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Priority Evidence-Practice Gaps in Aboriginal and Torres Strait Islander Mental Health and Wellbeing Care

Final Report

Engaging stakeholders in identifying priority evidence-practice gaps and strategies for improvement in primary health care (ESP project)

October 2016

ABCD NATIONAL RESEARCH PARTNERSHIP
Improving practice through research

CRE-IQI

One21seventy
National Centre for Quality Improvement in Indigenous Primary Health Care

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Abbreviations

ABCD	Audit and Best Practice in Chronic Disease
ABCD NRP	Audit and Best Practice in Chronic Disease National Research Partnership (the Partnership)
ATSIHW	Aboriginal or Torres Strait Islander Health Workers
CQI	Continuous Quality Improvement
EPGs	Evidence-practice gaps
ESP	Engaging Stakeholders in Identifying Priority Evidence-Practice Gaps and Strategies for Improvement
GP	General Practitioner
PHC	Primary Health Care
SAT	Systems Assessment Tool

Authors of this report

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Acknowledgements

We sincerely thank the employees of stakeholder organisations and individuals who have provided generous contributions to the ESP Project. The success of this project is built on feedback, engagement and participation by a range of individuals and groups within and beyond the ABCD National Research Partnership. We thank Perri Hull for her contribution to formatting and disseminating the ESP reports.

The ABCD National Research Partnership is led by Menzies School of Health Research and was funded by the National Health and Medical Research Council (ID No.545267) and the Lowitja Institute. The Partnership includes Aboriginal Community Controlled Health Organisation peak bodies and member services, government health departments, academic institutions, and primary health care services in five states and territories: the Northern Territory, Queensland, South Australia, Western Australia and New South Wales. Ethical approval has been granted by the Human Research Ethics Committees in all jurisdictions where there are participating health services.

Suggested citation:

Matthews V, Bailie J, Laycock A, Nagel T, Bailie R. Aboriginal and Torres Strait Islander Mental Health and Wellbeing Care: Final Report, ESP Project, Menzies School of Health Research, October 2016.

1 Guide to reading this report

This Final Report presents the findings from each of the phases of the Engaging Stakeholders in Identifying Priority Evidence-Practice Gaps and Strategies for Improvement in Primary Health Care (ESP) Project for mental health and wellbeing care.

The Final Report is presented in the following format:

- A brief statement of **key messages** – that is, the headline messages of particular interest to policy makers and managers.
- An **executive summary** that provides a brief background and description of the approach, findings and conclusions of the ESP mental health and wellbeing care processes. This executive summary is designed for people who want to know a little more about the project, beyond the key messages.
- The **main report** that provides a more complete description of the project, suited to the needs of those with a more specific and detailed interest in the project.

The appendices contain further detail on specific aspects of the project.

This Final Report presents findings for all participating health centres from all jurisdictions together. It collates analysis of aggregated continuous quality improvement (CQI) data and stakeholder views on priority evidence-practice gaps, barriers and enablers to addressing the priority evidence-practice gaps, and strategies for improvement.

The report is designed for people working in a range of roles including national and jurisdictional policy makers, managers, community-controlled organisations and government health authorities, peak bodies, clinical leaders, researchers, primary health care staff and CQI practitioners who may have an interest in the interpretation and use of aggregated CQI data to drive decision making.

A Data Supplement accompanies the report. The Supplement contains the detailed analysis of the findings presented in the first two phases of the project, which were the basis of the higher level findings presented in this Final Report. The Data Supplement is available by clicking here or emailing abcd@menzies.edu.au.

More detailed reports on each phase of the ESP Project are available on request.

2 Key messages

Healthcare stakeholders in diverse roles and organisations provided input to interpret continuous quality improvement data on mental health and wellbeing care, using data from 21 health centres. The findings and key messages are relevant to healthcare policy and planning.

Key message 1: We are likely to improve the overall quality of mental health and wellbeing care by focusing on six 'evidence-to-practice gaps' in care delivery. These gaps are common across many health centres.

The identified priorities were improving: 1) recording of shared care arrangements and referrals; 2) follow-up action for clients whose symptoms are getting worse; 3) recording of risk factors and brief interventions, particularly for alcohol and drug misuse; 4) organisational commitment to a culture, support structures and processes that promote high quality mental health care; 5) development of holistic health care teams with the right mix of skills and clear allocation of roles and responsibilities; and 6) linking with the community for service and regional planning and resource development.

Key message 2: A number of key barriers to improving the priorities for mental health care are experienced by many health centres. To overcome these barriers, systems need to be strengthened for recruiting staff, educating teams in culturally appropriate mental health care and providing ongoing support and advice from experienced colleagues.

The identified barriers and enablers highlighted the importance of a stable and appropriately skilled workforce to deliver effective mental health and wellbeing care in diverse cultural contexts. They identified the need to recruit and retain Aboriginal and Torres Strait Islander health care professionals and to ensure sufficient financial resourcing for adequate infrastructure and service delivery.

Key message 3: Action for improving mental health care needs to focus on overcoming the barriers and strengthening systems for recruiting and supporting staff with the required mix of skills. Some strategies, such as involving family members in clients' care and using quality improvement processes, can be put in place by health centre teams. Others, such as services working together in case management and using one data system for clients' records, need partnerships with policy makers, external services and communities.

Strengthening systems and processes to overcome specific barriers (such as staff capability and cultural competency and communication processes) may improve delivery of multiple aspects of mental health and wellbeing care and other aspects of PHC. The development of wide-scale strategies should involve a range of stakeholders and take account of evidence about how effective and appropriate those interventions are in different contexts.

From messages to action: an opportunity for wide-scale improvement

Taking action on these key messages for wide-scale improvement of mental health care will strengthen other key areas of care (given similarity of findings in other aspects of the ESP such as chronic illness). Policy makers, funders, leaders, managers and staff across levels of the health system need to take a coordinated approach to supporting key strategies within their levels and areas of influence.

3 Executive summary

3.1 Purpose

Mental health disorders are a leading contributor to the disease burden of Aboriginal and Torres Strait Islander people. The purpose of this project has been to engage key stakeholders in the use of aggregate continuous quality improvement (CQI) data to identify and address system-wide evidence-practice gaps in Aboriginal and Torres Strait Islander mental health and wellbeing care. We aimed to engage a range of stakeholders in different roles and across different levels of the primary health care (PHC) system - including service providers, managers, policy-makers and researchers - and capture their knowledge on the barriers and enablers to addressing the identified priority-evidence practice gaps and their suggestions on strategies for improvement.

System-wide gaps identified through the project are likely to be due to deficiencies in the broader PHC system, indicating that system-level action is required to improve performance. Such system-level action should be developed with a deep understanding of the holistic nature of Aboriginal and Torres Strait Islander wellbeing beyond just physical health, including healthy connections to culture, community and country. It should take account of the intergenerational impact of Australia's socio-political history on Aboriginal and Torres Strait Islander communities, and how social systems – including the health system - should be shaped to meet the needs of Aboriginal and Torres Strait Islander people.

This project builds on the collective strengths within PHC services in order to continue improving the quality of care for Aboriginal and Torres Strait Islander communities.

3.2 Approach

This final report forms the final third phase of the Engaging Stakeholders in Identifying Priority Evidence-Practice Gaps and Strategies for Improvement (ESP) project for mental health and wellbeing care. We have used de-identified data from all health centres participating in the Audit and Best Practice in Chronic Disease (ABCD) National Research Partnership that conducted audits of care for mental health clients between 2009 and 2014 (n=21 health centres; 975 client records).

Through the prior two phases of reporting and feedback, we aimed to engage stakeholders in a theory- based process using aggregate CQI data to identify:

1. priority evidence-practice gaps;
2. barriers and enablers to high quality care and system-wide strategies for achieving improvement.

Implementation research suggests that by using evidence to identify and link priority gaps to theoretical domains that are known to be system enablers or barriers, strategies can be developed that will most likely produce the desired change.

3.3 Summary of findings

Phase 1 – identifying the evidence-practice gaps

Mental health CQI data from 2012 to 2014 were used to identify preliminary priority evidence-practice gaps (n=17 health centres; 314 patient records; 11 system assessments). During the first phase, approximately fourteen stakeholders provided input (as an individual or part of a group) to refine and confirm six priority-evidence practice gaps in mental health and wellbeing care:

- Developing and recording shared care arrangements and referral (as part of complete client records, mental health summaries and care plans).
- Improving recording and follow-up action for clients whose symptoms are getting worse.
- Asking about and recording alcohol and drug misuse, and giving advice or counselling on tobacco use, nutrition and exercise.
- Organisational commitment to a culture, support structures and processes that promote high quality mental health care.
- Developing healthcare teams with the right mix of skills, clear allocation of roles and responsibilities, and development of processes for effective care.
- Linking with the community for service and regional planning and development of resources.

There was wide variation between health centres in almost all aspects of mental health and wellbeing care. Some were doing well in many aspects of mental health and wellbeing care, however the majority of health centres were not doing well in key areas.

Phase 2- Barriers and enablers to addressing the evidence-practice gaps and system-wide strategies for improvement

In the second phase, we presented trend audit data to examine variation over time in key indicators relevant to the priority evidence-practice gaps. This time period included 2011 to 2013 when there were sufficient numbers of health centres that completed mental health audits (n=21 health centres; 825 patient records). We also provided a brief synthesis of published evidence on improving the quality of Aboriginal and Torres Strait Islander PHC to stimulate feedback on strategies to overcome the identified barriers and enablers.

Health centre, system and staff attributes relevant to implementation of change interventions were provided as prompts to help project participants identify barriers and enablers. During this second phase, about fifty people (as an individual or part of a group) provided feedback on the relative importance of these domains to addressing the priority-evidence practice gaps. We also drew on responses to the Phase 1 survey that identified barriers and enablers to addressing gaps and/or strategies for improvement. Table 1 lists the health centre, system and staff attributes considered relevant to overcoming the barriers across all priority areas.

