

**A model for integrating alcohol and other drugs,
community mental health and primary health care in
Aboriginal Medical Services in the Northern Territory.**



Aboriginal Medical Services Alliance of the Northern Territory (AMSANT), 2008

(Revised 2011)

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Preface to the 2011 revised policy document

The AMSANT model has been revised as a result of ACCHSs having greater experience in providing Social and Emotional Well Being (SEWB) services over the last 3 years. When the model was developed, SEWB services had largely been provided by ACCHSs in regional areas but limited services are now being provided within primary health care in more remote regions. There was thus an opportunity for a range of ACCHSs to provide feedback on the strengths and weaknesses of the model. There have also been some constraints that have made it difficult for ACCHSs to implement the model. Key factors include lack of funding for SEWB services to ACCHSs as discussed further below. Additional factors include workforce shortages in remote areas, lack of clarity about training and support pathways for a local Aboriginal workforce, lack of staff accommodation and a complicated evolving PHC landscape that is now undergoing a transition to a regionalised model of community controlled service delivery as part of the Expanding Health Service Delivery Initiative (EHSDI).

Most services do not have the level of funding required to implement the full AMSANT model. This is largely because a significant proportion of new funding for mental health/AOD services for Aboriginal people continues to be allocated via competitive tendering processes rather than being directed towards primary health care. Also, in the last 3 years, SEWB service expansion has mainly occurred through AOD funding from the NTER (Northern Territory Emergency Response) and COAG funding. This has meant that these new services have been required to target people whose primary problem is substance abuse rather than cater to the full range of mental health and AOD issues in the community.

The Remote AOD workforce is supported by a Remote AOD support unit based in the Department of Health (Northern Territory Government). This unit has developed a Best Practice Model, assessment pathways and other resources. There are significant differences between some elements of the Best Practice Model and the AMSANT model which required further exploration.

As a result of all these factors, AMSANT held a workshop on alcohol and other drug treatment in primary health care in November 2009. The key agreed outcomes from the workshop included:

- 1) Currently the AMSANT model cannot be fully implemented because of insufficient funding and also because smaller ACCHSs do not have the capacity or population to employ the whole team. Staff accommodation is also a constraint. Therefore the model is currently aspirational and needs to be implemented in a staged fashion by ACCHSs depending on capacity and funding. There may need to be additional positions located in hubs (e.g regional ACCHSs) to support smaller ACCHSs in service delivery until regionalisation is complete.
- 2) Key principles of the workforce component of the model include that local Aboriginal people are central to SEWB teams, that there should be an appropriate gender balance in the workforce, and that a multidisciplinary team is required to deliver a full suite of effective AOD /mental health services.

- 3) Aboriginal AOD workers need to be included in the model and will be employed to do the same work as Aboriginal mental health workers or mental health nurses. Both AOD workers and mental health professionals will need upskilling to be competent in assessing and treating both AOD and mental health problems.
- 4) Some services have employed AOD nurses through specific AOD funding. It is important to assess the skills and proficiencies of the workforce rather than make assumptions about skills based on the professional background of the worker.
- 5) The community development arm of the model is just as important as the clinical arm. However, it is not useful to be too prescriptive about community development: it needs to develop from the ground up but also be informed by evidence.
- 6) Aboriginal health workers (AHWs) who have AOD/mental health training or who are keen to undertake this training are scarce but highly valuable members of SEWB teams. AHWs need to be supported to undertake mental health/AOD training. The lack of support for the AHW profession is impacting on the availability of AHWs to undertake SEWB training.
- 7) Training pathways for the workforce needs to be clearer in the model and in particular, how the Aboriginal workforce will be trained and supported needs further development.
- 8) The trend to fund services through competitive tendering continues and this is leading to further fragmentation of service delivery.

Executive Summary

Burden of disease

Aboriginal people in the Northern Territory experience a disproportionate morbidity and mortality burden from mental health and alcohol and other drug (AOD) problems. This includes a dramatic increase in suicide rates since the 1980s, growing rates of Aboriginal mental health admissions, high death rates from alcohol-related causes and increasing rates of alcohol-related problems, including injuries and criminal offences. There is also evidence of increasing harm from illicit drugs and gambling. There are common determinants of AOD and mental health issues, including the ongoing legacy of colonisation, dispossession, racism, poor educational opportunities, loss of autonomy and control, welfare dependency, high unemployment and lack of access to services. Dual diagnosis (coexistence of both mental health and AOD conditions in the one individual) is common, likely to be more prevalent in Aboriginal populations, and often poorly dealt with in specialist AOD and mental health services.

Responses to mental health and AOD issues

Multiple Aboriginal health strategies have recommended that AOD and mental health services be located in Aboriginal Community-Controlled Health Services (ACCHSs). Advantages include an approach that is community-controlled, culturally-appropriate to the needs of the community and is integrated with other primary health care services, including medical care. The 2006 Senate Inquiry into Mental Health focused attention on the deficiencies in the provision of services for people with dual diagnosis and the lack of progress in providing mental health and AOD services in ACCHSs.

The evidence base for Aboriginal mental health and alcohol and other drug issues

Counseling techniques that have proven efficacy in both AOD and mental health conditions include cognitive behaviour therapy (CBT), problem solving therapy and family therapy. Narrative and art therapy have also been found to be effective in Aboriginal contexts.

There is evidence from non-Aboriginal populations that AOD treatments provide the same degree of benefit as for other chronic conditions such as diabetes. Integrating alcohol treatment and primary health care treatment has been shown to improve abstinence rates. There is also good evidence that screening and brief interventions result in reduced drinking, including ethnographic evidence from Aboriginal populations. Community-based withdrawal and rehabilitation has equivalent outcomes to residential treatment provided the person has adequate supports and is medically stable. However, as these conditions are less likely to be met in Aboriginal community settings, it is important that residential rehabilitation services are available as well. Other proven relapse prevention strategies include alcohol pharmacotherapies (Naltrexone and Acamprosate) and counseling techniques, including CBT. There is also some evidence and considerable anecdotal experience with therapies that may be particularly suited to Aboriginal populations, such as narrative therapy and art therapy.

Current service system

The current AOD and mental health service system in the NT is based in the five larger regional centres. The larger urban ACCHSs have Social and Emotional Well Being (SEWB) teams. As a result of COAG funding for alcohol services in remote communities and NTER (Northern Territory Emergency Response) initiatives targeting alcohol abuse, there has been an increase in provision of AOD services in Aboriginal PHC in the NT over the last four years. However, this funding is targeting AOD problems only rather than the full spectrum of Social and Emotional Well Being services. Coverage remains incomplete with most remote ACCHSs still relying entirely on infrequent visiting specialist mental health services and regionally based AOD services. . This reflects a national trend of poor access to mental health and AOD services by Aboriginal people in remote areas. Nationally and in the NT, AOD services have been noted to be based on an abstinence model, focus on residential rehabilitation, and be less-suited to the needs of illicit drug users compared to alcohol users. There is a lack of attention to prevention and early intervention strategies. Recently, with the advent of the COAG mental health reforms and competitive tendering processes, as well as the delivery of funding through Divisions, there is increasing fragmentation of services with multiple new providers entering into “the market”. This represents a departure from the established collaborative needs-based planning approach through the Northern Territory Aboriginal Health Forum, resulting in increasing service fragmentation.

An integrated model for providing mental health and AOD services in Aboriginal Community-Controlled Health Services

The rationale for a new approach to the provision of SEWB (including mental health) services and AOD services for Aboriginal people in the NT includes recognising:

- Current high rates of morbidity and mortality and unmet need for AOD and mental health services;
- Current high rates of dual diagnosis and a lack of effective systems to deal with dual diagnosis;
- Common evidence-based treatments for both AOD and mental health problems;
- An approach is required that addresses social and historical determinants of illness and that treats problems in a culturally-acceptable, holistic way through community-controlled services;
- Integrated treatment and rehabilitation that addresses physical and mental health issues concurrently along with prevention and promotion within a single comprehensive primary health care service provider is likely to lead to better health outcomes;
- The existing primary health care infrastructure in remote communities is the only efficient and effective way to provide these services in the community compared with either duplicating that infrastructure in the community or centralised service models with visiting practitioners.

The model locates relevant SEWB and AOD services within comprehensive primary health care. It includes both community development and clinical components. Aboriginal Family Support Workers will be the core of the community development approach. Each community will have at least one female and one male Aboriginal Family Support Worker. They will lead preventative and health promotion approaches to AOD and mental health problems in conjunction with other practitioners in ACCHSs and external agencies. The work will be developed in line with local priorities and community concerns. Aboriginal Family Support Workers will also have a key role in facilitating access to clinical services, where they will be supported by other professional staff.

Clinical service delivery

The clinical service delivery component of the model is based on integrating AOD and mental health services utilising common evidence-based approaches such as cognitive behaviour therapy. Aboriginal Family Support Workers will be supported by counselors including Aboriginal AOD workers, mental health nurses and psychologists skilled in both AOD and mental health treatment. Their work will be guided by clinical pathways and referral protocols tailored to local needs. Nurses with AOD experience and qualifications should not be excluded as a potential workforce. However, they would need to be proficient in mental health assessment and treatment in order to provide integrated holistic treatment and so may need further training.

The model provides multiple entry points to the clinical service component, including self-referral and referral through the primary health care clinic. ACCHSs will aim to screen all patients for mental health and AOD issues as part of a yearly adult health check, as well as detecting AOD and mental health problems opportunistically. Those with early problems or at risk of developing problems will be offered brief interventions.

Patients with significant AOD and/or mental health diagnosis will be offered a comprehensive assessment by a skilled counselor. A mental health care plan will be formulated in conjunction with the patient, family, GP, Aboriginal Family Support Worker, counselor and other professionals as appropriate. This will include psychosocial supports and assistance with housing and employment as required.

