mobilization of community organizations and agencies to take the lead in mental health promotion?

It is possible that the AMHW Program and the development of community-based mental heath services will over time promote more active demands for services. This in turn should promote learning by service providers about how to respond. The AMHW Program might then contribute to new ways of talking about problems and acceptance of new kinds of solutions among indigenous community members. The improvements in literacy should be "two-way", and take place in the first instance *at the provider level*, by engaging both indigenous and non-indigenous MHWs in development of a community-oriented strategy.

Medical pluralism consists of acknowledgement that the mental health needs of individuals within a community cannot be met by standardized mainstream health services, but require access to a range of methods and practices of healing. Such pluralism exists today by dint of the persistence of modified or partial adherence to traditional systems of belief and practice in communities of the Northern Territory. However, it is not formally supported or institutionalised in health care. The AMHWs in some communities broker their clients' access to traditional healers from time to time, with some support by GPs. Less clear cut is the arena in which the AMHWs deploy their own cultural knowledge in forms of therapeutic intervention including counselling and mediation, which have resonance with traditional cultural value systems and practices. The AMHW Program provides AMHWs with the opportunity to develop these facets of their work, but without a particular strategy to support it. The potential for an *institutionalised* medical pluralism in mental health care in the NT appears to be limited. However, this should not inhibit attempts to elaborate local systems of response which make use of healers within the communities.

As the experiences of some communities have shown, the AMHW can be an effective agent of communication and collaboration in a framework of multi-agency care. This potential warrants greater support. The GP in Galiwin'ku for example has suggested that the AMHWs play a key role on a Healthy Lifestyles Committee to improve coordination between community organisations. Along the same lines, a study in South Australia identified the need to develop collaboration through regional intra-agency task groups and networking groups to operationalise service partnerships in the delivery of mental health in remote communities (Fuller et al. 2004).

In response to this expectation, it must be cautioned that externally funded programs and organisations often in effect compete with each other for 'runs on the board' and are not necessarily committed to working out the substance of genuine collaboration. It cannot be expected that AMHWs or other community-based program personnel will have the authority, the knowledge or the skills to achieve collaboration where funders and institutions are not committed to it as a primary objective. For this reason, the expectation that AMHWs can be responsible for achieving liaison and coordination between agencies and groups (Indigenous and non-Indigenous) in their communities is a line of discussion which may evade core problems surrounding the ways agencies and departments do business. These reflections apply to funders and partners to the AMHW Program as much as to any others active in participating communities.

Integration of mental health care into primary health care is not without its risks. Without a commitment to providing appropriate non-pharmacological *as well as* pharmacological treatments, there is the risk that mental health care will remain narrowly medicalised. If so, mental health practice will continue to be oriented to patterns of reactive acute care, with much of its resources dealing with the control of substance abuse-related episodes and with insufficient development of alternative strategies for counselling and mediation and prevention and early intervention. One manager interviewed for this evaluation claimed to have identified a trend towards over use of antidepressants and an overemphasis in general on treatment using psychotropic medications by resident GPs. Russell and Potters' study in the UK showed that 'fear, aggression and psychosis were sometimes confounded and that older people and individuals with learning disabilities were often medicated with major tranquillisers as a way of managing difficult and challenging behaviour in the community' (2002:122). Community GPs and others have already indicated that they sometimes come under substantial pressure to respond to social and medical emergency, in which there is a demand to evacuate difficult family members. They may incur criticism if tensions are not relieved through medication or evacuation and then again, if these difficult clients are immediately discharged from hospital without apparent "cure".

In this context, AMHWs are often able to demonstrate impressive non-medical skills in their response to crisis situations. However, the continuing orientation to acute care and pharmacological responses may ultimately devalue the social and cultural skills and knowledge of the AMHWs if there is a failure to more systematically support the development of these facets of their role.

In conclusion, criticisms of medicalised care should not in the view of the evaluators be taken to mean that the role of the AMHWs in the community should be promoted independently of clinical mental health care. On the contrary, it is suggested that for pragmatic reasons alone, strengthening the supports for clinical practice, involving AMHWs in collaboration between practitioners in the community and in the centrally located facilities, is a necessary foundation for their role in the community, and a basis for ongoing development of their skills. Appropriate links with other agencies with responsibilities in public health, substance misuse, domestic violence or community education can and should be built around a role in mental health practice.

Chapter 5. Resources, Support and Sustainability

5.1 Structures, Resources and Support

This Report has reviewed the Aboriginal Mental Health Worker Program to late 2004 in order to draw some conclusions concerning its further development. The Program's future funding is partly secured for a limited period. The basis on which that funding is deployed needs to be reassessed, and consideration of objectives for the Program by funders, partners and participants should be undertaken. Is progress such that the Program should simply continue to operate as it has already done or with only minor revision? Should some new objectives and benchmarks be set for the future? Of particular concern are two sets of factors:

1. those factors which might enhance the sustainability of the Program and, beyond the sustainability of the existing Program,
2. those factors which will allow the formulation of stronger Program objectives in terms of the practical outcomes of capacity-building and improved, more effective practice in both clinical and broader health promotional work.

In the following we review existing arrangements.

