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Mental healthcare pathways for urban Aboriginal children

Killian A, Kalucy D, Nixon J, Eades S, D'Este C,
Sherriff S, Fernando P, Williamson A

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Professor Emily Banks
Research School of Population Health
62 Mills Rd
The Australian National University
Canberra Acton 2600

E: emily.banks@anu.edu.au

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Background

Social and emotional wellbeing problems are the chief health issue experienced by young Australians ⁽¹⁾. Indeed, mental health and substance abuse disorders account for more than 50% of the burden of disease amongst 15-25 year olds ⁽²⁾. Available information suggests that Aboriginal young people experience higher levels of mental health related harm than non-Aboriginal young people in Australia ⁽³⁻⁷⁾.

These high levels of harm are linked to elevated levels of stressful life events ^(8, 9), the experience of racism ^(10, 11) and the ongoing grief, loss and disadvantage that are a legacy of colonisation ⁽¹²⁻¹⁴⁾. Left untreated, childhood mental health problems can continue into adulthood, impacting educational, professional, personal and social trajectories for the individual, and in turn impacting subsequent generations ⁽¹⁵⁾. Evidence suggests that young people who experience mental illness are less likely to finish school or university ⁽¹⁶⁾ and are more likely to be unemployed later in life ⁽¹⁷⁾. Moreover, it has been estimated that 90% of Aboriginal young people in the juvenile justice system in New South Wales have a psychological disorder ⁽¹⁸⁾. Tragic consequences of an insufficient response to the mental health needs of Aboriginal young people include high rates of self-harm and suicide, emphasising the urgency of this problem ⁽¹³⁾. Recent calls to include mental health in the Council Of Australian Governments' (COAG) Closing the Gap agenda ⁽¹⁹⁾ have been sparked by the increasing recognition of the flow-on effects of poor mental health.

In Australia, the field of mental health care has received particular attention from stakeholders in both clinical care and policy making ⁽²⁰⁻²⁴⁾. Recent demographic changes as well as federal policies, among other factors, have increased the emphasis on primary care, and have highlighted the need for inter-professional collaboration between different sectors ⁽²¹⁻²⁴⁾. Minority groups, including young people and Aboriginal and Torres Strait Islander populations have been identified as particularly vulnerable in the context of mental health disorders, with a higher reported prevalence and lower service use ⁽²⁵⁻²⁷⁾. In addition, multiple barriers to help-seeking and mental health service use among Aboriginal young people have been identified, indicating that this population may face particular difficulties obtaining appropriate care ⁽²⁸⁻³¹⁾. Despite this, little is known about the mental health of Aboriginal young people, and almost nothing about their patterns of mental health service use, existing effective resources, interventions and pathways, or levels of unmet need for services.

To meet the knowledge gap in this area, two literature reviews and a qualitative study were conducted under this program.

The first project, Project A, a literature review, examines existent literature on what is known about best practices for mental health care delivery in primary care for Aboriginal and Torres Strait Islander young people; and subsequently what barriers and facilitators exist in the adoption of evidence-based best practices and recommendations to address mental health challenges in Aboriginal and Torres Strait Islander young people.

The second literature review, Project B, explores the extent to which guidance for the treatment of common mental health disorders in Aboriginal young people is available to inform practice in a primary care setting.

The qualitative study, Project C, with health practitioners working with Aboriginal children investigates the pathways to mental health care for Aboriginal children and adolescents in urban NSW and what, if any, additional support GPs, nurses and Aboriginal health workers need to provide appropriate mental health care to Aboriginal young people.

Each of the above components of this project are reported severally within this single report.

Project A – Best practice for mental health care delivery for Aboriginal young people: A narrative review

DESCRIPTION OF THE PROJECT

This narrative review explores what is known about ideal care pathways in mental health, with a specific focus on Aboriginal young people in Australia, within the general practice setting. In Australia, the general practice setting acts as a gateway to specialist health services, including mental health care⁽³²⁾. As well, evidence suggests that mental health-related consults to GPs are made more frequently by Aboriginal people than non-Aboriginal people⁽³³⁾. This access pattern may be related to continued socio-economic disadvantage in Aboriginal communities⁽³⁴⁾, which may hinder access to other mental health services such as private psychologists. Given that the primary health care setting may play an important role in the pathways to mental health care for Aboriginal people, and Aboriginal young people in particular, a better understanding of current trends, as well as related barriers and facilitators to care in this setting has the potential to contribute to the systematic improvement of the health of future generations of Aboriginal people.

While western cultures tend to dichotomise health into physical and mental domains, the term 'Social and Emotional Wellbeing' (SEWB) reflects the holistic understanding of health among Aboriginal cultures as well as the connections of the individual to the community, and has been described thoroughly in other publications^(12, 35). From here on, though they are distinct concepts culturally and in practice, mental health and SEWB will be used interchangeably, as research examining service delivery in an Aboriginal and non-Aboriginal setting will be discussed. As well, for the purpose of this report, the term 'young people' will refer to all individuals of 0-18 years, inclusive.

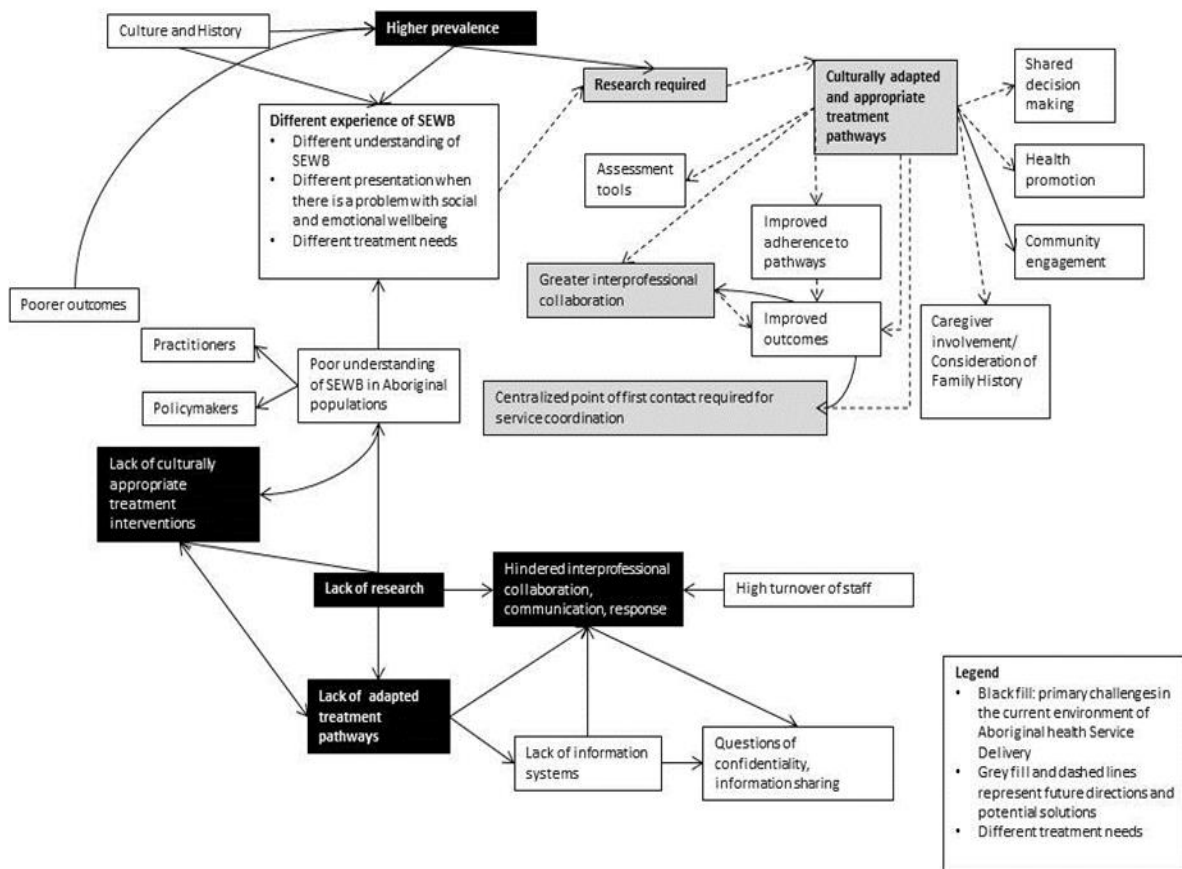
METHODS

A comprehensive search of databases was conducted to find published guidelines, as well as descriptive studies, reports and reviews that concern the delivery of mental health care in a primary care setting. A wide range of databases were searched, including, AMED, Embase, Global Health, Health and Psychosocial Instruments, Healthstar, MEDLINE, PsychINFO *via* Ovid, CINAHL *via* EBSCO, The Cochrane Library, Indigenous Collections, Informit and Health Systems Evidence. The search was filtered by 'Humans/English language/child or adolescent (0-18)/abstract available' where possible. No limits were set for date of publication. Additional references were identified *via* the 'snowballing' method, wherein reference lists of reviewed publications were assessed. This process was supplemented by searching Google Scholar.