In summary, the five key barriers and enablers to improving the priorities for mental health care were:

- Systems and approaches for recruiting and retaining primary health care staff, including Aboriginal Torres Strait Islander Health Practitioners.
- Systems to support staff to get advice and support from experienced colleagues and mental health professionals.
- Systems and processes to help staff understand the needs and hopes of people living in Aboriginal and Torres Strait Islander communities in relation to mental health and wellbeing care.
- Training and development to build awareness, knowledge and skills in mental health and culturally appropriate mental health and wellbeing care for Aboriginal and Torres Strait Islander people.
- Financing and resources for mental health and wellbeing care (from local and regional health authorities and government), including adequate PHC facilities.

Table 1. Aspects of the health system considered relevant to the barriers (or enablers) of best practice mental health and wellbeing care, particularly across the identified priority areas

HEALTH CENTRE AND SYSTEMS	**Staffing/workforce support, recruitment and retention** There is a need to strengthen systems to: • ensure adequate numbers of staff, and to improve recruitment and retention of staff (particularly ATSIHWs); and • ensure PHC staff have support from experienced staff, especially when health centres are affected by staff turnover and shortages.
	Patient-centred care There is a need to strengthen systems to support all members of the PHC team to: • understand the needs and aspirations of people living in Aboriginal and Torres Strait Islander communities, with respect to providing best practice mental health and wellbeing care.
	Finance and resources In general, there is a need for systems to: • ensure sufficient financial resources (e.g. from local/regional health authorities, government) to support best practice in mental health and wellbeing care; and ensure PHC facilities are of adequate size, design and condition.
STAFF	**Knowledge and skills** Generally, PHC staff require awareness and skills to provide best practice mental health care for Aboriginal and Torres Strait Islander people. Systems need to be strengthened to support PHC staff to increase their knowledge and skills in: • providing best practice mental health care • providing culturally appropriate and patient-centred mental health and wellbeing care for Aboriginal and Torres Strait Islander people.
	Emotion At times, PHC staff who currently provide mental health and wellbeing care feel unhappy, anxious or depressed about their work. There is a need for systems to: • support staff cope with the stressors of providing mental health care.

Strategies for improving mental health and wellbeing care across all priority areas

Respondents were asked to identify new or refined strategies to address the most common barriers and enablers across all priority evidence-practice gaps. Stakeholder feedback focused mostly on strategies relevant to improving health centre and higher level systems, as follows:

- Improve communication across services and between mental health acute and primary care teams to coordinate case management, especially to follow-up for suicidal ideation and attempts.
- Increase staff awareness of shared care and referral options for mental health.
- Establish and promote the use of one data system by local and visiting services, to increase accessibility of case histories, improve referral processes and continuation of care across providers.
- Enhance clinical information technology to ensure effective recall and reminder systems.
- Co-locate services and establish multidisciplinary team structures to overcome the stigma of using ‘mental health services’ and address co-morbidities related to mental health.
- Provide resources to build the capability and cultural competency of mental health services.

- Employ more Aboriginal and Torres Strait Islander mental health care staff.
- Improve understanding of mental health from a community perspective and integrate this into service delivery.
- Include family members in clients' care in relation to mental health and alcohol and other drug issues.
- Train staff in asking questions about alcohol and drug use, and educating clients in the health effects of misuse.
- Work with community programs to combat normalisation of excessive alcohol and drug use.
- Increase recognition of the central role of social and emotional wellbeing and mental health care within PHC. Embed quality improvement strategies that highlight links between best practice and client outcomes.

The ongoing disparities in mental health between Aboriginal and Torres Strait Islander and non-Indigenous populations and the ESP trend data show no clear improvement over years in delivery of mental health and wellbeing services. This indicates the need for renewed efforts in developing appropriate models to support mental health and wellbeing care needs of Aboriginal and Torres Strait Islander clients.

Many of the suggested strategies are relevant to a number of the identified barriers and enablers. In developing strategies for overcoming the barriers it will be important to ensure the more general strategies do include a focus on overcoming the specific identified barriers and strengthening specific enablers, rather than being too diffuse.

3.4 Next steps

System-wide change is required to address the priority evidence-practice gaps in Aboriginal and Torres Strait Islander mental health and wellbeing care through targeted strategies. The ESP process has enabled key people working within the Aboriginal and Torres Strait Islander health sector to reflect on aggregate data reports and has collated their views on priority system-wide evidence-practice gaps, barriers and enablers, and strategies for improvement.

Further work is required to ensure the detailed design of strategies is based on published evidence and practical experience of approaches that support effective interventions for improving the quality of mental health and wellbeing care for Aboriginal and Torres Strait Islander people and communities.

The main purpose of the ESP Project was to engage a variety of stakeholders in the use of aggregate CQI data and to stimulate discussion on the key areas requiring system-wide improvement and how best to achieve that improvement. The suggested strategies could provide the basis for continuing dialogue to address the most common barriers across the agreed priority evidence-practice gaps in mental health and wellbeing care. Through such dialogue, policy makers, managers, community-controlled organisations and government health authorities, peak bodies, clinical leaders, researchers, PHC staff and CQI practitioners can ensure that the detailed design of strategies address local contextual and organisational considerations.

The aggregated data and collated views and ideas provide a basis for stakeholders to continue to work collaboratively across regions and jurisdictions to share knowledge and experience, as strategies are put into action and evaluated.

This final report will be disseminated to respondents and more broadly to stakeholders across all levels of the health system, including national and jurisdictional community-controlled organisations and government health authorities, clinical leaders, researchers, PHC staff and CQI practitioners. We encourage stakeholders to utilise the report, along with the aggregate CQI data, to implement and advocate for change at local, organisational, regional and national levels.

4 Priority Evidence-Practice Gaps and Stakeholder Views on Barriers and Strategies for Improvement in Mental Health and Wellbeing Care

Mental health issues are prominent within the Aboriginal and Torres Strait Islander population. In 2011, fourteen percent of the health gap between Aboriginal and Torres Strait Islander people and other Australians was linked to mental health and substance use conditions [1]. Aboriginal and Torres Strait Islander adults experience psychological distress (anxiety and depression symptoms) at a rate three times that of non-Indigenous adults [2]. Understanding the current burden of disease requires reflection on Australia's socio-political history and its adverse intergenerational impact on Aboriginal and Torres Strait Islander health and wellbeing that holistically incorporates strong connections to land, culture and community. Without cultural identity and improved social determinants of health, disparities in mental health disease are likely to persist.

Despite higher levels of mental illness, Aboriginal and Torres Strait Islander people underutilise mental health services. Therefore, there is a need to improve pathways and access to mental health and substance use services for Aboriginal and Torres Strait Islander people [3]. The role of PHC in mental health early intervention and management is critical.

4.1 ABCD National Research Partnership/One21seventy

The ABCD National Research Partnership (the Partnership) and One21seventy, the National Centre for Quality Improvement on Indigenous Primary Health Care*, are founded on the premise that a holistic or comprehensive approach to PHC is fundamental to an effective health system. The One21seventy clinical audit and systems assessment tools are developed by expert reference groups and are based on widely accepted evidence-based guidelines that reflect best practice across the scope of primary health care. These tools have to date been used by more than 270 Aboriginal and Torres Strait Islander primary health care centres across the country. Automated reports are provided routinely to health centres and managers comprising their service level audit data as well as relevant regional or state comparison data to support local and regional level CQI efforts. Appendix A provides more information about the One21seventy data collection process and sources used to develop the audit tools.

One hundred and seventy five of these PHC centres have agreed to allow their data to be used to address the aims of the Partnership, including improving understanding of barriers and enablers to high quality care, and informing development of strategies for improvement. The ESP Project contributes to this process, increasing understanding and use of national aggregate CQI data for achieving wider system change. The establishment of this dataset has been made possible by the active contributions of health centre staff, CQI facilitators, managers, policy makers, community-controlled organisations and government health authorities, researchers and clinical leaders. Their ongoing contributions are vital to making the most effective use of data for improving the quality of care for Aboriginal and Torres Strait Islander people across Australia.

4.2 Large-scale health system strengthening

Large-scale improvement in the delivery of PHC requires change at multiple levels of the health system, not only at the local health centre level. Where aspects of care are not being done well across a range of health centres, this is likely to be due to inadequacies in the broader PHC delivery system. These broader systems

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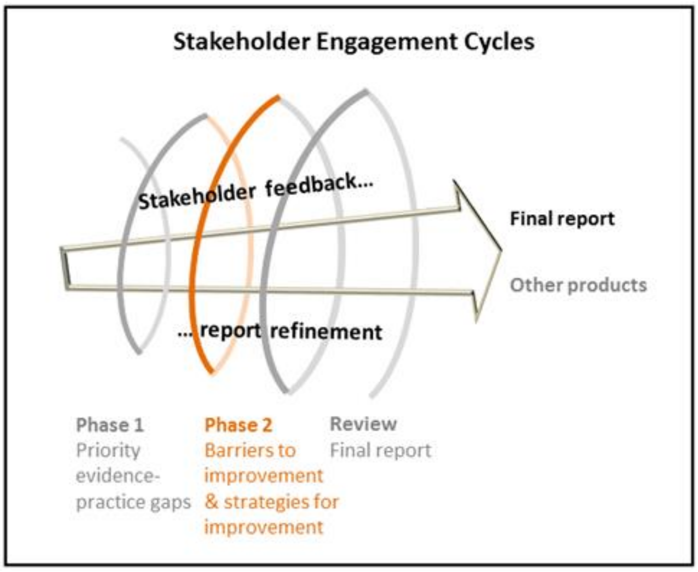
* For more information on the ABCD Partnership Project: <http://www.menzies.edu.au/abcd>.
For more information about One21seventy: <http://www.one21seventy.org.au/>.

directly impact health care and health outcomes for Aboriginal and Torres Strait Islander people. Improvements to systems should be based on evidence about what is working well and what service gaps need to be addressed. Aggregated CQI data can contribute to this evidence.