Employment arrangements

As a program managed by a non-Government organisation, decisions on pay scales do not need to conform to those received by NT Government employed AMHWs. They are lower than those received by NT Government AMHWs. The TEDGP Program's AMHWs receive around $30,000 to $35,000 per annum. This falls well short of the salaries of government-employed and most non-government-employed AHWs. The realities of remote area service provision are such that new services are increasingly premised on contributions by the Community Development Employment Program (CDEP). This funds half positions at an hourly rate of just over $10.00. Employers frequently top up this rate to a higher hourly rate to arrive at a more appropriate salary for employees. In most participating communities, decisions have been made to split the salary received from TEDGP and to use CDEP funding to create two AMHW positions. TEDGP transfers $38,500 per year in quarterly instalments to the employers of AMHWs; the employers (community government council or health care organisation) decide on the CDEP top up amount, and the split of funds between salary, insurance, superannuation and leave allocations. On the one hand, this use of the CDEP Program enables the undoubted benefit of employment for *two* AMHWs. On the other hand, this means that consideration must be givento the creation of a pathway to employment conditions for the AMHWs which can approach other categories in the health care sector.

The CDEP arrangements produce managerial complexity for health centre staff responsible for oversight of the AMHW positions - for timesheets, leave and monitoring of hours worked - and ultimately undermine the degree to which performance and accountability for time are effectively managed. The fact that AMHW duties have been substantially outside the clinic has in some contexts seemed to reduce managerial support and commitment to the AMHWs and their work.

Inequality and lack of recognition compared to other AHWs, , differences in pay and differences in qualifications required by employers have been criticised by AMHWs around Australia (Parker 2003:296). There is a lack of professional recognition of the AMHW through registration, the development of the AMHW workforce policy at a national level and membership of an association (Parker 2003). In the case of the AMHW Program, the use of CDEP funding seems unavoidable as a means of establishing basic employment for community health workers who may lack formal skills at commencement. However, this should be seen as a starting point for further training and improved conditions, with training and experience. Recognition of performance and training with appropriate improvements in pay and conditions should be built into the present Program.

In lieu of an award and registration for community mental health workers or Aboriginal mental health workers, the principle of topping up the CDEP hourly rate to an appropriate hourly rate for the full period employed should be adopted as a minimum requirement. Preferably, this would mean assent to a schedule of pay and conditions with appropriate increments for performance, set out in a specimen EBA or by contract by TEDGP to be adopted for entrants to the AMHW Program. With further development and consolidation of community mental health programs, full time employment should be available to those AMHWs who are able to achieve a high level of responsibility and performance in their work. This may mean further clarification of competencies and training requirements.

Program support, remote health centre capacity and infrastructure

Two Program Coordinators were employed by TEDGP, one female and one male. They play a vital role within the maintenance and ongoing support of the Program. Donna Mulholland has held her position since the commencement of the Program and Daniel Mulholland joined the Program in late 2003 after his predecessor left the position. Both are AMHWs with experience in DHCS at Cowdy Ward and in other services. . Their responsibilities include maintenance of contact with participants through regular community visits and by telephone, orientation of new AMHWs, brokerage between parties, forging links between organisations and reporting to funding bodies.

A number of AMHWs expressed appreciation at the support provided by the coordinators. For instance, Samuel in Numbulwar said that help from the coordinator is always forthcoming if he needs it 'yeah, help from her. All the time, ring her up, she gives me advice. Donna is alright, she's doing fine, you know, with us. Sometimes I ring her and talk to her. Sometimes she comes down, gives me advice', and Robert in Kalano is another who says that he has no problems drawing on the coordinators for assistance. Usually this occurs when Robert rings Donna but he also appreciates their visits, particularly the recent visits by the new male coordinator. At the time of writing, Warren, the AMHW in Borroloola also reports satisfaction with support received from the TEDGP. Warren will call on the Division for help when organising events or seeking promotional resources, and is happy with their response. Between them Donna and Daniel are responsible for overseeing the Program in all communities. Theexpansion of the Program is significantly reliant on the support provided through these two positions.

Despite the generally positive appraisal of the performance of the coordinators, some GPs and others have voiced concerns both about the timeliness of external support for the Program.

Theyhave stressed that community health personnel are unable to provide adequate support for the AMHWs locally.

TEDGP aims to provide an orientation to new AMHWs supported by a visit early in their work. Usually the coordinators are accompanied by an experienced AMHW from another community. However, there are instances where this has not occurred soon enough to counter experiences of isolation and lack of support.

According to one remote health centre GP who left his position in August 2003, TEDGP provided an orientation to the one AMHW about two or three months after she had started.

> 'I wanted TEDGP to come out much earlier that they did because working in an Aboriginal setting you need that personal touch. [You can't] talk to people on the phone and automatically have them trust you and call you when they have problems. You need that personal touch, [the AMHW] needs to be in touch with everyone, with all the group because she needed to have some direction, she needed to see that it can be done, by herself, within the clinic team. And she can only see that by talking to all the other people within the Program; the other MHWs in the other communities. Certainly TEDGP should have sent someone down much earlier to have that personal touch basically just to orient her and tell her what was expected of her in terms of more training which was exactly what she wants.'

It is expected by the TEDGP that the health centre will provide support to the AMHW, in return for the benefits of having the additional staff on board. Where this has happened, it has usually been due to the efforts of a committed health centre manager. GPs maintain that they do not have the time to devote to training and mentoring the AMHWs, although they attempt to do this as far as they can. However, staff turnover or staff shortages often confound local efforts to provide support to the AMHWs. Note that most health centre staff, including GPs, do not have formal training in mental health care. Only Galiwin'ku and Tiwi have an RN with some psychiatric training on staff.