Patients with alcohol dependence will be offered home-based withdrawal if medically suitable. If their home environment is unsuitable, they will be offered supported accommodation for the withdrawal period where available. Those with complex comorbidities and psychosocial issues will be referred for residential withdrawal and rehabilitation. Community-based treatments for alcohol and drug problems will include Naltrexone and Acamprosate for relapse prevention, evidence-based counseling and rehabilitation assistance.

Patients with anxiety, depression, grief and loss will be treated according to clinical pathways which will incorporate psychosocial and family support. The SEWB team will also support young people and children with behavioural problems. Patients with dual diagnosis problems will be treated for both problems concurrently. Patients with more complex problems, including those with dual diagnosis, will be offered intensive case management. Medication management will mainly occur through the

general practitioners in ACCHSs, with specialist support. The services will develop referral pathways and protocols with other agencies, including specialist mental health and AOD agencies.

Training, peer supervision and support are essential components of the model. Aboriginal Family Support Workers will be offered training in basic AOD and mental health assessment and treatment and community development approaches to prevention and health promotion. They could also progress to more formal AOD/mental health training to become an Aboriginal mental health or AOD worker. Or their basic training may assist with a transition to AHW training. All professionals will be trained so they are competent in both AOD and mental health assessment and treatment but the Aboriginal Family Support Workers will only be expected to recognise AOD and mental health issues, offer brief interventions and refer on to other team members for more detailed assessment and treatment.

Workforce and Funding

A community of 1500 people would require four Aboriginal Family Support Workers, two skilled counselors, and two of either an Aboriginal Mental Health Worker, Aboriginal AOD worker, or a nurse with mental health and /or AOD qualifications and experience. There would be one psychologist for 1500 people. SEWB teams would either be located in ACCHSs or be based zonally and work across smaller services. However, each community would have their own Aboriginal Family Support Worker. This model is likely to result in savings from reduced admissions and readmissions for psychiatric care and reduced demand for residential withdrawal and rehabilitation services. Funding would be sourced from the COAG mental health and AOD funds and through the Northern Territory Government. Supplementary funds would be obtained through Medicare. Funds would need to be pooled and allocated in a planned manner according to needs measured largely, but not exclusively, through staffing population ratios. This model will not be achieved with the current funding allocation processes.

1. Introduction

This document outlines a proposal for an integrated model of social and emotional well-being (SEWB) services, including mental health and alcohol and other drug (AOD) services, in Aboriginal Community-Controlled Services (ACCHSs) in the Northern Territory. Mental health and AOD problems have common underlying causes related to social and historical determinants, and many Aboriginal people present with both mental health and AOD problems. There is evidence of growing unmet need for mental health and AOD services for Aboriginal people in the NT. Current specialist sector responses are largely focused on severe illness with remote areas having particularly poor access to community-based treatment.

The response to these issues needs to be determined by the local community, be culturally-appropriate and be applied at the community, family and individual levels. The range of interventions should include prevention, early intervention, treatment and rehabilitation. It also needs to be suitable for the range of services found in the NT, including smaller remote services. The model needs to adapt to the changing PHC landscape as the PHC reforms underway through the Expanding Health Service Delivery Initiative result in a shift to community control and a regionalised model of health service delivery. The model proposed allows for both a community development and clinical approach to social and emotional well-being services. The model places Aboriginal Family Support Workers at the core of the service response. It uses the same evidence-based counseling techniques for both mental health and AOD issues.

The role of AMSANT

The integrated model has been developed by the Aboriginal Medical Services Alliance of the Northern Territory (AMSANT). AMSANT is the peak body of Aboriginal community-controlled health services (ACCHSs) in the Northern Territory. It has a key role in representing the interests of ACCHSs and the communities they serve in the NT. AMSANT is active in advocacy and provision of policy advice in the Northern Territory and at a national level.

2. Burden of disease

There is evidence of a high burden of disease both nationally and particularly in the NT for both AOD and mental health morbidity and mortality. Morbidity data is largely limited to hospital and mortality data in the NT. Hospital data has several limitations as it underestimates the burden due to illness that is more likely to go undetected and less likely to result in admission (GPPHCNT 2007).

Burden of disease related to mental health

Nationally, Aboriginal males are four times and women 1.9 times more likely to die from a mental health cause than non-Aboriginal people (OATSIH 2006). Suicide rates have more than doubled amongst Aboriginal people in the NT since the 1980s so that in 2002-2003, the NT Aboriginal rate was two to three times the national non-Aboriginal rate (Measey et al 2005, Nagel and Thompson 2007). The NT suicide rate has continued to rise whilst the national rate has stabilised over the last

decade (GPPHCNT 2007). The rates of admission for self-inflicted injury in Aboriginal males have increased fivefold from 1991 to 2002, with a less dramatic rise in women (Measey et al 2005).

The rate of admissions for mental health problems for Aboriginal people in the NT is also increasing at a much higher rate than for the non-Aboriginal population (NT Government 2006). The mental health admission rate for women in 1999-2003 was nearly double the rate for non-Aboriginal women at 757 admissions per 100,000 Aboriginal women compared to 374 admissions per 100,000 non-Aboriginal women (GPPHCNT 2007). The admission diagnoses that are substantially higher for Aboriginal people are psychotic disorders, including schizophrenia and drug-related psychoses and disorders related to alcohol. The rate of Aboriginal female mental health admissions due to psychoactive substance was six times the non-Aboriginal rate in 2003, whilst the delusion disorder admission rate was 2.5 times higher than the non-Aboriginal rate (GPPHCNT 2007).

Diagnoses related to affective illness, personality disorders and neurosis are lower than the non-Aboriginal rate and have been relatively stable over the last ten years (GPPHCNT 2007). However, the prevalence of affective illness in areas without culturally-appropriate and effective community-based mental health services is likely to be underestimated due to a lack of mental health and cross-cultural skills in primary health care practitioners (Nagel 2006, GPPHCNT 2007). The NT has the lowest per capita spending on PBS medications for psychiatric conditions in Australia. This is at least partly due to the lack of prescribers in primary health care and community-based specialist practice (GPPHCNT 2007). Central Australian Aboriginal Congress has a Social and Emotional Wellbeing Unit as part of its primary health care services, staffed by Aboriginal mental health workers, mental health nurses and psychologists. The most common presenting illness to this Unit is depression (GPPHCNT 2007). However, many ACCHSs lack the resources and staff to provide comprehensive SEWB programs.

Institutional racism can also influence detection of illness. The Royal Commission into Aboriginal Deaths in Custody noted that many Aboriginal men with a forensic history are diagnosed as having personality disorders and their depression is missed (GPPHCNT 2007). High rates of psychosis may be partly accounted for by misdiagnosing people from remote communities, especially given the lack of trained Aboriginal mental health workers who are best placed to distinguish between the normal expression of grief and other intense emotional states and psychotic illness (GPPHCNT 2007).

The rising rates of mental health-related admissions may also be partly due to increased access to services, especially hospital services. However, the high rates of substance abuse (which commonly occurs with affective disorders) and also high rates of self-inflicted injury and suicide, suggests that there is a substantial mental health disease burden (especially of affective disorders) that is not being detected and treated (GPPHCNT 2007, Measey et al 2005).

Burden of disease due to alcohol and other drugs

Alcohol

In the NT, the average per capita alcohol consumption is almost double the national per capita consumption (GPPHCNT 2007). Nationally, Aboriginal men die at seven times the rate, and women at nine times the rate of non-Aboriginal people, from alcohol-related causes (DoHA 2007). The

death rate from alcohol-related causes in Central Australia (14 per 10,000) was three times the national Aboriginal rate of 4.17 per 10,000 in 2004 (National Drug Research Institute 2007). The morbidity burden was also noted to be worsening in some regions with increasing rates of alcohol-related admissions in the Darwin, Katherine and Alice Springs regions (Healthcare Management Advisors 2005).

Criminal justice data in Tennant Creek and Alice Springs also indicate a rising burden of crime related to alcohol. Around 70-90% of cases of family violence are related to alcohol (Healthcare Management Advisors 2005). The proportion of suicides in which alcohol or other drugs were implicated in the Top End between 2000 and 2002 was 72% (Measey 2005). Aboriginal patients with self-inflicted injuries in the NT were also more likely to be diagnosed with an AOD problem and less likely to be diagnosed with a mental health problem than non-Aboriginal people, although this may be partly due to diagnostic bias (GPPHCNT 2007). Other problems strongly associated with alcohol include car accidents and violent crime (Measey et al 2005, Chikritzhs et al 2005).

Other licit drugs

Other major licit drug concerns include smoking, petrol and kava. Smoking rates are particularly high for Aboriginal people with an estimated 44% of women and 57% of men smoking in the NT (Jones et al 2005).

Illicit drugs

There are higher rates of illicit drugs use, including cannabis and amphetamines, in the NT than in other jurisdictions (Healthcare Management Advisors 2005). There is a lack of evidence about Aboriginal illicit drug use in the NT. Data from the National Aboriginal and Torres Strait Islander Health Survey for Northern Territory Aboriginal non-remote people aged 18 and over, indicate that about 30% reported using illicit substances in the 12 months prior to interview (28% used marijuana, hashish or cannabis resin, less than 3% amphetamines or speed and less than 2% analgesics and sedatives for non-medical purposes). About 50% stated they had never used illicit substances. This data may be an underestimate because it did not include homeless people. This compares to national Aboriginal rates of 23% for cannabis and 7% for amphetamines (Australian Bureau of Statistics 2005).

Central Australian Aboriginal Congress noted that cannabis is implicated in 10-15% of drug-related presentations to Congress (GPPHCNT 2007). A longitudinal study from three remote communities in Arnhem Land identified two thirds of males and 22% of females in the age group of 16-39 as current cannabis users (Clough et al 2004). Cannabis and associated behavioral effects, including violence, was a key concern of Aboriginal people consulted by the Taskforce on Illicit Drugs (Taskforce on Illicit Drugs 2001). Problematic amphetamine use by Aboriginal people in the two major urban centres is relatively common, whilst there is also anecdotal and police evidence of a growing amphetamine use in remote areas (Moon 2006, Putt and Delahunty 2006). Opiate misuse occurs in the larger urban centres at rates equivalent to national rates (Moon 2006). Poly-drug use is noted to be common in both Darwin (Moon 2006) and Alice Springs (GPPHCNT 2007).

