

REMOTE MENTAL HEALTH:

Indigenous women of the Top End

One in five Australians will experience a mental illness some time in their lives, most commonly depression. Unfortunately, only about half of those affected by mental illness receive treatment. Shame and stigma and just not knowing still get in the way of help-seeking and help-offering behaviour. In the end, those with the most training have the easiest task. By the time specialist help is sought through mental health services the problem is already identified. It is the general practitioners, the nurses, and other specialists dealing with depressed mothers, or with people with chronic physical illnesses, who may have more trouble reaching behind the masks. In the Top End of the Northern Territory (NT) it is the primary care practitioners who face the challenge—in a setting of geographic isolation and cultural diversity. More than one third of the population of the NT is Indigenous and most live in remote communities. The NT Australian Integrated Mental Health Initiative (AIMHI) is a five-year project targeting remote Indigenous people and aiming to improve outcomes for those with chronic mental illness. The project has developed an evidence base, best practice guidelines and a range of cross-cultural health promotion resources since 2003.

Indigenous mental health

Aboriginal and Torres Strait Islander people are over-represented in mental health care nationwide. In 2003–04, Indigenous males and females were up to twice as likely to be hospitalised for mental and behavioural disorders as other Australians. In particular, hospitalisations for 'mental and behavioural disorders due to psychoactive substance use' were around three and four times the national rate for Indigenous females and males respectively. Hospitalisation rates for mental and behavioural disorders were highest among people aged 25–44 years, where rates for Indigenous males were three times those for other males, and rates for Indigenous females were twice those for other females.¹ We do not know the prevalence of depression in Indigenous communities, but NT hospital admission rates tell us that depression is second to psychosis and substance misuse as a reason for admission to hospital, and that women are more likely to present with a mood disorder such as depression (Figure 1).

It is likely that admissions to hospital represent the tip of the iceberg. Many episodes of depression in remote communities will be unrecognised and untreated given the limited access to services, the limited access to culturally appropriate assessment, and the possibility that limited mental health literacy will impede help-seeking behaviour. A survey by

AIMHI in one Top End community, of 21 Aboriginal people with chronic mental illness, identified symptoms of depression in more than 60 per cent of the group. Most of those with symptoms of depression were untreated.

Mental health of Aboriginal mothers

Suicide data provide further indirect evidence of the increasing incidence of depression in the Indigenous community. Since 1991, the suicide death rate for NT Indigenous women has increased substantially. By 2001–2002, it was twice as high as that for all Australian females. Alcohol and drug use, mental illness, relationship problems and unemployment were the main factors associated with suicide in the Top End region of the NT.² These data highlight the importance of considering depression in Aboriginal women, particularly in the perinatal period.

In the NT during 2000–02, 39 per cent of births were to Indigenous mothers. Aboriginal mothers are surrounded by many known risk factors for



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depression—loss and grief, substance misuse, domestic violence, and poor socioeconomic circumstance. Indigenous families and pregnant women are at particular risk of domestic violence and Indigenous Australians are over-represented as both victims and perpetrators of all forms of violent crime in Australia.³

The impact of depression is felt far beyond the individual. It affects families, workplaces, and a range of social, welfare and health services. Children of depressed mothers are likely to have higher rates of mental illness themselves, as well as higher rates of substance misuse, learning difficulties and behavior disorders. Their mothers are less likely to engage in