According to comments of the GP formerly at Lajamanu, the lack of support can completely undermine a position:

> '[The AMHW] wanted to get [training in mental health care] now because she doesn't want to feel that she is useless in the clinic. She comes in, she doesn't know what to do. I gave her directions, she came to sit in with me a few times, but sometimes you get busy and . . . It was a little unclear what her role could be. That came from me. There was one other person, I knew I couldn't give her one hundred per cent because I had all these other issues that I had to attend to. So as soon as we got a nurse that was interested in mental health, he was actually a psychiatric nurse, I gave him the responsibility to deal with [the AMHWs] education and mentoring and paperwork, and encouraging her in every day tasks as much as he can. He was new so I had to mentor him to mentor. Unfortunately he . . . left the community within two months, so then [the AMHW] was left by herself again. So she just felt like everyone was deserting her I guess.'

On two occasions this AMHW had arranged with TEDGP to catch a plane to BIITE for training. On both occasions, according to the GP, she was informed that the plane was full and would not be able to collect her. 'When she found out that I was leaving', said the GP, 'I think that was probably the final straw.' The AMHW worked up to two weeks before the GP left.

According to both the GP and the current clinic manager, she was a very reliable worker and always came to work, but there was no-one at the clinic who could offer her the training she really needed. According to both the manager and the GP, the need for a more formalised support from TEDGP is the greatest need for the Program. This view will be considered again below.

The departure of the GP from Borroloola has impacted on Warren Timothy's work as their professional relationship was a close one. The GP's spouse, Maria Pyro, was manager of Mabunji Resource Association, Warren's employer, and was an important source of support for the AMHW's community health promotion work among young people and families. At the current time, Warren is attempting to consolidate his training in an environment that lacks guidance or leadership.

Much of the responsibility for the conditions of AMHW employment falls on the shoulders of health centre staff. In January of 2003, for instance, the AMHWs at Angurugu found that undertaking their work as AMHWs, study at BIITE and extended family life were an untenable mix. Although monitoring employment conditions falls with their employer, the Alyangula Community Government Council, it took the initiative and effort of the clinic manager to find alternative accommodation in Alyangula which enabled the AMHWs to continue in their positions. Most other clinic staff live outside the Angurugu community in Alyangula and feel that they need that break. Living in Angurugu, Muriel and Leonard had no respite, with frequent after hours demands.

These kinds of pressures – as well as all the matters associated with leave, time off in lieu, and pay issues – all need to be monitored and resolved by committed local managers. The Angurugu manager, for example, has negotiated with the council for conditions to be attached to the AMHW role to compensate, in part, for the significantly lower rate of pay they receive compared to the AMHWs at the health centre[13]. Most recently, this manager has gone to significant lengths to provide suitable office space to the AMHWs. Her support has assisted the Angurugu AMHWs to contribute to care in a way that complements the roles of other staff and probably decreases the workloads of the latter through the load they have taken on. The manager's efforts have also meant that the AMHWs have been able to deal with phases of potential burnout when the demands of their work become too great. This is a risk identified by a number of AMHWs.

The capacity of local agencies to manage (or absorb) new structures, systems, ideas and funds is often not adequately addressed when setting up new programs, and over-optimistic assumptions can be made. Getting this 'right' requires an attention to identifying local capacity to provide support during the assessment and startup phase for participating institutions; in this case, remote health centres and/or community government councils. This has only partly been factored into project costs, in the form of negotiation work done by the Program Manager and support staff. While the will to provide support to the AMHWs is present among most health centre staff, in many cases this is not matched by the capacity to do so. This has been particularly evident in the startup phase in a number of communities.

[13] Angurugu Council has 90 employees. Like the AMHWs, many of these staff receive payment from CDEP and some other source. The conditions applied to the AMHW positions include six weeks annual holiday and three weeks sick leave (instead of the normal ten days for other employees).

The words of the clinic manager from a community that was considering joining the Program, are worth heeding:

> 'I'm hoping to get a fair bit of support [from TEDGP], because a lot of people put programs on the ground and they expect the nurses on the ground to do it and it wouldn't be so bad if it were just one or two but there's a whole multitude of people who come out, research teams and its just endless, health workers and health worker education and that's without the enormous amount of work that goes into running a health centre and attending to the clientele who come in every day. So I can honestly so that we are stretched and I can't see that we'll be able to supply much support . . .every aspect of health is put onto the clinic with no resources and no training.' Furthermore, 'council aren't prepared to offer any [support] at all, not at all'.

Dr Fitzpatrick, formerly at Borroloola, Dr Hung formerly at Lajamanu and a number of other GPs, clinic managers and RNs advocated that the AMHW Program needed to provide stronger support to the AMHWs from within its resources. However, there is at most only limited funding available for this purpose, according to current arrangements with funding organisations. Observation continues to confirm that the chief determinants of successful development of the AMHWs' role is the quality of managerial support and clinical (and non-clinical) leadership from the local health service provider. This should be taken into account when pursuing the further development and extension of the AMHW Program, in establishing requirements both of funded community organisations and of parties to the partnership agreement, including DHCS and TEDGP.

Community Government Councils as employing organisations

In most of the participating communities, the contracting party and employer of the AMHWs is the local community government council, (on the Tiwi Islands, the regional health care organisation, at Borroloola, a local resource association, etc.), with the effect that the employer of the AMHWs is not always the manager of the community health centre where they work. Given the importance of managerial and other support from the health centres, this can have important consequences for the AMHWs.

Employers are expected to support the Program by supplying basic infrastructure such as office space, a car, or computer. This is set out in the Expression of Interest information form provided by the TEDGP, where employers are also requested to formally identify what resources they will be able to provide. However, the details of this support are not specified in the contracts eventually signed by both TEDGP and the employer. On occasion, the TEDGP has stepped in to provide support, such as partly funding a vehicle or providing a computer if these were unavailable from the employer or the health centre. However for reasons of equity and sustainability it would be preferable to ensure that communities are able to provide what is necessary for the Program to succeed.

