



Submission to the Senate Inquiry,
“Accessibility and quality of mental health services in rural and remote Australia” on behalf of the Centre for Research Excellence in Integrated Quality Improvement

May 2018



This submission is made on behalf of the Centre for Research Excellence in Integrated Quality Improvement (CRE-IQI). The CRE-IQI is a national research collaboration that builds on decades of experience and commitment to improving Aboriginal and Torres Strait Islander health through strengthening comprehensive primary health care (PHC) delivery. This submission provides input to the Senate Inquiry on *“Accessibility and quality of mental health services in rural and remote Australia.”*

Led by the University Centre for Rural Health and funded by the National Health and Medical Research Council, the CRE-IQI (2014 - 2019) is a national, open collaboration between researchers, policy and service delivery partners who have a long-standing commitment to improving Aboriginal and Torres Strait Islander health. As a national collaboration, we aim to improve Aboriginal and Torres Strait Islander health outcomes by strengthening health systems through supporting the use of continuous quality improvement, a systematic way of using data to guide changes to increase the efficiency and effectiveness of organisational systems.

This submission was drafted by Dr Veronica Matthews, Jodie Bailie, Alison Laycock and Professor Ross Bailie. It is based on the feedback from about 50 people in diverse roles and organisations involved in interpreting data to identify the priority gaps in mental health care, and identifying barriers, enablers and strategies for improvement. Our submission draws heavily on the work completed as part of the Engaging Stakeholders in Identifying Evidence Gaps and Strategies for Improvement in Primary Health Care (ESP Project) - Mental Health and Wellbeing, led by Dr Veronica Matthews:

- 1) Key Messages: <http://apo.org.au/system/files/68269/apo-nid68269-65556.pdf>
- 2) Final Report: <http://apo.org.au/system/files/68269/apo-nid68269-65546.pdf>
- 3) Data Supplement: <http://apo.org.au/system/files/68269/apo-nid68269-65551.pdf>

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INTRODUCTION

Our submission focuses on mental health service provision by primary health care (PHC) centres to Aboriginal and Torres Strait Islander people. The data and evidence we draw upon relates to Aboriginal and Torres Strait Islander community-control and government operated PHC clinics mainly in rural and remote settings.

Primary health care centres play a critical and cost-effective role in the early intervention and management of mental health and wellbeing care. We know that Aboriginal and Torres Strait Islander people utilise PHC mental health services at higher rates compared to non-Indigenous people, however, over a half of Aboriginal and Torres Strait Islander PHC services (54%) in receipt of federal funding have consistently reported gaps in their ability to provide mental health and social and emotional wellbeing services. (1, 2) Social and emotional screening services in PHC are critical to early identification and intervention for SEWB/mental health issues, yet work within our Centre for Research Excellence in Integrated Quality Improvement (CRE-IQI) has demonstrated a series of missed opportunities. A cross-sectional analysis between 2012 and 2014 of over 3,000 Indigenous client records from 100 PHC centres across Australia showed that 73.4% of clients were not screened and no further action was taken for 25.4% for whom an social and emotional wellbeing concern was identified.(3) There was also no follow up for just under half of those for whom action was taken. These findings suggest the lack of a clear model or set of guidelines on best practice for social and emotional wellbeing screening and follow-up in Aboriginal and Torres Strait Islander health.

The need for accessible and culturally appropriate mental health care is clear. In 2011, fourteen percent of the health gap between Aboriginal and Torres Strait Islander people and other Australians was linked to mental health and substance use conditions. (4) The 2012-13 national health survey showed Aboriginal and Torres Strait Islander adults experience psychological distress (anxiety and depression symptoms) at a rate 2.6 times that of non-Indigenous adults.(1) A 2016 youth survey indicated that around one third of Indigenous adolescents met the criteria for probable serious mental illness compared to one fifth of non-Indigenous young people.(5)

