

Better medication management for Aboriginal people with mental health disorders and their carers - Survey of Service Providers

This report was prepared by:

- Inge Kowanko
- Charlotte de Crespigny
- Helen Murray
- Mette Groenkjaer

Also involved in this project were:

- Anita De Bellis, Mike Turner and Sharon Cruse from Flinders University
- Scott Wilson, Warren Parfoot and Geoffrey Hawkins from the Aboriginal Drug and Alcohol Council Inc. (SA)

Better medication management for Aboriginal people with mental health disorders and their carers - Survey of Service Providers

*A collaborative project of the Flinders University School of
Nursing and Midwifery and the Aboriginal Drug and Alcohol
Council (SA).*

Acknowledgments

The project team thanks all survey participants for providing information. The project was supported by a grant from the Quality Use of Medicines Evaluation Program through the Commonwealth Department of Health and Aged Care.

The National Library of Australia Cataloguing-in-Publication entry

Kowanko, Inge

Better medication management for Aboriginal people with mental health disorders and their carers -
Survey of Service Providers

ISBN 0 646 33787 4
© March 2003

Graphic design and printing by
Inprint Design,
Bedford Park, South Australia
inprint@inprint.com.au

Contents

4	Introduction
5	Aim
6	Method
7	Results
21	Discussion and Implications
23	Conclusion
24	References
26	Appendix

Introduction

Past and ongoing policies and practices have resulted in profound and prolonged grief, disempowerment and social disadvantage for Aboriginal Australians, leading to multiple physical, spiritual and mental health challenges that are perpetuated down the generations. The latest statistics indicate that the Aboriginal population is still much sicker, younger and poorer than the non-Indigenous population [1, 2]. Mental health disorders (problems of social and emotional wellbeing) are widespread among Aboriginal people [1, 3-5], and often complicated by other chronic illness and/or substance misuse [6]. Quality medication management can be difficult for many Aboriginal clients, their carers or other family members [7-14]. Evidence suggests that unsafe or inappropriate use of medicines is common, with potentially damaging physical, social and economic consequences [7, 15-17].

This paper reports on a purposive survey of a wide range of health and other human service providers across South Australia (SA) regarding their knowledge, understanding and role in medication management for Aboriginal people with mental health disorders. The survey was one component of a large three year SA-wide project 'Better medication management for Aboriginal people with mental health disorders, their carers and other family members'. The SA-wide project explored complex issues around medication use among Aboriginal people with mental health disorders including drug and alcohol problems, from urban, rural and remote SA communities. A multiple methods approach was used, integrating findings from interviews with clients, carers and health professionals; a survey of health professionals (reported in this paper); and review of key statistical data and documents. Based on the integrated findings, recommendations for improving medication management and related strategies to improve social and emotional well being of Aboriginal people were developed, implemented and evaluated. The project was conducted by a partnership of researchers from the School of Nursing & Midwifery at Flinders University and the Aboriginal Drug and Alcohol Council (SA) Inc, working closely with Aboriginal communities, Aboriginal and mainstream service providers, and other stakeholders. The project was funded by the Commonwealth Department of Health and Ageing Quality Use of Medicines Evaluation Program, and was conducted in 2000-2003. A report on the pilot study for this research has already been published [8], and other reports arising from the wider project are in preparation and will be published in 2003.

Aim

The aim of the survey was to explore and describe the knowledge, understanding and role in medication management of a wide range of health professionals and related workers across SA who work with Aboriginal people with mental health disorders.

Method

Developing the survey questions

Survey questions were developed by the research team, guided by the steering committee, and informed by the literature and other data collected in the wider project. They comprised a mixture of open-ended and closed-ended questions. The survey was refined through an iterative process of drafting, testing and refining, and finally pilot-tested with 5 health professionals. Only minor adjustments were needed following the pilot. The survey form is attached. The first page is a cover letter, outlining the purpose of the survey, explaining that participation is voluntary and assuring anonymity and confidentiality. Ethics approval was given for the survey as a component of the wider project by the Social and Behavioural Research Ethics Committee of the Flinders University, Yunggoendi First Nations Centre for Higher Education and Research at Flinders University, and the Aboriginal Health Council of SA.

Administering the survey

A purposive sample of workers and managers from health and human service organisations was selected from across metropolitan, rural and remote SA. The inclusion criteria were that they have some contact and involvement with Aboriginal people with mental health problems, including problems with drug and alcohol use, and the management of their medications. Key people in each organisation were contacted by telephone, inviting them to participate. Survey forms were sent by mail to those who expressed interest. They were given the option of filling in the form at their convenience and returning it by post, or of responding orally to the survey questions by telephone at a mutually convenient date and time. Each survey was given a unique identifier number for administrative purposes, linked to a separate and confidential listing of addresses, enabling reminder calls to maximise response rate. Data was collected in 2002.

Analysis

The SPSS program was used for quantitative data analysis, using simple descriptive statistics and Pearson chi square exact 2 sided test to explore associations between certain variables. Qualitative data was analysed thematically. Results were integrated into a narrative report, illustrated with direct quotes from the responses to open-ended questions.

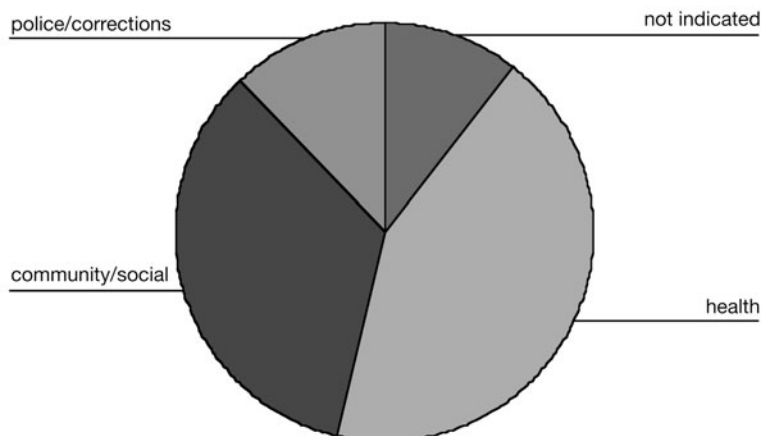
Results

114 surveys were returned/completed out of 225 distributed (51% reponse rate).