Gambling

Both unregulated gambling and regulated gambling is common in Aboriginal communities, although there is a lack of formal research. Anecdotally, high stake card games are increasing in remote communities, and a significant proportion of patrons at poker machine venues and the NT's two casinos are Aboriginal. There is also a link between gambling and substance abuse. Other adverse consequences are loss of income for other purposes and neglect of children and other family responsibilities (Brady 2004).

3. Underlying determinants and dual diagnosis

Determinants of mental health and AOD conditions

There are common determinants related to Aboriginal dispossession and continuing entrenched disadvantage for both mental health and AOD health problems. These include loss of land, stolen generation policies, unemployment, overcrowding, loss of autonomy and control, welfare dependency and lack of educational opportunities. Primary health care workers in the Top End reported that the rising burden of AOD and mental health problems over the last ten years was due to declining educational opportunities and literacy levels, high unemployment, fewer community activities and boredom (GPPHCNT 2007). In addition to this, the lack of access to effective treatment and rehabilitation services means we are failing to prevent the progression of early AOD and mental health problems into more long term and disabling illnesses.

There are high rates of dual diagnosis in mainstream service systems, although dual diagnosis is often under recognised (Senate Inquiry into Mental Health 2006). Dual diagnosis refers to patients who have both a mental health and an AOD diagnosis. Dual diagnosis was noted to be "the norm rather than the exception" (Senate Inquiry into Mental Health 2006). Service utilisation rates are higher for people with dual diagnosis and outcomes are poorer, with high rates of incarceration, homelessness and family violence (Condon et al 2005, Ministerial Council on Drug Strategy 2006b, Senate Inquiry into Mental Health 2006).

There is evidence both nationally and in the NT that dual diagnosis is common in Aboriginal people. OATSIH-funded alcohol and other drug services nationally noted that the most common emotional problems encountered in their clients were depression, hopelessness or despair (95%), anxiety or stress (90%), family/relationship issues (90%), and family and/or community violence (90%) (OATSIH 2006).

Morbidity and mortality from dual diagnosis in the NT

High and rising rates of suicide and self-inflicted injury are linked to both alcohol and mental illness (Nagel 2006). There are also high rates of Aboriginal admissions for psychosis due to psychoactive substances, which is nearly four times the non-Aboriginal rate (NT Govt 2006). The drugs associated with these illnesses were alcohol, followed by cannabis and other drugs (GPPHCNT 2007). Mental health disorders due to substance misuse were the most common diagnosis in Aboriginal men attending specialist community mental health services and the second most common diagnosis in Aboriginal women (GPPHCNT 2007). Cannabis use in remote communities in Arnhem Land was associated with high rates of anxiety symptoms in a longitudinal survey (Clough et al 2005). Primary

health care evidence from Wurli Wurlinjang (an ACCHS servicing Katherine) identifies alcohol as the most frequent reason for presentation to their Social and Emotional Wellbeing Unit, ahead of domestic violence, family issues, grief and loss (GPPHCNT 2007).

4. Aboriginal recommendations for mental health and AOD services

Overview

Many recent major reports and strategies (including the National Aboriginal Health Strategy, Royal Commission into Aboriginal Deaths in Custody, Aboriginal Drug and Alcohol Complementary Plan, National Strategy for Aboriginal and Torres Strait Islander Health, Senate Inquiry into Mental Health, and the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Social and Emotional Wellbeing and Mental Health 2004-2009) have recommended that Aboriginal people control their own mental health and AOD services in order to provide services that are culturally-appropriate and effective (Social Reference Group OATSIH 2004, Ministerial Council on Drug Strategy 2006b). There has been a consensus that these services should be provided in Aboriginal community-controlled health services (ACCHSs), given that these services aim to provide comprehensive primary health care, are controlled by the community, employ Aboriginal staff and are thus able to reduce the effects of institutionalised racism in health care delivery.

Senate Inquiry into Mental Health 2006

The Senate Inquiry into Mental Health found marked deficiencies in publicly-funded mental health services, including a lack of resources, poor communication with families and a lack of integration with AOD services. The report noted that in the past, AOD services and mental health services had been integrated but were now completely separate and had quite different treatment and service cultures. This was noted to be detrimental for patient care by many respondents to the inquiry, with significant “buck passing” between overloaded mental health and AOD services. Dual diagnosis was noted to be particularly prevalent in Aboriginal people. The Inquiry noted the lack of progress in expanding SEWB services in Aboriginal medical services. The inquiry also recommended more mental health training for Aboriginal health professionals, including Aboriginal health workers, and better screening for mental health and AOD problems in Aboriginal primary health care (Senate Inquiry into Mental Health 2006).

Emotional and Social Well Being Strategy 2004-2009

The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Social and Emotional Wellbeing and Mental Health 2004-2009, emphasised the importance of mental health services being delivered by Aboriginal workers in ACCHSs who were well-supported and trained. The strategy noted that larger ACCHSs could become the provider of choice for Aboriginal people with serious mental health disorders, providing case management, psychosocial support, medication management and family support. It noted the need to provide a spectrum of responses, including early intervention and prevention. Strategies to provide a trained Aboriginal workforce included formal education and on the job training. The strategy also identified the need for more psychologists, psychiatrists and other allied health professionals to work in the community-controlled sector (Social Health Reference Group 2004).

NT Aboriginal Health Forum Strategy for Social and Emotional Well Being

The NT Aboriginal Health Forum's Strategic Plan for Social and Emotional Well-Being emphasised the holistic view of Aboriginal mental health and building on strengths, whilst recognising trauma, loss, racial discrimination and social disadvantage. The key feature of this strategy was the recommendation to ensure that multidisciplinary social and emotional wellbeing teams were part of every Aboriginal community-controlled health service. The report noted that the recommendation from the *Bringing Them Home* report that Social and Emotional Well-Being units be established in ACCHSs had only partially been implemented. The plan supported the use of culturally-specific ways of healing from grief, loss and other psychological sequelae of Aboriginal history. It recommended expansion of services to remote areas, and a focus on prevention and health promotion in a range of areas, including suicide prevention and family violence (Northern Territory Aboriginal Health Forum Emotional and Social Wellbeing Working Party 2003).

National Drug Strategy: Aboriginal and Torres Strait Islander Peoples Complementary Action Plan (2003-2009)

The Complementary Aboriginal AOD Plan (2003-2009) recommended services be controlled by the community (Ministerial Council on Drug Strategy 2006). The strategy noted the growing evidence base for early interventions in primary health care, including Aboriginal evidence, and emphasised a broad approach encompassing prevention (Ministerial Council on Drug Strategy 2006a).

Common themes from major reports and strategies

Common themes from major reports and strategies include:

- An approach that addresses social and historical determinants (Social Health Reference Group 2004, Ministerial Council on Drug Strategy 2006a).
- The need for multidisciplinary Social and Emotional Well-being teams in every Aboriginal community-controlled health service, which will require:
 - Well-supported and trained Aboriginal mental health and AOD workers (Social Health Reference Group 2004, Ministerial Council on Drug Strategy 2006a).
 - Culturally-competent non-Aboriginal staff (National Aboriginal and Torres Strait Islander Health Council 2003, Ministerial Council on Drug Strategy 2006, Social Health Reference Group 2004).
- Well-defined links and protocols to other services, including specialist mainstream services (National Aboriginal and Torres Strait Islander Health Council 2003, Ministerial Council on Drug Strategy 2006, Social Health Reference Group 2004).
- Regionalised planning involving Aboriginal people (Social Health Reference Group 2004, Ministerial Council on Drug Strategy 2006a).
- Evidence-based interventions that are also culturally-acceptable (Ministerial Council on Drug Strategy 2006).

5. Aboriginal-specific evidence base

The following section briefly summarises findings from the literature that are relevant to the provision of integrated alcohol and other drug and mental health services in Aboriginal community-controlled health services.

There is a lack of Aboriginal-specific evidence for management of AOD and mental health issues, with most of the evidence drawn from mainstream research (OATSIH 2006, Ministerial Council on Drug Strategy 2006b). Much of the mainstream evidence is from specialist centres rather than primary health care.

Case management

There is some evidence of benefit of case management for both AOD and mental health problems in primary health care. Successful models have the following features (Wilson et al 2006):

- Readily-available psychiatric assessment in the primary care setting;
- Active screening in the primary care setting to identify high-risk patients who have psychiatric illnesses/disorders;
- Ability to apply pharmacotherapeutic and psychosocial interventions that have proven effectiveness;
- Coordination and integration of medical and psychiatric care among clinicians, and case management for patients with chronic or complex illnesses;
- Support for practitioners and treatment teams.

Case management has also been found in a randomised controlled trial to improve outcomes in addiction treatment centres, including reduced drinking and social outcomes such as housing and employment (McClellan et al 1999). This has been confirmed by other studies (Gerstein & Harwood 1990, Volpicelli et al 2000). However, it has also been shown that case management is less effective in overcoming the difficulties created when the multidisciplinary team is employed by multiple providers. This situation can lead to service fragmentation and poorer outcomes than with a single provider model, even with a multidisciplinary approach (Haggerty et al 2003). It is therefore not useful to create new providers unless existing providers are either unwilling or unable to provide mental health and AOD services. Unfortunately, at present, competitive tendering and the channeling of some funds through the Divisions is leading to the establishment of multiple new providers requiring a plethora of new “MOUs” in an attempt to get service coordination. In the Northern Territory there is a comprehensive primary health care sector that, if supported to provide these mental health and AOD services, could provide more efficient and effective outcomes.

