CENTRAL AUSTRALIAN ABORIGINAL CONGRESS

RESPONSE TO REVIEW OF CENTRAL AUSTRALIAN MENTAL HEALTH SERVICES

June, 1993.

'REPORT ON THE REVIEW OF ALICE SPRINGS, RURAL AND URBAN DISTRICTS, AND BARKLY REGION'

By Dr. Peter Yellowlees, Chief Psychiatrist, South Australian Mental Health Service. March, 1993.

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RESPONSE TO MENTAL HEALTH REVIEW

('Report on the Review of Alice Springs, Rural and Urban Districts, and Barkly Region.' Dr. Peter Yellowlees, SA Mental Health Service - March, 1993.)

GENERAL:

Congress believes the general thrust and direction of Dr. Yellowlees report is appropriate in that Mental Health Services need to be re-oriented, and community services need to be strengthened. In-patient services can almost certainly be reduced as community services become effective. However, no decision should be made to reduce services without an adequate time frame and allocation of resources for planning and developement of appropriate community services, including the range of facilities outlined in the report.

Psychiatry is an area of medicine and health care that is particularly culturally located. The awareness of this in psychiatric circles has resulted in an area of psychiatry known as 'cross cultural psychiatry'. Cross cultural issues, however, have not been seriously applied to the development of mental health services to Aboriginal communities except in a few cases such as the Victorian Aboriginal Health Services' Mental Health Program. Changes to the structure and function of mental health services in Alice Springs presents an opportunity to make changes in a culturally appropriate way. These issues have not been well addressed in the report.

THE REVIEW PROCESS:

The process by which the review was carried out is problematic.

1. The *lack of notice* of this review a major defect. Such lack of notice means that particular parties, particularly the community sector, had little time to prepare submissions. Congress was placed in the situation of attending a meeting with people from a broad range of organisations: this obviously restricted our ability to contribute as fully as we would wish. Our involvement in that meeting cannot be characterised as a serious consultation with our organisation. The discussions at that meeting were fairly wide ranging, but were predominantly focused on the Broken Hill model.

2. The *Terms of Reference were not available*. Our preparation for consultation was thus hampered.

3. We note in Appendix 1 *'Individuals Interviewed as Part of the Consultancy, Alice Springs 20th-22nd March, 1993'* that Congress is listed. Congress is not an individual, and the only involvement Congress had was a group discussion held at Community Health Centre. This was *not* an interview, and Congress resents having its name used in this way.

4. To expect a Review to be adequately conducted over 2 days (one of which was a Sunday) is fanciful.

These defects in process seriously compromise the status of the report.

THE MODEL

Dr. Yellowlees' recommended changes are based on the Broken Hill model. Clearly arrangements in Broken Hill were primitive, amounting to 2 padded cells. However, the situation in Alice Springs is very different, with a fully staffed psychiatric unit within the hospital. In addition, the number of Aboriginal communities that make up Central Australia presents service delivery problems of a different kind to Broken Hill.

COMMENTS ON REPORT CONTENT:

1. TERMS OF REFERENCE:

The first time Congress saw the Terms of Reference was in the Draft Report. They were not circulated before the 2 day review, and this made it impossible for participants to focus appropriately their points of view.

Congress is concerned that the Terms of Reference do not mention the National Aboriginal Health Strategy, or the Recommendations of the Royal Commission into Aboriginal Deaths in Custody. These are both major policy documents that Governments have endorsed, and which have been based on extensive investigations and consultations. Clearly many of the clients of Mental Health Services are Aboriginal, and a Review of these services which ignore such major policy documents cannot be viewed as complete.

It fails to mention the Community Controlled sector which is a significant part of service delivery in Central Australia. This sector received considerable support in the NAHS and RCIADIC reports.

2. *PREAMBLE:*

Congress did not agree, generally or otherwise, to the approach presented at the group meeting, as claimed in the Preamble. In fact, some issues that individuals from Congress tried to raise were ignored. Our view of this meeting was that it was very interesting, that some of the ideas deserved further consideration, but that Dr. Yellowlees was selling a proposal that, apparently, has had some success in Broken Hill. There really was not enough time to adequately consider these proposals, or for Dr. Yellowlees to understand some of the unique aspects of Central Australian Aboriginal life.