Quarterly Reporting requirements included in the contract between TEDGP and the employer at the commencement of the Program have since been dropped (see Chapter 2). Employers were required to submit a Quarterly Progress Report that included:

- Statement of date, organisation and person compiling this report,
- Description of your service and a summary of activities since the AMHW position started,

- Your evaluation plans (to be developed for each AMHW position to assist with the collection of information to monitor the results of this program. Appropriate indicators were to be discussed and agreed upon at a workshop between AMHWs and the GPs involved in the Program in September 2001),
- A list of agencies that the AMHW has liaised with, and the reason for collaboration,
- A work plan for the next quarter,
- Financial expenditure statement.

At the time of writing councils were only required to supply an acquittal of funds before receipt of their next quarterly instalment to cover the AMHW salaries. This variation to the contract suggests difficulty in demanding of the councils that they undertake such planning and reporting. It means that monitoring progress of the Program across all communities is dependent primarily on the travelling AMHW coordinators rather than any formal requirement to report on agreed targets. As indicated, this is exacerbated by the separation between employing organisation responsible for reporting and the place of employment, where no-one may be formally responsible for local managerial oversight of the Program. Measures need to be taken to address effects of the disjuncture between the employer and the place of employment. It would improve program sustainability and directly enhance program outcomes, if objectives and timelines for achievement of objectives in resources, support and management were identified both at commencement and at renewal of funding. Progress should then be reported and periodically reviewed. The form in which these can be attached to contracts should be reconsidered.

Contracting parties should commit to the following resources and arrangements, with appropriate timelines for achievement:

- Induction of AMHWs into basic use of health records and other clinical systems to support their clinical role mental health care,
- Measures to support the role of the AMHWs in collaboration between health centre staff and other organisations and stakeholders as appropriate, including delineation of management responsibilities and basic work practice arrangements
- Agreed conditions of AMHW employment including, where appropriate, an Enterprise Bargaining Agreement which provides a top-up to an appropriate hourly rate for CDEP-funded components of AMHW employment,
- Undertaking to meet basic performance management requirements for AMHWs
- Agreed infrastructure and premises to house the AMHWs,
- Capacity to meet record-keeping and reporting requirements,
- Assistance with setting up networks and resources to support the AMHW's community education and liaison roles and formulation of a plan to assist AMHWs to commence this work,
- Ability to meet program requirements for mental health practice.

As has been indicated, the most effective development of a role for the AMHWs has occurred where there has been substantial support from health centre staff, either health centre managers or mental health nurses. Numbulwar offers an example where an RN has on her own initiative chosen to address mental health care and pass on her psychiatric knowledge to the AMHWs. Galiwin'ku also has a nurse with psychiatric training, but it is early days and it is clear that demands on his time are already great:

> 'Some of my time has been spent in training the AMHWs, but not a great deal of time because the clinic is so busy and because of the funerals so many staff have been away. Most of [the training] centres around some patients refusing their medication. We don't just say no, but talk it over with the patient and explaining it and ninety nine per cent of the time they take the injection after talking. A little while back talked about drug induced psychosis, about *ganja* and the cumulative effects and how you can become psychotic and then get better again after that if you can reduce the intake, although some people stay sick.'

As mentioned in Chapter 3, the approach to defining the AMHW role has been to prioritise flexibility and allow the role to adapt to the needs of the community and health centre and the skills of the AMHWs. This is reflected by the views of one manager:

> 'I think it's best to let [the AMHW role] evolve. I think they need some direction, they can't just be untrained people and they need a lot of direction and support. I think that needs to come from us in the form of personal support, but I think they need guidance from Donna and Daniel. That's what I hope they'll do and that's what they've assured us they will do, is that they will be readily accessible for the Program.'

Remote community health staff experience high turnover. Some participating communities have been left without a GP for many months while recruiting takes place. When new staff begin work, there needs to be prompt induction into the process of the AMHW Program by support staff and local personnel.

The continuing concerns and uncertainties expressed by many practitioners about the clarity of the AMHW role – despite effective performance by AMHWs in fully participating communities – indicates that firmer attention to the development of adequate structures and support needs to be paid during the process of startup and again renewal of funding for existing communities. Support provided needs to be able to offset other sources of discontinuity, such as is caused by staff turnover. The question of whether resources should be applied to TEDGP to fill this gap, or whether it can be achieved by providing clearer expectations of community organisations (perhaps with some incentives) is a question which should be considered.

Summary

Although some communities have found the level of support provided through the TEDGP to be adequate, others have not. The steering group and other forums have seen some debate on the ability of the Program to fund more direct support for the communities. Some advocates of this view, such as Dr Fitzpatrick, formerly at Borroloola, indicate a preference for deepening the current Program by increasing the level of support for existing communities rather than simply adding to the number of communities funded under the Program. By contrast, funders have been interested in increasing the number of participating communities, and do not necessarily want to see new funds applied to already participating communities. *This issue is of considerable significance for the further development of the Program, as a different mix of expenditure may be required if certain objectives are to be met.*

The above material indicates that the most effective support for the AMHWs and for the ongoing development and stabilisation of their role has been in those communities where there is firm managerial support in the local hosting health care centre, support most often provided

by a health centre manager and/or a mental health nurse. Significantly, the GPs do not, and, as many have suggested, cannot provide much of this support. In those communities where this locally based organisational support is lacking, as at Lajamanu, where the health local service was not the employer and had no commitment to the Program, or breaks down, as at Borroloola, there are serious difficulties either in starting up or sustaining the Program.

