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Rekindling the Spirit: potential benefits for the North Coast Area Health Service

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Rekindling The Spirit: Potential Benefits for NCAHS

by Dr Sallie Newell, Evaluator (May 2008)

About the Health of Aboriginal Peoples

Local statistics (1) reflect national figures (2) demonstrating significantly poorer outcomes for Aboriginal peoples across a wide range of health indicators, including:

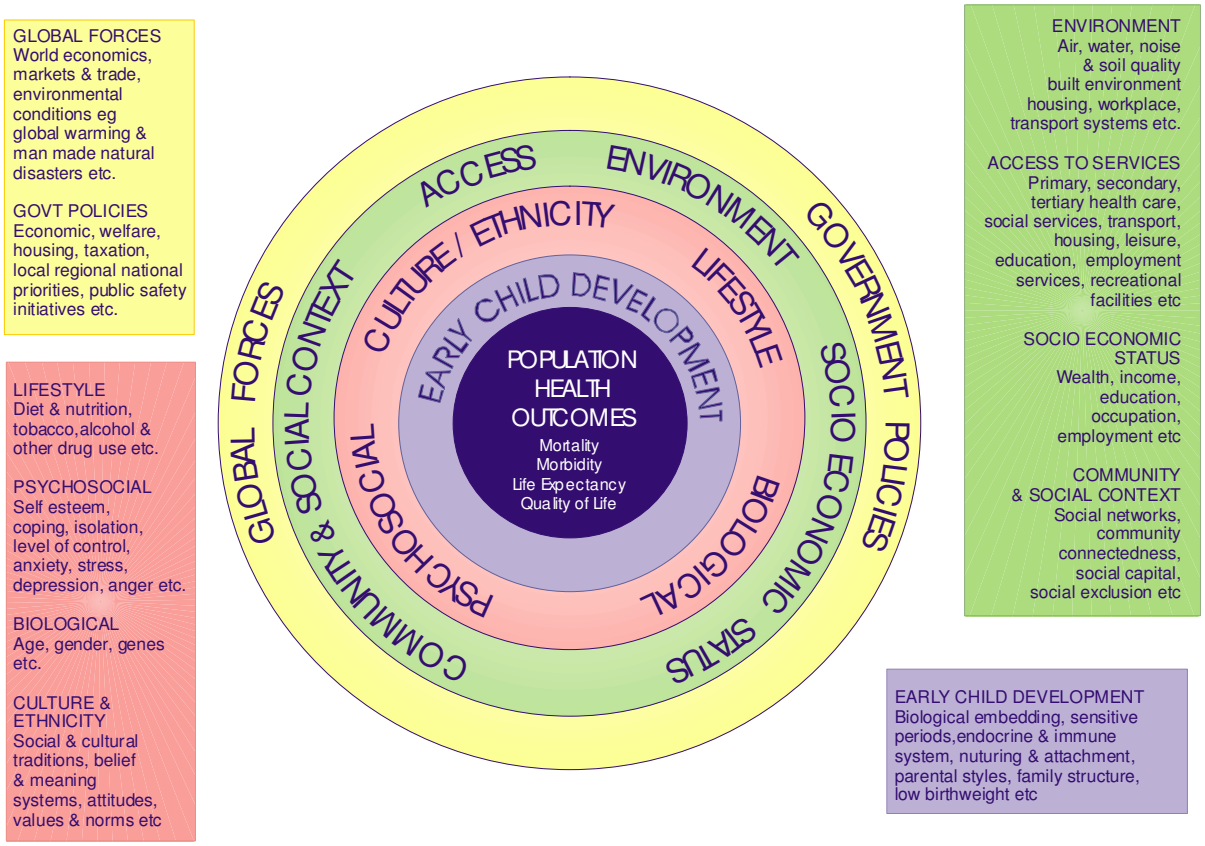
- higher rates of mortality – across all age groups, including infants and children – from all causes, cardiovascular disease, chronic respiratory disease, diabetes;
- considerably shorter life expectancies – for women and women;
- lower birth weights and higher perinatal mortality;
- high rates of hospitalisation – across all age groups, including infants and children;
- higher rates of disability and profound/ sever core activity limitations; and
- higher rates and earlier onsets of chronic health conditions.

