Individual and community responses to depression in a comprehensive primary health care model of service delivery: examination of equity and empowerment aspects

by

Elsa Barton

Thesis
Submitted to Flinders University
for the degree of Doctor of Philosophy

PhD
College of Medicine & Public Health
December 2017

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

SUMMARY

This thesis investigated individual and community responses to depression at four primary health care (PHC) services in South Australia. Comprehensive primary health care (CPHC), an approach to service delivery and health promotion, was the model used at the four PHC services. This study aimed to examine how comprehensive four case study PHC services were in practice and the extent to which they responded to depression in individuals and the community. Of particular interest is the way empowerment and equity featured in these models of practice. For the purposes of this thesis, the definition of CPHC is taken from the WHO Alma Ata Declaration (1978) and includes key elements of equity of access, collaboration across sectors beyond health and individual and community empowerment and participation in services.

This research used a critical inquiry approach to examine how comprehensive PHC services were in practice and the extent to which they operated from a social view of health that recognises the impact that social, physical, economic and cultural aspects of the environment have on the health of the community and individuals. Five questions guided this thesis:

1. What are the range of responses to depression offered in a PHC model of service delivery in terms of mental health promotion, prevention of depression, and treatment and rehabilitation for people with depression?
2. What are clients' experiences and understandings of PHC service delivery and how does this model help prevent/treat/manage/aid in the recovery of depression?
3. What are staff views and reflections about their practice both in terms of responding to depression among individuals and the community and how these services fit into the broader health system?
4. What are the opportunities for and barriers to individual and community empowerment in relation to mental health and the prevention of depression?
5. What system constraints and enablers support or detract from the implementation of CPHC service delivery for responding to depression in individuals and the community?

Quantitative and qualitative methods were used to investigate these questions. The quantitative component involved the analysis of 86 client journeys and provided an overall description of how the PHC services were working with clients and other agencies in terms of mental health promotion, prevention of depression, treatment and rehabilitation. This analysis complemented

the qualitative study which involved the analysis of 21 client interviews and 28 staff interviews. The interviews explored client experiences of PHC service delivery and how it helped their depression, and staff reflections about their practice in terms of the work they do with individuals and the community. In particular, the role of power and the way services consider equity in view of clients' social determinants of health was investigated.

This study found there were different models of PHC evident among the four case study sites. The PHC services were constrained in the extent to which they could respond to depression among individuals and the community in an approach that aligns with CPHC. A model of service delivery more aligned to CPHC was evident at the start of this study in 2011. The PHC services were able to respond to depression among individuals, for example, clients reported improved management of depression and some individual empowerment. However, a broader perspective on health that responds to depression among the community by considering the social determinants of health through health promotion, advocacy and community development, key principles of a CPHC model, were not evident. The findings identified the role of power in shaping PHC and showed how the implementation of CPHC was constrained by the dominance of neoliberalism and individualism that shaped health reforms and led to disempowerment of clients and staff. This finding confirmed other research that operation of a CPHC model is best supported in a favourable political and social context. This thesis offers insight into how the implementation of CPHC can be strengthened and supported through adequate funding and resources for health promotion and prevention activities, infrastructure to support community participation and social connectedness and training and support for mental health practitioners to undertake advocacy for individuals and to support broader forms of collective action.
Depression is one of the most prevalent mental illnesses and having a health system that can respond to individuals and communities in a comprehensive and culturally respectful way is important for mental health and wellbeing. Models of PHC that align with a CPHC response to depression offer an important perspective of health that has potential to improve mental health and wellbeing and reduce health inequities. This thesis offers new knowledge regarding the implementation of CPHC within PHC services and offers insights into factors that detract from the implementation of this model.

DECLARATION

I certify that this thesis does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

ACKNOWLEDGEMENTS

I would like to thank the many people have who have supported me on this PhD journey. A piece of research such as this is never due to one person’s endeavour and I am grateful for their support and encouragement of me and my research.

Firstly, I express my gratitude to the clients of the four primary health care services that gave up their time to take part in participating in this research. Many of you shared personal details about your lives with me and I am thankful for your openness. I also thank the staff employed at these primary health care services, who gave up their time to participate in interviews and completed questionnaires. I appreciate the time you took out of your busy schedules to assist me with this research.

I would like to express my deepest gratitude to my supervisors, Professor Fran Baum, Dr Angela Lawless and Dr Toby Freeman. Throughout my time working on this PhD, they have provided me with valuable guidance, support and encouragement. In addition they have been generous with their time to respond to my queries, and their advice and suggestions have improved the quality of this thesis. Thank you Fran, Angela and Toby, for challenging and encouraging me.

I would also like to thank the staff and the other PhD students within the Southgate Institute of Health, Society and Equity at Flinders University who have had a positive influence during my candidature. Their friendship, encouragement and support were invaluable during this PhD journey. Additionally my new friends at Flinders Rural Health SA have been equally supportive. Particular thanks go to Professor Lucie Walters and Professor Jennene Greenhill for their encouragement and support in the final stages of this PhD.

Finally, I would like to thank my remarkable family Chris, Billy, Tommy and Oscar as well as my sister Susie and my Mum, Christine who supported me in many ways throughout this journey. It has been a family journey and without your love, support and encouragement I would never have able to complete this thesis. Thank you for being such a special part of my life.

CHAPTER 1: INTRODUCTION

1.1 Overview of this study

This study is about the implementation of CPHC within PHC services for people with depression. The research was undertaken during a time of considerable health system reform and reorganisation and this study documents the impact of these reforms on the extent to which PHC services aligned with CPHC principles in their response to depression. There is little literature on the implementation of CPHC in relation to a mental illness such as depression and this research sought to address this gap. The policy reforms that occurred during the research period also allowed insight into factors that constrained or enabled services' capacity to implement CPHC in relation to mental illness, which is also a novel contribution of this thesis.