It is suggested here that appropriate responses to these needs include the following:

1. Identification of needs for support and particular needs for development at startup (and again at funding renewal) to plan for adequate levels of managerial support and resources to be provided
2. Review of contractual requirements of the Program with a view to specifying objectives for development of mental health team and AHW role, with requirements for reporting of progress
3. Consideration of allocation of a funded or seconded position to provide developmental support for communities. This could enable a coordinator to spend further time in individual communities:
    a) To assist with startup and development of practices.
    b) To deal with major discontinuities.
    c) To function as an advocate for the AMHWs in negotiations with their employing organisation, and to collaborate with this organisation to ensure initial AMHW role clarification and subsequent reporting obligations are met.
    d) To assist with planning and development of processes to support work of AMHWs in the health centres and/or in community education, health promotion, including specific priority areas such as alcohol intervention, domestic violence, suicide prevention youth and community education, etc.

Extension of the Program across more communities should not occur at the expense of dealing both with the contractual requirements of community organisations to fulfil their commitments, or with the needs for ongoing and occasional intensive support for program development.

5.2 Training, Education and Career Development

Both Batchelor Institute of Indigenous Tertiary Education (BIITE) and Top End Mental Health Services (TEMHS) are to provide education and training to AMHWs according to the Partnership Agreement.

Most AMHWs are either undertaking or have recently completed the Certificate III in Community Services (Mental Health, Non-clinical). On completion of Certificate III, the AMHWs now receive a pay rise that is arranged between the TEDGP and the employer. The first to receive this were the AMHWs at Angurugu in late 2003.

All AMHWs who have undertaken the course report that they have found it useful and in many ways relevant to the work they do, reporting that the teaching staff are helpful. The format of providing the course in concentrated blocks of study at Batchelor suits their needs and provides a welcomed chance to meet with MHWs from other communities.

On offer for the first time in 2004, the Certificate IV in Mental Health Work (Non-clinical) builds on the generalist Certificate III course. The Certificate IV covers case management, undertaking mental health assessments, alcohol and other drugs, consumer support and training in suicide response. These inclusions are at the request of the AMHWs and the TEDGP.

Some areas not included (due to conformity with national course requirements) are:

- Mental health promotion
- Mental health counselling

Counselling training is scattered across units of the Certificate III. However it is reported that this does not assist AMHWs in building counselling skills that enable them to bridge the Indigenous/non-Indigenous approaches. According to AMHW with KMHS:

> 'We need more culturally based training. It's just your run of the mill counselling and it's cultural counselling but it's not a cultural-type counselling. It's aimed predominantly at your traditional Aboriginal person, so your counselling is sitting down with them, doing things with the family. But we actually need mainstream counselling skills that are more aimed at cultural beliefs. We need some Western counselling skills to go with the cultural counselling skills we've got. If you notice around the Top End there's no specific Indigenous counselling services by Indigenous people……we don't have Indigenous people who have actually trained in counselling and I think that's something we do need.'

This practitioner suggests that what is taught at BIITE has limited bearing on real life contexts. There are in fact few if any working models for counselling which are *simultaneously* grounded in knowledge of indigenous social and cultural patterns and family processes *and* in the key psychological disciplines and therapeutic approaches. The mental health nurses and other personnel within the mental health teams are not in a position to systematically develop a joint approach to counselling with the AMHWs in their communities. The need to develop counselling skills is a challenge to be taken up by the partners.

Training needs are not limited to AMHWs. The RN who works closely with the AMHWs in Galiwin'ku says: 'I feel a bit behind the eight ball with Indigenous mental health. I've been looking at courses but there's just not much around even by distance.'[14]

Many remote area health workers have had no previous experience of mental health care in any context. The resultant lack of confidence in making correct assessments and diagnoses a consequence is only amplified in a cross-cultural setting.[15] A survey of Top End Remote Service Providers conducted in late 2003 and early 2004 revealed that 68% of practitioners report levels of confidence in assessment as only 'somewhat', 'slightly' or 'not at all' (Nagel 2004). The limited confidence and experience of non-indigenous practitioners only underlines the limits on their ability to provide mentorship and direction to AMHWs when it comes to developing objectives for clinical mental health work alike. These practitioners simply do not have the experience or support to overcome the constraints of their own training and roles.

[14] TEDGP encourages all GPs to attend a course on cross-cultural health care provided by Richard Trudgeon in Gove.

[15] In addition to the shortage of training in mental health care experienced by remote health workers, is a paucity of Cultural Training opportunities for GPs working in Aboriginal and Torres Strait Islander health, as reported in a recent review on Cultural Training for GPs across Australia (Commonwealth 2004).

Deficits in basic training need most urgent attention during the initial phase of Program implementation in each community. Short work placements – of AMHWs from Numbulwar at Angurugu –have been trialled to help with the initial stages of training. Work placements, or 'onsite health clinic team inservices' were identified as important forms of AMHW training in the Program's original Needs Assessment Report, following discussions held at BIITE in December 2001 (TEDGP 2001). Further development of these approaches could help meet basic training needs.

AMHW training in clinical systems and practice skills

BIITE has considered the provision of clinical training to AMHWs. AMHWs are not currently eligible for independent professional registration. This limits clinical responsibilities of AMHWs under the AMHW Program; for example, they cannot legally administer medications unless registered as an AHW. This affects the prospects for raising their employment status as discussed above.