General questions

Respondents included a wide range of health and other human service workers including Aboriginal health workers, nurses, mental health workers, substance misuse workers, managers, liaison officers, social workers, police, pharmacists, GPs, community workers, counsellors, paramedics, educators, family support workers and others. For ease of analysis, the position/job titles were categorised broadly into health, community/social (includes education), police/corrections, and not indicated. Most respondents were employed in the health (43%) or the community/social services (34%) sectors (Figure 1).

Figure 1. Employment profile



They worked in organisations such as Aboriginal health services, community centres, medical clinics, police, drug and alcohol services, metropolitan and country hospitals, flying doctor, divisions of general practice, regional mental health services, correctional services, family and youth services, TAFE and non-government organisations.

The sample included workers from a range of rural, remote and metropolitan regions across SA (Table 1), and reflected the regions in which other aspects of this SA-wide project were conducted.

Table 1. Number of responses from each SA region

Region	Frequency
Not indicated	12
Port Lincoln and Ceduna	17
Port Augusta (including Copley, Nepabunna)	13
Riverland	10
Cooper Pedy	10
Murray Bridge	3
Metropolitan Adelaide	49
Total	114

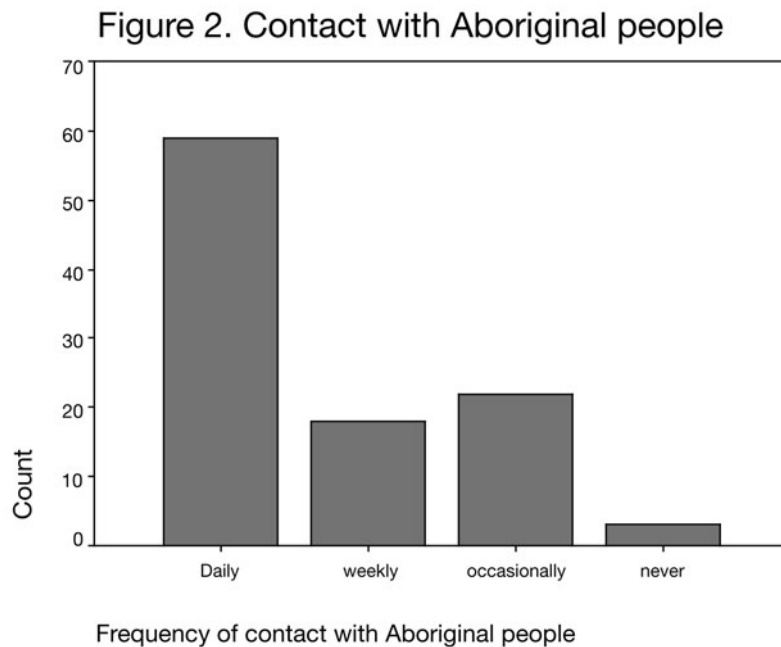
17% of respondents worked in an Aboriginal community controlled organisation. 30% of respondents were of Aboriginal or Torres Strait Islander descent. Although these proportions may not reflect the composition of all SA health/community organisations, they are appropriate for this survey, as staff/organisations that deal with Aboriginal people were purposively selected. Not surprisingly, there was a positive association between working in an Aboriginal community controlled organisation and being of Aboriginal or Torres Strait Islander descent ($\chi^2=5.44$, $df=1$, $P=0.038$). 84% of all respondents said their organisation employed people of Aboriginal or Torres Strait Islander descent.

69% of respondents had received some training about Aboriginal cultural awareness/safety, through workshops and in-service training in their workplace, as part of tertiary education, and informally through experience living and working with Aboriginal people. About two thirds of the respondents from the health and community/social sectors, and 100% from the police/corrections sector, reported receiving some cultural awareness education. Interestingly, respondents were less likely to have received such training if they worked in an Aboriginal community controlled organisation ($\chi^2=7.79$, $df=1$, $P=0.009$), but this was not related to being of Aboriginal descent.

Participants were asked how many years experience they had in their current and related roles. There were 100 and 59 responses, respectively. The duration of experience in the current role varied widely, ranging from 0.1-30 years with a mean of 6.5 years. Around half the respondents had less

than 5 years experience in their current role, perhaps reflecting high turnover of staff in these positions. The mean length of experience in related roles was greater at 13.6 years, with a wide range of 1-42 years. About two thirds of respondents had worked for more than 10 years in related roles, indicating a high degree of relevant experience. There was no significant difference between Aboriginal and non-Aboriginal workers in terms of years of experience.

Most people had frequent (daily or weekly) contact with Aboriginal people in their work, with over half having daily contact (Figure 2).



Not surprisingly, participants had more contact with Aboriginal clients if they worked in Aboriginal community controlled organisations ($\chi^2=15.1$, $df=3$, $P=0.005$), or organisations that employ Aboriginal people ($\chi^2=29.5$, $df=3$, $P<0.001$); if they had been trained in cultural awareness ($\chi^2=8.7$, $df=3$, $P=0.03$), or if they were of Aboriginal descent ($\chi^2=32.4$, $df=3$, $P<0.001$).

Most participants had professional and/or vocational qualifications, ranging from vocational education certificates in primary health care to postgraduate awards. Only 11 people (9%) had not been involved in any formal education beyond school.