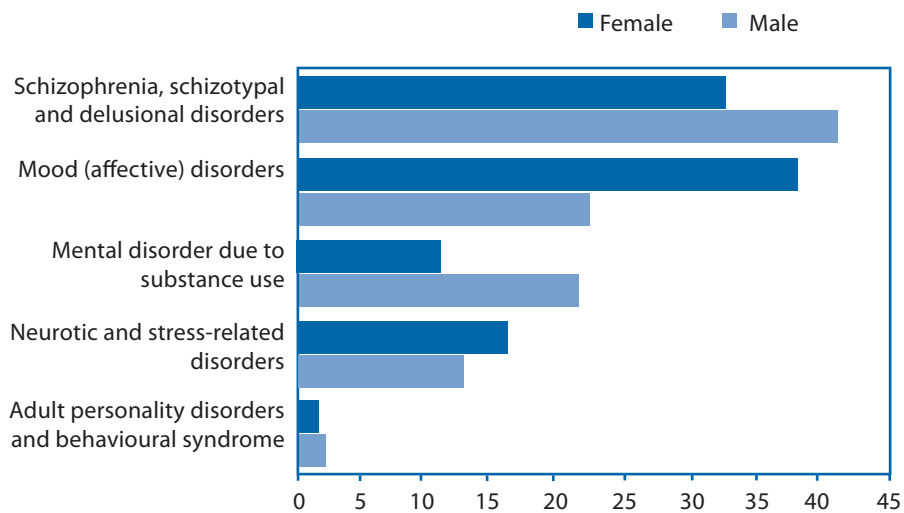


Figure 1
Type of mental disorders by sex, hospital admissions, Royal Darwin Hospital, 2002-2003

safe behaviors such as care with electricity plugs, with car seats, and with smoke detectors. Even the physical health of babies is affected by depression in pregnancy. Depressed mothers have less antenatal care, higher rates of premature labor and give birth to lower birth weight babies.⁴

Depression in Aboriginal mothers adds to the other risk factors already impinging on the health of Aboriginal children. For example, they are born to younger mothers who are more likely to smoke cigarettes and to drink alcohol.¹ The physical and mental health of mothers and children is intertwined and requires an integrated approach to assessment and treatment. Without action, generations will transmit this hidden sickness—and generations will suffer. The situation is becoming urgent with the World Health Organisation alerting us that depression will reach epidemic proportions by 2020 and that it carries one of the highest burdens of disability.

Are we prepared for the epidemic?

There are four clear prerequisites for this battle: a 'mental health literate' community, accessible services, a trained workforce and tools for assessment and treatment. The NT is struggling on each of these fronts. Access to services in the remote NT is limited. Remote communities are served by small community health centers far from specialist services. Remote service providers reported in an AIMHI NT survey that they had low levels of training and confidence in managing and treating mental illness. They are supported by infrequent visits from specialist mental health outreach teams and regional services. The cross-cultural divide requires cultural sensitivity and preferably a cultural broker—but Aboriginal Mental Health Workers are a scarce resource.⁵ An overarching framework of guidelines, policy and best practice for mental health in primary care is also missing and there are few resources available for quality feedback and outcome measurement.

Promoting mental health literacy

Campaigns by Rotary and beyondblue, the national Australian depression initiative, have been major steps toward improved community mental health literacy. Internet resources such as 'moodgym' and 'blue pages' and the community training package *Mental Health First Aid*⁶⁻⁹ all offer hope of accessible treatment. But these strategies remain culture-bound and out of reach of many in the community. The resources require computer literacy, internet access or proficiency in English language and are likely to leave many vulnerable groups such as remote Indigenous people behind.

Has the tide turned?

The need to enhance the capacity of community services in the NT has been addressed at a number of levels from Commonwealth strategy to NT Government initiatives. The Better Outcomes in Mental Health Care Initiative supporting general practitioners, and Commonwealth-funded Specialist Outreach services complementing the outreach of Top End Mental Health Services, are two examples of service enhancement. Aboriginal Mental Health Workers are now employed by the Top End Division of General Practice in eight remote communities, and two other recent initiatives are the Australian Integrated Mental Health initiative (2003), and the NT government Building Healthier Communities strategy (2004). The trend of increasing hospital admissions for Indigenous people—which had continued unchecked for nearly a decade—may have been stemmed though it is too early to tell (Figure 2). Nevertheless, the latest data are encouraging and may represent improved community capacity to treat mental illness and maintain treatment. However, in terms of the key areas of need—a trained workforce, accessible services, tools and guidelines for assessment and treatment and ongoing quality feedback—there is work to be done.