RESULTS

Our narrative review has identified several interconnected themes that emerge from the existing literature regarding Aboriginal SEWB. Individual factors are explained in depth, while the connections between these factors summarised in Figure 1.

Figure 1: Aboriginal Social and Emotional Wellbeing (SEWB)



Current challenges

Lack of research

The higher prevalence of mental health disorders among Aboriginal populations related to a wide range of current and historical factors that are acknowledged and supported in the literature. The Western Australian Aboriginal Child Health Survey (WAACHS) found that 21% of Aboriginal young people were at high risk of clinically significant emotional or behavioural difficulties. Comparatively, only 7% of non-Aboriginal young people faced similar risks⁽⁶⁾. Similar results have been replicated across the majority of community surveys⁽³⁶⁾. Yet, despite a clear need for research to guide mental health interventions in Aboriginal populations, there is a lack of research on this topic and significant limitations to the existing evidence base.

Firstly, as demonstrated by Black et al., many of the studies exploring Aboriginal mental health are based on a sample of incarcerated adults, and as such are not appropriate sources to inform an understanding of SEWB among Aboriginal young people in a community setting⁽¹⁴⁾. Moreover, a 2013 systematic review found that less than 6% of all descriptive studies on Australian Indigenous (Aboriginal and Torres Strait Islander) young people aged 10-24 years of age focused on mental health issues other than substance abuse and outside of incarceration⁽³⁷⁾. In most national paediatric data sets, including the Longitudinal Study of Australian Children, the child component of the National Survey of Mental Health and Wellbeing, as well as research from the Australian Paediatric Surveillance Unit (APSU), Aboriginal children are proportionally underrepresented and the included sample of Aboriginal children rarely represents the diversity of Aboriginal cultures in Australia⁽³⁸⁾.

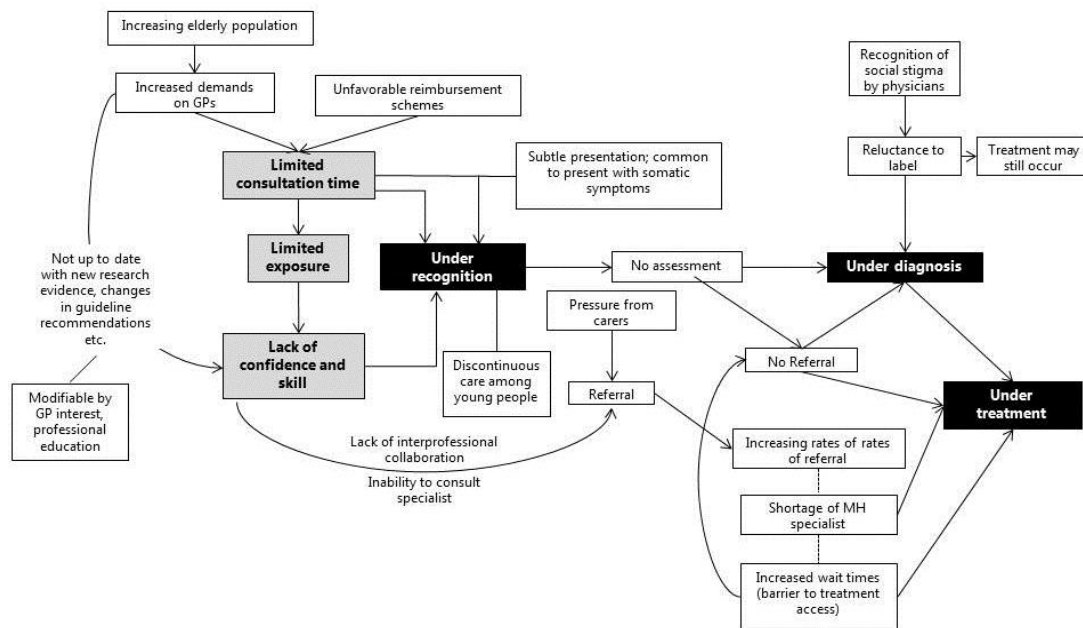
When looking towards community-based studies, a paradox seems to emerge. While national, longitudinal data sets are not necessarily applicable to individual communities, and thus may be limited in their use to inform specific interventions, community-based studies are often not continuous nor sufficiently comprehensive to be applied in a nation-wide policy-making context ⁽³⁶⁾.

This poor understanding of Aboriginal SEWB is a barrier to the delivery of culturally safe care by mainstream services in many ways. Firstly, without a validated theoretical framework, cultural competency is difficult to teach effectively during medical training and is difficult for individual clinicians to achieve in practice ⁽³⁹⁾. Moreover, lack of empirical research on the topic hinders the development of evidence-informed policy to drive systemic change in service delivery ^(30, 39). Several studies support the findings that mental health care pathways and systems lack cultural appropriateness; that services and care settings are insufficiently culturally safe, and that there is a lack of appropriate modification to and responsiveness of mainstream protocols to Aboriginal needs ^(12, 30, 31, 40, 41). This lack of cultural appropriateness can hinder access to services, thus contributing to poorer health outcomes. This cycle may partially explain and maintain the higher prevalence of poor SEWB in Aboriginal communities ⁽³⁹⁾.

Pathways to mental health care

Goldberg and Huxley's model of pathways to care provides a framework for understanding the movement of patients into and through the health-care system ⁽⁴²⁾. The model proposes that the mental health care system can be conceptualised in terms of five discrete sectors of care, from community to inpatient specialist mental health care. Sectors are separated by filters that reflect factors such as accessibility and patient values, as well as consultation, diagnostic, referral and admission procedures and decisions ^(42, 43). Figure 2 presents factors identified through this literature review that influence an individual's passage through the filters and sectors, thus determining the treatment trajectory.

Figure 2: Factors influence mental healthcare pathways in Australia



Despite recommendations for and evidence of an increased role for GPs in mental health care in Australia ^(44, 45), the current role of GPs and other health care professionals in the mental health sector has not been clearly articulated. Specifically, we were unable to identify any studies that have directly examined detailed pathways to mental health care and service use, and treatment patterns among Aboriginal young people.

The research regarding pathways to care is also lacking in the broader Australian population. In the only study that was identified explicitly investigating pathways to care in an Australian health care setting, the sample consisted of Australian-born Asian and Arabic speaking adult patients. This study illustrated that a wide range of pathways was followed to access and receive adequate mental health care. The majority (60%) of pathways included contact with two or more professionals, with an average of three professional consultations, over a median period of six months, prior to first contact with public mental health services. In addition to emphasising that pathways are often quite convoluted, this study showed that 53% of pathways included a consultation with a GP therein confirming that GPs play a primary role in the pathway to mental health care ⁽⁴⁶⁾. Similarly, Sawyer et al., found that, among Australian children seeking professional help for mental health concerns, approximately 50% had attended a family doctor or paediatrician, or had received counselling at school ⁽⁴⁷⁾. There is additional evidence suggesting that school-based mental health services, such as counselling, may play an important part in the pathway for some populations ⁽⁴⁸⁾, and some evidence suggests that this may also be true in Aboriginal populations ⁽⁴⁹⁾, though further research is needed into the development of culturally appropriate programs.

Barriers to effective mental health care in general practice

Barrier 1: Low service use and patient help-seeking

The second Australian Child and Adolescent Survey of Mental Health and Wellbeing, one of the most current and comprehensive documents concerning the mental health of young people in Australia, is explicitly unable to draw conclusions on the prevalence of mental health challenges and patterns of service use among Aboriginal young people, once again emphasising the paucity of research on this topic ⁽⁵⁰⁾. Of note, the WAACHS found that mental health service use was associated with emotional and behavioural difficulties in Aboriginal children, with those at higher risk being more likely to use services than those at low risk. However, service use was low, even among high risk patients. Only 8% and 22% of high risk patients aged 4-11 and 12-17 respectively, were in contact with mental health services ⁽⁵¹⁾.

Factors that may hinder help seeking in both Aboriginal and non-Aboriginal populations of young people include stigma ^(31, 48, 52-55), poor accessibility to services ^(54, 56, 57), lack of service awareness ^(48, 53, 54, 56) the perception that GPs are not associated with mental health ^(48, 52, 55) and reliance on informal supports ^(53, 57). Accessibility includes factors such as transport, waitlists and costs and should be considered when planning service interventions, particularly in a rural setting.

Caregivers who recognise mental distress among young people and have positive attitudes about help seeking can promote service use ^(52, 58, 59). An Australian study found that greater contact with one's social support system was associated with increased help seeking ⁽⁴⁶⁾.

Barrier 2: Under-recognition and under-diagnoses

The under recognition of mental health disorders by GPs has been identified as a primary barrier to receiving treatments and/or appropriate referrals ⁽⁶⁰⁾. Though specific research examining GP confidence and accuracy in the detection of mental health problems among

Aboriginal young people could not be identified, the evidence suggests that GP detection rates of mental health concerns in a wide range of populations is low^(60, 61). Across the literature, GP recognition has a high specificity (low false positive) but lower sensitivity (low true positive)^(57, 61-69). In an Australian sample of GPs and adult patients, the specificity was 87%, while sensitivity was 51%⁽⁶⁴⁾. Though rates vary across providers, patient groups and practice settings^(62, 65), this finding is consistent with international studies⁽⁶²⁾. Multiple contributing factors have been proposed in the literature to explain under-recognition of mental health conditions in primary care.