4.3 Engaging stakeholders in identifying priority evidence-practice gaps and strategies for improvement

Figure 1. ESP Project phases



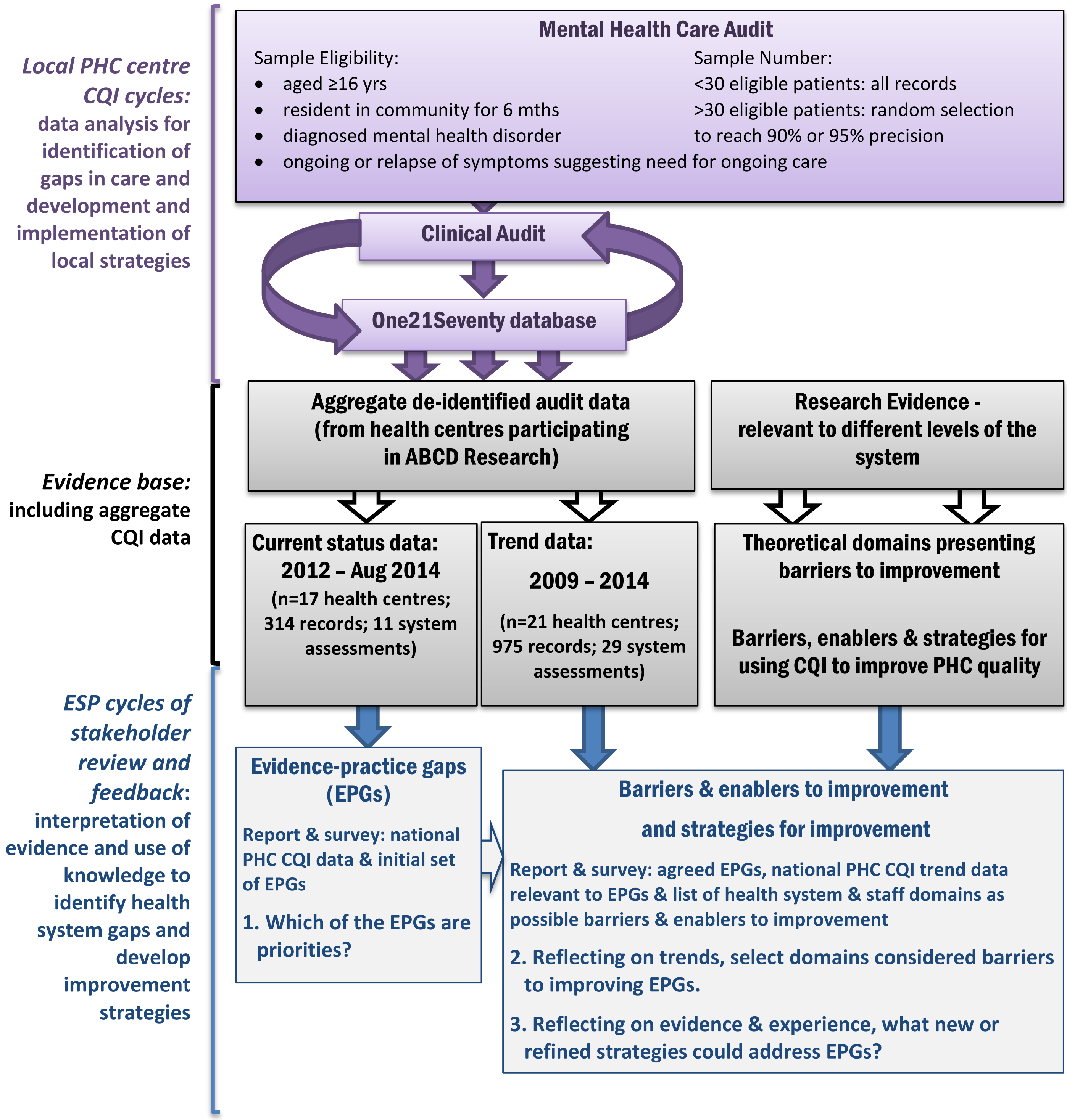
The ESP Project is a major initiative of the Partnership, and is consistent with the purpose of supporting development of the health system to provide high quality comprehensive primary healthcare on a wide-scale. It explores how aggregated CQI data can be used across the broader health system in a series of action-research cycles to: 1) identify evidence-practice gaps; 2) identify barriers, enablers and system-wide strategies to addressing these evidence-practice gaps (Figure 1).

This phased approach (Figure 1) has been adapted from systematic methods designed to link interventions to modifiable barriers to address evidence-practice gaps [4,5]. As part of their approach, French and colleagues utilised previously tested theoretical domains relevant to behaviour change of healthcare professionals to identify barriers to be addressed as part of intervention strategies [4,6,7]. In recognition that there are multiple barriers at different levels of the health system, the ESP Project has drawn on other research to extend the theoretical domains to include broader system factors relevant to the Aboriginal and Torres Strait Islander PHC sector [5,8,9]. For more information about the ESP process, see Appendix B or Laycock et al (2016) [10].

The ESP Project aims to encourage national and State/Territory level conversations about systemic barriers or enablers that could affect improvement in the delivery of PHC, and help inform system changes to direct resources and efforts where they can most improve the health of Aboriginal and Torres Strait Islander communities.

Figure 2 illustrates the components of the ESP project cycle for mental health and wellbeing care.

Figure 2. Use of aggregated CQI data for stakeholder identification of system wide evidence-practice gaps and strategies for improvement.



Report & survey: national PHC CQI data & initial set of EPGs

1. Which of the EPGs are priorities?

Report & survey: agreed EPGs, national PHC CQI trend data relevant to EPGs & list of health system & staff domains as possible barriers & enablers to improvement

2. Reflecting on trends, select domains considered barriers to improving EPGs.

3. Reflecting on evidence & experience, what new or refined strategies could address EPGs?

5 Aboriginal and Torres Strait Islander Mental Health and Wellbeing Care

5.1 Stakeholder engagement

The ESP process for Aboriginal and Torres Strait Islander mental health and wellbeing care began in March 2015. Our aim was to circulate reports as widely as possible to engage a variety of stakeholders in the use and interpretation of aggregate data on the quality of mental health and wellbeing care. We adopted a snowballing distribution technique, whereby key stakeholders were requested to forward reports on to other interested people. Our purpose was to draw on stakeholder knowledge and experience to identify priority evidence-practice gaps, barriers and enablers to improvement and gather views on strategies to address the gaps.

Over 50 stakeholders provided feedback through online surveys over the course of the project (Table 2). Organisations represented included community controlled and government health services, Medicare Locals, research organisations and policy makers. Respondents included practitioners, Aboriginal Health Workers (ATSIHWs), managers, policy-makers, and researchers (Appendix C).

Table 2. Level of engagement in the mental health and wellbeing care ESP Project.

(n= Approximate number of stakeholder responses)	Phase 1 (n=14)		Phase 2^ (n=52)	
	Individual	Group	Individual	Group
Number of survey responses	**12**	**1**	**22**	**3**
Number of attendees per group: Less than 5	▨	1	▨	1
5 to 10		-		1
11 to 20		-		1
More than 20		-		-
Jurisdictions of interest for respondents#				
National	1		3	
NSW	-		1	
SA	2		1	
Queensland	3		6	
WA	-		5	
NT	6		8	
Victoria	1		2	
Tasmania	-		0	
ACT	-		0	

Note: Some groups indicated large numbers – considerably more than 20 and in some instances more than 100. It was not clear how many individuals actually provided input. For the purpose of estimating the numbers who provided input we have used a figure of 20 individuals for groups that were reported to be larger than 20. The estimated number of people providing input may therefore be conservative.

^ Less than 5 responses were received during the third phase of feedback (draft final report). The feedback has been incorporated into the final report, however, information on the respondent is not shown.

Numbers may not tally with the total number of respondents, as respondents were able to select multiple categories when answering some questions. For example, in a group response, group members may have represented a number of jurisdictions.

5.2 Phase 1: Identifying priority evidence-practice gaps

During Phase 1 we presented national clinical audit and systems assessment data collected between 2012 to 2014 on adherence to best practice across the broad scope of mental health and wellbeing care for the purpose of consulting with stakeholders to identify priority evidence-practice gaps (n=17 health centres; 314 client records; 11 systems assessments).

To start the discussion, the ABCD Project team and a clinical expert identified a preliminary set of priorities using the following criteria:

a. important aspects of comprehensive PHC that were generally recorded at low levels;

b. aspects of care where there was wide variation in recorded delivery of care;

c. basic aspects of clinical care that were being delivered and recorded at a high level of performance by the majority of health centres, but that were being delivered at a much lower level by a proportion of health centres; and

d. components of PHC centre systems that were relatively poorly developed.

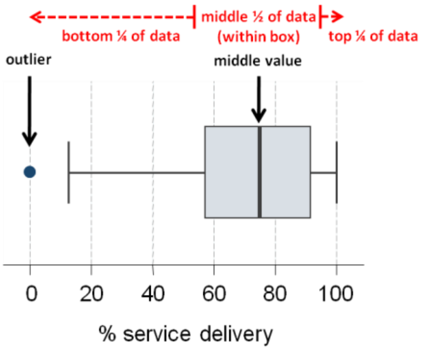
Although a proportion of health centres are doing well in many aspects of mental health and wellbeing care, the majority of health centres are not doing well in a number of key aspects of mental health and wellbeing care. The evidence-practice gaps identified as priorities for improvement in Phase 1 are listed below. More detail on these and other parameters are presented in the data supplement.