Understanding the current burden of mental health illness requires reflection on Australia's socio-political history and its adverse intergenerational impact on Aboriginal and Torres Strait Islander health and wellbeing that holistically incorporates strong connections to land, culture and community.(6) Mental health and wellbeing along the life course is strongly linked to cultural identity and social determinants. While the focus of this submission is improving gaps in PHC service provision for adults

with a mental health diagnosis, to holistically address mental health and wellbeing of Aboriginal and Torres Strait Islander people, we recognise the need for:

- a) Stepped care approach starting with social and emotional wellbeing screening services in PHC to identify and intervene at early stages and across all age groups; (1);
- b) development of clear mental-health related treatment pathways across health sectors to improve continuity of care; (7) and
- c) collaboration and integration across a number of service sectors (health, housing, employment, justice and social services) to improve social determinants.(1)

This submission reports on the findings from our 'Engaging Stakeholders in Identifying Evidence-Practice Gaps and Strategies for Improvement in Primary Health Care (ESP)(8) project for mental health and wellbeing care.(9) The findings and key messages can be used to develop system level solutions for priorities in mental health and wellbeing care for Aboriginal and Torres Strait Islander people and communities. From the Inquiry's Terms of Reference, the findings directly relate to: the nature of the mental health workforce; challenges of delivering mental health services in the regions, and; related matters. The findings also offer strategies relating to the higher rate of suicide in rural and remote Australia and community attitudes towards mental health services.

ESP PROJECT – MENTAL HEALTH AND WELLBEING CARE IN THE ABORIGINAL AND TORRES STRAIT ISLANDER PHC SECTOR

In a phased participatory research approach between 2015 and 2016, over 50 stakeholders in Aboriginal and Torres Strait Islander PHC, working in a variety of roles and organisations, interpreted data about the provision of mental health and wellbeing care and identified:

- 1) Six priority evidence-to-practice gaps in the delivery of mental health care in PHC centres; and
- 2) Barriers and enablers, and strategies to address these identified gaps in care.

The process drew on clinical audit data from 21 health centres, including community-controlled and government-managed health services in different Australian jurisdictions that undertook the mental health audit between 2011 and 2013. Of these 21 PHC centres, 75% (18/21) were from regional and remote areas. PHC teams in these health centres conducted audits of more than 975 client records (adults with a diagnosed mental health condition) against best practice guidelines (developed by mental health experts working within the Indigenous health sector). Health centre teams also completed 29 system assessments (10) over the period 2011 to 2013, which analysed the functioning of health centre and broader health systems in relation to delivering best practice mental health care.

KEY MESSAGE 1: *We are likely to improve the overall quality of mental health and wellbeing care by focusing on six 'evidence-to-practice gaps' in care delivery. These gaps are common across many PHC centres. See Supporting Data on Page 10 of this Submission for the clinical audit data related to these evidence-to-practice gaps.*

- 1) Developing and recording shared care arrangements and referral (as part of complete client records, mental health summaries and care plans);
- 2) Improving recording and follow-up action for clients whose symptoms are getting worse;
- 3) Asking about and recording alcohol and drug misuse, and giving advice or counselling on tobacco use, nutrition and exercise;
- 4) Organisational commitment to a culture, support structures and processes that promote high quality mental health care;
- 5) Developing healthcare teams with the right mix of skills (for example having psychologists and/or cultural healers), clear allocation of roles and responsibilities and development of processes for effective care; and

- 6) Linking with the community for service and regional planning and development of resources.

These priorities were identified because they were: a) important areas of clinical care that were being recorded at low levels by most services; or b) aspects of care where there was wide variation in recorded delivery of care; and/or c) components of PHC centre systems that were poorly developed compared with others.

Evidence-practice gaps across many health centres are often due to failures or weaknesses of the wider health system. Large-scale improvement in mental PHC delivery could be achieved through identifying priority evidence-practice gaps in care and using the information to inform action across the health system.