Patient presentation

Evidence suggests that the presentation of young people with mental disorders in primary care may be complex, with physical symptoms often presented as the main concern, thus complicating recognition^(62, 69-72). This pattern of presentation may also be seen among Aboriginal patients. In a survey of a Central Australian Aboriginal population, Jones and de la Horne noted high rates of physical symptoms associated with mood disorders^(12, 73, 74). Consideration of presentation is important, as a meta-analysis, not limited to a population of Aboriginal young people, found that the presentation of patients to primary care was associated with detection rates. Specifically, patients presenting with explicit psychological complaints had higher rates of detection⁽⁶⁵⁾.

Limited consultation time

As mental health concerns are often covert and patients may be reluctant to discuss these concerns with their practitioner^(55, 70, 75), extended consultations may be required to facilitate recognition, diagnosis and management. Aboriginal mentors and Aboriginal Health Workers (AHWs) in urban New South Wales have emphasised the importance of allowing adequate consultation time for the relationship-building necessary for disclosure⁽⁷⁶⁾. However, limited consultation time, particularly with youth, is repeatedly reported by GPs^(52, 55, 59, 62, 65, 70, 72, 75, 77-80). Concordantly, feeling rushed during medical consultations has been a sentiment expressed by members of Aboriginal communities in urban New South Wales⁽⁷⁶⁾. Some literature hypothesises that, related to inadequate consultation times, GPs might not be probing enough in regards to SEWB for adolescents⁽⁵⁵⁾, thus partially explaining the previously discussed low rates of detection^(57, 61-65, 67-69, 77, 81). Notably, a British study found that whether or not psychological issues were discussed was a predictor of recognition of mental health problems among adolescents, but that such discussions took place during less than 20% of consultations⁽⁶⁸⁾. Supplementary evidence indicates that for some GPs, reimbursement schemes may also play a role in determining amount of time spent with patients and decision to treat^(75, 77, 82).

Lack of confidence

There is evidence that current practitioners do not feel confident providing care to young Aboriginal people. Specifically, children, youth and Aboriginal populations were identified by a group of rural physicians in Western Australia as groups that are difficult to manage⁽⁷⁸⁾. There is also a lack of confidence regarding mental health diagnosis and treatment more generally. In an Australian study insufficient knowledge regarding proper diagnosis and uncertainty regarding treatment approaches were barriers identified by 56% and 36% of GPs in the study, respectively⁽⁷⁵⁾. The same study demonstrated that self-reported confidence in diagnosing and treating patients was lowest for children, and varied by condition and treatment intervention⁽⁷⁵⁾. Some evidence points to increased physicians' confidence for pharmacological interventions, as compared to psychological interventions^(70, 75), though low confidence for pharmacological interventions among GPs has also been reported⁽⁸²⁾. Low confidence may be related to medical training; physicians trained in Australia expressed dissatisfaction with their medical training in counselling^(78, 83).

Referral patterns

Though some mental health conditions, such as ADHD, require a referral to a secondary care clinician⁽⁸⁴⁾, guidelines for other disorders such as depression⁽²⁵⁾ promote their diagnosis and management by GPs in a primary care setting. Data from the 'Bettering the Evaluation and Care of Health' (BEACH) study published in 2011, indicated that the majority of referrals from GP for paediatric mental health problems in the general population were to psychologists (27%), and paediatricians (28%). Referral rates to psychiatrists and to speech therapists were much lower at approximately 6% each⁽⁴⁴⁾. Comparable referral rates were seen elsewhere⁽⁸⁵⁾.

Though there is little current data on referral practices specific to Aboriginal patients, research on practice trends among Australian GPs indicates overall increasing rate of referrals to secondary care for paediatric patients presenting with behavioural or mental health conditions. This includes high rates of referral for paediatric mental health disorders that can be managed in general practice. Specifically, more than 40% of patients presenting with anxiety and depression received referrals from general practice registrars⁽⁸⁵⁾. This practice trend may have consequences for the care pathway by increasing wait times to secondary care^(70, 85).

High rates of referral have been attributed to lack of confidence and skill in working with paediatric mental health problems amongst GPs^(44, 66, 75, 85). In addition, the need for counselling was a primary reason cited to justify referrals. This aligns with the previous research reporting decreased confidence with and perceptions of inadequate medical training to provide counselling⁽⁷⁵⁾. In addition to being driven by lack of confidence and skill, increasing rates of referral may also be related to the demands on GPs to manage a wide range of conditions in a wide range of patients with varying needs^(75, 85). The high demand on GP services may also hinder their ability remain up to date with new developments in the field, further decreasing confidence⁽⁸⁵⁾. A possible additional factor contributing to high rates of referral is pressure from carers⁽⁸⁵⁾. Leahy et al. suggested that promoting an understanding among GPs of interventions that can be initiated in primary care could decrease the rate of inappropriate referral and increase access to treatment⁽⁵²⁾. Additional research is required to understand where and for what reasons Aboriginal young people are referred after their presentation to primary care with a mental health concern.

Additional factors

Though there is no research regarding GP recognition of mental health challenges in Aboriginal young people, recurring themes in the research concerning the general population may merit consideration. Across multiple studies, under-recognition by GPs is concentrated among less severe cases likely related to more subtle presentations that require a longer, more detailed examination. These rarely occur in a primary care setting. On the other hand, more severe cases are often recognised and responded to appropriately by GPs^(43, 62, 65, 67-69, 71, 86-88). Moreover, caregiver^(60, 62, 81) and self-recognition^(54, 67-69) of the problem, presented as expressions of concern or demands for referral, can be related to severity and presence of comorbidity and have been found to be positively correlated with service access and GP recognition. It is clear that there are multiple factors that affect GP recognition and further research is required to better understand the relative impact of each factor on GP recognition in Aboriginal patients.

Barrier 3: Under-treatment

Once a patient has sought help and has been recognised by a health care professional as requiring treatment, there are still various barriers that may hinder access to treatment thus resulting in the under-treatment of mental health conditions⁽⁴²⁾. There is little evidence specifically regarding treatment rates in Aboriginal populations and thus it is difficult to conclude to what extent under-treatment is a significant problem among Aboriginal patients.

However, data from the Australian Institute of Health and Welfare (AIHW) indicates that there are higher proportions of mental health-related presentations to the emergency room⁽⁸⁹⁾ and higher rates of hospitalisation for mental health amongst Aboriginal people⁽⁹⁰⁾, compared with non-Aboriginal people, which suggests that current treatment options for Aboriginal patients are suboptimal. In the general population, factors related to under-treatment include a lack of access to, and associated wait times with, mental health specialist services, including services targeted at youth^(52, 55, 57, 75, 78). Additional challenges to detection and treatment in an Aboriginal setting include a lack of sustainable services and resources, shame and stigma, as well as providers' limited knowledge regarding Aboriginal culture and mental health⁽³¹⁾.

Other challenges

A high turnover of staff has been noted in health care services in Aboriginal communities, particularly in rural and remote communities in Central Australia^(31, 40) and the Top End of the Northern Territory⁽³¹⁾. As the pathways of individual patients can be altered and made discontinuous by changes in staff, this is an additional factor that complicates the treatment process.