Views among Northern Territory stakeholders, such as AMSANT, NACCHO, DHCS and others are divided on the appropriate strategy for professional recognition of AMHWs. Broadly, one side wishes to see AMHW training strictly subsumed under AHW training as a specialisation. All other community mental health work and associated training would be strictly non-registered and limited. Another view suggests that this approach would be too restrictive and would limit the pool of recruits willing to enter mental health work. This group suggests that AMHWs should remain a distinct category with specific training and, eventually, with professional recognition paralleling that of the AHW.

The provision of clinical training (and all formal training for that matter) is a matter for careful consideration for the AMHW Program. Its personnel with one exception (now no longer within the Program) are not former AHWs and have limited experience working with a health care environment. In most cases, the issue of training at a level suitable to gain professional recognition is remote. However, the issue of eventual professional recognition should not be confused with the needs for training to support the clinical component of the AMHW's role.

Opinion among participants generally supports the improvement of the clinical skills and capacities of the AMHWs. As an AMHW with TEMHS points out:

> 'having those clinical skills would be beneficial, because you do need a certain degree of clinical experience to do the job. When you look at an Aboriginal person they have spiritual and emotional as well as physical problems and the whole approach is supposed to be holistic. So having the clinical background is very useful. You need to understand the biomedical side of it so you can explain it to the client. So you can understand the medications and side effects of medication they're on. For example, they're starting to look at the relationship between olanzapine and diabetes now because olanzapine has that extreme weight gain. There's also antidepressants and renal failure. These are now linked together because they've linked chronic disease and mental illness. So having that background does help you a lot.'

As reported above, in many health centres AMHWs are excluded from entering consultations in client files, and may be discouraged from accessing client files directly, either to consult an individual client's record, or to access information on clients due for recall or follow-up. Only

at Angurugu did AMHWs fully access files for these purposes, and enter activity as consultations in clients' records. It is telling that, at other health centres, such as Nguiu – despite the relatively high level of resources – the absence of AMHW consultations was accompanied by an absence of reference to AMHWs in consultations recorded by GPs and RNs. This absence from the recordindicates low levels of training, and, to some extent, of integration of AMHWs in clinical practice. At Nguiu, the AMHWs work within the regime of a health centre which hardly varies its practices to accommodate them. The current role of the Mental Health Nurse/Manager maintains the clearly separate division of responsibilities between health centre and the mental health team.

In current circumstances, there would be little point in AMHWs receiving training in clinical mental health assessment if the results of these assessments are never entered in a client's records, either directly by the AMHW as a consultation, or indirectly, by a GP or other practitioner who conducts a joint assessment with an AMHW. The fact is, assessments will cease to be done if they are not entered into clients' records for reference by other practitioners. As was stated in the baseline report, 'there would be only limited value in recording consultations on activity sheets, if the information in these sheets had no linkage to the information in the patient's primary record and, in theory at least, to the records kept by TEMHS personnel' (Robinson et al. 2003:89).

As a matter of policy, the AMHW Program should expect that:
- AMHWs will receive basic training in record keeping, reading information in medical records and in entry of consultations
- AMHWs will enter consultation activity in client records

Training should aim to equip AMHWs to carry out these basic elements of practice. Other training should aim to improve understanding of medications and of recall and follow-up systems to monitor patients (allowing for variation according to systems and resources).

As already noted, some relevant training is already provided in Certificate III. However, unless this is confirmed by workplace assessmentof the AMHW's ability to implement these elements of practice, this training remains largely irrelevant. This may occur even where there is effective, informal collaboration between AMHWs and GPs or others, as at Nguiu or Angurugu.

According to BIITE, AMHWs were provided with clear instructions on the use of diaries for recording the number of clients, incidents and services provided. However, the evaluation has found that their use across the communities is inconsistent and variable. As argued above, these diaries may be useful to AMHWs, not as a substitute for clinical record-keeping, but as a record of casework which could be used to inform their input into case conferencing, to record decisions made in conferences with or under direction of GP or other staff, (including visitors) and so on. They could potentially be a useful tool in workplace-assessed training aimed at assisting AMHWs to participate in basic clinical processes.

The evaluation audits reported in Chapter 4 indicated that medical records of mental health care planning and assessment by all practitioners were very thin and made almost no reference to AMHWs (or other providers) in any specification of services to be provided. Further, there were few case-conferences involving DHCS and community based staff, and those between local health centre staff were either not recorded at all, or did not lead to recorded outcomes.

The lack of adoption of a standard framework of practice objectives for the AMHW Program was noted in the Baseline Report. *The lack of formulation of common practice objectives for the Program has limited the capacity to provide adequate relevant training and support.*

There are constraints on adoption of a standard care plan by participating communities. It is suggested here that a more basic developmental process be undertaken to highlight practices relating to the keeping of records of mental health care planning and assessment, including those elements which explicitly include collaboration between AMHWs and other practitioners. This will need to be reflected in commitments within the Partnership Agreement to provide services to support practice strategies for each mental health team. Progress in meeting these strategies may in turn be more or less flexibly linked to program contracts. Training can then be developed around basic practices which include AMHWs in clinical mental health work in a manner appropriate to the strategies adopted across the Program.

Under the Partnership Agreement, TEMHS (or EAMHS and KMHS), has agreed to welcome AMHWs to participate in appropriate TEMHS inservice, training and educational opportunities (TEDGP 2002:6). The visiting teams from EAMHS have been an important and valued source of on the job training for the AMHWs in East Arnhem communities; as discussed, this appears to be becoming a two-way process. AMHWs receive training in psychiatric concepts from the MHN nurses when they visit and some MHNs report that their approach to interviewing is being rethought on the advice of the AMHWs. However, access to formal training has not been available through TEMHS. KMHS has undertaken to forward information on training opportunities to Robert Broom in Kalano in the future.