The results show that one third of all respondents had received no training whatsoever in mental health (social and emotional wellbeing), and a similar proportion had never been trained in alcohol and other drugs. This deficit is of grave concern, given that the participants were selected from organisations that provide services to people with mental health problems, including substance misuse. Closer examination of the data showed that police/corrections workers had nearly all received such training, but that many workers from the health and community/social sectors were untrained in mental health and drug and alcohol (Figures 3 and 4). There were statistically significant relationships between job category and being trained in mental health ($\chi^2=7.6$, $df=3$, $P=0.05$), and between job category and being trained in alcohol and other drugs ($\chi^2=8.7$, $df=3$, $P=0.03$). Those who had been trained in these fields had received it in several formats including special workshops and in-service education sessions, professional development modules, and specific tertiary courses or subjects. Several had attended short courses provided by this research team in direct response to our previous research findings in this three year, SA-wide project.

Figure 3. Number trained in alcohol and other drugs by job category

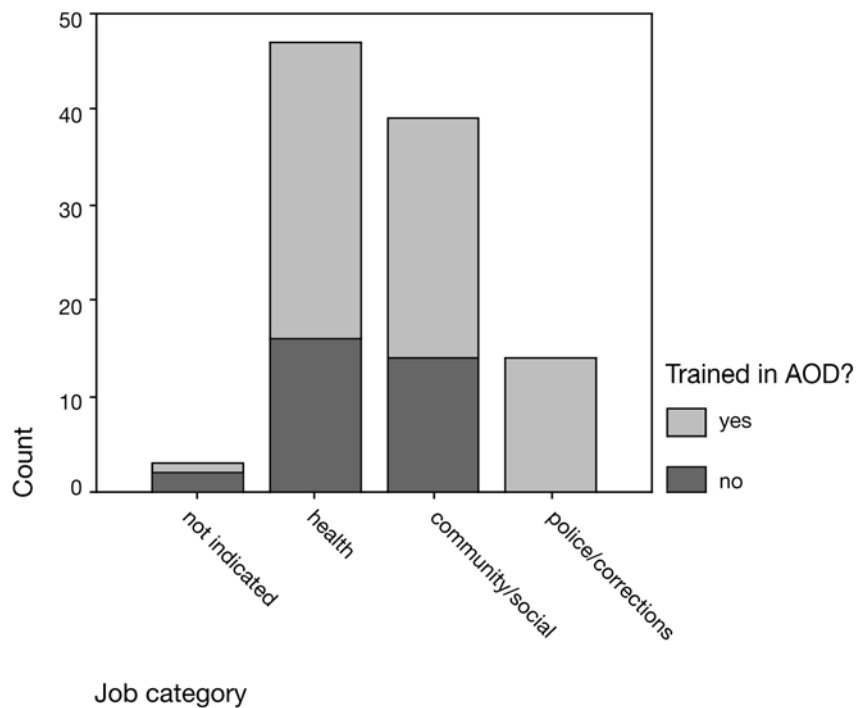
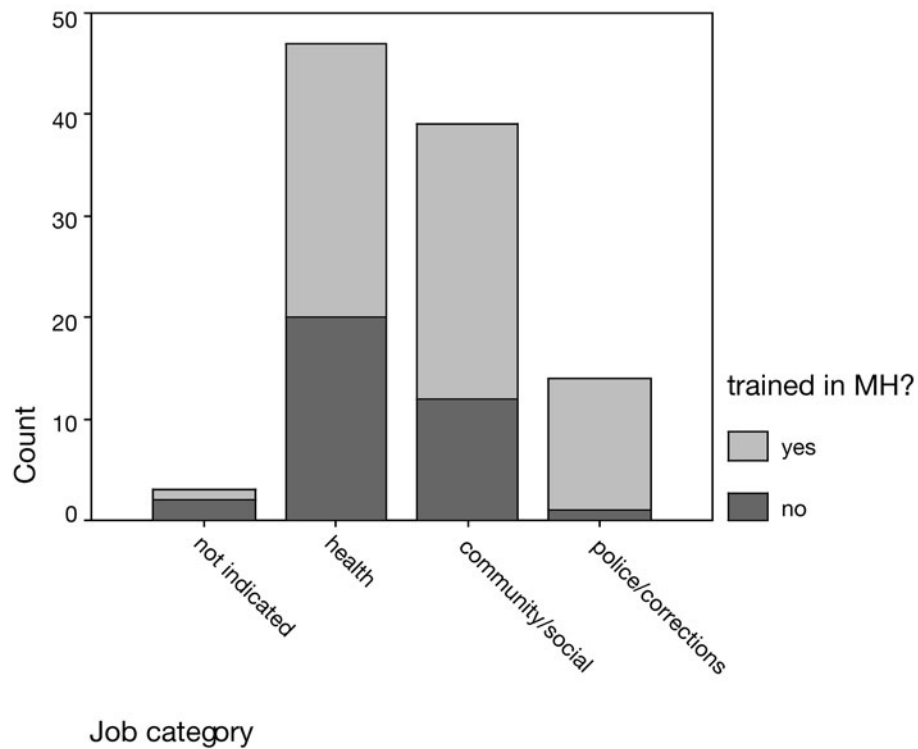