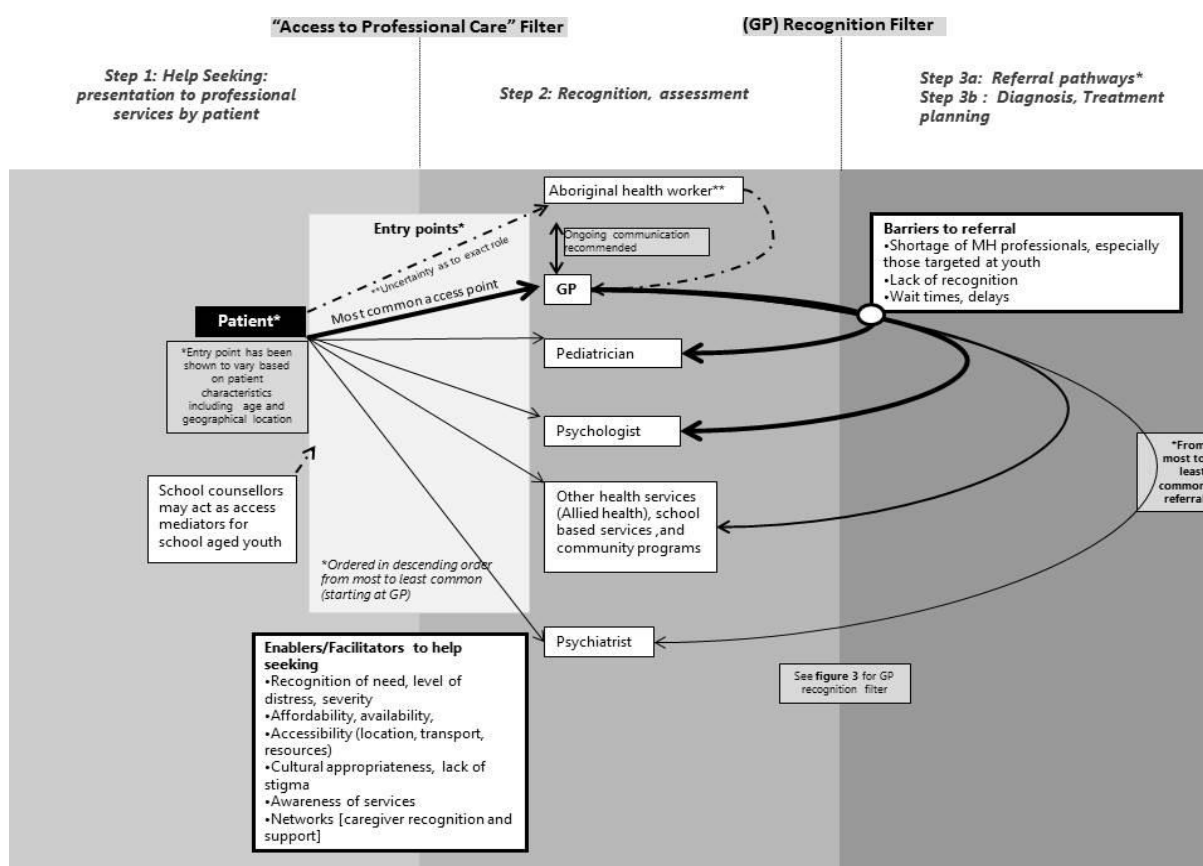
Concern that information sharing to facilitate inter-professional collaboration may jeopardise confidentiality was a recurring theme in the literature on the mental health of Aboriginal young people^(40, 53, 91). Formalised care pathways have the potential to address this concern by creating schemes in which it is clear to all parties which information should be shared, and how. Care pathways can also promote the creation of secure information systems to facilitate this process, while respecting and maintaining patient confidentiality⁽⁹²⁾. Moreover information systems can facilitate service linkage⁽⁹³⁾, as well as collect and provide valuable feedback about outcomes and inform decision making, planning and further modification^(91, 92).

Overall, the current body of evidence emphasises that an absence of pathways to guide care is a significant barrier to effective and efficient mental health service delivery in an Aboriginal setting as it hinders inter-professional collaboration and service coordination. Without pathways to guide care, the roles of various professionals involved are imprecisely defined, and there are no formalised communication routes to facilitate coordination, information sharing and the delegation of responsibilities^(31, 40, 78, 91, 92, 94, 95).

FUTURE DIRECTIONS TO IMPROVE TREATMENT PATHWAYS FOR ABORIGINAL YOUNG PEOPLE

It is clear that little is known about help-seeking, referral and treatment patterns for Aboriginal young people seeking support for mental health concerns. Moreover, despite the potential of care pathways to improve efficiency, effectiveness and cultural responsiveness of service delivery, there have not been any pathways specifically adapted for and validated in Aboriginal communities. Given the need for a concentrated effort to develop, validate and disseminate culturally responsive pathways, our review has identified several elements with broad support in the literature for their potential to improve Aboriginal SEWB. These are summarised in Figure 3.

Figure 3: Mental healthcare pathways of Aboriginal children in Australia



Central coordination and flexibility

In the development of a referral pathway model to respond to high rates of Aboriginal youth suicide and attempted suicide in Central Australia, Taylor et al., emphasised the need for a centralised point of first contact to facilitate service access and aid in the coordination of referrals. They also called for the development of data collection systems to help understand patterns, needs and improve the targeting of responses, as well as facilitate the communication and feedback mechanisms within and between services⁽⁹¹⁾. These recommendations may be applicable to other mental health challenges in Aboriginal populations, particularly as they have been echoed in the literature examining mainstream Australian mental health care^(92, 93). In addition to creating centrally-coordinated pathways, the literature emphasises that mental health care pathways must be flexible and take into account various factors that determine service use and trajectories, particularly in Aboriginal populations^(31, 39, 72). This includes geographical location, age, cultural background and other demographic factors.

Concerning geographical location, the ‘Footprints in Time’ reports provide evidence that service access, including the *type* of service that is accessed, as well as how often, and for what conditions, may be dependent on remoteness. Specifically, families in areas of no isolation were much more likely to take their child to a doctor’s surgery or clinic, while families in very isolated areas were much more likely to access health services at a community health centre or clinic, including an Aboriginal Community Controlled Health Service (ACCHS)⁽⁹⁶⁾. Rural and urban settings may also impact on experiences of stigma, accessibility of services and help-seeking behaviours^(48, 56, 95, 97).

Treatment pathways, and especially entry points, may also vary based on age. Sawyer et al., found that 4–12-year-old children, with mental health problems most frequently attended

paediatricians and family doctors. In contrast, school-based counselling was the service most frequently used by adolescents ⁽⁴⁷⁾. It should be noted that though this study did not specifically explore service use among Aboriginal children, it reinforces the idea that pathways for Aboriginal youth should consider age-based differences in service use.

In addition to being modifiable based on individual characteristics of patients, care pathways need to be responsive to local contexts, considerations and constraints ^(40, 98). The importance of flexibility was echoed in a study examining the uptake of an integrated care pathway for mental health care delivery in a community setting; multiple stakeholders recognised that flexibility would enhance uptake of guidelines and improve care for patients ⁽⁹⁹⁾.

Cultural modifications *via* caregiver and community involvement

Though the existing body of evidence suggests that current mental health service delivery is not culturally responsive to the needs of Aboriginal young people, Hinton et al., found that there was a range of treatment options that were considered appropriate by Aboriginal communities, with an emphasis on community-based resources and cultural activities ⁽³¹⁾. This finding should be considered when developing treatment pathways.

Aboriginal Health Workers, cultural consultants, community members and elders, as well as patients themselves, have the potential to inform appropriate cultural modifications and should be actively consulted throughout the treatment process ⁽³⁹⁾. These stakeholders, as well as caregivers, family members, and support networks more broadly, act as enablers to care, and the importance of involving these individuals in care pathways is consistently reiterated in the literature ^(31, 40, 41, 91, 94, 100). Mohajer et al. established that family was considered to be the most important support for Aboriginal patients ⁽¹⁰⁰⁾, while Williamson et al. found that Aboriginal participants felt that the observation of familial interactions and relations is fundamental to the accurate assessment of young people's mental health ⁽⁹⁴⁾. Similarly, Lampe et al., in a survey of Australian GPs not limited to Aboriginal patients, reported that GPs felt that "family history [is] essential to understanding the patient and making a diagnosis" ⁽⁷²⁾. Despite this evidence, our search did not yield many studies that assessed the extent to which families were invited to participate in the treatment pathway in practice, among Aboriginal patients or otherwise. One study, not limited to an Aboriginal population, examined the roles of the caregiver, client (aged 12-24) and clinician in decision-making in a mental health context. The study found that, while there was significant variation in what was occurring in client experience, most clients did not report caregiver involvement in the decision making process ⁽¹⁰¹⁾. Future research initiatives may be warranted to determine how best to facilitate positive caregiver involvement and to delineate its conclusive benefits.

In addition to caregiver and family involvement, Hinton et al. also proposed cultural awareness training for non-Aboriginal staff, to increase the cultural safety of the services that are being delivered ⁽³¹⁾, while ongoing cultural supervision was proposed elsewhere ⁽³⁹⁾. Additional propositions include the continuous training for all service providers, including Aboriginal community members involved in treatment, in order to ensure consistent, high quality care and promote the uptake of and adherence to guidelines ⁽⁴⁰⁾.

Finally, Westerman indicates that cultural adaptations, and good practices that ensure the cultural responsiveness of a service need to be shared across services and systems in order to promote the empirical and cultural validation of these practices across different contexts and increase uptake at the both the level of the individual clinician and systematically ⁽³⁹⁾.

Health promotion and information provision

The body of literature to inform treatment pathways for Aboriginal young people emphasises the need for early intervention, health promotion and information provision to increase community engagement and awareness of the issues, signs and symptoms and available programs as well as decrease cultural stigma, thus facilitating help seeking, implementation and uptake of any guidelines or pathways^(31, 53, 57, 72, 91). There have been several successful examples of initiatives in Aboriginal communities that have been designed with the aim of improving health literacy⁽¹⁰²⁻¹⁰⁵⁾. Future initiatives should follow these examples and partner with community members to ensure cultural appropriateness and maximise the impact of health promotion in Aboriginal communities.