The data and preliminary priorities were circulated to key stakeholders in a Phase 1. The data were presented as boxplots to show distribution of performance across health centres (Figure 3).

Figure 3. How to read boxplots representing service delivery in 2012-2014

Box and whisker plots show:

- minimum and maximum values (ends of whiskers if no outliers);
- outliers which are values far away from most other values in the data set (or a distance that is greater than 1.5 times the length of the box);
- range of delivery by dividing the dataset into quarters:
  - the box represents the middle 50% of the dataset, and the line within the box represents the median (or middle value);
  - the right hand whisker (and outliers if present) represents the top 25% of the data
  - the left hand whisker (and outliers if present) represents the bottom 25% of the data; and
- the longer the boxplot, the greater the range (or variation).

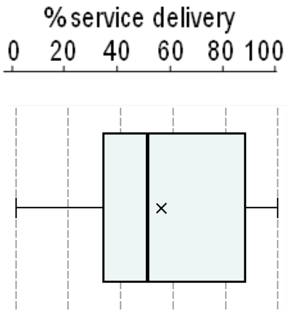


The report was accompanied by an online survey that asked respondents to comment on the importance of each of the preliminary priorities; whether the number of priorities was about right, too many or too few; whether they aligned with priorities they were already aware of; and whether other priorities should be included. Approximately fourteen people provided input into the identification of priority evidence-practice gaps. The priority evidence-practice gaps, as confirmed by respondents, are shown below with relevant indicators from the Phase 1 report.

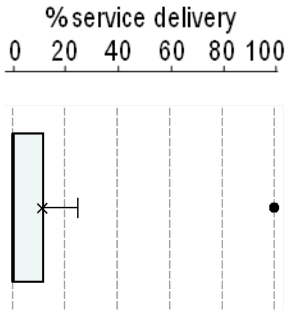
Figure 4. ***Evidence Practice Gap priorities with a selection of representative indicators from Phase 1 report (n=health centres, patient records)***

1. Development and documentation of shared care arrangements and referrals (100% of respondents viewed this as a priority).

Record of shared care arrangement
(n=17; 314)



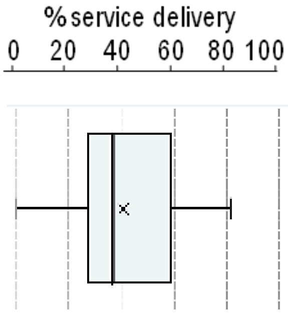
If no shared care arrangement, record of referral to mental health worker (n=16;142)



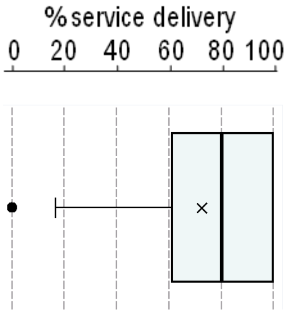
2. Documentation of follow-up action for clients with a deterioration or exacerbation of symptoms (100% of respondents viewed this as a priority).

Eg. Medication adjustment; psychosocial and/or culturally appropriate intervention

Medication adjustment
(if concern documented)
(n=17; 226)

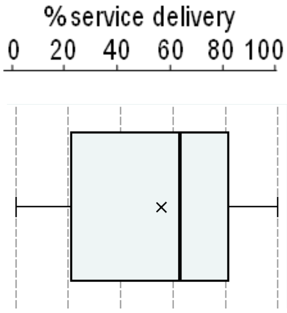


Psychosocial and/or culturally appropriate intervention
(if concern documented)
(n=17; 226)

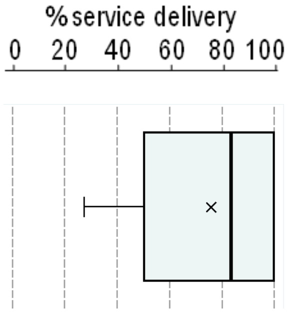


3. Documentation of risk factors and associated brief interventions particularly for drug misuse (100% of respondents viewed this as a priority).

Drug misuse recorded (if attended clinic in last 12 months)
(n=17; 312)

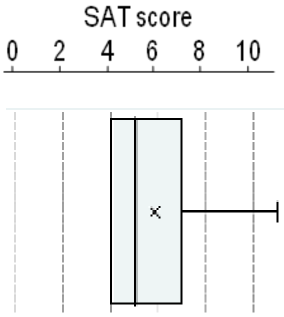


Record of brief intervention for drug misuse (if documented as misusing drugs)
(n=15; 101)

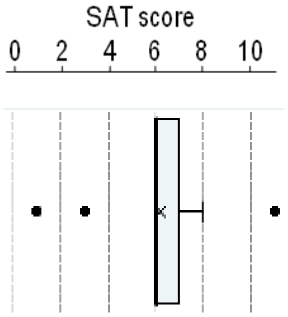


4. **Organisational commitment behind structures and processes to support safe, high quality mental health care (100% of respondents viewed this as a priority).**
5. **Improve team structure and functioning through appropriate staffing profiles and client flow and care processes to maximise effectiveness of mental health and wellbeing care service delivery (100% of respondents viewed this as a priority).**

Organisational commitment
(n=11 centres)

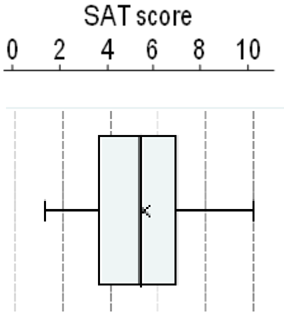


Team structure and function
(n=11 centres)

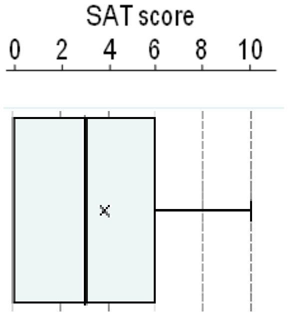


6. **Improved links to community particularly for service planning purposes (90% of respondents viewed this as a priority).**

Links with community and other services
(n=11 centres)



Communication and cooperation on regional health planning and development of health resources
(n=11 centres)



All respondents stated that the evidence-practice gaps highlighted in Phase 1 were consistent with their views prior to reading the report. Respondents also highlighted other priorities that were not identified from the Phase 1 data such as access to relevant referral services, particularly in remote communities and having psychologists as core staff members of PHC centres to better integrate mental health care services and to improve service responsiveness to emerging trends such as drug use. Most respondents (90%) reflected that the priority evidence-practice gaps for their State/Territory would be the same as those arising from the national data. For more remote jurisdictions, there is a priority to involve cultural brokers as an essential aspect of mental health and wellbeing care.

5.3 Phase 2: Identifying barriers and enablers to addressing the priority evidence–practice gaps and strategies for improvement

In the second phase, we presented trend audit data (2011-2013: 825 audited records from 21 health centres) in boxplots to examine variation over time in key indicators relevant to the priority evidence-practice gaps (Figure 5). We asked respondents to focus on the trends in general over time, particularly whether the variation between health centres was getting less, and whether there was improvement for health centres at the lower end of the range. Table 3 summarises the trend data presented in the Phase 2 report (see Data Supplement).

Figure 5. How to read trend boxplots over years and cycles

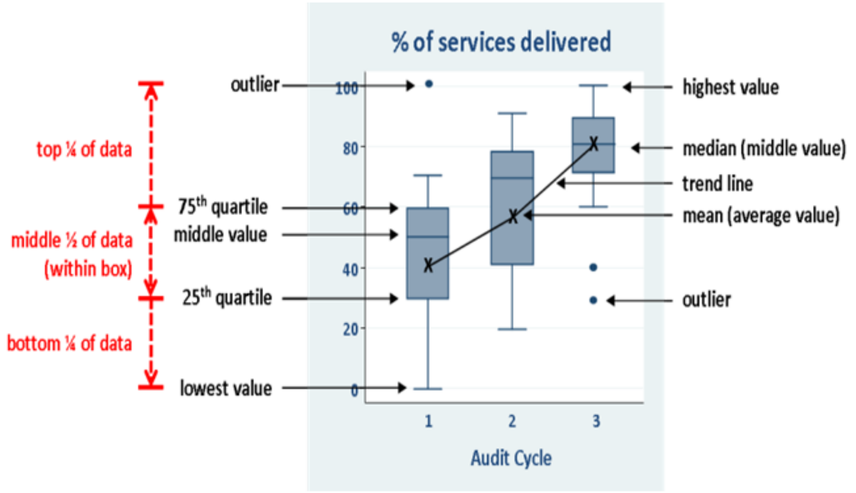
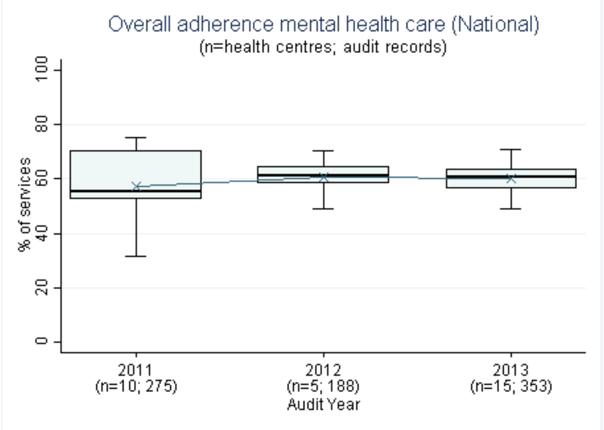


Table 3. Trends in overall mental health and wellbeing care service delivery[1] (as shown in Phase 2 report).