Counseling

There is *not* good evidence for the effectiveness of generalist counseling, even though that is generally what is provided (Healthcare Management Advisors 2005). There is good evidence for structured counseling that derives from a theoretical base. These include the therapies listed below:

- Cognitive Behavioral Therapy (CBT). Cognitive Behaviour Therapy has proven to have considerable efficacy for a range of mental health conditions, including anxiety and panic

disorder (Hunot et al 2007, Butler et al 2005), post traumatic stress disorder (Bisson et al 2007, Butler et al 2005), depression (Butler et al 2005), social phobia (Butler et al 2005), and childhood depressive disorders (Butler et al 2005). CBT is also moderately effective in marital distress, anger, childhood somatic disorders, and chronic pain (Butler et al 2005). There is strong evidence for the effectiveness of CBT in addictive behaviours (Irvin et al 1999, Shand et al 2004) and gambling (Petry et al 2006).

- Motivational interviewing has a good evidence base in treating AOD problems (Shand et al 2004), and is useful in chronic disease management (Resicnow et al 2002, Rubak et al 2005). There is also growing evidence of its effectiveness in treating psychological conditions, including depression (Rubak et al 2005, Arkowitz et al 2004).
- Problem solving therapy has been shown to be effective in AOD treatment (DoHA 2007, Best Practice in Alcohol and Other Drug Interventions Working Group 2000) and is also effective in primary care for depression and anxiety (Huibers et al 2007, Pierce and Gunn 2007).
- Family therapy is effective in treating AOD conditions if the person has a functioning relationship with their family (Edwards and Steinglass 1995, Miller and Hester 1986, Stanton et al 1982, Mattick, Ward & Hall 1998). It is also effective in a wide range of psychological disorders (Shadis et al 1995), and is effective in children and adolescents, especially for conduct disorders, eating disorders and substance misuse (Cottrell et al 2002).
- Therapy specifically tailored to the cultural needs of Aboriginal people, including narrative therapy and art therapy. Narrative therapy has been adopted as a respectful, empowering therapeutic style in which the patient is the expert on their own life (Swan and Raphael 1995). It is recommended for AOD problems (DoHA 2007) and also in a wide spectrum of psychological disorders (Hunter 2004).

There is no available evidence about the efficacy of focused psychological therapies in Aboriginal contexts. Some practitioners believe that Aboriginal people are unable to express their thoughts in enough detail to enable CBT to be effective. However, psychologists at the Social and Emotional Well Being Unit at Central Australian Aboriginal Congress have been using CBT and other focused psychological therapies successfully for several years (personal communication, Central Australian Aboriginal Congress). There is every reason to believe that focused psychological therapies will be just as effective amongst Aboriginal people as they are amongst all other populations.

Addiction treatment evidence base

The strongest evidence for improving outcomes in Aboriginal AOD conditions is from socio economic initiatives that improve social determinants and supply reduction measures (Ministerial Council on Drug Strategy 2006b, D'abbs and Togni 2000). These two key strategies are not dealt with in this paper. However, AMSANT has been a key player in the alcohol debate in the Northern Territory and has an endorsed policy on alcohol supply. AMSANT and Aboriginal community-controlled services strongly advocate for action on improving the social determinants of health.

Mainstream treatment outcomes for AOD conditions are similar to those for other chronic diseases such as diabetes and asthma, despite the perception that treatment may be of limited effectiveness (Taskforce on Illicit Drugs 2001). A considerable proportion of both Aboriginal and non-Aboriginal problem drinkers stop or moderate their alcohol intake without any formal treatment (Brady 1993, Brady 1995, Hunter et al 2000). However, adverse social circumstances and other co-morbidities are often experienced by Aboriginal people and effort may need to be more intensive than in non-Aboriginal settings (Hunter et al 2000).

Integrated alcohol treatment and primary health care

Patients with drug and alcohol problems seen in specialist centres may lack a comprehensive primary health care approach to their problems (Furler et al 2000). A comprehensive approach is particularly important in treating Aboriginal people, given the high burden of chronic disease. A randomised trial found that integrated treatment which provided medical outpatient care and alcohol interventions in a combined outpatient clinic resulted in more attendances and improved rates of abstinence compared to medical treatment and referrals to specialist alcohol and drug treatment centres (Willenberg and Olson 1999). Another study found that those patients treated at AOD facilities with primary care providers on site had lower addiction severity (as measured by validated scales) at 12 months compared to those treated at sites without primary health care facilities (Friedman et al 2003). A prospective cohort study of patients with alcohol and heroin dependence followed patients for two years after residential withdrawal treatment and measured addiction severity at two years and visits to primary care providers. There was an inverse relationship between the number of visits to primary care providers and addiction severity with those who had visited primary care providers twice or more during the two year follow up, having significantly lower addiction severity compared to those with no visits to primary care providers (Saitz et al 2005).

Screening and Brief interventions

Screening and brief interventions in primary health care settings are generally well-received by patients (Saunders and Lee 1999). Without screening, around three quarters of alcohol problems will be missed in general practice (Saunders and Lee 1999). Compared to those receiving no intervention, studies have routinely found those receiving a brief intervention are at least twice as likely to modify their drinking (Wilk et al 1997). This finding has been confirmed by a Cochrane review (Kaner et al 2008). Qualitative evidence also suggests that Aboriginal patients accept brief intervention advice well from a health practitioner and that it can be effective, even late in a drinking career (Brady 1993, 1995). Introducing screening and brief intervention into general practice in a sustainable way is possible but requires both multi-faceted practitioner education and system support (Anderson et al 2004, Anderson 2003a). General practitioners are more likely to screen for alcohol problems if they can easily refer patients with more severe problems to specialist alcohol treatment services (Anderson 2003a, 2003b, Roche et al 2002).

Withdrawal treatment

Community withdrawal is recommended as the first option if the person has good social support, no major medical or psychological co morbidity, low risk of complicated withdrawal and good access to 24 hour medical support (NSW Health Department 1999). This may exclude many Aboriginal people

because of the lack of a supportive home environment. However, if a home-like supported environment can be provided, this option may be available to a much higher proportion of Aboriginal people. Withdrawal (whether residential or community-based) should be best regarded as a gateway to further treatment rather than a treatment in itself (Healthcare Management Advisors 2005).

Rehabilitation

Outcomes for community-based rehabilitation are equivalent to residential rehabilitation if the person has adequate family and social supports (Healthcare Management Advisors 2005). Some people find it difficult to access residential services because of their family, social or work responsibilities and they may not wish to be away from their communities for long periods. However, an extended period of residential rehabilitation can be very beneficial for people whose social and family situation does not support them in stopping or reducing their alcohol or drug use (Ministerial Council on Drug Strategy 2006b). Residential rehabilitation should be reserved for those with more severe problems, lack of social and family support and past treatment failure, given its cost and evidence that outcomes of community-based treatment are equivalent (Healthcare Management Advisors 2005).

Alcoholics Anonymous

A recent Cochrane review found Alcoholics Anonymous to have equivalent efficacy to Cognitive Behaviour Therapy and motivational enhancement (Feri et al 2007). Some Aboriginal people may find AA too shameful and may prefer one-on-one interaction (Hunter et al 2000).

Pharmacotherapies

Acamprosate and Naltrexone have been shown to be effective in the prevention of relapse to heavy alcohol consumption. Both medications are well-tolerated and safe and have a modest but definite effect (Bouza et al 2004, Garbutt West et al 2001, Mason 2001, Streeton and Whelan 2001, Sirisuraponont and Jarururaisin 2003). There is limited evidence of the efficacy of Acamprosate and Naltrexone in general practice. A French primary care study found that Acamprosate did reduce drinking and improve quality of life compared to standard GP care and that retention rates were high (80%) at 12 months compared to trials in specialist centres (Kiritize-Topor et al 2005). Pharmacotherapies have been recommended in national guidelines for general practice treatment of alcohol problems but are generally under-utilised (Shand et al 2004).

Opiate replacement treatments have been proven to reduce drug use, overdose, HIV risk, and social and criminal consequences of drug use. Opiate replacement treatment is prescribed by general practitioners in Australia, provided they have undertaken accredited training, and is prescribed in AMSs in larger urban centres (Taskforce on Illicit Drugs 2001). More intensive specialist-based treatment has marginal benefit over community-based settings (Taskforce on Illicit Drugs 2001). Medications to assist with smoking cessation should be promoted to Aboriginal people given the high burden of smoking-related disease in this population.

Mental health and Dual Diagnosis Services

Mental health services have been provided successfully through Social and Emotional Well Being (SEWB) services for twenty or more years (Cooperative Research Centre on Aboriginal Health 2006). However, only the larger ACCHSs in the NT are able to provide a comprehensive SEWB service despite the documented need for these services in remote communities (Northern Territory Aboriginal Health Forum Emotional and Social Wellbeing Working Party 2003). People with dual diagnosis are usually believed to require specialist services even though dual diagnosis is common in primary care settings and specialist services are difficult to access. However, core counseling techniques such as CBT and problem solving therapy are effective in both mental health and AOD problems. There is also evidence of their efficacy in people with dual diagnosis (Best Practice in Alcohol and Other Drug Interventions Working Group 2000). An indigenous-specific screening tool has now been developed that can detect mental health and drug and alcohol issues as well as dual diagnosis. The tool (known as IRIS or Indigenous Risk Impact Screen and Brief Intervention) has been validated with other AOD and mental health scales, including the Audit Dependence Scale, Leeds Dependence Scale and the Depression, Anxiety and Stress Scale (Schlesinger et al 2007). It will enable detection of these problems at the primary health care level and allow for early intervention.

The multidisciplinary team

Recruitment and retention of health professionals

Recruitment and retention of health professionals is likely to be a major barrier to expanding the capacity of primary health care in remote areas for many years to come. Professional support from colleagues (medical and non-medical) has been found to be a positive factor in influencing retention in rural general practitioners (Gardiner et al 2005). Working in a multidisciplinary team including Aboriginal Health Workers is cited as a positive factor influencing retention by general practitioners in the NT (Ball 2005).

Lack of specialist services and professional isolation are key issues negatively impacting on GP retention (Ball 2006). Evidence from primary health care in the Top End indicates that general practitioners and other primary health care workforce do not feel confident in assessing Aboriginal mental health issues (Nagel 2006). The lack of a mental health workforce has been reported as a considerable source of stress in the remote primary health workforce (Harris and Robinson 2007).