Figure 4. Number trained in mental health by job category



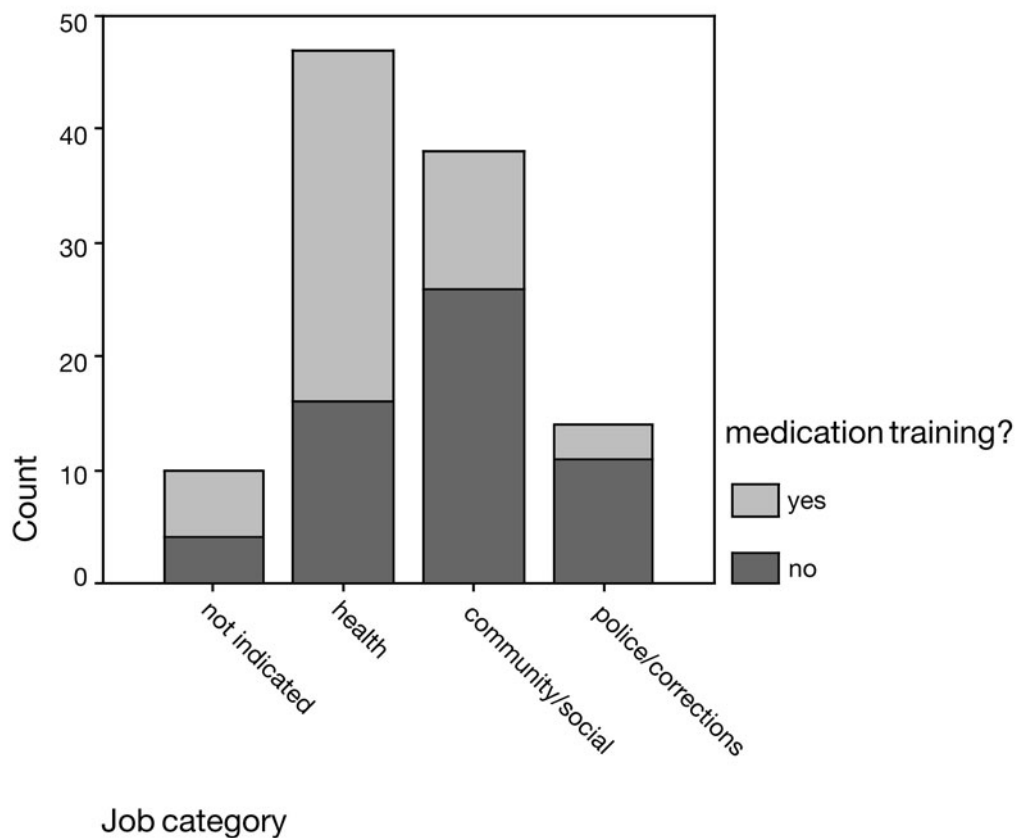
Understanding of medications

Most people (81% and 91%, respectively) rated their own understanding of prescribed and non-prescribed medicines, and their understanding of other drugs like illicit substances, alcohol and tobacco, as adequate/good. Interestingly, there was no significant association between these self-rated understandings and prior exposure to training in alcohol and other drugs or training in safe medication use, that is some people rated their knowledge highly but had not been trained. The reasons for this discrepancy are not clear, but may be related to the quality, relevance or recency of formal training, or respondents might over-estimate their understanding.

70% reported having a poor understanding of traditional Aboriginal medicines.

Only about half of all the respondents said they had received some training in quality use of medicines, eg as part of their professional or tertiary studies and as in-service workshops. Several had done the training offered through Pika Wiya and the Port Augusta pharmacists for Aboriginal health workers. It is of concern that most of the police/corrections workers, more than half of the workers in the community/social sector and 42% of health professionals are untrained in safe use of medicines (Figure 5). Inspection of the data revealed that all the registered nurses and pharmacists had been trained in medications, but that 2 of 6 doctors and many allied health workers said they had never received such training.

Figure 5. Number trained in safe use of medicines by job category



To put this result in context, about one third of all respondents reported ever giving or managing clients' medications, but a considerable number of these had never been trained for this role. Of the 36 people who reported ever giving clients medication, 11 had never been trained in safe use of

medicines. Similarly, 7 of the 35 people who reported ever managing clients' medication were untrained. These people worked mostly in the health and police/corrections sectors.

Most people who had not been trained in safe use of medications believed it would be relevant to their practice, but had not yet taken part, citing factors such as access (40%), availability (48%), cost (36%), suitability (34%) and time (44%). Involving untrained workers in any aspect of medication management potentially puts the client and the worker at risk, and this was recognised by participants. For example:

'We distribute drugs in our community, and clients ask us what these are for, but we only know what the doctor or RN tells us. We are reluctant to distribute drugs because some clients share these drugs and mix with alcohol. We should be educated more about medications and information on what these medications are for.' (#502, Aboriginal men's health worker, remote area)

Those who believed that training in safe use of medications would not be very relevant mostly gave the reason that handling medications was not part of their job. However, these people often wanted basic information to inform their work with Aboriginal people with mental health problems and to give to community members, eg:

'Whilst we might play a critical role in first contact intervention, as police we have no role in treatment. We act in a referral role when treatment is required. Sometimes treatment intervention is not appropriate but a good leaflet/pamphlet which we could provide to persons/supports might assist in the sourcing of assistance prior to police intervention being required.' (#542, community program manager, police)

Health service issues impacting on Aboriginal people with mental health problems

Participants were asked to nominate major health service issues in urban, rural and remote areas that impact on Aboriginal people who have mental health problems, based on their experience. 102 people completed this question, and the results are collated in Table 2. In urban areas, the most frequently nominated service issues were money problems and racial discrimination, with availability of traditional health care and specialist mental health services also named. Money problems and transport were the most frequently nominated service issues for rural and remote areas, where availability of a range of special services, access, reticence to use services and racism were also seen as important service factors.

Table 2. Health service issues impacting on Aboriginal people with mental health problems

Health service issue	Percentage of respondents nominating each issue		
	Urban	Rural	Remote
Health service availability	20	49	47
Access to health services	26	47	46
Reticence to use health services	39	47	37
Transport to/from health services	37	57	50
Availability of specific services for Aboriginal people	35	46	39
Availability of gender specific services	27	43	37
Availability of specific services for youth	32	50	45
Availability of specific services for older people	24	42	39
Availability of specialist mental health services	40	54	51
Availability of alcohol and other drug services	29	44	48
Exposure to racial discrimination	47	41	34
Money problems	54	57	49
Information about health services	23	31	31
Availability of traditional health care	42	42	30
Physical environment of the service	28	33	23
Other	6	6	6

Many people made additional comments to explain or expand on the service problems that they nominated. Several commented that some Aboriginal people are coping with multiple issues in their lives and may not always prioritise their health over other problems, and therefore may not seek help, accept diagnosis, or comply with medical/social interventions.