Shoring up the levy

There remains a large gap between the evidence (what we know works in practice) and evidence in practice (what we actually do). An important approach to evaluating service delivery is the search for strategies to link guidelines with practice. Integrated care pathways attempt to identify the evidence base, to link that with practice through developing a 'recipe' for progress through the treatment process, and to allow 'variation' from the pathways to be recorded and analysed for feedback and quality control. Pathways were introduced into the United Kingdom in the early 1990s and are used for treating patients with a wide variety of clinical conditions in primary, secondary and tertiary care.¹⁰ In Australia, integrated care pathways have been introduced in the general hospital setting, but are infrequently found in community mental health settings, and even less so in remote services. The well-established antenatal care pathway is one example of best practice guidelines informing practice. It is important to ensure not only that depression screening is included in the antenatal pathway, but also that mental health care pathways become similarly established and recognised in primary care.

A new project in the NT provides an exciting approach to developing integrated care pathways which are adapted to different settings and different levels of readiness to change. The trial is the Audit of Best practice in Chronic Disease Extension (ABCDE). Remote health centres will participate in a systems mapping exercise each year and conduct an audit of clinical records using clinical audit tools. Data from the systems mapping and clinical audits will be analysed and reported to each health centre. Health centre staff will examine their current systems and patterns of clinical care against best practice guidelines, and define priorities and goals for the next year. The audit tools aim to measure service delivery against best practice guidelines, whilst the systems mapping tool assesses the policy environment and broader health service structure. This process reflects the key principles of an integrated care pathway whilst maintaining ownership and control at health centre level. AIMHI has developed a mental health audit with the ABCDE trial. The mental health audit identifies that education is a key best practice principle. AIMHI has developed cross-cultural resources, which aim to educate clients and family about symptoms, treatment and prevention of mental illness. Participating communities and local health staff will receive training in the AIMHI cross-cultural care plan-training package. The ABCDE trial is an innovative approach toward improving mental health literacy and service delivery in remote areas.

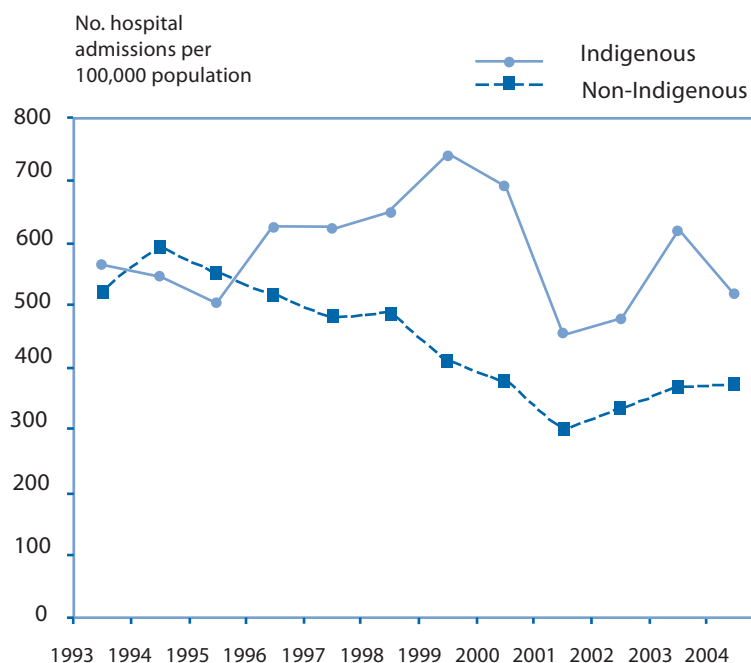


Figure 2

Number of hospital admissions by Indigenous status
Northern Territory, 1993-2004

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