KEY MESSAGE 2: *Five key barriers to improving the priorities for mental health and wellbeing care are experienced by many PHC centres. To overcome these barriers, we need:*

- 1) Systems and approaches for recruiting and retaining primary health care staff, including Aboriginal Torres Strait Islander Health Practitioners;
- 2) Systems to support staff to get advice and support from experienced colleagues and mental health professionals;
- 3) Systems and processes to help staff understand the needs and hopes of people living in Aboriginal and Torres Strait Islander communities in relation to mental health and wellbeing care;
- 4) Training and development to build awareness, knowledge and skills in culturally appropriate mental health and wellbeing care for Aboriginal and Torres Strait Islander people; and
- 5) Financing and resources for mental health and wellbeing care (from local and regional health authorities and government), including adequate PHC facilities.

It is important to target barriers to improvement, to build on what is working well, and to work with people who bring different knowledge and views when developing solutions. These barriers and enablers are much the same as those identified in the ESP project on other aspects of PHC (e.g., chronic illness care).

KEY MESSAGE 3: *Action for improving mental health care needs to focus on overcoming the barriers and strengthening systems for recruiting and supporting staff with the required mix of skills. Some strategies, such as involving family members in clients' care and using quality improvement processes, can be put in place by health centre teams. Others, such as services working together in case management and using one data system for clients' records, need partnerships with policy makers, external services and communities.*

Drawing on their knowledge and experience in Aboriginal and Torres Strait Islander healthcare, participants suggested strategies and actions to overcome the identified barriers and address the priority evidence-to-practice gaps.

- 1) Improve communication across services and between mental health acute and primary care teams to coordinate case management, especially follow-up for suicidal ideation and attempts;
- 2) Through health services capacity building, increase staff awareness of shared care and referral options for mental health;
- 3) Establish and promote the use of one data system by local and visiting services to increase the efficiency of accessing case histories, streamline referral processes and pathways, and to improve continuation of care across providers.
- 4) Enhance clinical information technology to ensure effective recall and reminder systems;
- 5) Co-locate services and establish multidisciplinary team structures to overcome the stigma of using 'mental health services' and address co-morbidities related to mental health;
- 6) Provide resources to build the capability and cultural competency of mental health services;
- 7) Employ more Aboriginal and Torres Strait Islander mental health care staff;
- 8) Improve understanding of mental health from a community perspective and integrate this into service delivery;
- 9) Include family members in clients' care in relation to mental health and alcohol and other drug issues.
- 10) Train staff in asking questions about alcohol and drug use, and educate clients in the health effects of misuse;
- 11) Work with community programs to combat normalisation of excessive alcohol and drug use;
and
- 12) Increase recognition of the central role of social and emotional wellbeing and mental health care within PHC.

- 13) Embed quality improvement strategies that highlight links between best practice and client outcomes.

Implementing the suggested strategies to improve mental health and wellbeing care will strengthen other key areas of care, because they will result in improvement to health care systems and practice which will have flow-on effects.

Continuous quality improvement in health care is a systematic and structured way of using data to guide changes in how health care is designed, structured and organised. Health system support for continuous quality improvement approaches in PHC have enabled adherence to best practice guidelines and improved patient attendance.(11-13)

WHY IS IT IMPORTANT TO TAKE ACTION ON THE ESP PROJECT FINDINGS AND KEY MESSAGES FOR MENTAL HEALTH CARE?

- The findings and key messages are based on the analysis and interpretation of the largest and most recent available sets of continuous quality improvement data for Aboriginal and Torres Strait Islander primary health care.
- The majority of the audit data is based on regional and remote services and the majority of the respondents to the ESP Project were answering from a regional and remote perspective thereby making the data from this process highly relevant to this Senate Inquiry.
- The findings represent the work and expertise of people working in different roles in Aboriginal and Torres Strait Islander healthcare – clinicians, managers, policy-makers, researchers, staff of health service support organisations and peak bodies representing the interests of communities and community-controlled health services.
- Solutions or interventions designed to address known barriers to quality care are more likely to produce change.
- The findings and key messages can be used to develop system level solutions for priorities in mental health and wellbeing care for Aboriginal and Torres Strait Islander people and communities.
- Primary health care centres play a critical and cost-effective role in the early intervention and management of mental health and wellbeing care, and continuing to improve the quality of care being delivered by PHC services is important.