It seems appropriate that further development of the AMHW Program aim at formulation of targets for development of basic practices for participating health centres. These should be undertaken in conjunction with the delivery of appropriate related training by DHCS and BIITE and specified in the Partnership Agreement.

5.3 Program Design and Management

The Partnership Agreement

One of the aims of this report is to examine the objectives and commitments in the current Partnership Agreement with a view to formulating revised objectives for future development of the Program, should its funding be secured.

The Partnership Agreement between TEDGP, TEMHS, BIITE and CDU (NTU) was finalised in August 2002, about one year after commencement of the Program. The Agreement is based on an ethos of partnership, and in addition to the general Vision it sets out in detail the areas where various partner organisations are to work collaboratively toward specified outcomes. However, the Agreement does not specify responsibilities for initiating particular contributions, lacks agreed target objectives and timelines for them to be met.

As has been suggested, this generality has allowed for considerable flexibility in bringing communities into the Program, and responding to the generally undeveloped state of infrastructure and capacity in those communities. As a result, the Program has been successfully established in six of eight communities. However, the generality of commitment

has also had the undoubted consequence that the AMHW Program has been unable to set objectives for clinical practice, community education, counselling, training and support - in other words, it has been unable to set objectives beyond the employment and retention of AMHWs in the communities. It is now appropriate to review these achievements and to define new targets for the development of the Program. This should include responsibilities for targets to be met not only by community organisations, but also by the parties to the Partnership Agreement.

The current Agreement stipulates six monthly reviews. This has not been occurring. A revised Agreement should be reviewed six monthly with a focus on monitoring performance against clearer objectives and targets.

In its present form, the agreement does not stipulate how promised contributions are to be given effect. Ensuring that case-conferencing occurs, for example, is no-one's responsibility, and any party that takes the initiative must rely on the goodwill of others to participate. In this area, as with provision of training and support, the extent of the commitments of DHCS, BIITE and TEDGP need to be clarified.

Regarding the provision and disbursement of funds, in its current form, the Agreement does not address funding or how funds are to be used. A stronger Agreement might include a financial plan for the Program linked to the achievement of agreed objectives. This would enable partners to calculate in-kind contributions to the Program, as part of the overall agreement with funding bodies. This would enable more realistic assessments of the costs of provision of program support and training through both program funds and in-kind contributions. This in turn might give greater certainty regarding what is being demanded of employer organisations. A reference or steering group to monitor the Program on a six monthly or yearly basis would take responsibility for risk management. It is suggested that a risk management strategy be developed by the Program managers in consultation with other stakeholders and included as part of the Partnership Agreement.

5.4 Funding, Program Objectives and Sustainability

The financial sustainability of the AMHW Program is uncertain. To date the Program has existed on the basis of non-recurrent funding which ends in December 2005. Funding beyond mid 2004 provides for four new salaries only. Discussions are currently underway with the Australian Government to secure recurrent funding or at least funding for a further three years.

A model for future funding needs to resolve a number of risks to the Program which would arise if the current arrangements were simply extended into the future. These include the following objectives:

1. *Adequacy of funded and in-kind support for Program objectives*
2. *Appropriate and realistic contractual arrangements with community organisations delineating agreed policies on practice, employment conditions and commitments of resources*
3. *Clear delineation of objectives, responsibilities and of the substantive commitments of in-kind resources under the Partnership Agreement*

4. Appropriate agreement on the part of funding bodies (to date, Australian Government, Alcohol Education and Rehabilitation Foundation, beyondblue inc) about Program objectives and the purpose and mix of expenditure under the Program.

Funding and Program Objectives

It was recently argued that the Northern Territory needs to shift remote community-based mental health services from current insecure, non-recurrent funding to a secure recurrent funding base (Healthcare Management Advisors, 2003). This will clearly confront the AMHW Program at the end of the current two-year period.

In early discussions, Professor Ian Hickie, the former CEO of *beyondblue* expressed some concerns about the original program model, the over-reliance on general practitioners to provide direction at community level, and the likely difficulty TEDGP would encounter in managing the program to clear objectives. These concerns were clearly warranted, as outlined. However, it is also the case that Program Partners and Program Funders alike need to review the present mix of expenditures which limit ability to move beyond simple employment of AMHWs without other objectives.

Funding contributions cannot be limited to the simple extension of the Program into new communities. Sustainability of the Program requires that funding also be applied to address the lack of resources available to provide support and to develop processes and infrastructure. The continued application of funds for AMHW salaries alone, particularly salaries for new positions, would pose a risk to continuing development of the Program and its capacity to achieve measurable outcomes. Review of the Program's ability to provide ongoing development support, if not to fund a developmental program with objectives in clinical practice and community education, should be a priority. However, any revision of Program Objectives demands development of an appropriate funding strategy.

The Alcohol Education and Rehabilitation Foundations provided funding for *Alcohol and Other Drug* Health Promotion workers for two communities (of whom only one is within the AMHW Program). This funding option has proven largely inconsequential for the Program as the funded positions do not contribute to the Program's consolidation, much less expansion. In short, funding too stringently tied by requirements of the funding body will not provide the flexibility needed to consolidate a differentiated community-based mental health strategy.