DISCUSSION

This literature review found that very little is known about ideal or actual pathways for the treatment of mental health concerns in Aboriginal youth. Moreover, descriptions and evaluations of current practice trends and their effectiveness are essentially non-existent. Despite this lack of research, the need for evidence-based improvements in mental health service delivery is undeniably urgent, given the disproportionate burden of social and emotional wellbeing concerns; the existing evidence that current services are insufficient, as reflected in higher rates of emergency room presentation and hospitalisation, and the tragic long-term consequences of untreated mental distress, including suicide, in Aboriginal populations.

It is also likely that barriers accessing mental health care observed in the general population are exacerbated in Aboriginal settings, given the challenges of accessing services that are not culturally responsive, and the complex socio-cultural factors that play a role in the experience of mental illness in this population. Without a specific understanding of practice trends in Aboriginal settings, as well as barriers and facilitators at various stages of the pathway, it may be almost impossible to understand how to develop desperately needed solutions and interventions to ensure equitable health service access and delivery. As such, through our analysis we emphasise the role of research in informing the development and implementation of culturally appropriate care pathways for Aboriginal young people seeking treatment for mental health concerns, and the need for continuous modifications based on the results of constant monitoring and evaluation. Research can also play a role in informing complementary public policy initiatives that are necessary to drive change at the systemic level, thus ensuring the long-term success and sustainability of future interventions.

In an attempt to drive improved service delivery in Aboriginal health, we identified elements of culturally appropriate care that have wide support in the literature,

- > the use of assessment tools and treatments that have been validated in Aboriginal populations
- > the recognition of the importance of families and caregivers by involving them in the decision making and treatment process with client consent
- > an acknowledgement of the role of the community in health promotion, and,
- > greater inter-professional collaboration and information-sharing through the establishment of central points of first contact, responsible for the coordination of service delivery and communication.

Though comprehensive best practices for mental health care in this population have not yet been identified, there is significant potential to achieve improvements in service delivery for Aboriginal young people by relying on existing evidence as well as the input and leadership of Aboriginal Australians to trial the implementation of the promising strategies identified here.

Project B – Assessing the extent of evidence-informed practice in response to the mental health needs of Aboriginal young people in a primary care setting

DESCRIPTION OF THE PROJECT

Considering the high prevalence of mental health disorders ^(30, 31), the patterns of low service use ⁽³⁰⁾, and the intersection of culture on the understanding and experiences of social and emotional wellbeing (SEWB) ^(12, 30, 106), there is some evidence that suggests that Aboriginal youth may have some unique needs in terms of mental health service delivery and treatment ^(12, 30, 31, 39, 107, 108). While guidelines for specific diagnoses have been developed to inform care for mainstream populations, it is unclear whether guidelines for prevalent mental health conditions have been modified to aid providers in addressing the needs of Aboriginal young people presenting with SEWB-related concerns.

In response to this gap in the literature, this review examines the extent to which guidance for the treatment of common mental health disorders in Aboriginal young people is available to inform practice in a primary care setting. This review also considers the evidence that exists to assess uptake of any existing guidelines in practice. Based on a review of the literature, we focused our research on five conditions, as there is evidence that these are particularly prevalent in young people in the general population ^(44, 109), as well as in Aboriginal and Torres Strait Islander young people ⁽¹²⁾.

- > attention deficit hyperactivity disorder (ADHD)
- > major depressive disorder (MDD)
- > post-traumatic stress disorder (PTSD)
- > generalised anxiety disorder (GAD), and
- > conduct disorder (CD)

METHODS

A comprehensive search of databases was conducted to find published guidelines, as well as peer-reviewed descriptive studies and reviews that concern the delivery of mental health care in a primary care setting, with a specific focus on the five aforementioned conditions and the specified population. A wide range of databases was searched, including, AMED, Embase, Global Health, Health and Psychosocial Instruments, Healthstar, MEDLINE, PsychINFO *via* Ovid, CINAHL *via* EBSCO, The Cochrane Library, Indigenous Collections Informit and Health Systems Evidence. The search was filtered by 'Humans/English language/child or adolescent (0-18)/abstract available' where possible. No limits were set for date of publication. Additional references were identified *via* the 'snowballing' method, wherein reference lists of reviewed publications were assessed. This process was supplemented by searching Google Scholar.

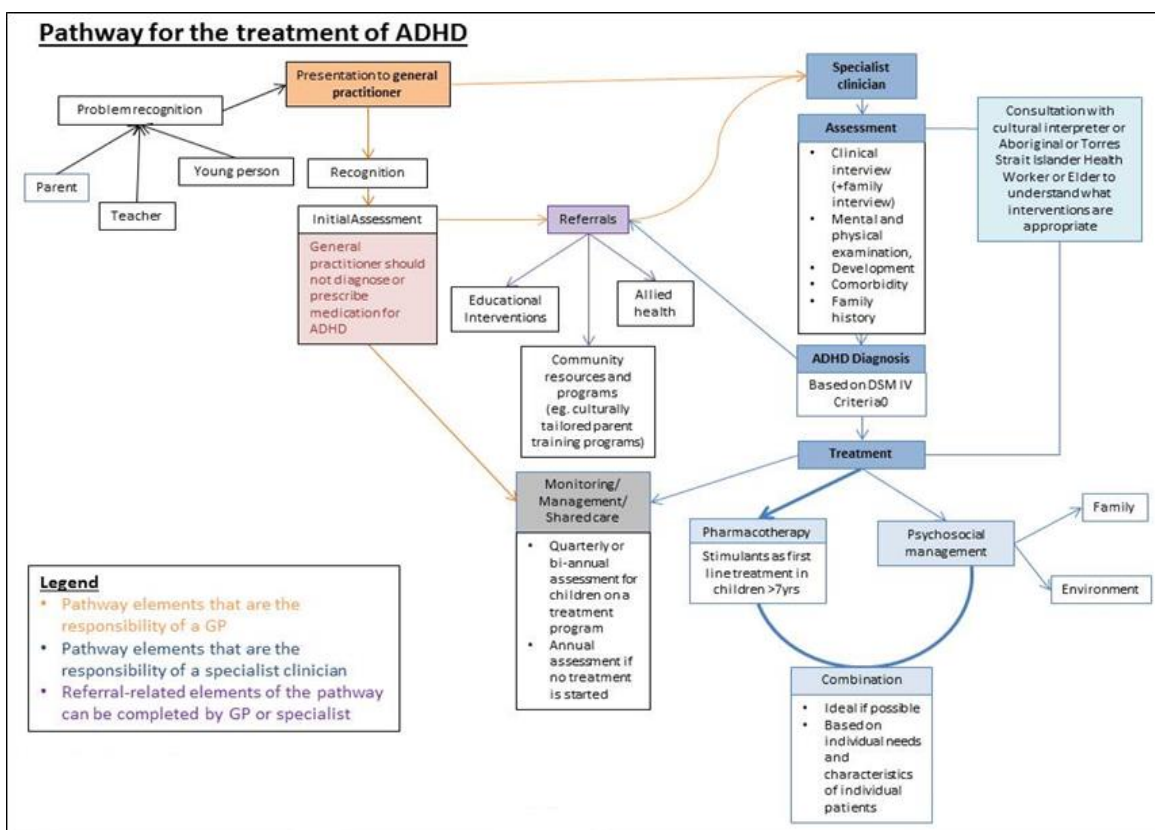
RESULTS

The results of our literature review are summarised according to diagnosis, despite the fact that many of these diagnoses are comorbid with one another.

Attention Deficit Hyperactivity Disorder (ADHD)

In 2000, the prevalence of ADHD in an Australian paediatric population was estimated to be approximately 11.2% ⁽¹⁰⁹⁾. Data from an audit of paediatric practice conducted in 2008 indicates that, among all children that presented to a paediatrician for any reason, 18% received a diagnosis of ADHD, making it the most frequent diagnosis in a secondary paediatric setting ⁽¹¹⁰⁾. Recognising the prevalence of this condition in the paediatric population, the National Health and Medical Research Council (NHMRC) issued a document of clinical practice points (CPPs) to inform the management of ADHD ⁽¹¹¹⁾. These guidelines have been summarised in Figure 4.

Figure 4: ADHD pathway



Adapted from the National Health and Medical Research Council's 'Clinical Practice points on the diagnosis, assessment and management of attention deficit hyperactivity disorder in children and adolescents. Commonwealth of Australia, 2012'.

Considerations specific to Aboriginal populations

The Australian Clinical Practice Points (CPPs) indicate that potential modifications may be required for the recognition, diagnosis and management of ADHD among children and adolescents of an Aboriginal or Torres Strait Islander background. Specifically, the guidelines encourage consultation with a cultural interpreter/consultant, Aboriginal mental health worker, or Elder.