SUPPORTING DATA - IDENTIFIED PRIORITY GAPS TO ADDRESS

The supporting data below are the clinical audit data related to the evidence-practice gaps identified by stakeholders (page 6 of this Submission). The clinical audit data are from 21 PHC centres, including community-controlled and government-managed PHC centres in different Australian jurisdictions that undertook the mental health audit between 2011 and 2013. PHC teams in these PHC centres conducted audits of more than 975 client records (adults with a diagnosed mental health condition) against best practice guidelines (developed by mental health experts working within the Indigenous health sector).

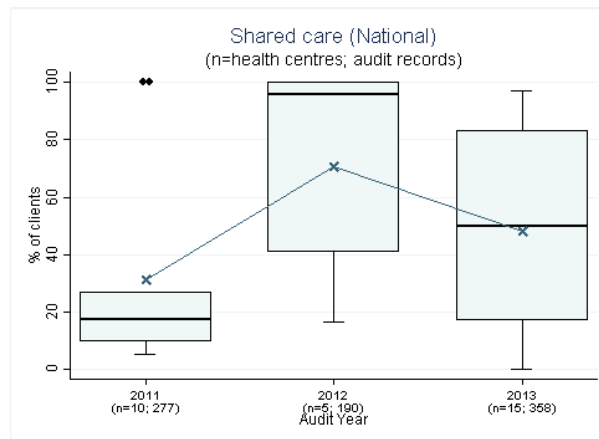
Development and documentation of shared care arrangements and referral

Figure 1 shows the mean health centre record of shared care planning, by audit year for all health centres.

Summary of trends (Figure 1):

- There was no clear evidence of improvement from 2011 to 2013; and
- There was wide variation amongst health centres for 2011 and 2012.

Figure 1: Mean health centre record of clients being in shared care in the last 12 months, by year (n=number of health centres; number of client records audited).