Over years 2011-2013	
- There is no clear improvement in the overall service delivery of mental health and wellbeing care. The mean and median level of care delivery is about 60% over the three years. - There was a reduction in variation in service delivery between health centres. Performance of health centres at the lower end of the range was around 30% in 2011 and was around 50% in 2012 and 2013.	

We encouraged stakeholders to reflect on the influences underlying the data trends, and on their experience in PHC, to identify barriers and enablers to improvement. To assist this process, the Phase 2 report survey listed health centre, system and staff domains drawn from international and national research [5,7,8] that could present potential obstacles to improvement. Respondents were asked to rate each domain according to its relative importance in improving each of the priority evidence-practice gaps. Approximately 50 stakeholders (22 individuals and 3 group responses) provided input, representing the community-controlled and government health sectors, general practice and research organisations. Roles represented included nurses, doctors, public health physicians, middle and senior management, policy officers, researchers and

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[1] Services included in composite indicator include: recording of alcohol, tobacco and drug use; brief interventions for alcohol and drug misuse; health check within the last 12 months; blood pressure check in last 6 months; mental health assessment (if client attended in last 3 months); provision of social issues and family or individual counselling (if client attended in last 3 months); joint discussion regarding culturally appropriate interventions (if client attended in last 3 months); liver function test; serum creatinine; thyroid function test; full blood count; and follow up action if deterioration in symptoms including medication review and adjustment, referral or psychosocial/culturally appropriate intervention.

ATSIHWs. We also drew on the qualitative comments from several Phase 1 survey respondents who identified barriers and enablers to improvement and/or strategies to address gaps.

In relation to respondents' assessment of current health centre and staff systems, the areas with the greatest impact on quality of care are listed below. Most respondents rated both health centre systems and staff attributes as having equal importance with respect to achieving improvements in mental health and wellbeing care delivery. Appendix D has all responses.

Staffing/workforce support, recruitment and retention

Most respondents indicated that there were inadequate numbers of mental health and wellbeing care staff in PHC services. In terms of staff roles, most agreed that there were inadequate support systems to recruit and retain Aboriginal and Torres Strait Islander Health Practitioners/Workers.

Patient-centred care

A majority of respondents indicated there were inadequate systems to support all members of the PHC team to understand the needs and aspirations of Aboriginal and Torres Strait Islander communities for the purpose of providing best practice mental health care.

Finance and resources

Most respondents indicated there was insufficient financial support from government or health authorities to support best practice in mental health and wellbeing care and PHC facilities were generally inadequate in terms of size, design and condition.

The qualitative responses on health centre system barriers and enablers included the need to increase cultural competency of staff with respect to the broader context of Indigenous wellbeing (employment of more Aboriginal and Torres Strait Islander health practitioners); lack of access to mental health referral services, particularly in remote areas; better integration of mental health care teams into PHC; stable workforce to allow building of relationships and trust between practitioners and clients; and the need to improve information systems to share client mental health histories across facilities.

Staff attributes

Most respondents saw a need to increase the knowledge and skills of PHC staff to provide best practice mental health care for Aboriginal and Torres Strait Islander people. A majority believed that PHC staff occasionally/often or always have negative emotions (unhappy, depressed, anxious) about their current provision of mental health care to Indigenous clients.

The majority of qualitative comments on staff enablers and barriers focused on the lack of support systems to improve knowledge and skills in provision of culturally appropriate mental health and wellbeing care. Due to competing priorities (precedence of acute care delivery), there is inadequate time for complex consultations. The environment does not allow for the development of trusting relationships and, combined with non-Indigenous staff general lack of knowledge of Indigenous ways of healing, can lead to gaps in best practice mental health care delivery. The lack of referral services (referrals take too long) and de-briefing sessions for staff are contributing factors.

5.4 Strategies for addressing the priority evidence-practice gaps

We presented a brief synthesis of published evidence on improving the quality of Aboriginal and Torres Strait Islander PHC (Appendix E). The purpose of this 'evidence brief' was to stimulate feedback on strategies to overcome the identified barriers and enablers.

Respondents proposed the following strategies:

- Improve communication across services and between mental health acute and primary care teams to coordinate case management, especially in relation to follow-up for suicidal ideation and attempts.
- Increase staff awareness of shared care and referral options.
- Establish and promote the use of one data system by local and visiting services to increase accessibility of case histories across services. This will strengthen the referral process and continuation of care across providers.
- Enhance clinical information technology to strengthen recall and reminder systems.
- Allocate resources to build capability and cultural competency of mental health services.
- Employ more Aboriginal and Torres Strait Islander staff specialised in mental health care provision.
- Improve understanding by health staff of community perspectives of mental health, and integrate into service delivery.
- Include family members in clients' care in relation to mental health and alcohol and other drug issues, with attention to family connections in influencing Aboriginal and Torres Strait Islander wellbeing.
- Train staff to educate clients on alcohol and other drugs from a clinical perspective, and increase skills in communication to improve staff confidence in asking questions on possible misuse.
- Work with community level programs to combat the normalisation of excessive alcohol and drug use.
- Increase recognition of the central role of social and emotional wellbeing and mental health care within PHC and embed quality improvement strategies that highlight links between best practice and client outcomes.
- Co-locate services and establish multi-disciplinary team structures to overcome the stigma of using 'mental health services'. Multidisciplinary teams will also address co-morbidities related to mental health.

The ongoing disparities in mental health between Indigenous and non-Indigenous populations and the ESP trend data show no clear improvement over years in delivery of mental health and wellbeing services (Table 3). This indicates the need for renewed efforts in developing appropriate models to support mental health and wellbeing care needs of Aboriginal and Torres Strait Islander clients.

Stakeholder feedback on the priorities for improvement, barriers to addressing gaps and strategies is consistent with recently published research on mental health and social and emotional wellbeing care for Indigenous people [1,2].

The identified barriers and suggested strategies present areas of opportunity for those developing PHC policy and interventions to develop barrier driven, tailored interventions to improve health outcomes for Aboriginal and Torres Strait Islander people. Our hope is that the suggested strategies will spark conversations and ideas on how to address the known barriers to care, and that these will lead to wide-scale action for improving care.

6 ESP Project strengths and limitations

To date, the mental health audit tool has been the least utilised out of the suite of tools available in the ABCD/One21seventy CQI program. This may be indicative of the need to increase recognition of the importance of mental health and wellbeing care in PHC as suggested by stakeholders. Despite the limited uptake, the dataset used for the ESP Project is the most comprehensive dataset relating to health centre performance available for Aboriginal and Torres Strait Islander mental health and wellbeing care. As stated, the aggregate CQI data are from around 975 clinical records of patients from multiple services across several jurisdictions, audited against best practice guidelines over multiple audit cycles. From this evidence base, stakeholders were able to identify current priority evidence-practice gaps.

An open process was used to engage stakeholders, consistent with the principle that ‘CQI is everybody’s business’. Stakeholders could choose to participate in any or all project phases. However, the ESP project has relied, in part, on stakeholders sending reports to others, thus it has not been possible to accurately measure reach or response rates. Although the survey information from Phase 2 may be of relatively limited generalisability, the data on barriers and enablers and on strategies for improvement are valuable in that they reflect tacit knowledge of front-line health workers and others working within the health system. In recognition that barriers exist across multiple levels of the health sector, we included questions on broader health centre and system determinants of performance in the Phase 2 survey. These additional questions on influences on quality of care have not been validated in the way that has been done for other questions covering the theoretical domains framework.

Responses to surveys could be made as an individual or representing a group. We have actively encouraged the facilitation of group discussion and group responses.

It will be important to ensure the detailed design of strategies is based on published evidence and expert knowledge of approaches that support effective interventions for improving the quality of mental health and wellbeing care for Aboriginal and Torres Strait Islander people and communities. Strategies implemented in community settings need to be developed and/or adapted by people with local knowledge. It will also be important to evaluate the effectiveness of these strategies in a range of contexts. If intervention efforts are documented appropriately, use of this theory-based process will assist with developing the knowledge base of what works and in what contexts to improve mental health and wellbeing care for Aboriginal and Torres Strait Islander communities.

An iterative process was used to develop and refine reports through the project phases, with adjustments to content and presentation made over time in response to stakeholder feedback. A concurrent developmental evaluation is guiding ESP process improvements. Based on the evaluation, further refinements are being incorporated into ESP projects on other aspects of Aboriginal and Torres Strait Islander PHC, in an effort to improve engagement and use of reports.

7 Conclusions

To our knowledge, this is the first use of an aggregate CQI dataset beyond the regional level to enable a range of key stakeholders to identify priority gaps in delivery of best practice mental health and wellbeing care in Aboriginal and Torres Strait Islander communities. The main purpose of ESP was to engage a variety of stakeholders in the use of aggregate CQI data and to stimulate conversation on priority areas for improvement and how best to achieve improvement. Implementation research suggests that interventions to achieve improvement should be focussed on the key barriers and enablers of good performance, and that such interventions are more likely to produce the desired change.

We encourage stakeholders to take on the key messages and utilise the report, along with the aggregate CQI data, to implement and advocate for change at the local, regional and national level.

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Appendix A: One21seventy data collection and reporting

Where do the data in this report come from? The report is based on analysis of audits of clinical records of well adults who attend services that use One21seventy CQI tools AND participate in the ABCD National Research Partnership. The mental health audit tool was developed by an expert working group, with participation of experts and health service staff. The tool is designed to enable services to assess their actual practice against best practice standards, and is accompanied by a protocol that includes reference to the guidelines and standards that form the basis of the tool. The audit data are supported by a summary of system performance as assessed by staff in health centres that completed a systems assessment tool (SAT) related to mental health care delivery. Copies of the One21seventy mental health audit tool and how the audits are conducted are available on request.