The reluctance of some people to access help for social and emotional wellbeing problems was linked to experience of racism, illustrated by this comment:

‘I believe the reticence of Aboriginal people to use/access appropriate services is related to their experience of institutional racism, individual prejudice and lack of respect for Aboriginal people in general. (#579, Manager, Social and Emotional Wellbeing Team)

Many participants commented on the need for services to be more welcoming to Aboriginal people, eg through employing more Aboriginal workers in a variety of roles and provision of regular cultural awareness training for all mainstream staff. Another highlighted the importance of promoting existing services:

‘My experience dealing with Aboriginal people are that many of the “barriers” to accessing services are perceived barriers only. Just as much a barrier but actually harder to overcome. Information about available services is more important than more services. And particular emphasis placed on selling the services to the community. Spend some money on promoting what is there.’
(#542, Community Program Manager, Police)

Perceived lack of confidentiality in some Aboriginal services was identified by some respondents as a major issue impacting on use of services by Aboriginal people with mental health problems, illustrated in this quote:

‘Clients find if they go to an Aboriginal service, their personal info re health status gets back to other people through family members whereas if they go to white organisation, clients know confidentiality will be maintained.’
(#526, Mental Health Team Leader)

The need for adequately resourced mental health services, especially in country areas, was seen as particularly important, eg:

‘Government, both state and federal, need to address the issue of funding for mental health workers for remote areas. I have on too many occasions had to deal with people (both Aboriginal and non-Aboriginal) with mental health problems. The mental health team... is grossly understaffed. It is almost impossible to organise an appointment for people with mental health problems.’
(#518, Community Police).

‘I find it quite disturbing that there are not a lot of services/treatment institutions for people living outside of the city.’ (#524, Aboriginal Liaison Officer)

‘I am living/working in a remote area. The Aboriginal community are suffering a lack of delivery of many services because of lack of or poor management of funds, and the lack of funds to treat health/alcohol problems at their core, ie in the home through education.’ (#574, Police)

Provision of information about mental health to clients

Two thirds of respondents said their organisations provided information about mental health (social and emotional well being) to their Aboriginal clients, either routinely (45%) or only on request (55%), depending on the nature of the organisation. The information was given in several forms: verbal (19%), written (6%) or both (75%). Verbal information included one-to-one or group counselling, community seminars, and individual referrals to mental health specialists or Aboriginal social and emotional well being services. Written information included pamphlets, posters and patient

information sheets, but these were often described as generic, and not specifically designed for Aboriginal people. Graphical information was rarely available, and verbal information in Aboriginal languages was provided only where there were interpreters, eg:

'I do not have any pictorial material, or information in any Aboriginal languages' (#573, Social Worker)

Some respondents wanted more or different information to give to their clients, eg:

'I would like more culturally appropriate hand-held information' (#507, General Practitioner)

'We have a lack of information to give clients. Booklets and info sheet would be a good start for us, as case managers.' (#552, Community Corrections Officer)

The majority (88%) of respondents thought the information they provided about mental health was useful to their clients and most thought their clients understood the information. When asked how they knew if their clients understood, some assumed that simply having Aboriginal health workers to provide explanations would ensure comprehension, whereas others judged understanding from client feedback, eg:

'By asking the client to repeat what I have said, and ask them do they understand me. If not, go over it again until they understand.' (#501, Aboriginal Health Worker)

Suggestions for improving the types and provision of information about mental health for Aboriginal people included pictorial resources and leaflets with non-medical language:

'Make (written information) user friendly, short and simple, include pictures.' (#570, Aboriginal Health Worker)

Other ideas included provision of information by trained Aboriginal workers with knowledge of local Indigenous languages, community and school workshops. In particular, the use of story telling with supporting resources was suggested, especially for remote areas and traditional clients with limited English literacy:

'Story flip charts where the person giving information can speak (Aboriginal) language and just show pictures of what they are talking about, felt body narratives etc.' (#503, registered remote area nurse)

Raising community awareness about mental health was also considered important in reducing shame and stigma associated with mental health problems and increasing the acceptance of counselling and medication interventions, eg:

'More promotions and community awareness workshops at least every quarter.' (#537, CEO, Aboriginal community council)
Imaginative use of mass media (TV, radio, video) and positive role-modelling by Aboriginal celebrities were other suggestions.

Provision of information about quality use of medication to Aboriginal clients

54% of respondents said they, or their organisations, provided information about medications to Aboriginal clients, either routinely (65%) or on request (35%). The information varied greatly, from *'routine verbal info & brochures'* to more extensive explanations based on individual need:

'Being careful about dosage of medication/ Taking it at specified times/ What the medication is used for e.g. why they have it, what it contains.' (#534, Family support worker)

Information was given verbally (41%), in writing (5%) or both (55%). Compared to information about mental health, there was relatively more reliance on verbal information about medications, reflecting the lack of culturally appropriate written resources. Information was provided in English, with translation into Aboriginal languages (mostly Pitjantjatjara) according to need and availability of interpreters.

97% of respondents agreed that clients understood the medication information provided, and that it was useful to them. They knew that information was understood from the questions asked by the client and feedback from the client and family, and several people mentioned compliance as an indicator of understanding. Suggestions for improving the type and provision of information about quality use of medicines were similar to those described above in relation to information on mental health.

Major medication issues for Aboriginal people with mental health problems

Participants were asked to nominate which of the listed issues affected the quality use of medications by Aboriginal people with mental health problems. 83 people completed this question, and the results are shown Table 3 below. It is evident that most of the listed issues were considered by 20% or more of respondents as important factors impacting on quality use of medicines by Aboriginal people with mental health problems.