Other than parent training programs that have been validated in Aboriginal populations ^(112, 113), there is limited evidence of effective interventions for Aboriginal and Torres Strait

Islander populations ⁽¹¹¹⁾. The lack of Aboriginal-specific research to inform the management of ADHD was reflected in the results of our literature review, as well as in other studies ⁽¹¹⁴⁾

Through discussions with 27 caregivers of children with ADHD from Aboriginal communities in urban Perth, Western Australia, Loh et al. provide some much needed insight into Aboriginal perceptions of and attitude towards the diagnosis of ADHD and various treatment options ⁽¹¹⁴⁾. Though ADHD-related behaviours were recognised as undesirable, past negative experiences and the view that these medications slowed children down made caregivers hesitant to pursue pharmacological treatment ⁽¹¹⁴⁾. Caregivers supported non-pharmacological interventions and combinations of interventions that would reduce ADHD symptoms ⁽¹¹⁴⁾. Caregivers emphasised that a one-size-fits-all approach to treatment was ineffective and that the wider family and social context must be considered in developing a treatment plan ⁽¹¹⁴⁾. Though assessment and response to individual, familial and cultural needs are included in the Australian CPPs ⁽¹¹¹⁾, this qualitative finding provides evidence that these guidelines may not be systematically implemented in practice.

Evidence confirms that preliminary research with the target audience is necessary to ensure that messages are tailored to the needs and preferences of the intended population ⁽¹¹⁵⁾. Following this model, the Australian Integrated Mental Health initiative in the Northern Territory (AIMHI NT) developed the story telling project with an aim of improving mental health literacy in an Aboriginal setting ⁽¹⁰²⁾. The project was developed in consultation with Aboriginal community members and received positive feedback from stakeholders ⁽¹⁰²⁾. As well, a mental health first aid (MHFA) course was developed to address the need for mental health literacy in the general population and to provide information on how to assist an individual who is developing a mental illness or in a mental health crisis ^(116, 117). In consultation with Aboriginal people, MHFA has since been adapted for Aboriginal adults, with evaluations indicating promising results ⁽¹⁰³⁻¹⁰⁵⁾. Given these promising results, further research into strategies to improve mental health literacy in Aboriginal settings is warranted.

Finally, no study, to our knowledge, has evaluated the extent to which community services are implicated in the treatment of ADHD despite the recommendation in the CPPs ⁽¹¹¹⁾ and evidence of the importance of community linkages in Aboriginal health service delivery ^(31, 40, 41, 91, 94, 100).

Major Depressive Disorder (MDD)

The prevalence of depression in Australian young people was estimated to be approximately 3.7% in the year 2000 ⁽¹⁰⁹⁾. The estimated prevalence increases when a general practice setting is considered, where it has been reported to range between 10% and 23% ^(65, 70). Moreover, there is evidence of increased risk for and prevalence of depression in Aboriginal populations ^(25, 118). In 2011, beyondblue, an independent not-for-profit organisation that aims to combat mental health challenges, published Australian national guidelines to inform the management of depression in young people aged 13-24 ⁽²⁵⁾. A corresponding flow chart was not created as flowcharts to inform care in mainstream populations are included in the published guidelines ⁽²⁵⁾. Despite the existence of comprehensive national guidelines, there has been little research concerning the uptake of these guidelines in Australian general practice.

Internationally, there is a similar lack of research concerning practice trends in depression management. Specifically, a 2007 systematic review identified only 17 observational studies of depression in primary care ⁽¹¹⁹⁾. Though the review was international, most studies were conducted in the US and Europe, rather than Australia ⁽¹¹⁹⁾; and limiting the focus to young people or Aboriginal populations yields even fewer results ^(82, 119, 120).

The Guidelines for Adolescent Depression in Primary Care (GLAD-PC), which have been endorsed by several American and Canadian organisations, served as our primary international comparator ^(121, 122). These also include comprehensive flow charts to inform the

management of depression. There are several important similarities between these guidelines and Australian guidelines in terms of initial assessment and management of depression in young people. Australian and international guidelines recommend conducting a comprehensive assessment based on information from multiple informants ^(25, 121). Assessment tools may facilitate the comparison of symptoms with diagnostic criteria for depression based on the ICD-10 and DSM-IV-TR ^(25, 121). In order to inform care in Aboriginal populations, the Australian guidelines indicate that the Westerman Aboriginal Symptom Checklist—Youth (WASC-Y) is an appropriate tool to facilitate the identification of depression, anxiety, suicidal behaviours and self-esteem problems in Aboriginal young people aged 13 to 17 years ^(25, 123).

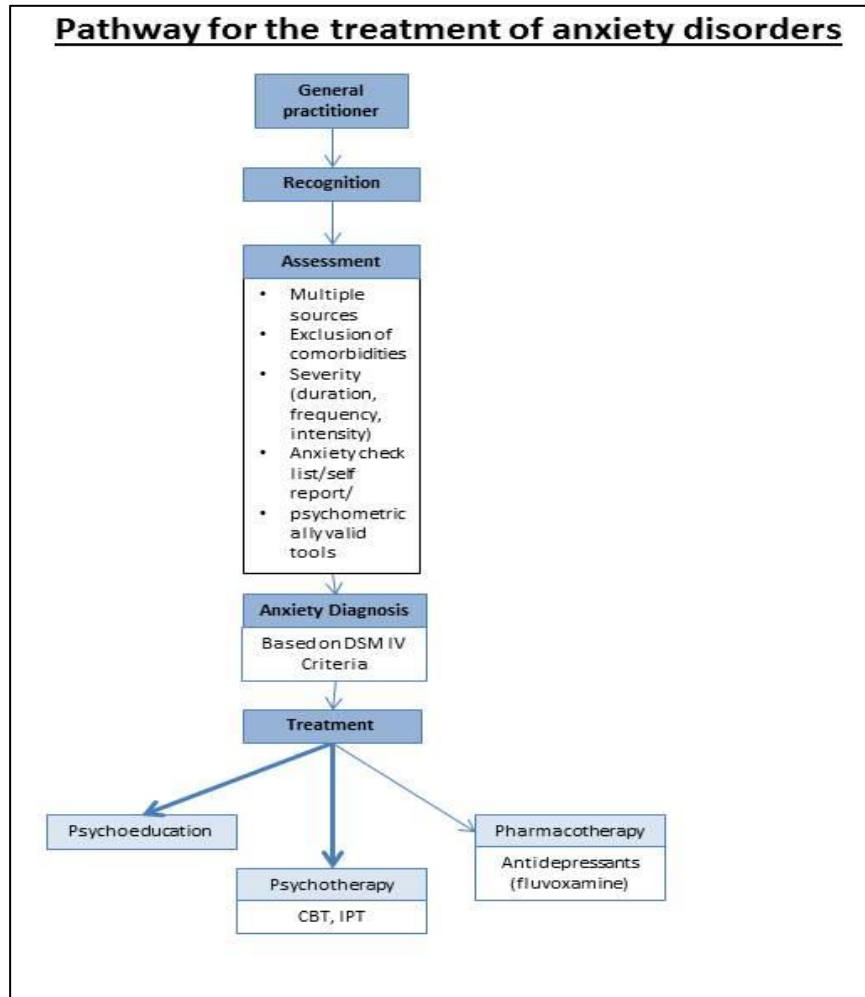
Considerations specific to Aboriginal young people

The Australian guidelines for depression emphasise the need for cultural responsiveness and propose several interventions, including increased Aboriginal staff, improved information provision and intersectoral collaboration ⁽²⁵⁾. However, as with the ADHD guidelines, no evidence-based modifications or treatment approaches are recommended. Moreover, there are no descriptive studies that can be used to understand current approaches or practice trends being applied in Aboriginal populations.

Generalised Anxiety Disorder (GAD)

Based on results from the second Australian Child and Adolescent Survey of Mental Health and Wellbeing, the current estimate prevalence of anxiety disorders among young people aged 4-17 is 6.9% ⁽¹²⁴⁾. As anxiety disorders include generalised anxiety disorder (GAD), social and specific phobias, obsessive compulsive disorder (OCD) and panic conditions, specific conclusions regarding the prevalence of GAD are not possible. The Royal Australian College of General Practitioners (RACGP) published a short description of strategies and procedures for the diagnosis, assessment and management of anxiety disorders in the general practice setting, however this was not specific to children ⁽¹²⁵⁾. The Australian Psychological Society briefly outlines treatment guideline points for 'childhood anxiety disorders' on their website ⁽¹²⁶⁾. The Western Australian Psychotropic Drugs Committee published guidelines specifically regarding the pharmacological treatment of anxiety disorders, including GAD ⁽¹²⁷⁾. These are summarised in a flow chart in Figure 5. Our primary international comparator was the set of practice parameters outlined by the American Academic of Child and Adolescent Psychiatry (AACAP) ⁽¹²⁸⁾.

Figure 5: Anxiety pathway



Considerations specific to Aboriginal young people

None of the three Australian guidelines listed above included any specific mention of modification for Aboriginal people, which represents a significant and urgent gap in research and care. The Westerman Aboriginal Symptom Checklist—Youth (WASC-Y) was recommended elsewhere for the assessment of anxiety in Aboriginal young people ^(12, 123).

To our knowledge, there exists no research on the management of GAD in an Australian Aboriginal setting, nor is there evidence of practice trends for the management of anxiety in the general population. Despite this, the results of the second Australian Child and Adolescent Survey of Mental Health and Wellbeing give some insight into elements related to the experience and treatment of anxiety among young people in the general population ⁽¹²⁴⁾.