Who collects the audit and systems assessment data? The clinical audits are generally done by health centre staff, trained in the use of One21seventy tools and supported by quality improvement facilitators and One21seventy staff. In some centres where staff are not available or lack skills or confidence the audits are done by CQI facilitators. The systems assessment is completed by health centre staff in a process that is facilitated by a CQI facilitator.

How do health centres use the data? The data collected through One21seventy CQI tools and entered into the One21seventy web-based information system are analysed and made available to health centres in real time for use in quality improvement processes. Reports of aggregated data for clusters of health centres, by region or by state are also available through the One21seventy web-based information system in order to support regional or State/Territory level CQI efforts. The ESP Project is intended to contribute to enhancing the quality of reporting and use of aggregated CQI data for the purpose of service improvement.

Restrictions and limitations on the data presented. The data in this report are not expected to be representative of all health centres nationally or for specific jurisdictions because participation of health centres is either through self-selection or through regional decision making processes. In jurisdictions where a high proportion of health centres are participating, the data may be more generalisable; for jurisdictions where there are relatively few health centres participating the data are less generalisable.

The data reflect what has been documented in electronic and paper based client records, depending on what record systems are used in each health centre. There has been a trend in recent years to increasing use of electronic records. Many health centres are still using paper-based systems, and some are using a mix of paper and electronic systems. The quality of recording of clinical care is variable in both paper and electronic systems, and the audit data may not provide a true reflection of actual care. We have no way of collecting data or reporting on services that are not recorded. Accurate and clear recording of care is an important aspect of quality of care and has important implications for continuity and coordination of care, for medico-legal purposes and for efficient use of resources.

Criteria for inclusion of records in the audit: To be eligible for inclusion in a mental health clinical audit, a client must: be 16 years or older; have a diagnosed mental illness or a mental health disorder; have experienced symptoms for more than six months in the past or at least one relapse/recurrence of symptoms suggesting a need for ongoing care; be currently unwell or have been identified as unwell in the last 12 months; and have been resident in the community for 6 months or more in the last 12 months. Where the eligible population is 30 clients or less, the audit protocol recommends including all records. Where the eligible population is greater than 30, the protocol provides guidance on the random selection of a number of records, with the number depending on the precision of estimates required by health service staff.

Appendix B: Overview of the ESP Project

Phase 1 – Evidence-practice gaps

This phase focuses on the identification of priority areas for improvement (priority evidence-practice gaps) in the delivery of mental health care in Aboriginal and Torres Strait Islander PHC.

Information provided to participants

1. aggregated CQI data (2012-2014) about the delivery of care presented in national and State/Territory reports
2. preliminary priority areas for improvement, based on national data

Feedback/data collection

Online survey, workshop sessions and email responses.

Outputs

Draft report on preliminary priority evidence-practice gaps in best practice care. Refinements based on stakeholder feedback and survey data will be incorporated into Phase 2 report.

Phase 2 – Barriers and enablers to addressing gaps and strategies for improvement

This phase focuses on trends in indicators relevant to the identified priority evidence-practice gaps, and on influences that may enable or hinder improvement at different points in the health system. In particular, it seeks to:

1. identify those factors that may be most important in addressing the identified priority evidence-practice gaps in best practice care identified in Phase 1.
2. identify new or existing strategies that could be introduced or strengthened to enable improvement in priority evidence-practice gaps.

Information provided to participants

- Report on trends over time for key indicators relevant to priority evidence-practice gaps in best practice care.
- An evidence brief synthesising findings from research about barriers, enablers and strategies for improvement in the delivery of PHC, with particular attention to research in the Australian Aboriginal and Torres Strait Islander health context.

Feedback/data collection

Online survey, including questions about barriers and enablers to improvement based on international, national and Aboriginal and Torres Strait Islander-specific evidence and frameworks.

Participants will be encouraged to draw on their own experience, the evidence brief and the data presented throughout the project to identify strategies to address priority evidence-practice gaps.

Outputs

Draft report on barriers and enablers to improvement in care relevant to identified priority evidence-practice gaps and identified strategies for improvement, based on responses to the online questionnaire. The draft report will be returned to participants for review in Phase 3.

Review and final report

A draft report on strategies for improvement will be returned to participants for review. Comments from the review will be used to inform a final report on strategies for improvement in identified priority-evidence practice gaps. This final report will be provided to key stakeholders in all participating jurisdictions. Project findings will be reported in academic journals and in conference presentations and workshops.

Appendix C: Survey respondents

	Phase 1		Phase 2^	
	Individual responses	Group responses	Individual responses	Group responses
Number of responses	12	1	22	3
Number of attendees per group (recorded attendees in group)				
Less than 5		1		-
5 to 10		-		1
11 to 20		-		1
More than 20		-		-
Jurisdictions of interest for respondents*				
National	1		3	
NSW	-		1	
SA	2		1	
Queensland	3		6	
WA	-		5	
NT	6		8	
Victoria	1		2	
Tasmania	-		0	
ACT	-		0	
Rurality of population group to which responses relate*				
Urban	4		10	
Regional	3		8	
Remote	9		15	
Number of group responses to question about Indigenous status				
All		-		1
Majority (more than half)		-		-
Minority (less than half)		-		2
None		1		-
Number of individual responses identified as Indigenous				
Indigenous	3		8	
Non Indigenous	9		14	
Not stated	0		0	
Position types				
Nurse	3	-	6	-
Middle Manager	1	-	2	1
Doctor	2	1	1	-
Public Health Physician	1	-	-	-

Other Medical Specialist	1	-	-	1
Senior Management/executive	-	1	-	1
CQI facilitator	-	-	-	-
Board member	-	-	-	-
Policy officer	-	-	-	-
Aboriginal and/or Torres Strait Islander practitioner	-	-	7	2
Research/Academic	2	-	1	-
Other	2	-	5	1
Organisation types				
Community controlled health centre	5	1	7	1
Community controlled peak body	-	-	-	-
Government health centre	2	-	2	-
Government health department	2	-	2	-
Medicare Local	-	-	4	1
General Practice	-	-	-	-
University/Research organisation	1	-	3	-
Other	2	-	4	1

^ Less than 5 responses were received during the third phase of feedback (draft final report). The feedback has been incorporated into the final report, however, information on the respondent is not shown.

*Numbers may not tally with total number of respondents as respondents were able to select multiple answers

Appendix D: Responses to Phase 2 survey on barriers and enablers to addressing priority evidence-practice gaps in mental health and wellbeing care

Table D1: Responses regarding the extent to which health centre and system attributes present barriers or enablers to addressing priority evidence-practice gaps *(Data shows percentage (number) of respondents in each response category)*

		Strongly Disagree	Partly Disagree	Partly Agree	Strongly Agree	Don't know	No. of respondents
Within the socio-political context, there is sufficient financial support (e.g., from local/regional health authorities, government) to support best practice in mental health care as relevant to the priority evidence-practice gaps		28% (7)	40% (10)	28% (7)	0	4% (1)	25
PHC facilities are generally of adequate, size, design, and condition		32% (8)	36% (9)	32% (8)	0	0	25
PHC facilities generally have adequate equipment		24% (6)	36% (9)	36% (9)	4% (1)	0	25
PHC centres generally have adequate numbers of staff		40% (10)	44% (11)	12% (3)	4% (1)	0	25
PHC centres generally have appropriate numbers of each of the following categories of staff	Nurses	18% (4)	32% (7)	32% (7)	18% (4)	0	22
	Aboriginal or Torres Strait Islander Health Workers	52% (13)	32% (8)	4% (1)	12% (3)	0	25
	Doctors (GPs)	4% (1)	46% (11)	29% (7)	21% (5)	0	24
	Medical specialists	8% (2)	38% (9)	25% (6)	25% (6)	4% (1)	24
	Allied health workers	21% (5)	42% (10)	17% (4)	21% (5)	0	24
	Administrative staff	8% (2)	33% (8)	33% (8)	21% (5)	4% (1)	24
There are good systems in place to ensure PHC staff have support from experienced staff, especially when health centres are affected by turnover of staff and staff shortages		20% (5)	52% (13)	20% (5)	4% (1)	4% (1)	25
There are good systems in place to recruit, retain and support each of the following categories of staff (full time or visiting) as integral members of PHC teams.	Nurses	21% (5)	29% (7)	33% (8)	8% (2)	8% (2)	24
	Aboriginal or Torres Strait Islander Health Workers	45% (10)	36% (8)	5% (1)	5% (1)	9% (2)	22
	Doctors (GPs)	0	38% (9)	29% (7)	21% (5)	13% (3)	24
	Medical specialists	4% (1)	39% (9)	17% (4)	22% (5)	17% (4)	23
	Allied health workers	16% (4)	36% (9)	20% (5)	8% (2)	20% (5)	25
	Administrative staff	8% (2)	25% (6)	38% (9)	13% (3)	17% (4)	24
PHC staff function effectively in teams		8% (2)	20% (5)	40% (10)	32% (8)	0	25
PHC staff are generally clear about their roles in relation to other members of the PHC team		8% (2)	28% (7)	48% (12)	16% (4)	0	25