Table 3. Medication issues impacting on Aboriginal people with mental health problems

Medication issues	Percentage of respondents nominating each issue		
	Urban	Rural	Remote
Class of medication	21	21	20
Dosage	22	30	22
Cost of prescription	42	41	31
In what form and how given	20	24	24
Assistance	24	30	22
Advice	26	26	27
Compliance	39	42	36
Information/knowledge of client about medication	33	37	36
Quality of explanation and reinforcement of medication information	31	33	25
Feelings about medication	36	39	31
Treatment orders (ie legally imposed taking of medication)	32	27	30
Sharing of medications	38	37	26
Doctor shopping	31	30	19
Drug or alcohol use	51	54	39
Non-prescription legal medications	32	25	21
Side effects	39	39	31
Inappropriate prescribing/dispensing	30	22	21
Availability of pharmacy services	19	24	21
Availability of accident and emergency services (crisis intervention)	24	24	25
Delivery of medications	20	20	22
Storage of medications	30	27	23
Disposal of medications	21	21	20
Waiting for medication	19	15	19
Safe use of medication	37	36	32
Other	6	3	2

The most frequently cited issue for both urban and rural areas was drug or alcohol use, closely followed by prescription cost, compliance, feelings about medications, sharing of medicines and side effects. For remote areas, drug and alcohol use was most commonly cited (as in urban and rural areas), with information/knowledge about medication also frequently nominated. Some participants stated that health and medication were not priority issues for some Aboriginal people.

Some illustrative comments in relation to important issues affecting quality use of medications by Aboriginal people with mental health disorders follow. For example the cost of medicines was regarded by most participants as a major barrier to quality use of medicines, particularly for people who do not consider their health to be important compared to other problems in their lives, or for people who have difficulty budgeting.

‘Majority of my clients run out of their medication and have to wait until the next pension/pay day until they can get their scripts filled. In the meantime they are on nil medication.’ (#520, Aboriginal health worker)

‘Cost of prescription major problem, pokie machine are other priorities over buying medication and may expect Aboriginal health service to pay for prescriptions.’ (#569, registered nurse, Aboriginal health service)

For clients with major mental health disorders, lack of compliance with prescribed medications may result in treatment orders and involvement of the Guardianship Board, which can be frightening and further alienate Aboriginal clients and families from mainstream services:

‘Sometimes treatment orders can alienate Aboriginal people, especially when they are provided by non-Aboriginal health professionals.’ (#521, Aboriginal health service coordinator)

Self medication with alcohol or cannabis is reportedly common, but may lead to problems:

‘Drug/alcohol use is often the preferred option of self medicating and socially acceptable.’ (#563, Coordinator, non government welfare organisation)

‘Mixing drugs/alcohol/medication is common and can produce unpredictable, often violent, results’ (#512, Police Drug Action team coordinator)

Itinerant people with mental health problems have particular difficulty storing their medicines safely or maintaining a medication regime, in part due to fragmented and discontinuous service provision, as illustrated by these quotes:

‘Many of our Aboriginal people are itinerant. It is hard to find them to ensure medication is taken. Need to ensure proper understanding of the benefits of the medication.’ (#574, police)

‘Availability of the medication is a huge issue in rural/remote communities, particularly if the person travels they don’t usually take their medication with them.’ (#595, Education manager, TAFE)

Several participants believed that compliance is enhanced if medication is dispensed in Webster packs or dosettes.

Professional supports

46% received assistance or support in working with Aboriginal clients with mental health problems and their medications. They included money (12%), resources (15%), education (19%), links with Aboriginal-specific services (35%), links with other services (35%), best practice information (14%), and multidisciplinary team support (23%).

There was no association between receiving such supports and giving or managing client's medications, nor was there any association between receiving such supports and prior training in mental health, drug and alcohol, or safe use of medications. These results suggest that many people are managing or giving clients' medications without any support or training, potentially putting workers and clients at grave risk.

Discussion and implications

The survey highlighted that the major health service issues for Aboriginal people with mental health disorders are related to access, availability and appropriateness of services. In urban, rural and remote locations these issues include lack of money and transport problems, and in remote areas an additional major problem was limited access to specialist services.

Reluctance to access services was cited as a major issue affecting services across all regions in SA, and was related to experiences or perceptions of racism and compromised confidentiality. These findings confirm findings from our previous research [8] and our concurrent research where we interviewed clients, carers and health workers (reports in preparation). The obvious implication is that health and related services for many Aboriginal people in SA are inadequate. Since it is well known from aggregated statistical information that Aboriginal people generally are poorer and sicker than their non-Aboriginal peers, and that social and emotional wellbeing problems are of particular concern in Aboriginal communities [1-5], it is clear that this vulnerable group is poorly served. Recent publications from other research groups echo these views [18].

According to the survey results, the major issues impacting on quality use of medications by Aboriginal people with mental health disorders are drug and alcohol misuse, cost, compliance, feelings about the value of medicines, sharing of medications and unwanted side effects. Again these findings concur with our other research from this project (reports in preparation), our previous studies [7, 8], and the work of other groups [9-14].

The survey showed that the range of workers who provide services to Aboriginal clients with mental health disorders is very wide, and includes not only health professionals, but also community workers, police, educators and others. The survey results indicate that many of these workers lack adequate training and/or resources on mental health and safe medication management, yet are required to provide advice or assistance on these matters. This has potentially serious implications for clients, their carers and other family members who may not receive correct or timely information or help, and untrained workers may also put themselves at risk.

In direct response to this identified need for training, members of the research team and their colleagues have developed, delivered and evaluated a range of short courses (as part of our larger research program). For example an intensive 3 day course on safe medication management for Aboriginal mental health was conducted. This course was designed a variety of workers including drivers, substance misuse workers, and mental health workers, who need to know how to safely transport, handle or otherwise

manage medications. Members of the research team also conduct accredited 3-day intensive drug and alcohol and mental health comorbidity courses; and specific alcohol and drug training for Sobering Up Unit, Mobile Assistance Patrol and other community workers. We estimate that more than half of the workforce of Aboriginal health services in SA attended one or more of these courses during 2002, and we will continue to promote and make them available to anyone who needs such training. The research team has also facilitated workshops in response to local issues uncovered during this research, for example regarding treatment orders and the guardianship Board, supports for carers, clinical guidelines and legal responsibilities for hospital staff in relation to Aboriginal clients, and so on.