Post-Traumatic Stress Disorder (PTSD)

Evidence of the rate and experience of PTSD is lacking among both Australian and Aboriginal children. Despite this, we felt that the consideration of PTSD in this publication was important for several reasons. Firstly, there is evidence of higher rates of PTSD among Aboriginal adults, as compared to the mainstream population ⁽¹²⁹⁾. Specifically, results from the 2007 Australian Survey of Mental Health and Wellbeing indicate that the prevalence of 12-month PTSD in the adult Australian general population was 6.4% ⁽¹³⁰⁾, while a survey of

221 Aboriginal people conducted in 2012, from three Western Australian towns, found that the rate of life time exposure to traumatic events was 97.3%, and that 55.2% of participants met the DSM-IV diagnostic criteria for PTSD ⁽¹³¹⁾. Secondly, trauma is an Aboriginal and Torres Strait Islander-identified determinant of SEWB ⁽¹²⁾ as there is evidence that trauma can contribute to mental distress. Trauma in Aboriginal communities stems from a wide range of experiences, including those related to the history of and current impacts of colonialism and as well as acute events in communities ^(12, 132-134). Additionally, there may be some differences in the experience of PTSD in Aboriginal populations as compared with mainstream populations. Specifically, evidence suggests that PTSD often co-exists with prolonged grief/depression in Aboriginal populations; and that trauma and grief in Aboriginal populations is experienced on a community level which in turn impacts younger generations ^(12, 132-134). The need to develop strategies and tools to manage PTSD in Aboriginal populations is great, given the observed high rates of comorbid mental health disorders, elevated risk of attempting suicide, and significant impacts on social functioning ⁽¹³⁵⁾.

Considerations specific to Aboriginal people

Given the complex intersection of Aboriginal culture and the experience of trauma, the Australian guidelines for the Treatment of Acute Stress Disorder (ASD) and PTSD devote a chapter to considering issues relevant to the application of the guidelines in specific populations, including Aboriginal and Torres Strait Islander peoples ⁽¹³²⁾. However, the guidelines were unable to offer evidence-based recommendations and despite conducting a systematic review on the topic, no studies related to the experience and treatment of PTSD in Aboriginal populations were identified ⁽¹³²⁾. As a result, the guidelines relied on expert opinion rather than evidence from the empirical literature to inform relevant recommendations ⁽¹³²⁾.

Based on expert opinion, the guidelines propose several action items that should be considered by practitioners working with Aboriginal populations in order to ensure a culturally-appropriate application of mainstream guidelines. Firstly, the guidelines emphasise that the assessment of PTSD should not be limited to a recent traumatic event, but should take into account previous traumatic experiences for a more holistic understanding of the current experience. In addition, the guidelines draw attention to culture-related differences in presentation. Additionally, the guidelines note that characteristics such as age and gender impact social interactions in Aboriginal populations and thus should be considered when treatment is being administered. The guidelines specifically draw attention to transgenerational issues that may affect interactions between practitioners and children ⁽¹³²⁾. The guidelines conclude that overall, there is no evidence that a radically different approach would be required; however, it is still concerning that current recommendations, or indeed any treatments for PTSD, have not been validated in an Aboriginal setting.

Considerations specific to young people

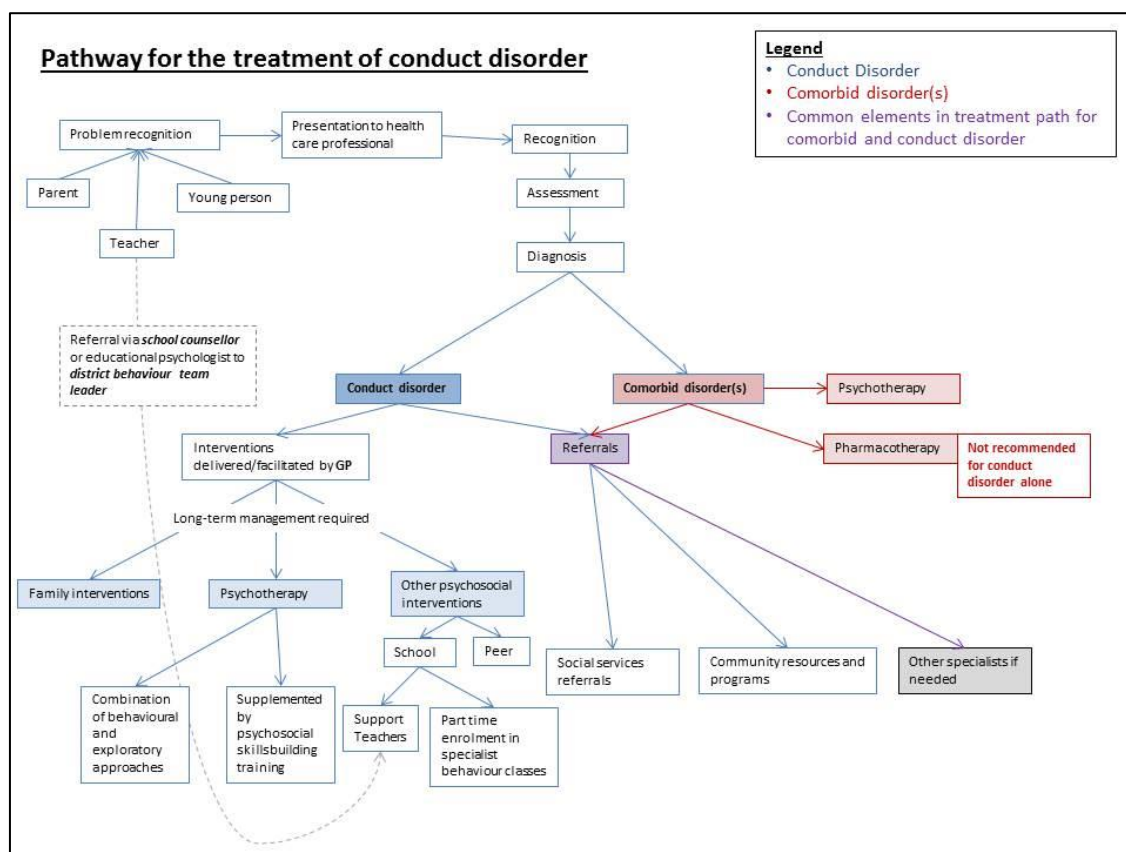
The mainstream guidelines specifically consider young people. Overall, it is postulated that, while most good practice points outlined in the guidelines apply across all age groups, engagement with family, including parents, may have particular importance in young populations as these stakeholders can modify help seeking, engagement, and adherence to treatment ⁽¹³²⁾. This may be particularly relevant to Aboriginal populations as several sources have emphasised the importance of family in the understanding of Aboriginal social and emotional wellbeing and promoting treatment uptake ^(94, 100). As well, it is noted that the evidence in mainstream populations points to a low rate of agreement between parents and children regarding internalising symptoms, thus consultations with both parties is recommended, even if the client is of a very young age ⁽¹³²⁾. The guidelines note that there

are few cost effective and valid screening tools for the identification of PTSD in children. This poses an additional challenge for practitioners ⁽¹³²⁾.

Conduct Disorder (CD)

The prevalence of conduct disorder (CD) in the Australian paediatric population was estimated to be approximately 3% ^(109, 136). There is evidence of a higher rate in Aboriginal populations, with the WAACHS concluding that greatest difference between Aboriginal and non-Aboriginal Strengths and Difficulty Questionnaire (SDQ) scores was related to conduct difficulties. The survey found that 31.4% Aboriginal young people were at high risk of clinically significant conduct problems compared with 13.1% of the non-Aboriginal sample ⁽⁶⁾. However, our literature review failed to identify Australian guidelines to guide the treatment of CD by general practitioners in a primary care setting. Given this lack of guidelines specific to an Australian general practice setting, Figure 6 summarises the treatment guidelines from other international organisations ⁽¹³⁷⁻¹⁴¹⁾.

Figure 6: Conduct Disorder pathway



According to multiple guidelines, the assessment of CD requires a multi-dimensional model relying on multiple informants to make a diagnosis based on DSM IV criteria and identify any comorbid disorders ⁽¹³⁷⁻¹⁴¹⁾. For assessment, the SDQ is completed by a parent, carer or teacher is recommended ⁽¹⁴¹⁾. This has been validated in an Aboriginal population ^(142, 143). Use of the Strengths and Difficulties Questionnaire is positive as a review of the literature from 1998-2008 examining psychometric measurement tools in Indigenous populations internationally found only six instruments that demonstrated adequate levels of reliability and validity within particular Indigenous communities. One of those instruments, the Flower of Two Soils (FOTS) module, included a component that was developed for CD. However, it was validated in an American Indigenous population and not an Australian Aboriginal

population⁽¹⁴⁴⁾. The importance of using validated assessment tools in Aboriginal populations has been emphasised as an important element of culturally appropriate mental health care^(12, 144). Though CBT has been modified and validated for use in an Indigenous population, cognitive problem solving therapy, a recommended intervention, has not been explicitly validated^(145, 146). Overall, no studies were located which evaluated the direct acceptability or impact of child-focused interventions in the treatment of conduct disorder amongst Aboriginal young people.