	Strongly Disagree	Partly Disagree	Partly Agree	Strongly Agree	Don't know	No. of respondents
PHC staff are trained to work effectively in teams	4% (1)	28% (7)	56% (14)	12% (3)	0	25
There are good systems in place to support staff development, including the development of knowledge and skills required	8% (2)	32% (8)	48% (12)	12% (3)	0	25
There are good systems in place to support inter-organisational and intra-organisational learning	24% (6)	32% (8)	32% (8)	12% (3)	0	25
Staff are well trained in the principles of client self-management as relevant to mental health care	24% (6)	24% (6)	32% (8)	8% (2)	12% (3)	25
There are good self-management resources that are relevant to mental health care available to PHC staff	16% (4)	28% (7)	40% (10)	12% (3)	4% (1)	25
There are good systems in place to support all members of PHC teams in understanding the needs and aspirations of people living in Aboriginal and Torres Strait Islander communities for the purpose of providing best practice mental health care	18% (4)	55% (12)	23% (5)	5% (1)	0	22
There are good systems in place to support all members of PHC teams to provide care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions	18% (4)	36% (8)	32% (7)	14% (3)	0	22
There are good systems in place to train all members of PHC teams in providing patient-centred care for people living in Aboriginal and Torres Strait Islander communities	18% (4)	36% (8)	36% (8)	9% (2)	0	22
There are good systems in place to ensure PHC teams have a clear understanding of the size, diversity and other key features of their service populations and to apply this knowledge	14% (3)	36% (8)	41% (9)	9% (2)	0	22
There are good systems in place to ensure PHC teams are able to apply the principles of population health	14% (3)	43% (9)	29% (6)	14% (3)	0	21
There are good systems in place to ensure PHC teams staff are well trained in the principles of population health	23% (5)	36% (8)	32% (7)	9% (2)	0	22
Best practice guidelines and other decision support resources are available to PHC staff	0	14% (3)	43% (9)	38% (8)	5% (1)	21
PHC staff are adequately trained to use the available best practice guidelines and other decision support resources	5% (1)	23% (5)	55% (12)	14% (3)	5% (1)	22
The clinical information systems and communication technology in place have the functionality to support provision of best practice care	14% (3)	23% (5)	23% (5)	37% (8)	5% (1)	22
PHC staff are trained and effectively supported to use clinical information systems and communication technology for supporting and providing best practice	14% (3)	23% (5)	37% (8)	18% (4)	9% (2)	22
There are good quality improvement tools available in health centres for supporting and improving delivery of best practice care	9% (2)	14% (3)	64% (14)	14% (3)	0	22
PHC staff are adequately trained to use quality improvement tools and resources for supporting and improving delivery of best practice care	14% (3)	27% (6)	41% (9)	18% (4)	0	22

	Strongly Disagree	Partly Disagree	Partly Agree	Strongly Agree	Don't know	No. of respondents
Managers are adequately trained to support effective use of quality improvement tools and resources for monitoring and enhancing delivery of best practice care	18% (4)	23% (5)	32% (7)	23% (5)	5% (1)	22
There is good local ownership by PHC staff of CQI data and CQI processes for supporting and improving delivery of best practice care	22% (5)	18% (4)	41% (9)	18% (4)	0	22
Managers provide clear and appropriate support for effective use of quality improvement tools and resources by PHC staff for monitoring and enhancing delivery of best practice care	9% (2)	36% (8)	36% (8)	18% (4)	0	22
PHC staff generally believe that CQI data and CQI processes can be used for supporting and improving delivery of best practice	14% (3)	14% (3)	50% (11)	23% (5)	0	22
There are good systems in place to increase the expectation of community members with regard to best practice care	23% (5)	23% (5)	27% (6)	18% (4)	9% (2)	22
There are good systems in place to strengthen community leadership for quality with regard to best practice	23% (5)	27% (6)	27% (6)	18% (4)	5% (1)	22
There are good systems in place to enhance the health literacy of community members with regard to best practice care	27% (6)	27% (6)	27% (6)	14% (3)	5% (1)	22
There are good systems in place to build the capability and to support PHC staff to develop effective links to work in partnership with the communities they serve in providing best practice care	23% (5)	32% (7)	32% (7)	14% (3)	0	22
There is good clinical and management leadership at the regional, state, national level for supporting and providing best practice	9% (2)	32% (7)	32% (7)	23% (5)	5% (1)	22
There are good networks and regional coordination between parties involved in supporting and providing best practice	14% (3)	32% (7)	41% (9)	9% (2)	5% (1)	22
Managers actively support the development of partnerships across the health sector for the purpose of enhancing delivery of best practice care	5% (1)	27% (6)	36% (8)	32% (7)	0	22

Note: Primary health care (PHC)

Table D2: Responses regarding the extent to which primary health care staff attributes present barriers or enablers to addressing priority evidence-practice gaps *(Data show percentage (number) of respondents in each response category)*

	Strongly Disagree	Partly Disagree	Partly Agree	Strongly Agree	Don't know	No. of respondents
PHC staff know the content and objectives of best practice care	5% (1)	35% (7)	50% (10)	10% (2)	0	20
PHC staff are aware of how to provide best practice care for Aboriginal and Torres Strait Islander people with a mental health illness	10% (2)	45% (9)	35% (7)	10% (2)	0	20
PHC staff have the skills to provide best practice care for Aboriginal and Torres Strait Islander people with a mental health illness	15% (3)	35% (7)	40% (8)	10% (2)	0	20
PHC staff recognise that it is their professional responsibility to provide best practice care for Aboriginal and Torres Strait Islander people with a mental health Illness	5% (1)	25% (5)	30% (6)	5% (1)	0	20
PHC staff are confident in their ability to provide best practice care for Aboriginal and Torres Strait Islander people with a mental health illness	20% (4)	30% (6)	35% (7)	10% (2)	5% (1)	20
With regard to providing best practice care for Aboriginal and Torres Strait Islander people with a mental health illness, PHC staff are optimistic about the future	20% (4)	10% (2)	55% (11)	10% (2)	5% (1)	20
PHC staff believe that if they provide best practice care for Aboriginal and Torres Strait Islander people with a mental health illness, it will have benefits for the health of Aboriginal and Torres Strait Islander people more generally at a population level	5% (1)	10% (2)	50% (10)	25% (5)	10% (2)	20
PHC staff believe that if they provide best practice care for Aboriginal and Torres Strait Islander people it will have disadvantages for their relationships with Aboriginal and Torres Strait Islander people	20% (4)	20% (4)	40% (8)	10% (2)	10% (2)	20
How strong is the intention of PHC staff to provide best practice care every day to Aboriginal and Torres Strait Islander people with a mental health illness attending their services *Note response options: Not strong at all; Quite strong; Mostly strong; Always very strong; Don't know*	10% (2)	15% (3)	25% (5)	40% (8)	10% (2)	20
How often do PHC staff remember to provide best practice care for Aboriginal and Torres Strait Islander people with a mental health illness *Note response options: Never; Occasionally; Often; Always; Don't know*	0	40% (8)	25% (5)	15% (3)	20% (4)	20
PHC staff believe that when they need to concentrate to provide best practice care for Aboriginal and Torres Strait Islander people with a mental health illness, they have no trouble focusing their attention	20% (4)	10% (2)	35% (7)	25% (5)	10% (2)	20
Most people of influence in Aboriginal and Torres Strait IslanderPHC services are seen by primary health care staff to support the provision of best practice care for Aboriginal and Torres Strait Islander people	10% (2)	10% (2)	45% (9)	25% (5)	10% (2)	20
Are PHC staff who provide care for Aboriginal and Torres Strait Islander people with a mental health illness currently able to enjoy their normal day-to-day work activities? *Note response options: Never; Occasionally; Often; Always; Don't know*	0	30% (6)	30% (6)	5% (1)	35% (7)	20
Do PHC staff who currently provide care for Aboriginal and Torres Strait Islander people with a mental health illness feel unhappy, anxious or depressed about their work? *Note response options: Never; Occasionally; Often; Always; Don't know*	0	45% (9)	25% (5)	10% (2)	20% (4)	20

Note: Primary health care (PHC)

Appendix E: Evidence Brief

Improving the quality of Aboriginal and Torres Strait Islander primary health care

What the research shows

This draft evidence brief has been prepared for the 'Engaging Stakeholders in Identifying Evidence-Practice Gaps and Strategies for Improvement in Primary Health Care (ESP)' project. You are invited to provide feedback to refine the brief, using the online project questionnaire**.**

The Aboriginal and Torres Strait Islander primary health care (PHC) sector has embraced continuous quality improvement (CQI) as a way of improving the overall quality of care delivered to Aboriginal and Torres Strait Islander Australians, in order to **improve health outcomes**. This evidence brief presents an overview of findings from local and international research about **barriers, enablers and strategies** for using CQI to make improvements in PHC quality.

Local research has reflected the diversity and complexity of Aboriginal and Torres Strait Islander PHC delivery – geographic diversity, remote-rural-urban health care settings and community-controlled, government, non-government or private providers. Data have been gathered in settings in which political, cultural, social, educational, technological, emotional and ideological factors interact in complex ways. Despite this diversity and complexity, there are some common messages from the research findings, which are supported by international literature about CQI.

Who is this evidence brief for?

Primary health care policy makers, managers, clinical governance groups. The information will also interest providers and practitioners.

Key messages

- Don't wait for perfect data before commencing CQI. Even where good quality data on care processes are not consistently available at the start, the use of data in CQI cycles can act as a catalyst for improved data quality. Meanwhile, invest in developing good health centre systems and staff skills in using data.
- Emphasise use of CQI data for improving care for patients and populations. Practical use of CQI data helps to motivate clinicians and managers to participate in CQI.
- Design improvement strategies to suit local conditions – or adapt strategies that are working successfully in similar settings.
- Build on staff skills and strengths to implement improvement strategies. Share success stories and information about CQI between health centres to enable learning between peers.
- Work on developing a common vision and culture for CQI. Address any underlying organisational leadership and management issues that may detract from implementing CQI.
- Empower Aboriginal and Torres Strait Islander staff and managers to lead, participate in and promote CQI, to ensure improvement strategies match local population and community needs.
- Invest in developing leadership for CQI at each level of the system.
- Use system-wide approaches to integrate CQI across the whole system. Use CQI processes to achieve large-scale change.