3. *INTRODUCTION:*

In paragraph 3, (page 6) the report states that *'...the Alice Springs service was becoming reasonably community focused by about 1988 & 1989 but, for a variety of reasons, over the last two to three years the focus for this service has reformed more in the hospital area.'* It is a shame that the report did not identify the 'variety of reasons'. A fuller discussion of these reasons, may be important in understanding where things are coming from, and what may be possible for better service delivery in the future. A fuller understanding of what 'reasonably community focused' meant would also be useful in looking at how changes might be made. Without serious consideration of the history of the service, its' strengths and weakness, etc., lessons will not be learned and new failures will occur.

The reasons for high turnover of staff needs to be more fully considered. It is likely that lack of professional support is one cause, but there are almost certainly other reasons that need exploration.

page 6, para 7. The argument that many patients are not being treated, or are being treated by 'general practitioners' without support from the mental health services team, is not substantiated with any evidence. The report also asserts that this particularly applies to the Aboriginal population. Congress sees a number of clients who are also seen by mental health services. Whilst liaison and coordination could be improved, there is some client focused relationship between Congress and mental health services that seems to have escaped the Review's attention.

page 7, para 2 claims that Ward 1 *'... has a poor reputation within the community ...'* There is no doubt that Ward 1, like mental hospitals/ institutions around the country, is stigmatised. It is also true that the physical environment that is Ward 1 is inappropriate. However, the functionings of Ward 1, that is, how people are treated by the staff, tends to be seen by many in the community as very good, compared with some other sections of the hospital.

Later in the paragraph, the report again refers to general lack of liaison with GPs and other health services. In the course of the review Congress, the major health service for Aboriginal people in Central Australia, was not asked its' view of liaison issues. Therefore, it is not clear on what the Reviewer's opinion is based.

Page 7, para 3 refers to issues relating to confidentiality and privacy *' ... that appear not to be being recognised ...'*. This is a serious allegation, but lacks any detail. This lack makes it impossible for urgent and appropriate changes to be made by the appropriate people to ensure that breaches of confidentiality cease.

Page 7 para 6, claims that there has been *'... almost no research ...'*. Is Dr. Yellowlees aware of the *'Rama Rama Report'* produced by Congress about the needs of people with disturbed behaviour? Whilst this focuses on people who do not fit the criteria Mental Health Services use to determine who can use their services, the report nevertheless contains much useful information relevant to Mental Health Services. The community do not make distinctions between a brain damaged individual with behaviour problems, and a schizophrenic with behaviour problems.

4. Clinical Systems of Care and Case Management

In the first paragraph (page 9), the ideal makeup of the Mental Health multi-disciplinary team is defined. But it fails to include Aboriginal Health Workers or Aboriginal Mental Health Workers in this team. This is a serious and major omission, unless the Rural Team becomes an Aboriginal Team.

We cannot support the assertion that *' ...the early priority must be to recruit at least two psychologists and 2 social workers to the community team.'* (page 10) The most urgent priority is to recruit Aboriginal staff, with appropriate training and support, to mental health services.

5. Present Services Within The Alice Springs Area:

This whole section narrowly focuses on the formal Mental Health Services. There is no consideration, or apparent appreciation, of the community and Primary Health Care resources that play a role in mental health care, both in bush communities and Alice Springs. This gives a false view of the situation.

Whilst Congress is strongly of the view that hospitalisation should be avoided wherever possible, the resources in bush communities or in the communities around Alice Springs, are poorly resourced to deal with crisis situations involving disturbed behaviour, which is often frightening and violent. These communities cannot be compared to country towns or suburbia. They are fundamentally different. This does not appear to be appreciated by the Reviewer.

6. Organisational Structure - Mental Health Services, Alice Springs:

This section discusses management issues, but does not address the makeup or actual functions of the teams.

7. Comments on Specific Positions Within the Mental Health Services.

Again this section focuses on management structures and responsibilities.