Overall, these inequities result in Aboriginal peoples requiring a higher proportion of the health service budget – with the vast majority of expenditure going into tertiary-level care.

About the Causes of Aboriginal Peoples' Poorer Health

As shown in the figure below, population health outcomes are influenced by a broad range of biological, behavioural, physical, socioeconomic and environmental factors. The circular format of the model highlights the inter-relationships between determinants and the cumulative impact they have on health outcomes.

Northern Rivers Health Equity Working Group (HEWG) Determinants of Health Model (3)



On average, Aboriginal peoples tend to have lower levels across most of these health determinants – as summarised in a locally-produced, extensive literature review (4).

> *Many Aboriginal communities are locked into a cycle of poverty and powerlessness. This demoralising sense of hopelessness, constitutes a major health problem. When trauma is suppressed, denied or ignored symptoms often manifest by people self-abusing with alcohol or drugs. Repressed anger, shame, grief, frustration and hopelessness often erupt in violence toward the self and others. Dysfunctional adoptive survival responses such as violence, substance abuse and similar behaviours may occur when the individual has been a victim of family and community violence. Racism, the pain of our history and the denial of the truth by the media, education, welfare and legal systems continues to generate Aboriginal oppression even today. Substance abuse in the form of licit and illicit drugs and family violence amongst Aboriginal people appears to be a response to the deterioration of Aboriginal culture.*

Improving Aboriginal Peoples' Health & Wellbeing

Equity in health is a core value of NSW Health, as acknowledged in two recent publications: *Healthy People 2005 – New Directions for Public Health* (5) and the *NSW Health and Equity Statement: In All Fairness* (6). The former aims to improve health for all people in NSW through an effective and comprehensive public health framework for action that identifies reducing health inequities as one of three streams for improving health outcomes. The latter identifies six key focus areas to effectively reduce health inequities across NSW:

- investing in the early years of life;
- recognising the importance of individual and community participation and fostering partnerships between consumers, the community and the health system to improve health outcomes;
- developing a stronger primary health care system, making it more accessible and proactive in meeting the needs of local communities;
- working collaboratively through regional planning and intersectoral action;
- improving systems and infrastructure through organisational development; building our capacity to act; and
- interventions which are implemented over realistic timeframes and are adequately resourced to achieve long term improvement in health and equity.

The local review discussed earlier recommended that (4):

> *In order to improve the poor health status and socio-economic condition of Aboriginal people we need to recognise and support the goals and aspirations of Aboriginal people towards self-determination and self-management. It is imperative for trust to be established before any positive changes can take place. The need for individual, family and community support systems is essential to health.*
>
> *In conclusion, Aboriginal health issues necessitates the acknowledgment that Aboriginal problems are shared issues which include and influence individuals, families and communities. Precedence should be given to promoting interventions built on accessing and strengthening existing Aboriginal contemporary cultural practices at the individual, family and community level. For the provision of sensitive, culturally appropriate health care services to take place a greater awareness of Aboriginal family and Kinship connections, grief and loss, racism and socio-economic disadvantage and political issues influencing the health status of Aboriginal people is imperative. Aboriginal people need to collectively work together with Government and non-Government organisations to address the socio-economic and political causes of the problems in a culturally positive and culturally directed way. In addition, Aboriginal people need greater encouragement and support to become more involved with policy, planning and decision making as well as the development of Aboriginal programs by Aboriginal people.*

How RTS Contributes Towards Such Improvements

In keeping with recommendations from the literature, RTS is actively contributing towards improving Aboriginal peoples' health & wellbeing by:

- Being a program **developed, owned, managed and governed by Aboriginal people**.

- Working with individuals **and their families**.