As there are no Australian guidelines, it follows that there are no explicit guidelines to inform management of CD in Australian Aboriginal young people. Moreover, there are no studies that give insight into the current practice trends in the management of conduct disorder among Aboriginal young people. The need to close this evidence gap was emphasised by Zubrick et al. who highlighted the need for epidemiological estimates of the burden of mental health disorders in order to inform interventions, given the relationship between mental health problems and outcomes such as juvenile delinquency, particularly for conditions such as CD^(136, 147). In addition, the lack of information about CD management for Aboriginal young people is concerning given the higher prevalence and the unique needs of this population.

DISCUSSION

Through a comprehensive literature review, we summarised the current state of mental health care for Australian Aboriginal young people. Though guidelines do exist for the management of common mental health disorders in a general population of young people, there are few explicit modifications to these guidelines to respond to the unique needs of Aboriginal young people. Our review indicates that Australian guidelines have been published for ADHD, MDD, GAD and PTSD, but no Australian treatment guidelines are available for the management of CD. Though most guidelines recognise the importance of cultural consultations, understanding and responsiveness, there are few frameworks to guide the implementation of cultural competence in practice⁽¹⁴⁸⁾. Moreover, terminology surrounding cultural competence varies, and a clear, consistent and accepted definition of cultural competence across various practice settings is lacking⁽¹⁴⁸⁾. As well, interventions to promote best practices for cultural competence in Aboriginal health care settings have not been systematically evaluated, leading to limited conclusions about their effectiveness and thus hindering wider dissemination^(148, 149). Given the limited amount of research and consensus on cultural competence and the evidence that there are significant gaps in achieving cultural competence in practice^(12, 31, 40, 41), there is a clear need for further research to define cultural competence and develop strategies for its acceptance and implementation in mainstream practice in order to improve service delivery for Aboriginal young people.

Project C - Exploring pathways to mental health care for children and adolescents attending SEARCH ACCHSs

DESCRIPTION OF THE PROJECT

Given the high burden of mental health-related harm Aboriginal children and adolescents experience ⁽¹⁵⁰⁾ it is essential that appropriate social and emotional services and support are available to them. In qualitative work previously conducted in partnership with Sydney Aboriginal Community Controlled Health Services (ACCHSs), however, Aboriginal parents, carers and health workers reported serious concerns about the shortage of mental health services available for young people and the many barriers families faced in letting their children and adolescents access the services that were available ⁽¹⁵¹⁾. ACCHSs were identified as places where families felt safe to seek help for social and emotional wellbeing issues, yet many services had no dedicated staff to provide this support. In this context, general practitioners (GPs) who are known to be the main providers of care for adults with common mental disorders ⁽¹⁵²⁾, emerge as the only source of mental health care for many Aboriginal children and adolescents.

The importance of GPs' role in the provision of mental health care for Aboriginal young people seems clear. The extent to which they feel equipped and supported to fulfil this role, however, is unknown. The small amount of research to date suggests that many GPs do not feel confident to assess or manage mental health problems in children and adolescents ⁽¹⁵³⁾. Furthermore, research suggests that GPs do not detect the majority of children and adolescents experiencing common mental health problems ⁽¹⁵⁴⁾ and only respond when levels of emotional distress are evidentially high ⁽¹⁵³⁾. As GPs are often a major gatekeeper to specialised mental health care,⁽⁶²⁾ the consequence of this is that many children and adolescents experiencing problems may not be offered professional help.

The reasons why GPs are less likely to assess and manage child and adolescent mental health problems have received little exploration, particularly in Australia and in regards to GPs servicing Aboriginal child populations. The small amount of international data available suggests that GPs consider themselves unskilled in this area ⁽¹⁵⁵⁾ and are reluctant to diagnose mental health conditions in this age group or to raise concerns about childrens' mental health with parents ⁽¹⁵⁶⁾. There is also research which suggests that parents often do not recognise or readily seek help for mental health concerns ^(157, 158). On the other hand, studies show that extended GP involvement in the assessment and management of emotional and behavioural problems in children and adolescents presenting to primary care leads to a reduction in referrals to mainstream and is welcomed by young people themselves and their families ⁽¹⁵⁹⁾.

The current study aims to discover what the pathways to mental health care are for Aboriginal children and adolescents in urban NSW and what, if any, additional support GPs, nurses and Aboriginal health workers need to provide appropriate mental health care to Aboriginal young people.

METHODS

Sample: Semi-structured, qualitative interviews were conducted with staff involved in referring and treating children with mental health concerns at two ACCHSs located in urban and large regional cities in NSW who are participating in the SEARCH program. GPs, practice nurses, Aboriginal health workers and Aboriginal mental health workers were interviewed. At each service, interviews were held with a range of staff members to allow us to capture variation in views without overburdening the ACCHS.

Method: All interviews were conducted by an Aboriginal and a non-Aboriginal researcher. The two researchers worked in partnership, using a semi-structured approach to elicit participants' views regarding: how much of their work with young people involved mental health; the types of mental health difficulties that were the most common; the training and tools available to assist with assessment and management of Aboriginal child and mental health problems; the treatment pathways for mental health that staff thought should be followed; the pathways that were actually followed; the barriers which cause this variation and what impact deviations from the ideal treatment pathway were thought to have on outcomes.

Sample size and analysis of interviews: Sixteen interviews were held at two ACCHSs, at which point there was a saturation of themes. The transcribed data is currently being analysed using NVivo, a software program developed to facilitate the analysis of qualitative data. The data has been dual coded independently using the constant comparative method whereby each piece of data is compared to the rest of the data to establish analytical categories and dominant themes. The analysis of discussion will be thematic following Glaser and Strauss (Grounded Theory).

RESULTS

Participants reported that a high percentage of their work with children involved mental health concerns, with the proportion ranging from 50%-100% of their overall work with children. Aboriginal health workers reported having some training in mental health, including with Aboriginal children. GPs and Nurses reported having some training in mental health, but it was mainly generalist or 'learnt on the job'. Across all job types there was an interest in further training around child mental health concerns, particularly around providing care to Aboriginal children.

Staff were generally not aware of any formal screening tools for Aboriginal children with suspected mental health concerns and tended to use a combination of their own judgement, sometimes guided by structured questioning such as that outlined in the HEADSS (Home, Education and employment, eating and exercise, Activities and peer relationships, Drug use, including cigarettes and alcohol, Sexuality, Suicide and depression, safety and spirituality) or the child health check. Participants expressed interest in getting access to a short tool for use in detecting and assessing mental health concerns in Aboriginal children, and noted that training in its use should be provided.

A previous review ('Assessing the extent of evidence-informed practice in response to the mental health needs of Aboriginal young people in a primary care setting' reported above) showed there are no established guidelines to direct the mental health care of Aboriginal children. Therefore, unsurprisingly respondents didn't know of any guidelines to help direct the provision of care to children with mental health concerns. While participants stated that guidelines would be useful, they argued that any guidelines developed should include flexible pathways and be accompanied by training.

Across the participant groups a number of factors effecting parents' and adolescents' willingness and ability to seek help for mental health concerns were highlighted. Positive factors that facilitated help-seeking for mental health concerns included trust and relationships built with the children and families. Negative factors, which were thought to sometimes result in an unwillingness to seek care include: shame and stigma around being known to have, or be labelled with, a mental health concern; not wanting other community members to know of the mental health concern and the fear that children may be removed from the parent/caregiver if they report mental health concerns.

Five key elements of successful mental health service provision were identified in the interviews. Firstly the key role of Aboriginal Health Workers (AHW) in both bringing clients in

initially and providing culturally safe support, including transport, health system navigation and facilitating communication between practitioners and the children and parents. Second, a whole of family focus was seen as necessary to address other mental health issues that may be present in the child's home, and ACCHSs are uniquely placed to offer this family-based care. ACCHS staff noted that they proactively 'keep an eye out' for at-risk children and given their close link with the community and families this allows them to get more care for the children that are most at risk. Third, participants noted that there was a need to be flexible and to provide care to the children opportunistically when they present at the service. Fourth, the availability of mental health care specialists was considered important and where this wasn't available it put greater stress on the front-line practitioners. Finally consistent, coordinated care was thought to increase the likelihood of children and adolescents successfully receiving care for their mental health concerns.

DISCUSSION

Participants noted a desire for training, screening tools and guidelines for those providing care to children with mental health concerns. Shame, stigma and privacy may prevent parents/caregivers from seeking help but by building relationships and trust this can help to breakdown these barriers. Within the ACCHSs, support for families and children experiencing mental health concerns can help families access care, and the AHW is key person who can provide this support. Mental health pathways that are flexible, coordinated and focus on the whole family unit are more likely to be successful. It is important that appropriate specialist services are available first within the ACCHS, however, if that is not possible, good relationships with external providers that can provide culturally appropriate care can also be useful.

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