Retention of Aboriginal staff

It is recognised that an Aboriginal workforce is vital to improving primary mental health and alcohol and other drug care and this includes Aboriginal psychologists, mental health nurses and social workers and not only certificate level paraprofessionals (Social Health Reference Group 2004, Ministerial Council on Drug Strategy 2006a). Issues contributing to poor retention of the Aboriginal health workforce include remuneration, high stress levels, lack of professional recognition and training and lack of career pathways (Mitchell and Hussey 2007). Aboriginal mental health, AOD and family support workers need to be well-supported and integrated into existing primary health care structures in ACCHSs (Harris and Robinson et al 2007). A program to incorporate Aboriginal mental health workers into primary health care in the Top End was hampered by a lack of clarity about their role in both mental health promotion and clinical illness and who would supervise and support them

in these roles, poor support by management, rapid staff turnover and the resistance of other health professionals to the role of Aboriginal mental health workers (Harris and Robinson 2007).

These findings reinforce the need for a well-structured, comprehensive team-based approach to SEWB services in Aboriginal community-controlled services. It is clear that the valuable role being played by Aboriginal mental health workers was one of cultural broker and community liaison. In our model, we have called these workers Aboriginal Family Support Workers. AMSANT believes that the term 'Aboriginal mental health worker' should be reserved and used for a registered Aboriginal health worker who has completed the necessary mental health training in the new competency standards to become a specialised mental health worker. It is envisaged that with adequate training and support, such workers would be able to replace the need for mental health nurses. If this is shown to be the case, then Aboriginal mental health workers will need to be given the same access to Medicare item numbers as mental health nurses. The major constraint here is the stagnating number of registered AHWs and the lack of new people entering the profession.

Aboriginal AOD workers have certificate four level training in alcohol and other drugs. These workers are valuable team members in SEWB services but may require support and additional training to provide integrated AOD and mental health services.

Community development approaches

There is a lack of research on community-driven approaches to mental health promotion. The Family Life Promotion Program in Yarrabah in North Queensland is a well-documented example of local people successfully developing their own service model. The program arose because of three waves of suicides starting in the late eighties. The Aboriginal community received visiting mental health services from Cairns. They were concerned that people were referred to psychiatric services without consultation with families and returned "damaged". They identified a need for local people to respond rather than totally relying on outside visiting professionals (Hunter et al 2001).

The community received funding for local Aboriginal people to be trained to deal with mental health crisis. After initial success, a third wave of suicides occurred in the 1990s. A crisis group was formed and a large number of volunteer counselors were identified. The group gradually shifted its focus towards health promotion and was successful in obtaining funding for Aboriginal mental health workers. The workers did not have substantial formal training and dealt with a challenging environment, leading to worker stress and burnout. Training support was eventually obtained and protocols for dealing with mental health crisis and liaising with specialist services were developed. The visiting professional staff also provided mentoring and support.

Key features of the Family Life Promotion Program included:

- The program was driven by the community with active involvement of elders;
- It identified and worked with young people at risk;

- It was based on strengthening family and community supports and resources as well as identifying and treating illness;
- There were effective linkages with mainstream AOD and mental health agencies;
- The program worked collaboratively with agencies outside the health sphere, such as sporting bodies and recreation officers, to promote healthy activity (Hunter et al 2001).

6. Current services

Mental health services

Specialist mental health services in the NT are largely provided through stand-alone mainstream mental health services with remote outreach teams. Psychiatric inpatient beds are located in Alice Springs and Darwin hospitals. Major ACCHSs in urban areas have SEWB units, but the smaller ACCHSs usually do not provide mental health services and rely on infrequent remote visiting services. However, with the advent of the COAG mental health reforms, Divisions, the Red Cross and other private providers are now beginning to provide mental health services.

Only one third of ACCHSs can provide ongoing mental health care for the full range of common problems found in Aboriginal people, despite the majority identifying mental health as a major issue (OATSIH 2006). The lack of mental health services is particularly dire for remote communities. A study of 50 discrete Aboriginal communities located more than 10 kilometers from a hospital found that less than half (47%) had access to mental health professionals (OATSIH 2006).

In 2002-2003, nearly one quarter of all mental health admissions in the Top End were readmitted as an emergency within 28 days, indicating deficiencies in community mental health care (Nagel 2006). A review of mental health utilisation by Aboriginal people found that Aboriginal people were 1.6 -2.6 times more likely to have contact with mental health professionals compared to non-Aboriginal people (DoHA 2006). However, in the NT, contact for Aboriginal people was 11% less than the national average. This is likely to indicate unmet need rather than lower illness rates (DoHA 2006).

Other factors contributing to poor community mental health care for remote Aboriginal people include language barriers, insufficient capacity in primary health care, including a lack of GPs and nurse practitioners with appropriate mental health and cross cultural skills, a lack of appropriately-skilled Aboriginal Health Workers and poor mental health literacy in Aboriginal communities (GPPHCNT 2007, Nagel and Thompson 2007, Nagel 2006).

Alcohol and other drug services

AOD services are largely concentrated in the five regional centers (Darwin, Nhulunbuy, Katherine, Tennant Creek and Alice Springs) and include detoxification centres, residential rehabilitation services, sobering-up shelters and specialist community AOD treatment centres. Community-controlled and/or Aboriginal services included CAAAPU (Central Australian Aboriginal Alcohol Program Unit) and CAAPS (Council for Aboriginal Alcohol Program Services) both of which provide residential rehabilitation in the Alice Springs and Darwin area respectively. CAAPS also provides drug and alcohol training. The five ACCHSs located in regional towns all have Social and Emotional Well

Being services. However, the level of resourcing of these services is not adequate to meet the demand and until relatively recently, some were not funded to provide alcohol and other drug services. Most do now have dedicated AOD positions through COAG funding. This has increased capacity but has worked against realising the AMSANT model where clinicians provide integrated rather than siloed care to people with AOD and /or mental health problems.

Nationally and in the NT, the proportion of AOD treatment services delivered to Aboriginal people is significantly higher than their population proportion. In the NT, 60% of services were delivered to Aboriginal people whereas nationally it was 9% (Jones et al 2005). Nationally and in the NT, there is a focus on residential rehabilitation in Aboriginal-specific services and these are usually based on an abstinence model. Many services have been designed for drinkers with a relative lack of services for other drugs, including injecting drug users and poly drug users (Ministerial Council on Drug Strategy 2006b, Healthcare Management Advisors 2005). In the NT, two thirds of services are provided primarily for alcohol misuse (Jones et al 2005). Nationally and in the NT, there has also been a lack of emphasis on prevention (apart from largely ineffective stand-alone events that are not integrated into ongoing care) and early intervention, especially in primary health care (Ministerial Council on Drugs 2006b, Healthcare Management Advisors 2005). There is also a lack of effective after care systems for those discharged from residential rehabilitation (Healthcare Management Advisors 2005).

In the NT, mainstream services have not always modified their services to suit Aboriginal needs. There is a lack of services in some areas (Katherine, Tennant creek, all remote areas) and a lack of linkage between services in AOD and between AOD and mental health and AOD and welfare/ancillary support services (Healthcare Management Advisors 2005). The Taskforce on Illicit Drugs in 2001 identified several areas of weakness, including services to people under eighteen, aftercare and early intervention, and community-based responses. The Taskforce recommended a proactive strategy with Aboriginal illicit drug use, given the concerns about cannabis use and the potential for rapid uptake of other illicit drugs (Taskforce on Illicit Drugs 2001).

Recent Developments in Alcohol and Other drug treatments in primary health care

In 2007, COAG funding was provided to improve AOD services in remote communities by funding AOD workers in selected remote communities in both government and community controlled clinics. These workers were supported by a central workforce coordinator unit within Remote Health (DoH NTG). At the same time, short term funding was made available to respond to alcohol issues through the NTER, with this funding initially only guaranteed from late 2007 to 30th June 2008. This funding provided for 24 additional AOD positions in primary health care in five ACCHSs and one AOD service. A clinical director was also appointed with a pre requisite that this position be a doctor with AOD experience. At the end of the NTER funding, all of the ACCHSs that had appointed additional short term positions received funding for ongoing positions through COAG 2008 AOD funding, although some teams had to be reduced in size. The Clinical Director position was continued but when it became vacant in 2010, a decision was made that the primary need of the remote AOD workforce was for clinical supervision of counselling rather than for medical oversight. Importantly, despite these recent workforce developments, the majority of remote communities do not have access to on site AOD workers and still rely on infrequent visiting mental health services.

Regional ACCHSs that have been supported through COAG funding have generally employed teams of workers usually consisting of one professional with relevant AOD experience and two community workers who are supported to undergo further training.

The remote AOD workforce support unit is located within Remote Health and now consists of a remote workforce coordinator, a clinical psychologist and a training position. This unit has provided support to the workforce in both the community controlled sector and workers based within Remote Health (DHF) and has also produced resources such as assessment forms and treatment resources.

As noted in the preface, aspects of the NTG Remote AOD support unit's Best Practice Model conflict with AMSANT's model. However, there is also significant agreement over core principles, including that both community development and clinical treatment are required and that Aboriginal workforce is crucial. The Best Practice Model developed by the workforce unit states that a key principle is that if one worker only is to be employed in a remote clinic, that this worker should be an Aboriginal person. AMSANT believes that a multidisciplinary team is required and that a single AOD worker within a PHC service will only be able to provide a very limited service and is an unsustainable model.

Central Australian Aboriginal Congress has also received funding through the Alice Springs Transformation Plan to provide ambulatory treatment for people with alcohol related problems in Alice Springs.