- Using a **holistic, quality case-management approach** and offering **a range of treatment options** (groups, individual counselling, home visits, camps) to understand and address clients' issues, within the broad context of their lives – all characteristics associated with the most effective programs in recent reviews of drug diversion and violence prevention programs (7, 8).

- **Supporting clients with overcoming many barriers** that could prevent them from seeking treatment – by providing transport (to RTS and various other services), food vouchers, advocacy and various other forms of support.

- **Servicing over 620 clients** (441 male and 181 female) between July 2004 to November 2007 – although the circle of influence is likely to be much greater (possibly around 300 other adults and 750 children) – with about half the clients naming partners and having children (usually more than one) in just their immediate families. Allowing for some overlap between the male and female clients, it's reasonable to estimate that at least **800 Aboriginal adults and 600 Aboriginal children received some form of benefit from RTS** during this period. This represents about 20% of the total Aboriginal population in the area serviced by RTS.

  Note: 2006 Census data indicate about 3680 persons (all ages) identifying as Aboriginal in the Lismore, Ballina, Casino, Kyogle and Byron Statistical Local Areas. However, local knowledge and experience indicate that the actual number of Aboriginal peoples is likely to be at least double any Census-based estimate.

- Supporting **clients who have &/or are currently experiencing a broad range of serious, negative wellbeing issues** – as shown in the table below, based on information from RTS workers:

Wellbeing Issues	% RTS Clients Experiencing It	
	Male Clients	Female Clients
Victim of Sexual Abuse	90%+	90%+
Victim of Domestic Violence	90%+	90%+
Perpetrator of Violence Against Others	98%	98%
Mental Health Issues	25% diagnosed Many more undiagnosed All have psychosocial wellbeing issues	80% have depression All have psychosocial wellbeing issues
Alcohol Misuse	99%	90%
Other Drug Misuse	94%	90%

- Supporting **RTS clients to return to education or the workforce** – which improves their basic socioeconomic status, another major health determinant.

RTS Clients' Progress To Date

As shown in the table below, RTS workers perceived **75% of male and 50% of female DCS-referred clients to have made at least a little progress** on each of the key areas, with greater progress perceived among clients more engaged with RTS group sessions.

Perceived Progress Level		Male Clients	Female Clients
Self-awareness / Self-determination (Male: n = 146, Female: n = 31)	Rated 0 (None)	31 (21%)	15 (48%)
	Rated 1-2 (A little / Some)	88 (60%)	8 (26%)
	Rated 3-4 (Quite a bit / Lots)	27 (18%)	8 (26%)
	Mean rating	1.40 (overall) 0.61 (0 groups attended) 1.54 (1+ groups attended) 1.89 (5+ groups attended)	1.29 (overall) 0.63 (0 groups attended) 1.91 (1+ groups attended)
Drinking (Male: n = 144, Female: n = 30)	Rated 0 (None)	31 (22%)	16 (53%)
	Rated 1-2 (A little / Some)	83 (58%)	8 (27%)
	Rated 3-4 (Quite a bit / Lots)	30 (21%)	6 (20%)
	Mean rating	1.55 (overall) 0.57 (0 groups attended) 1.74 (1+ groups attended) 2.16 (5+ groups attended)	1.08 (overall) 0.25 (0 groups attended) 1.81 (1+ groups attended)
Drug-taking (Male: n = 135, Female: n = 31)	Rated 0 (None)	31 (23%)	16 (52%)
	Rated 1-2 (A little / Some)	88 (65%)	11 (35%)
	Rated 3-4 (Quite a bit / Lots)	16 (12%)	4 (13%)
	Mean rating	1.25 (overall) 0.41 (0 groups attended) 1.42 (1+ groups attended) 1.68 (5+ groups attended)	0.89 (overall) 0.30 (0 groups attended) 1.44 (1+ groups attended)
Violence / Anger Management (Male: n = 143, Female: n = 30)	Rated 0 (None)	31 (22%)	15 (50%)
	Rated 1-2 (A little / Some)	96 (67%)	13 (43%)
	Rated 3-4 (Quite a bit / Lots)	16 (11%)	2 (7%)
	Mean rating	1.22 (overall) 0.39 (0 groups attended) 1.38 (1+ groups attended) 1.67 (5+ groups attended)	0.92 (overall) 0.50 (0 groups attended) 1.33 (1+ groups attended)
Driving Offences (Male: n = 95, Female: n = 21)	Rated 0 (None)	30 (32%)	16 (76%)
	Rated 1-2 (A little / Some)	57 (60%)	4 (19%)
	Rated 3-4 (Quite a bit / Lots)	8 (8%)	1 (5%)
	Mean rating	1.01 (overall) 0.30 (0 groups attended) 1.20 (1+ groups attended) 1.62 (5+ groups attended)	0.43 (overall) 0.15 (0 groups attended) 0.88 (1+ groups attended)