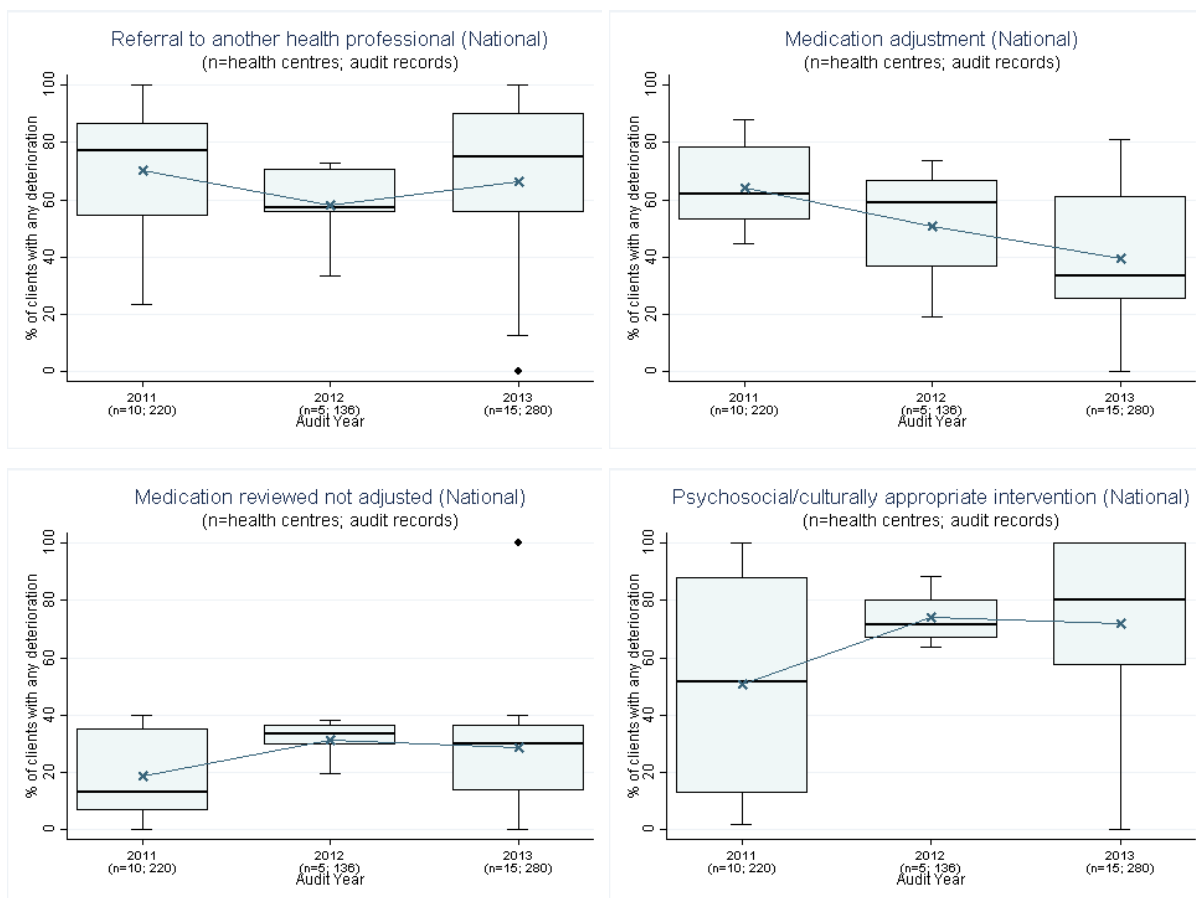
Improve recording and delivery of follow-up of abnormal findings across the scope of best practice, with a specific focus on appropriate follow-up for clients with a deterioration or exacerbation of symptoms.

Figure 2 shows the mean health centre recording of various follow-up actions if there is evidence of exacerbation or deterioration of symptoms, by audit year for all health centres.

Summary of trends (Figure 2):

- For follow-up actions if a client shows signs of exacerbation or deterioration of symptoms, there was some improvement in the level of delivery for culturally appropriate interventions;
- A decrease in the mean level of medication adjustment; and
- Widening variation between health centres in delivery of all follow-up actions.

Figure 2: Mean health centre record of follow-up action if evidence of exacerbation or deterioration of symptoms/behaviours (n=number of health centres; number of client records audited).



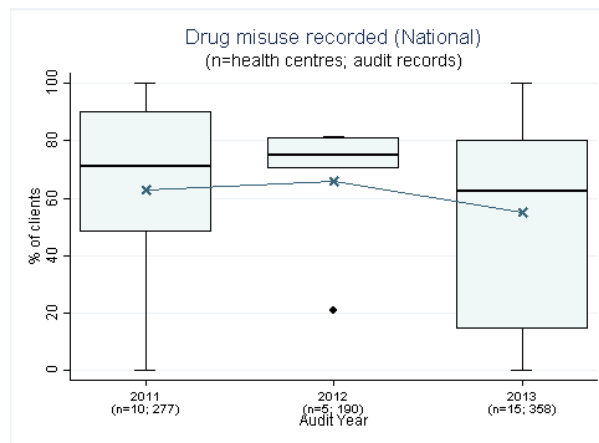
Enquiry and recording of drug misuse.

Figure 3 shows the mean health centre record of drug misuse for clients with a mental health condition, by audit year for all health centres.

Summary of trends (Figure 3):

There was no clear evidence of improvement in the mean level of delivery or reduction in the level of variation between health centres.

Figure 3: Mean health centre record of enquiry regarding drug misuse (n=number of health centres; number of client records audited).



SIGNATORIES

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