Legislative Alcohol reforms in the NT

The NT is currently implementing major AOD reforms (Enough is enough) based on the principle that access to alcohol is a privilege rather than a right and that it is justifiable to withdraw that privilege if a person is putting others at significant harm from their drinking. The reforms include

- 1) Establishment of an AOD tribunal that can assess people referred because of harmful alcohol consumption, particularly if it is harming others. This is a non-criminal tribunal which will have the power to ban someone from buying takeaway alcohol and to quarantine welfare income.
- 2) A system of banning orders issued for drink driving offences, violent offences related to alcohol and being in protective custody repeatedly. People who are banned may be reviewed by a clinician (doctor, nurse or AHW) and have their banning order reduced if the clinician feels this is appropriate. This is not possible if the banning order was issued because of alcohol related violent offences.
- 3) Requirement to show photo ID when buying takeaway alcohol so that those who are on a banning order can be refused purchase.
- 4) Reforms to the criminal justice system so that people charged with alcohol related offences will be dealt with by a specific alcohol court which will also be able to issue banning orders and where people will be assessed by a clinician and can have their sentence reduced if they engage in treatment.

AMSANT is strongly supportive of these reforms but is disappointed that a floor price has not been introduced as outlined in AMSANT's Alcohol control policy. The reforms will enable clinicians to help those with the most entrenched drinking problems. Reducing a person's access to alcohol is likely to assist them even if they will not accept drug and alcohol treatment. Importantly, alcohol and other drug treatment can only be recommended by the Tribunal but cannot be made mandatory. There is little evidence that mandatory treatment is effective and there are considerable ethical issues with enforced treatment out of the criminal justice system (Pritchard et al, 2007).

7. The AMSANT model for integrating AOD and community mental health care into Aboriginal Medical Services in the NT

Rationale for the AMSANT model

The rationale for an enhanced social and emotional well-being (SEWB) system in ACCHSs, including remote services, that includes both drug and alcohol and mental health services, can be summarised as follows:

- AOD and mental health issues cause a high burden of both mortality and morbidity in the Aboriginal population in the NT.
- There is unmet need for services for Aboriginal people, especially in remote areas.
- The most effective and efficient way to provide these services is to ensure they are community-based and operating through the existing primary health care service infrastructure. The creation of multiple service providers, especially in remote areas, is making the service system unnecessarily complex and more fragmented.
- Dual diagnosis is common and generally poorly dealt with in the specialist AOD and mental health sectors.
- Treatment for both AOD and mental health issues needs to be addressed in a culturally-effective, holistic way that also addresses determinants of these problems at a community and individual level. Aboriginal communities should control these services.
- Therapies such as Cognitive Behaviour Therapy and problem solving therapy are effective in both mental health and AOD problems.
- Treatment for mental health and AOD problems needs to be integrated with other aspects of primary health care, including medical care and health promotion.
- There is a paucity of Australian research evidence for Aboriginal mental health and AOD services, either in specialist or Aboriginal services. However, many ACCHSs have been successfully providing mental health and AOD services in SEWB units during the last twenty years.
- A model is required that allows for the full range of services to be provided to remote populations through Aboriginal community-controlled health services.
- The model needs to be centred on multidisciplinary SEWB health teams, including a strong Aboriginal workforce.

AMSANT Model and comprehensive primary health care

Comprehensive primary health care is first level care which is universally available, scientifically sound as well as socially and culturally acceptable. It addresses equity both at the individual level but also at the political and community level and collaborates with other sectors to improve health outcomes. Community participation and control is a key feature of comprehensive primary health care as defined by the declaration of Alma Ata (World Health Organization).

Aboriginal community-controlled health services deliver comprehensive primary health care which encompasses:

- Health promotion
- Illness prevention
- Treatment and care of the sick
- Community developments
- Advocacy
- Rehabilitation (World Health Organization)

SEWB services are a key part of this model, in line with the Aboriginal view of emotional and physical health being inseparable. The model advocated by AMSANT is based on the provision of SEWB and AOD services within ACCHSs as part of comprehensive primary health care¹. The model encompasses the full spectrum of responses, including prevention, screening and early intervention, treatment, rehabilitation and welfare support. Specialist services would be provided within the comprehensive primary health framework. The model also allows for flexibility at the local level.

Community development approach

The AMSANT model is based on a community development approach, utilising Aboriginal Family Support Workers whose core function will be around working with families and building resilience in their communities using an approach that builds on cultural and community strengths. They will also work with individuals and families with significant mental health and AOD issues in conjunction with counselors and psychologists. The Aboriginal Family Support Workers will be local people with strong community and kinship networks. This will enable them to work at an individual, family and community level. Each remote community will have at least one male and one female worker.

The workers will be provided supervision and support from counselors and psychologists for their work with individual patients and families. However, they will determine their own work priorities and preventative approaches in conjunction with senior Aboriginal management. These work priorities would focus on health promotion and preventative activities within their own communities. This will allow for a culturally-strengthening approach that enhances access to cultural interventions and psychological and other treatments. The Aboriginal Family Support Workers will work with other preventative services, including universal home visitation services for women with

¹ The model recognises that some AOD and mental health services are not part of PHC, including residential rehabilitation and treatment; community-based residential withdrawal and hospital withdrawal; respite care and supported accommodation services; acute psychiatric hospital services; and supported employment programs.

young children and other welfare and family support services. Aboriginal family/community workers have been at the core of the SEWB unit at Anyinginyi Congress in Tennant Creek for several years.

Clinical service delivery

Overview

The clinical service delivery is based on integrating AOD and mental health services utilising common evidence-based approaches such as Cognitive Behaviour Therapy. Aboriginal Family Support Workers will be supported by counselors, mental health nurses and psychologists skilled in both AOD and mental health treatment.

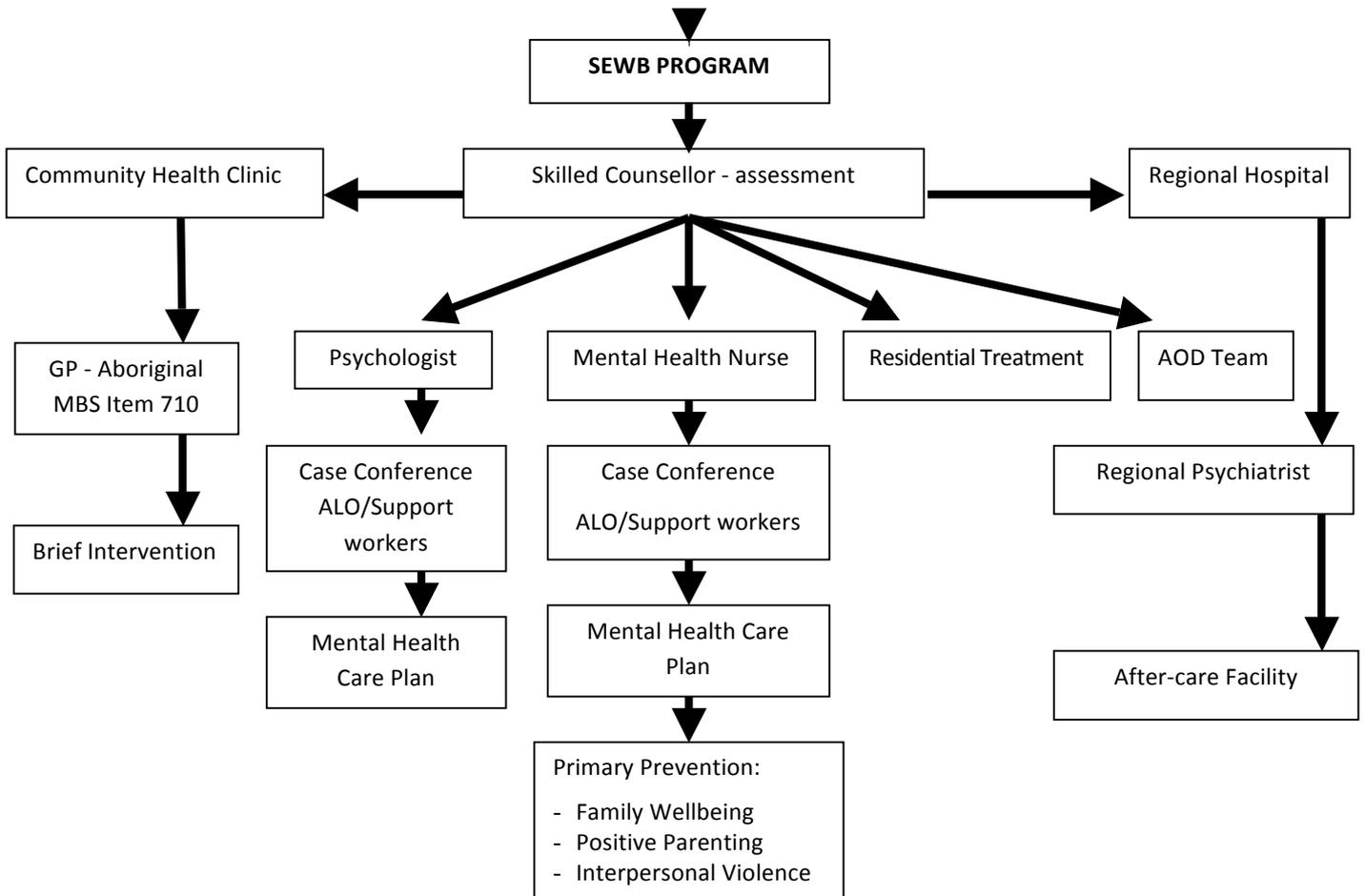
The following clinical components will be provided through this model:

- Entry through multiple points including self referral;
- Screening and brief interventions for clinical AOD and mental health problems and people at high risk of developing problems;
- Multidisciplinary care plans and mental health care plans for those with significant AOD and mental health issues involving client, family and community;
- Clinical pathways for common mental health and alcohol conditions;
- Rehabilitation and case management;
- Clear protocols and pathways for referrals to external agencies and shared care;
- Professional support and training for mental health workers;
- A workforce model based on population.

Entry to the SEWB service

Patients or families can self-refer to Aboriginal Family Support Workers or counselors in the SEWB unit and be triaged according to the assessment, with options including the primary health care team, the psychologist, mental health nurse, acute psychiatric services, the AOD worker and residential withdrawal services (see flow chart for SEWB referral). Other referral points include through primary health care (either via screening or via a presenting problem), external agencies, including schools and welfare agencies, and from secondary or tertiary services (see Entry Via Social and Emotional Wellbeing Pathway).