In a number of isolated incidents, since the re-structure of the Women's Program, the senior Women's Family Worker has also provided specific outdoor and home-based clinical interventions that have addressed urgent psychological matters with female clients – resulting in the **prevention of 5 imminent self-harm incidents** in 2008 alone.

How This Benefits the NCAHS

- In **meeting *NSW Health Equity* objectives** – if all Australians had the same health status as the most affluent 20% of the population, annual health costs would be reduced by $3 billion, nationally (9).
- By **engaging clients not being reached by mainstream NCAHS facilities** (eg: Riverlands & Richmond Clinic) – and ultimately re-introducing them to the mainstream services.
- By **reducing RTS clients' (&/or their families) number of visits to the emergency** departments.
- By **increasing RTS clients' (&/or their families) number of visits to Child & Family Health** and the Women's Health Centre – for more primary and secondary level services.
- In **reducing short-term hospital & health service costs** – due to reduced drug, alcohol &/or violence related incidents among RTS clients.
- In **reducing medium-term hospital & health service costs** – due to improved psychosocial, socioeconomic and lifestyle circumstances among RTS clients.
- In **reducing long-term hospital & health service costs** – due to reduced chronic disease levels among RTS clients and to improved childhood experiences and family functioning for the children of RTS clients.
- In **building capacity in stronger family units to prevent violence** and unsafe family situations in isolated communities and certain urban settings, RTS provides the guidance to extended families to support each other in avoiding conflict that has in the past resulted in injury, trauma and hospitalisation.

Note: Dr Newell is currently working with RTS staff to **comprehensively review and enhance the overall RTS data management and evaluation processes** – to overcome some already-identified limitations and to strengthen future evaluations of RTS services. One aspect of this review is ensuring that RTS staff routinely collect information relevant to all their funding contributors – which will include concrete, prospective information around a number of the indicators described in this brief report, as well as any others considered useful.

Health Service Costs Associated with Key RTS Risk Factors

Recent economic data highlights the large cost burdens placed on the Australian health system as a result of just some of the issues experienced by many RTS clients and their families (10, 11, 12):

Risk Factor	Estimations of Direct Service Costs	% RTS Clients Experiencing It
Domestic Violence	• NSW (2000 study) – $500 million annually – in direct costs to government • Queensland (1988 study) – $51,000 per adult female victim – in direct service costs, mostly health costs • Tasmania (1994 study) – $9,400 per adult female victim per year – in direct service costs • NT (1996 study) – $12,000 per adult female victim per year – in direct service costs • National (2004 study) – $769 million annually – in direct service costs, due to impact on children	90%+
Child Abuse & Neglect	• National (2004 study) – $4.9 billion annually – in direct service costs	Many
Alcohol Abuse	• National (2008 study) – $4.2 billion annually – in direct health system costs, including $1.3 billion annual cost on medical, hospital & ambulance services	99%
Tobacco Smoking	• National (2008 study) – $381 million annually – in direct health system costs, including $418 million annual cost on medical, hospital & ambulance services	Most
Illicit Drug Abuse	• National (2008 study) – $729 million annually – in direct health system costs, including $196 million annual cost on medical, hospital & ambulance services	94%

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