8. REVISED ACCOMMODATION PLANS:

The recommendation that the whole of the Mental Health Services be located at Flynn Drive needs much further consideration. NAHS & RCIADIC both strongly recommended that the Aboriginal community should be consulted, in how services should be delivered. The Community Health Centre is a direct extension of Government services, with no input from the community. It is 'community' only in the sense that it is not 'hospital', and that some of the service does outreach into the community. It is certainly not controlled by the community. How to make changes that ensure equity of access and appropriateness to the Aboriginal community will require serious consultations with existing Aboriginal health and community organisations.

Clearly, there is a need to develop transitional accommodation, as well as 'club' facilities, etc. But it may not be easy to accommodate both Aboriginal and non-Aboriginal needs in a single facility. Given the likely tightness of funds, it is essential that thorough consultation occur to ensure that *all* people's needs are as appropriately accommodated as possible.

The recommendation that Community House be handed over to the Mental Health Association also needs further consultations. The Mental Health Association has little to do with the Aboriginal community, and Congress suspects that no Aboriginal people are involved. There are a range of other possible arrangements which could better ensure appropriate representation from the Aboriginal community in the management of the facility, and to ensure the appropriate development from the Aboriginal communities point of view.

The recommendation that a 'Special Care Suite' be integrated into a medical ward, for short term accommodation for the mentally ill, with patients requiring a significant length of hospitalisation being transferred out of Alice Springs is strongly opposed by Congress. On page 32, the reviewer recognises the Victorian Aboriginal Health Services' Mental Health Program as the most successful such program in Australia. However, Congress' understanding of that program is that it is designed to overcome historic and generational loss, by admitting the whole family for care, not taking the person in crisis away from their families. The idea of transferring people away from their families and support in Alice Springs, is contrary to this central tenet of the Victorian program. Dr. Yellowlee's assertion that this is what happens in medical and surgical practice is untrue. Patients are transferred to other centres only if the expertise and technology is not available locally. They are not transferred simply on the base of expected time of hospitalisation.

To provide care to people with acute episodes of mental illness through the use of general nurses in the hospital is inappropriate. Would it be acceptable to staff other specialist sections with psychiatric nurses? It is a denial of the special skills of properly trained psychiatric nurse to suggest that 20-30 general nurses would be available within the hospital who would be *'fully trained'* through a process of one nurse working 50% of the time on staff development.

Whilst it is appreciated that the attempt is to clearly focus mental health services to the community, the need for specialist in-patient care must be recognised. **To inadequately provide resources for in-patient care is to overburden the community based primary health care systems with crisis management of mentally ill people.** Community-based services must be used in preventive mental health processes with their community with the support of hospital specialist mental health services.

In principle, keeping mental health beds exclusively for mental health patients is desirable. However, it is important that in an under-resourced region like Central Australia flexibility is maintained in the use of resources. Respite facilities are scarce, and Ward 1 has been used, sparingly, for this purpose from time to time. Such access to respite, is important for the general mental health of carers, and others in a small community.

One position for crisis call out will only benefit those in the town areas. Bush communities will not be able to access such a crisis service when it is needed.

9. REVIEW OF PROPOSED MENTAL HEALTH SERVICE.

The Community Team:

The suggestion that lists of general practitioners with an interest in psychiatry be developed may be an appropriate for the non-Aboriginal population living in Alice Springs. However, this recommendation reveals no appreciation of the primary health care system servicing Aboriginal people in Central Australia. To employ GPs part time in the Mental Health Services as a way of developing skills etc. in general practice is opposed, as it will only assist services to the non-Aboriginal population. Alternative training options could be developed that will serve the needs of all PHC staff, not just GPs.

The whole section on Crisis Assessments fails to address the needs of Aboriginal people. It needs to be re-worked so that such a system addresses the whole population.