ENTRY VIA SOCIAL & EMOTIONAL WELLBEING PROGRAM



Screening and brief interventions

ACCHSs aim to screen all adult patients yearly using the Medicare item 710 (Aboriginal adult health check). Screening for AOD and mental health problems will incorporate into this screen, using the Audit C and Iris screening tools. Screening for illicit drugs will also be incorporated into the assessment. Screening will also occur opportunistically especially when the person is at high risk e.g. if they have a family history of mental illness or they have previously had mental illness or AOD problems. If the person is identified as being at risk of mental health or AOD problems, a brief intervention will be offered with an invitation for more help if required. Brief interventions will also be offered if the individual has a major AOD and/or mental health problem, but does not want in-depth assessment at that point.

Multidisciplinary care plans

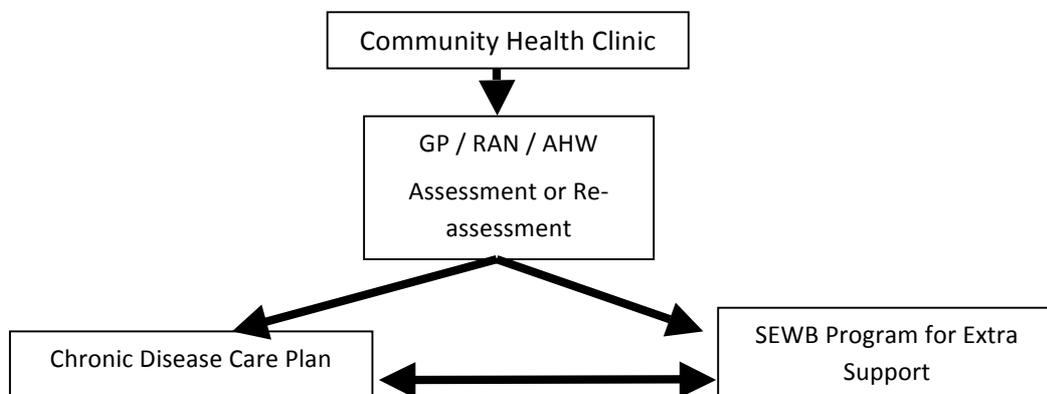
Patients are eligible for a Medicare Extended Primary Care mental health care plan for a wide range of AOD and mental health problems. At assessment, eligible patients who are willing to participate in ongoing care will have a care plan formulated. The planning process would include the patient and their family as well as other significant people in the person's life. The professionals involved would depend on the presenting problem but would always include the general practitioner and the Aboriginal Family Support Worker and would include at least one of the allied health professionals involved in the team (counselor, Aboriginal mental health /AOD worker, mental health /AOD nurse or psychologist). The plans will include clinical components but also focus on broader psychosocial aspects including home support and supported employment where appropriate.

Clinical pathways

Community health pathway

Patients with significant AOD and/or mental health problems who present to the primary health care team and who want further help will be referred for assessment by a qualified mental health worker. Patients who are dealing with chronic illness and may be struggling to maintain their health and adapt to treatment regimes will also be referred for supportive counseling and treatment of associated depression or grief (see comprehensive primary health care - chronic disease flow chart).

COMPREHENSIVE PRIMARY HEALTH CARE (CHRONIC DISEASE)



Alcohol and other drug pathway

The following steps will be followed in those presenting with AOD problems:

- Assess for dependence and the need for withdrawal services (including whether the person requires supported accommodation or referral to residential or hospital withdrawal);
- Manage community-based withdrawal according to CARPA (Central Australian Remote Practitioner Association) guidelines if the patient meets the criteria for home-based withdrawal. This will involve daily supervision and working with the family;
- If the person is not physically dependent, they can be offered ongoing support as for dependent patients post-withdrawal.

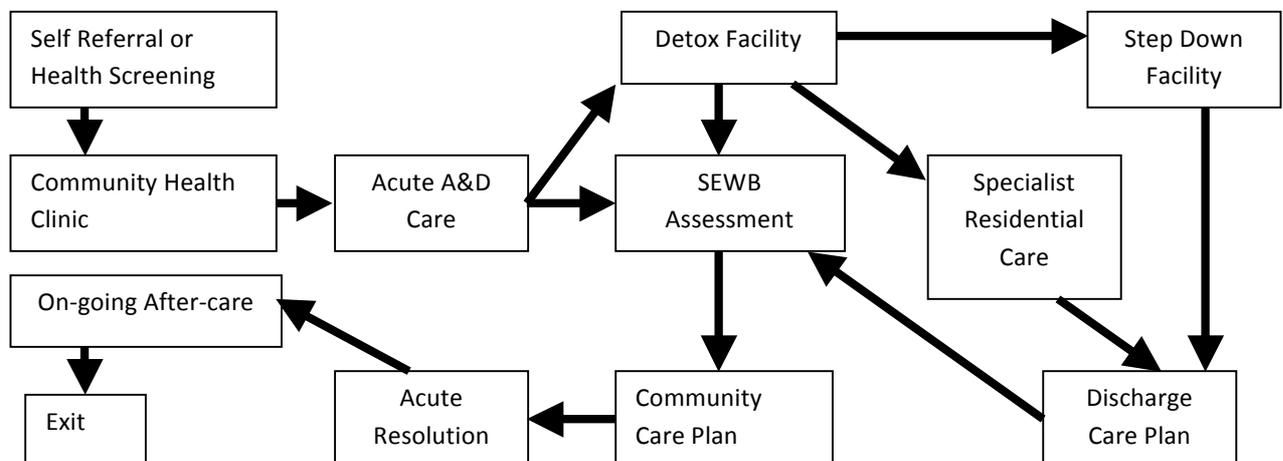
Those who are suitable can be offered a supported home withdrawal. If the person does not have major medical complications but does not have suitable home environment, they can be offered supported accommodation whilst undertaking a home withdrawal. This would greatly increase the number of people eligible for home withdrawal. Those who are not suitable for supported home withdrawal will be referred to a residential withdrawal service.

After-care and relapse prevention

After-care is required in the community where the client lives, following the successful completion of residential treatment. It is a service that needs to be embedded in the local community-based primary health care service and cannot be effectively provided on a visiting outreach basis.

A plan for ongoing care will be formulated in conjunction with the patient, family, Aboriginal Family Support Worker, counselor and, if required, other allied health professionals and the general practitioner. Evidence-based approaches to relapse prevention and counseling will be offered, including CBT and motivational interviewing. Alcoholics Anonymous will also be offered to those interested. Patients who do have a major relapse will be able to re-enter treatment through the primary health care clinic or the SEWB unit (See acute alcohol rehabilitation pathway).

ACUTE ALCOHOL REHABILITATION PATHWAY

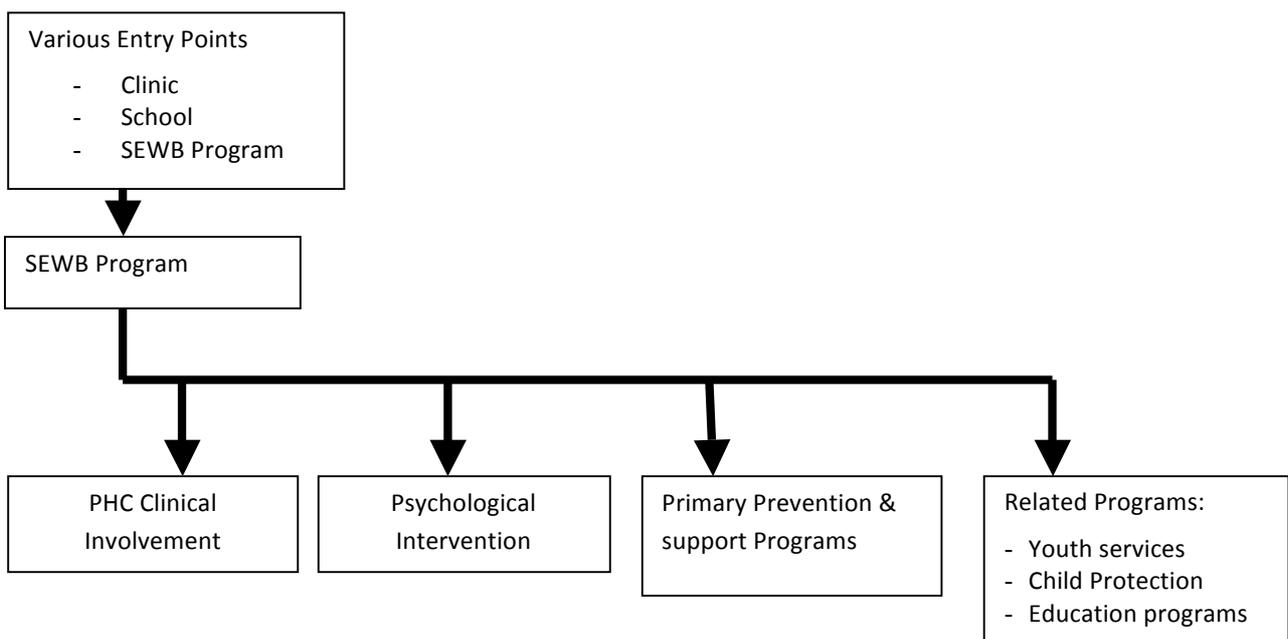


In order to ensure the seamless transition and continuity of care from residential treatment facilities to community-based follow-up or after-care, the psychologists and Aboriginal Family Support Workers in the primary health care SEWB teams should be involved in providing care to clients while they are within residential treatment. For clients from the same town as the residential treatment centre, the psychologist could provide all of the necessary CBT sessions. For clients from more remote communities, the psychologist would need to enter a shared-care arrangement with a resident psychologist in the rehabilitation service.