Don't wait for perfect data before commencing CQI. Even where good quality data on care processes are not consistently available at the start, the use of data in CQI cycles can act as a catalyst for improved data quality. Meanwhile, invest in developing good health centre systems and staff skills in using data.

In PHC generally, clinical information systems are often poor and fragmented. Policy makers may therefore find it difficult to access consistent and broad scale data on relative need, priorities, performance and quality of care. In addition, there is limited focus and capability at various levels of the system to manage, interpret and use data for the purpose of improving system performance[1], and skills in the use of data to inform improvements in service delivery appear highly variable across all levels of the health system[2,3].

The quality of data is important. Technical advancements (electronic patient information and recall systems, tools, guides, practice standards) can make CQI processes easier and quicker, but if CQI data are perceived to be inaccurate it will not be credible[4,5]. At the health centre level, there is evidence that the quality of health system data can be improved by staff carrying out audits of client records[4].

Competing pressures and perceptions about unreasonable workloads, poor resources and support are often seen as barriers to CQI in Aboriginal and Torres Strait Islander health centres. Staffing constraints influence capacity to deliver guideline-scheduled care – or to make improvements in care. Health centres able to sustain performance in the face of high staff turnover tend to have strong regional support systems together with commitment to good health centre systems[6].

Emphasise use of CQI data for improving care for patients and populations. Practical use of CQI data helps to motivate clinicians and managers to participate in CQI.

For CQI to work successfully, staff need to value the use of data for improvement purposes and believe they can influence change[6]. Local staff increase their support for CQI when they see demonstrated improvements in care and clinical outcomes for clients. Hands-on auditing and participation in feedback and planning sessions by nurses and Aboriginal and Torres Strait Islander practitioners also increases staff support[2,4].

Many staff in Aboriginal and Torres Strait Islander PHC have enthusiasm and a sense of urgency to improve health outcomes[4]. In remote areas in particular, staff may also have a sense of burden and hopelessness (due to long work hours and lack of apparent improvement in health and social determinants) that can lead to clinical inertia. Quality improvement initiatives have been demonstrated to boost morale in these contexts, because they can demonstrate that the hard work is producing results[4,6].

Design improvement strategies to suit local conditions – or adapt strategies that are working successfully in similar settings.

There is strong evidence that improving the quality of care requires a good match between the conditions or context for care delivery, and the strategies used to achieve improvement[7]. Decision makers need to consider **what works, for whom, under what conditions** when planning for improvement. A one-size-fits-all approach is unlikely to be successful. However, successful strategies for improvement may require taking on the core elements of a proven product or strategy and adapting the way it is presented or used locally[8].

Adaptability is important in large-scale application of strategies for improvement; however the underpinning logic of a new product or strategy should be made explicit, so implementers understand the core that should not be compromised. In addition, problem-solving suggestions may help implementers make adaptations for the local context[9]. This approach may help policy makers and program managers to meet the dual challenges of supporting large-scale implementation of best practice, while also enabling local decision making and tailoring to specific needs.

Build on staff skills and strengths to implement improvement strategies. Share success stories and information about CQI between health centres to enable learning between peers.

Strategies for improvement need to build on the skills and attributes of the existing Aboriginal and Torres Strait Islander PHC workforce. Staff need to be involved in completing the latter steps of CQI cycles in order to strengthen the interpretation of data, but also to go beyond focusing only on data or specific indicators to define and act on systemic problems, including through group interpretation and community consultation[3]. The ability to work and communicate effectively in cross- and inter-cultural settings is a critical component of the skills and attributes needed to achieve improvements[10,11].

CQI networks and training events are important opportunities to build relationships, share CQI knowledge and learn practical information about 'what works' from others[2,3]. The remote location and geographic dispersion of many health centres serving Aboriginal and Torres Strait Islander populations mean that staff tend to value opportunities to connect through CQI and to form CQI networks[6].

How evidence was identified

We drew evidence from the ABCD program of work and other publications on CQI in Aboriginal and Torres Strait Islander PHC, then extended our search to include relevant national and international literature about implementation of CQI and innovations in PHC.

Work on developing a common vision and culture for CQI. Address any underlying organisational leadership and management issues that may detract from implementing CQI.

Effective and sustained quality improvement needs a shared understanding of the purpose of CQI and a common vision shared by multiple stakeholders. CQI needs to be embedded into the day to day work of front-line health workers, clinical leaders and managers through routines and relationships that function across and between organisations[4].

What helps to develop a culture of quality improvement?

- Top and middle managers aligned in their CQI vision and goals.
- Commitment to workforce development, with management and staff participation in CQI training at all levels of an organisation.
- Strong team orientation and 'no blame' culture.
- Active management of CQI (e.g., dedicated CQI facilitators, regular progress reviews)
- Use and promotion of small scale projects that demonstrate change is possible and which, if successful and appropriate, may be scaled up across the health system.
- Willingness to embrace change and initiative[4,5,12,13].

Organisations with a strong CQI culture treat barriers such as funding or staff shortages as motivators for CQI. Instead of being viewed as 'extra work', CQI is seen as 'a way of working smarter and making jobs easier'. Disruptions such as restructuring or disease outbreaks can slow CQI work, but can also be used as a platform to apply CQI approaches in responding to the issue[13].

Where there is a culture of CQI, staff values are more likely to align with best practice in Aboriginal and Torres Strait Islander PHC[1].

Where there is poor management, uncertainty and confusion over roles, staff are discouraged and place less value on their data. Interventions to tackle unfavourable service delivery conditions need to be developed alongside CQI implementation[6].

Poor support for collaboration for CQI can lead to competitiveness, fatigue, staff who feel disillusioned with CQI and lack of cooperation. Identifying health centres with similar conditions and working to build adequate trust for networking might help staff believe they can influence change[6].

Empower Aboriginal and Torres Strait Islander staff and managers to lead, participate in and promote CQI, to ensure improvement strategies match local population and community needs.

Aboriginal and Torres Strait Islander leadership in CQI is most important[4,5,14], for example, through active involvement of community health boards or Aboriginal and Torres Strait Islander staff and managers committed to CQI. This leadership for CQI can help ensure the 'cultural, linguistic and practical relevance of health care and population health services'[14].

When planning or implementing strategies for change, the risk of overlooking cultural and historical influences on Aboriginal and Torres Strait Islander health care contexts is reduced where Aboriginal and Torres Strait Islander health practitioners actively lead or are engaged in CQI initiatives. Aboriginal and Torres Strait Islander health practitioners' involvement in clinical care and CQI processes is important in influencing the extent to which CQI processes result in improvements in delivery of guideline-scheduled services[15].

In Aboriginal and Torres Strait Islander settings the credibility of a strategy for improvement is likely to be influenced by who makes the decision to adopt a particular strategy, and how that decision is made[10,16].

Invest in developing leadership for CQI at each level of the system.

Leadership for improving the quality of care is needed at all levels of the health system to guide, support and facilitate CQI efforts[4,5,7,13]. Leaders for CQI are not necessarily in management roles; 'distributed' leadership with leadership functions vested in 'a set of people who can collectively perform them' is effective[12]. Shared responsibility and control of CQI by local staff as well as area/regional and jurisdiction managers is important for successful and sustainable CQI in health systems[5,17].

The attitudes of leaders and managers within the health system towards CQI can influence how clinic staff respond[4,13]. If management or reporting requirements are focused more on using data for accountability than to drive improvements in care, other managers and staff are likely to be suspicious of CQI and perceive it as 'checking up'[3-5].

Use system-wide approaches to integrate CQI across the whole system. Use CQI processes to achieve large-scale change.

The Australian health system operates at three levels; the service and health centre level (individual organisations), the regional level (regional and state/territory health bodies, community-controlled peak bodies, general practice networks), and the national level (nationwide policies and programs, accreditation and regulatory regimes)[18]. At each level, multiple factors influence the context in which improvement might take place. What happens at each level is partly dependent on, and influences, what happens at other levels. So achieving large-scale improvement in the quality of care is likely to require specific attention at each level of the health system[7].

Mechanisms needed to support improvement at the upper levels of the system are often overlooked. Large-scale change may require a package of interventions and long term 'institution-building' for regional and national level organisations to adapt to new ways of functioning[19].

Building a system wide and sustainable approach to CQI across Aboriginal and Torres Strait Islander PHC centres requires certain and sustained funding[3,5]**.** Dedicated funding has resulted in measurable improvement outcomes in service delivery, often achieved by allocating responsibility for CQI processes to a particular staff member and/or establishing regional quality systems[5,6,15]. Resources invested in CQI facilitator roles enable health centres to move to a higher level of capability and capacity in CQI[3].

Applied system-wide, integrated CQI uses multi-site, multi-faceted approaches that reflect the enablers described by the evidence and aim to achieve change at various levels of the system. In successfully integrated CQI models, CQI programs are: part of core business (rather than an add-on or one-off project); engage front-line workers, clinical leaders, and managers in CQI processes; distribute leadership for CQI across the whole health system; use CQI processes and tools to address multiple enablers of good quality care, and; use data from different stakeholders at different levels of relevant organisations to understand and inform broader system level performance[17,20,21].

A **Partnership Learning Model**[20] illustrates how large-scale change can lead to improved Aboriginal and Torres Strait Islander population health outcomes, through the interaction of comprehensive PHC, integrated CQI, system-based research networks, and system-based participatory action research. In its development and application through the ABCD National Research Partnership (2010-2014), the model showed potential for achieving wide-scale engagement of researchers, practitioners, managers, and policy makers in efforts to scale-up and spread effective quality improvement programs. It provides mechanisms to build or strengthen the capacity of a health system to continually work towards improving its performance.

For more information

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Acknowledgements: ESP team input from Ross Bailie, Gill Schierhout, Jodie Bailie, Anna Sheahan, Veronica Matthews and Cynthia Croft.

Date: March 2014

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