Conclusion

A comment from one of the survey respondents was:

'We've got a long way to go haven't we! I'm glad you're doing this research. I hope you are able to make some use of it to benefit the community.' (#598, Counsellor)

We believe that this research is a step in the right direction. The survey provides new, reliable and current evidence relevant to mental health services and medication management for SA Aboriginal people with social and emotional wellbeing problems. It highlights the major issues impacting on quality of care and service provision, demonstrates the wide range of health and allied workers that provide advice and assistance to these people, and uncovers workforce development needs. This survey is one component of a larger SA-wide project, in which practical strategies to address issues identified by primary research are implemented and evaluated, such as training programs and local workshops.

References

1. Edwards, R. and R. Madden, *The health and welfare of Australia's Aboriginal and Torres Strait Islander people 2001*. Australian Bureau of Statistics and Australian Institute of Health and Welfare.
2. O'Donoghue, L., *Towards a culture of improving indigenous health in Australia*. Australian Journal of Rural Health, 1999. 7(1): 64-69.
3. Swan, P.R., B., *Ways Forward. National Consultancy Report on Aboriginal and Torres Strait Islander Mental Health*. 1995, Australian Government Publishing Service.
4. Commonwealth Department of Health and Aged Care, *Promotion, prevention and early intervention for mental health. A monograph 2000*. Commonwealth Department of Health and Aged Care.
5. Human Rights and Equal Opportunity Commission, *Bringing Them Home: A guide to the findings and recommendations of the National Inquiry into the separation of Aboriginal and Torres Strait Islander children from their families*. 1997: Human Rights and Equal Opportunity Commission.
6. Office for Aboriginal and Torres Strait Islander Health, *Review of the Commonwealth's Aboriginal and Torres Strait Islander substance misuse program*. 1999, Office for Aboriginal and Torres Strait Islander Health Division, Commonwealth Department of Health and Aged Care.
7. de Crespigny, C., C. Grbich, and J. Watson, *Older Aboriginal Women's Experiences of Medications in Urban South Australia*. Australian Journal of Primary Health Interchange, 1998. 4(4): 6-15.
8. de Crespigny, C., *Better Medication Management for Aboriginal People with Mental Health Disorders and their Carers - A Pilot Study in Northern Metropolitan Adelaide*. 2002, Bedford Park, South Australia: Inprint Design.
9. Mackenzie, G. and B. Currie, *Communication between hospitals and isolated Aboriginal Community Health Clinics*. Australian and New Zealand Journal of Public Health, 1999. 23(2): 204-206.
10. London, J. and S. Guthridge, *Aboriginal perspectives of diabetes in a remote community in the Northern Territory*. Australian and New Zealand Journal of Public Health, 1998. 22(6): 726-728.
11. Quality use of medicines mapping project, *Tablet taking in Aboriginal health*. 2002, Commonwealth Department of Health and Aged Care. www.qumap.health.gov.au/
12. Emerson, L., K. Bell, and K. Croucher, *Quality use of medicines in Aboriginal communities project. Final report*. 2001, Pharmacy Guild of Australia, Canberra.

13. Quality use of medicines mapping project, *GP Participation in the provision of primary health care for ATSI people*. 2002, Commonwealth Department of Health and Aged Care. www.qumap.health.gov.au/
14. Sanburg, A., *South Australian Aboriginal Health Services - review of pharmacy services*. 2001, RGH Pharmacy Consulting Services, Port Augusta Hospital: Port Augusta.
15. Grbich, C., C. de Crespigny, and J. Watson, *Women who are older and access to medication information*. *Australian Journal of Primary Health Interchange*, 1997. 3(1): 16-25.
16. National Health Strategy, *Issues in pharmaceutical drug use in Australia*. Issues paper. Vol. 4 (June). 1992, Melbourne.
17. National Drug Strategy, *National Drug Strategy Household Survey. Survey Report*. 1995, Canberra: Commonwealth Department of Health and Family Services.
18. Bailie, R., et al., *Atlas of health-related infrastructure in discrete Indigenous communities*. 2002, Aboriginal and Torres Strait Islander Commission.

Appendix



FLINDERS UNIVERSITY
ADELAIDE • AUSTRALIA



ABORIGINAL
DRUG AND ALCOHOL
COUNCIL (SA) INC.

Professor Charlotte de Crespigny
Professor of Nursing (Alcohol & Other Drugs)
School of Nursing & Midwifery,
Faculty of Health Science
Flinders University, GPO Box 2100
Adelaide 5001 Australia
Ph (+61 8) 82015226
Fax 0(+61 8) 8201.3401
E-mail: charlotte.decrepigny@flinders.edu.au

Mr Scott Wilson
State Director
Aboriginal Drug & Alcohol Council (SA) Inc
53 King William Street
Kent Town 5067 Australia
Ph (+61 8) 8362 0395
Fax 08 8362 0327
E-mail: adac@adac.org.au

You are cordially invited to complete this questionnaire. It should only take about 30 minutes to fill in, either in writing yourself or over the telephone. Your responses will help us to explore and improve medication management for Aboriginal people with mental health (social and emotional wellbeing) problems in South Australia such as dementia, Korsakoffs psychosis, alcohol related or acquired brain injury, Attention Deficit Hyperactivity Disorder, schizophrenia and depression.

This project has been approved by Flinders University research ethics committee, Yunggorendi and the Aboriginal Health Council of SA. **Please be assured that all questions are voluntary, your responses are confidential, and you will not be identifiable in any report.** You are free to withdraw from the survey at any time and may choose not to answer any question.

We have posted the questionnaire, following a recent telephone conversation with yourself. This will allow you to look at the questionnaire before a research assistant contacts you to make a time to ask you the questions over the phone. If that is not convenient you can complete the questionnaire in writing and return it to Helen by post in the enclosed pre-paid envelope, or fax 08 82013410.

Thank you in advance for your participation. Please phone Helen on 08 82015587 or email helen.murray@flinders.edu.au if you have any questions about this survey.