Grief and loss pathway

Issues relating to grief and loss and family stress could be identified through the clinic, school or by direct referral. Individuals or families with these problems would be supported through primary prevention programs such as family visiting and support services, but would also be supported through psychological assistance to the family or individuals. Other programs which could provide support as needed to individuals and families include youth programs and education support. See grief/loss flow chart.

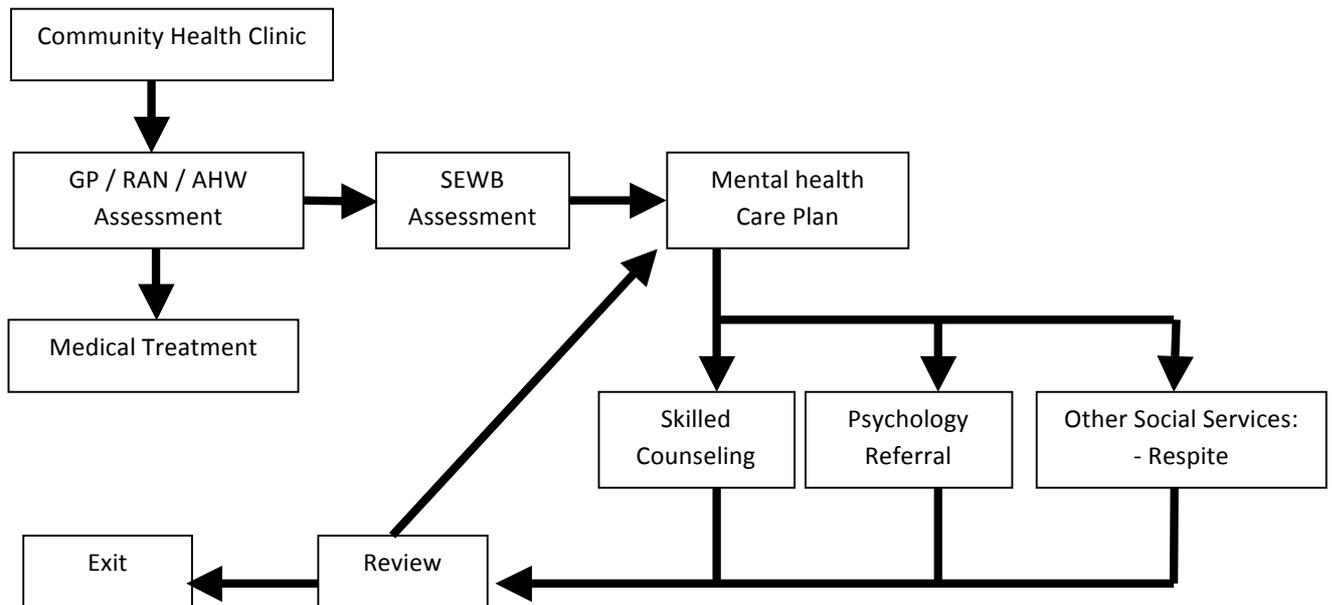
GRIEF AND LOSS (FAMILY STRESS)



Anxiety and depression pathway

People with anxiety and depression will have an Extended Primary Care mental health care plan and be referred for counseling by either the counselor or the psychologist. If severe or not improving, they will be referred back to the primary health care team for consideration of medications. Other supports, such as respite from family responsibilities, can be organised in conjunction with Aboriginal Family Support Workers. Patients who fail to improve will be referred for specialist assessment. This is outlined in the basic depression/anxiety pathway.

BASIC DEPRESSION/ANXIETY PATHWAY



Low prevalence psychotic disorders pathway

Low prevalence psychotic disorders (schizophrenia, bipolar disorders etc) need psychiatric review and case management. The management may need to be through a shared-care arrangement until the person's health is stable. However, many of these chronic disorders would be best managed within a comprehensive primary health care framework with yearly or six monthly psychiatric review when stable, case management within the ACCHSs, and referral for urgent assessment if unstable.

Clinical pathway for young people

Young people aged 12-18 will be provided with support through Aboriginal Family Support Workers and counselors. Young people could be referred to youth-specific services if available and appropriate. Young people with particularly complex problems will be seen by the psychologist and may need to be referred on to child and adolescent specialist services. However, local community people would initially be best placed to identify troubled young people and work with them and their families.

Pathway for families with younger children

Families in which children are having behavioral problems will be supported by Aboriginal Family Support Workers and counselors, in conjunction with other specialist workers if required, including paediatric review. Common behavioral issues will usually be dealt with by a community-based family strengthening approach. Mental health, AOD, welfare and housing issues affecting the parenting capacity of the family can be addressed in a holistic way through this model.

Dual diagnosis

It is expected that some degree of dual diagnosis will be very common. Patients with dual diagnosis will be assessed and managed for their presenting problems by the SEWB team without requiring

specialist dual diagnosis workers or services. This will stop the “buck-passing” that occurs between specialist AOD and mental health services. Alcohol dependence and other addictions may need to be dealt with first before the psychological issues can be fully treated. However, they will generally be treated concurrently.

Rehabilitation and Case Management

Patients and families will be referred to services that can assist with housing, employment and education. Patients with more severe problems, including those with psychotic disorders, dual diagnosis and individuals or families with multiple social and family issues, will be offered more intensive case management by an experienced member of the team. This will include liaison with the family and other agencies involved in the care of the individual and regular review of the care plan in conjunction with other members of the treatment team, including the primary health care team.

Pharmacotherapies and Psychiatric Medication

With appropriate specialist support and training, general practitioners would provide most of the medical management. In the larger regional centres, visiting psychiatrists would be part of the SEWB teams and would be directly responsible for the management of clients with more complex and severe problems. They would also visit remote communities to see complex patients. Treatments provided by general practitioners would include:

- Pharmacotherapies for alcohol relapse prevention (Naltrexone and Acamprosate);
- Opiate replacement therapy;
- Smoking therapies (Nicotine Replacement Therapy, Variciline, Bupinorphone);
- Psychiatric medication, including antidepressants and antipsychotic medication.

Referrals and shared-care

A coordinated approach to referral and post discharge care would be required with:

- Residential and hospital detoxification centres;
- Residential rehab/therapeutic communities;
- Acute psychiatric services.

A coordinated approach to referral and shared-care would be required for:

- Specialist drug and alcohol services;
- Community mental health service.

An effective referral system and joint case management for complex clients would be required for:

- Supported employment services;
- Housing services;
- Educational support.

Support and professional development

Primary health care staff

Primary health care staff would require some up-skilling in screening, brief interventions and other basic techniques such as motivational interviewing. This could be provided through larger ACCHSs or through Divisional programs.

Aboriginal Family Support Workers

Aboriginal Family Support Workers will be offered training in community development approaches and mental health and AOD assessment and treatment through the community health worker stream of health worker training at certificate 1 and 2 levels. They will also be encouraged to qualify as Aboriginal mental health workers through accredited training, but this won't be mandatory.

Nurses

Nurses will often have experience and training predominantly in AOD or mental health assessment and management. They will need appropriate upskilling tailored to their specific needs. This may include training in cognitive behavioural therapy and other focused psychological therapies.

Allied health: Training in dual diagnosis and cultural training

Mostly psychologists and counselors will have experience in either the AOD or mental health system. They will be offered appropriate up-skilling through professional associations so they are competent in mental health, AOD and dual diagnosis problems. Allied health staff will also be provided with cultural orientation and mentoring through working with Aboriginal Family Support Workers.

Ongoing support for workers

Aboriginal Family Support Workers will need support if this model is to be sustainable, given the level of distress and grief in Aboriginal communities. Aboriginal Family Support Workers would be supported by senior Aboriginal management in ACCHSs and by their peers. Psychologists would provide professional support and training to counselors, Aboriginal mental health workers and Aboriginal Family Support Workers in dealing with clinical issues. Each professional group in the model would be encouraged to join peer networks for professional support with workers from groups of smaller services forming professional networks. Ongoing professional development would be provided as part of this model.

Workforce

The core social and emotional well-being team

A community of 1500 people would require four Aboriginal Family Support Workers (including at least one of each gender) with one position identified as a manager, two skilled counselors able to deliver CBT, and two of either a mental health/AOD nurse or registered Aboriginal Mental Health/AOD Worker. It would be important to ensure that the whole team had an appropriate mix of competencies across mental health and AOD problems and that a training strategy was developed for the workforce. This workforce would be in addition to the core primary health care clinical staff of two general practitioners, six nurses and eight Aboriginal Health Workers. If the population size

was 750 or more, the team would be based in the clinic. If the population size was smaller than 750, the team would be zonal but would be based in the largest community in the zone. However, the Aboriginal Family Support Workers would be based in their own communities.

Specialist workforce: Psychologists and psychiatrists

Psychologists would be based zonally with one for every 1500 people. They would provide supervision to counselors and see those with more complex situations, including addiction, interpersonal violence and complex problems in young people. There would be one psychiatrist for every 8,000 people, based in the regional centres of Nhulunbuy, Katherine, Tennant Creek, Alice Springs and Darwin. This is slightly higher ration than the national average of 1 per 10 000 because of the higher rates of AOD and mental health problems in the Northern Territory (Australian Medical Workforce Advisory Committee 1999).

Funding

Funding sources include the COAG mental health and AOD funds. Supplementary funds would be procured through Medicare mental health care items. There should also be a funds pooling arrangement with the Department of Health and Community Services, as much of the workload of community mental health and AOD treatment currently provided in the specialist community mental health and AOD sector would be provided through ACCHSs in this model. Also, increase in community care should result in reduced admissions and readmissions for psychiatric care as well as reduced need for residential withdrawal and rehabilitation services.

Funds should be allocated in a planned manner according to need through the Northern Territory Aboriginal Health Forum and not through a competitive tendering approach. They should also be allocated according to the population staffing ratios outlined in this document given the evidence of unmet need with current service provision and the strong endorsement of SEWB services being provided through ACCHSs in multiple inquiries and government strategies. This model is evidence-based and will cater to the diverse needs of the NT Aboriginal population.

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