The Rural Team:
There is no doubt that the implementation of an Aboriginal Mental Health program in Central Australia is urgently needed. However, it should not be called a Rural Team. It must be an Aboriginal Mental Health Team. Firstly, in demographic terms, Alice Springs is rural, not urban. 25% of the Alice Springs population is Aboriginal. The vast majority of these people have close relationships with families living out bush. Many live in both environments for significant periods of time. Some of the concerns about Aboriginal involvement in the delivery of the Community Team, would be modified if this program was clearly an Aboriginal one, and not Rural, which implies to some a service to bush communities only. Alice Springs is a resource centre for Central Australia. This is often understood in non-Aboriginal and/or economic terms; what is often not understood is that this applies to Aboriginal people as well, with the Alice Springs Aboriginal community being an important resource for bush people, and vice versa. Programs should be rooted in the community, not geographic locations, or in different expressions of Aboriginal culture.

Such a team could be allocated responsibilities in terms of language groups, rather than geographic regions. Such questions need to be determined by the Aboriginal community and its' organisations.

In principle, Congress supports the development of this type of Aboriginal mental health program, providing that the details are worked out with the Aboriginal community.

Staff Retention:

Staff recruitment and retention issues exist across the health system. Already, there are a number of in-service resources dealing with one group of NT Health employees or other. Programs developed to address these issues need to be better coordinated. It is not logical for Mental Health Services to develop their own programs in isolation from similar programs already operating. The proposed Central Australian Rural Health Training Unit, could be a vehicle for better coordination of training programs, whether in-service in nature, or more formal course work through inter-state institutions. Likewise, the proposed Central Australian Division of Primary Health Care, might assist in providing support. (The proposed Division is multi-disciplinary, not just GPs.)

Miscellaneous Issues:

In *2. Relationships with Consumer Groups* the total focus is on support for the newly formed Mental Health Association. Congress knows little of this organisation, and does not wish to suggest that the Association should not be used and involved. However, Congress does not accept that the Association represents the Aboriginal community. We are sure they do not make such a claim. The most challenging aspect of these proposed reforms will be to ensure that the services meet both Aboriginal and non-Aboriginal needs. Congress appreciates that in other sections of the report Dr. Yellowlees has recognised the importance of this.

The most effective use and location of mental health resources need further consideration.

Congress does not support public resources being used specifically to accommodate private practice. Public patients deserve the same standards as those being treated privately. All patients deserve confidential waiting areas, and all consultations require adequate secretarial support.

12. IMPLEMENTATION ISSUES:

The implementation plan does not allow for a period of community consultation, and consultation with other sections of the health system. A more appropriate implementation plan would begin by a consultation process with the Aboriginal community and its' organisations on ways to retain Ward 1 whilst developing the community mental health program. After a period of 12 months, or so, it ought to be able to assess how many admissions the community program has prevented, and what sort of reduction in in-patient service is appropriate. Over a period of time further reductions in in-patient facilities might be possible. In many other areas of Australia, the closure of mental health in-patient facilities has not been accompanied by adequate resourcing of community-based facilities. This has resulted in psychiatric patients being homeless, living in hostels, etc. A similar situation must be guarded against in Central Australia. Aboriginal communities have a relatively high threshold when it comes to caring for disturbed people in their community. But a limit does exist, and when this is reached they deserve relief. At present the Ward 1 facilities provide some opportunity for that. It would be a retrograde step to find that these well intentioned reforms remove an important support for such families and communities.

THE WAY AHEAD:

1. Consultations with the Aboriginal community, through community controlled health services and AHW forums should proceed. Representatives of the Aboriginal community should be resourced to investigate interstate initiatives in Aboriginal Mental Health Programs.

2. The development of three Aboriginal Mental Health teams focused on language groups in Central Australia, and one team in the Barkly should proceed. These teams should be developed in line with the NAHS and RCIADIC, and be under appropriate community control wherever possible.

3. Negotiations focused on appropriate mix of control of the transitional accommodation facility, and the 'club house' should proceed.

4. Ward 1 staff should monitor their admissions, to assess how many over a period of time might have been accommodated adequately in a minimal care half-way situation. This may allow some resources to be released from Ward 1 to the community programs early.

5. Ways of providing better training and support to community-based primary health care workers should be explored. The proposed Rural Health Training Unit could be a base for programs.

6. Developing a reoriented mental health service should maintain the objective of adapting the service to fit supportively with existing Primary Health Care services and support networks.