General questions about you

1. What is your position or job title?
2. What is the full name of the service or organisation where you work?
3. Is this an Aboriginal community controlled organisation?
 yes no
4. Are you of Aboriginal or Torres Strait Islander descent?
 yes no
5. Does your organisation employ people of Aboriginal or Torres Strait Islander descent?
 yes no
6. Have you had any training in Aboriginal cultural awareness or safety?
 no
 yes (*please describe*)
7. Please describe your role within this organisation
8. Years of experience
 in this role in related roles
9. How much contact do you have with Aboriginal clients in your work?
 daily weekly occasionally never
10. What are your highest educational and professional qualifications?
11. Have you had any training in mental health (social and emotional wellbeing)?
 no
 yes (*please describe*)
12. Have you had any training in alcohol & other drugs?
 no
 yes (*please describe*)

Your understanding about medications

13. How would you rate your understanding about prescribed and non-prescribed medicines?
 poor adequate good
14. How would you rate your understanding about other drugs including illicit drugs, alcohol and tobacco?
 poor adequate good
15. How would you rate your understanding about traditional Aboriginal medicines?
 poor adequate good
16. Do you ever give clients their medications?
 yes no
17. Do you ever manage medications for clients?
 yes no
18. Have you received training/education about safe use of medications?
 yes (*go to question 19*) no (*go to question 20*)
19. Please describe your training/education about medications
(ie what, where, when)

(*go to question 23*)
20. Would training/education about medications be relevant to your practice?
 yes (*go to question 21*) no (*go to question 22*)
21. What factors have stopped you from doing training/education about medications?
 cost
 time
 access
 suitability
 availability
 other (please specify)
22. Why is training/education about medications not relevant to your practice?

Major health service issues that impact on Aboriginal people with mental health problems

23. From your experience, which of the following do you think are significant health service issues for Aboriginal people with mental health (social and emotional wellbeing) problems in relation to medications (please tick as many as you like from the list).

	Urban	Rural	Remote
Health service availability			
Access to health services			
Reticence to use health services			
Transport to/from health services			
Availability of specific services for Aboriginal people			
Availability of gender specific services			
Availability of specific services for youth			
Availability of specific services for older people			
Availability of specialist mental health services			
Availability of alcohol and other drug services			
Exposure to racial discrimination			
Money problems			
Information about health services			
Availability of traditional health care eg ngangkari			
Physical environment of the service			
Other (please specify)			

24. Do you wish to make comments on any of the above?

Provision of information about mental health to Aboriginal clients

25. Do you or your organisation provide information to Aboriginal clients about mental health (social and emotional wellbeing)?
 yes no (*go to question 34*)
26. If so, what information is provided by your organisation to Aboriginal clients about mental health (social and emotional wellbeing) problems?
27. In what form is this information provided?
 verbal explanations written information
28. What percentage of your worktime is spent in an average week providing information about mental health to Aboriginal clients?
29. In what languages is the information about mental health provided?
30. When is information about mental health provided to Aboriginal clients?
 routinely only as requested
31. Do your Aboriginal clients understand the information about mental health?
 yes no (*go to question 34*)
32. How do you know if your clients understand this information?
33. Do you think the information provided about mental health is useful to your clients?
 yes no
34. What suggestions to you have for improving the type and provision of information about mental health (social and emotional wellbeing)?

Provision of information about quality use of medication to Aboriginal clients

35. Do you or your organisation provide information to Aboriginal clients about medications and medication use issues?
 yes no (*go to question 44*)
36. If so, what information is provided by your organisation to Aboriginal clients about quality use of medications?
37. In what form is this information provided?
 verbal explanations written information
38. Please estimate the percentage of your worktime spent providing information about medications to Aboriginal clients.
39. In what languages is the information about medications provided?
40. When is information about medications provided to Aboriginal clients?
 routinely only as requested
41. Do your Aboriginal clients understand the information about medications?
 yes no
42. How do you know if your clients understand this information?
43. Do you think the information provided about medications is useful to your clients?
 yes no
44. What suggestions to you have for improving the type and provision of information about quality use of medications?

Major medication issues for Aboriginal people with mental health problems

45. In your experience, what are the significant issues affecting the quality use of medications by Aboriginal people with mental health problems (please tick as many as you like from the list)

	Urban	Rural	Remote
Class of medication			
Dosage			
Cost of prescription			
In what form and how given			
Assistance			
Advice			
Compliance			
Information/knowledge of client about medication			
Quality of explanation and reinforcement of medication information			
Feelings about medication			
Treatment orders (ie legally imposed taking of medication)			
Sharing of medications			
Doctor shopping			
Drug or alcohol use			
Non-prescription legal medications			
Side effects			
Inappropriate prescribing/dispensing			
Availability of pharmacy services			
Availability of accident and emergency services (crisis intervention)			
Delivery of medications			
Storage of medications			
Disposal of medications			
Waiting for medication			
Safe use of medication			
Other (<i>please specify</i>)			

46. Please expand on the 3 most important issues identified in the previous question affecting the quality use of medications by Aboriginal people with mental health problems.

Your professional supports

47. Do you or your organisation receive any assistance or support in working with Aboriginal clients with mental health problems and their medication management?
 yes no (*go to question 51*)
48. Which of the following forms of supports do you or your organisation receive? (please check as many as you like from the list)
- money
 - resources
 - education
 - links with other services
 - links with Aboriginal-specific services
 - best practice information
 - multidisciplinary team support
 - other (*please specify*)
49. Please expand on the most useful supports you receive.
50. Are there any new initiatives in the last 12 months in your area which are relevant to quality use of medicines by Aboriginal people with mental health problems?
 no
 yes (*please expand*)
51. Any further comments you wish to make in regard to Aboriginal persons with mental health problems and their medication management.

Thank you for participating in this questionnaire.
We will telephone you to record your answers, or you may prefer to post it to Helen Murray, School of Nursing and Midwifery, Flinders University, GPO Box 2100, Adelaide 5001, or fax 82013410.