In this context, the task for a funding body such as *beyondblue* may be to work with stakeholders to leverage both further funding and stronger organisational commitments of participants to the Program, and at the same time to provide the incentives to the revision and development of program objectives. Indeed, it is likely that the funding objectives of the AMHW Program will eventually need to be clarified in relation to the longer term requirement for the funding of mental health care in the NT. If the NT Government and its partners are to move towards strengthened recurrent funding for community-based mental health, then the role of the AMHW Program may well be to help with set-up of basic mental health resources in communities, but not necessarily to commit to provision of recurrent funding in perpetuity. Communities where resources can be consolidated and funded on a stronger basis might then leave the program to allow resources to go to those in need of the kinds of support the Program has been able to provide to date. This kind of question about the place of the AMHW Program in the ongoing development of community mental health needs to form part of

ongoing dialogue between the Partners and Funders. Resolution of this question might assist with clarification of the developmental objectives of the Program itself.

Research and development

The current evaluation has focused largely on process and support for the development and sustainability of the AMHW Program. It has not been able to focus on the effectiveness of mental health strategies including clinical interventions and counselling, education and health promotion in terms of their outcomes for clients and communities. With consolidation of the Program, a shift of evaluation emphasis to effectiveness and client outcomes might be warranted.

The reality is that community health centres and program managers, including TEDGP and DHCS, are continually subjected to exigency caused by staff turnover, mild to severe institutional failure, funding shortfalls and insufficient investment in human and technical capacity. Further, clinical and non-clinical practice alike in remote communities is driven by reactive styles of response to acute care needs. These pressures are likely to overwhelm or at least undermine any attempt to develop new systems of practice and organisation. Assuming recurrent funding for the base program, attempts to overcome these problems should be supported by some investment in well-focused research and evaluation.

The area of Indigenous mental health, particularly in remote Northern Australia is not well understood and can draw on little in the way of an evidence base to support practice in a context of cross-cultural uncertainty and complex social and cultural change. It is therefore not a straightforward matter for the AMHW Program to adopt specific methodologies and practice objectives – for example, evidence based protocols or care plans, or specific mental health assessment tools – where the validity and effectiveness of these instruments have not been established through research trials among Indigenous populations.

These considerations apply not only for clinical practice, but also for many areas of public health and related intervention – for example in areas such as suicide prevention, mental health promotion for youth, domestic violence or substance abuse. Similarly strategies for counselling have not been developed or their effectiveness tested in Indigenous settings.

Development initiatives amenable to evaluation might focus on basic clinical practices as outlined above, with the objective of developing systems of record-keeping to support monitoring and recall, as well as interdisciplinary collaboration. Beyond the AMHW Program itself, such a focus for research and development would be of considerable interest to NT DHCS, if not nationally, for the contribution it could make for establishing cost-effective models for community mental health service delivery.

It is suggested that the Program funders and partners identify opportunities to develop one or more projects amenable to development through funded research. (Funding might be from national competitive grants or a range of other funding bodies, and include allowance for some evaluation funding within the Program itself.) Projects could be identified for areas of clinical practice (around particular health problems, groups according to age and gender, and so on), or for specific community interventions, and their effectiveness subjected to more rigorous evaluation, with the objective of enhancing their implementation within the Program, and, ideally, beyond it. A significant research partnership would enhance the prospects that

important disciplines could be developed and sustained within the Program overall, and would provide funders and stakeholders with greater value for their investment in terms of evidence about effectiveness of one or more strategies or projects within the Program.

More broadly, the work of the AMHWs outside the health centres in community education, heath promotion and prevention, has been the subject of considerable discussion between participants. Cost effective mental health promotion can be developed as a collaborative effort between a health centre and other community organisations. However, as Sweeney and Kisely (2003) note, geographical proximity does not guarantee good communication and working relationships. In fact, the opposite may be true in remote communities where organisations may operate either in competition or in surprising isolation from one another. A number of Program participants expressed their desire to see AMHWs act to facilitate better collaboration between community organisations. The GP from Galiwin'ku suggested that AMHWs participate in a 'Healthy Lifestyles Committee'. This initiative was put to the Galiwin'ku council for approval in late 2003. Through similar activity, the AMHWs in Angurugu are making progress in forging links between community organisations and agents. However, the assertion of a leadership role in this sense may not be within the ability of every AMHW recruited to the program, or in every community; agencies and their managers or Directors may also need to play a facilitative role.

It is clear that the health centres currently provide only limited support and guidance for the development of these areas of the AMHWs' role – indeed of the work of the mental health teams including non-indigenous practitioners. Consequently, the work of the AMHWs has here been variable in focus across the communities, and to a large extent dependent on existing resources, programs and supports. In some communities – such as Numbulwar - these resources are almost non-existent, while at others, such as Kalano, they are dominated by particular provider preferences (alcohol rehabilitation) at the expense of development of a broad preventive or educational approach. The Program through its Coordinators, and assisted on occasions by BIITE personnel, has assisted numerous communities with "mental health weeks", and similar educational initiatives. In other contexts, as at Nguiu, suicide prevention workshops and "men's groups" have been held, but lack the systematic support and evaluation to enhance or assess their effectiveness. It is time that the investment in community health promotion be subject to improved evidence of benefit.

Final Considerations

The focus of the AMHW Program to date has been the recruitment of AMHWs and securing the basic framework for their work at participating health centres. Beyond this, a key concern about the Program remains that the Program Manager and the partners under the Partnership Agreement have been unable to develop or adhere to further specific developmental objectives of the kind flagged at the outset. To a certain extent this is a constraint of the original model, which was focused on funding AMHW positions in health centres employing resident GPs, with no formal commitment to the initiation and support of strategies to develop practices and programs at the health centres or in the communities.

The Program participants and communities have yet to develop objectives or models for development of clinical mental health practice, nor of a community mental health education or healthy living strategy to be a focus of the work of AMHWs. Consideration of how to define and to support all components of a community mental health strategy (and to weigh up their

effectiveness against other options) should be central to future planning of the Program's direction.

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