Comprehensive Primary Health Care (CPHC) is an approach to service delivery and health promotion underpinned by a social view of health, community participation, empowerment, social justice, equity, and action on social determinants of health (Baum, 2016; World Health Organisation, 1978). Depression is a major health issue in Australia that is often unrecognised and untreated (Goldney, Eckert, Hawthorne, & Taylor, 2010) and there are calls to reduce the burden of depression experienced by individuals and populations and its impact on health systems and society (Miret, Ayuso-Mateos, Sanchez-Moreno, & Vieta, 2013). Depression was chosen as an example of a chronic disease and a way of investigating the extent to which PHC services are aligned to a CPHC model. CPHC provides a potentially strong model of service delivery for responding to depression at both community and individual levels. CPHC has the potential to provide a service framework within which depression can be managed and prevented, more equitable health outcomes can be achieved, and communities can participate in planning and managing services. It has a focus on equity and community empowerment that differentiates it from medically focused selective Primary Health Care (PHC) with its individualised care and disease-based approach.

In South Australia, where this research was undertaken, CPHC has had a long history since Community Health Centres (CHCs) were developed during the 1970s and 1980s. The degree of implementation of CPHC has varied over this period. This study adopted a critical inquiry approach to examine models of PHC being used by four PHC services (former CHCs) in their response to depression in individuals and the community. In particular, the study examined the range of mental health responses to depression, client experiences and understandings of PHC, and staff views and reflections about their practice in this model of service delivery. CPHC philosophy is grounded in principles of social justice, equity and empowerment which underpin a social view of health. CPHC as a philosophy and approach to service delivery and health promotion that incorporates principles of health equity and social justice, was the overarching theoretical framework that guided the study, the research questions, the analysis and conclusions.

The implementation of CPHC is dependent on the broader operating environment. Therefore, it was important to document and analyse the policy context, which included substantial health system reorganisation, and mental health reform in Australia (described in chapter 4). The impact of this reform on the extent to which PHC services could incorporate principles of CPHC in their response to depression among individuals and the community was examined. National networks of federally funded PHC organisations, Medicare Locals (now Primary Health Networks) were established in July 2011-2012. In South Australia, structural changes to the PHC landscape occurred where CHCs relocated to new buildings and became GP Plus Health Care centres and GP Super Clinics just prior to data collection commencing in 2012. The findings of this research contribute to improved understandings of how policy and contextual factors affect the capacity for a CPHC approach in responding to mental health in PHC. Furthermore, the findings provide insights into the role of power in shaping PHC service delivery and improved understandings of client’s perceptions of empowerment and PHC service delivery.

This chapter provides an overview of this thesis, beginning with a description of the aims and followed by the approach and methods undertaken. The key terms used throughout this thesis are defined and the chapter concludes with a brief precis of the chapters that make up this thesis.

1.2 Research questions

The aim of this study was to examine how comprehensive four case study PHC services were in practice and the extent to which they align with CPHC in terms of their response to depression in individuals and the community ,including the promotion of good mental health, and treatment and prevention of mental illness. Clients’ experiences of PHC and staff views about their practice in this model of service delivery were also investigated. The following research questions guided this thesis:

1. What are the range of responses to depression offered in a PHC model of service delivery in terms of mental health promotion, prevention of depression and treatment and rehabilitation for people with depression?

2. What are client experiences and understandings of PHC service delivery and how it helps prevent/treat/manage/aid in the recovery of their depression and in their health and wellbeing in general?

3. What are staff views and reflections about their practice in a PHC model of service delivery in terms of work responding to depression in individuals and the community? How do they see the PHC services fit into the broader health system?

4. What are the opportunities and barriers to individual and community empowerment in a PHC model of service delivery in relation to mental health and especially prevention of depression?

5. What system constraints and enablers support or detract from CPHC service delivery for responding to depression at a community and individual level?

This research was conducted as part of a broader five-year National Health and Medical Research Council (NHMRC) funded study that examined the effectiveness of Primary Health Care in local communities. My research contributed to this broader study and focused on individual and community responses to depression offered in a CPHC model and represents my own intellectual work. Where I’ve used material and findings from the broader NHMRC study, this is acknowledged. Further information regarding the research design is provided in chapter 3.

1.3 Research approach

This research drew on a critical inquiry approach to examine the extent to which four PHC services implemented CPHC models of service delivery and adopted a social view of health that recognises the impact that social, physical, economic and cultural aspects of the environment have on the health of the community and individuals. Of particular interest to me were two of the core values of CPHC – equity and empowerment. In order to analyse how power plays out among staff and clients using four PHC services I drew upon theories of power by Michel Foucault, Ronald Labonte and Stephen Lukes. These three theories were used as both a conceptual definition of power but also provided a framework in which to analyse how power played out and what potential there was for empowering practice among the PHC services.

A descriptive multiple case study design was used that incorporated quantitative and qualitative data. Four PHC services became case study sites which were assessed against CPHC as a theory and model of practice to examine the extent to which these services implemented CPHC in their response to depression among individuals and the community.

The broader work the services undertook to support clients through advocacy and the work done towards addressing the social determinants of health was examined. Quantitative case tracking questionnaire data were used to generate client journeys which were used as a way of examining the extent to which four case study PHC services were implementing a CPHC model in response to depression. Another source of quantitative data was generated from an empowerment tool, the Patient Enablement Instrument, provided information on how empowered clients felt and complemented the qualitative data. Qualitative data through a number of different sources (in-depth interviews with clients and staff, service audits on mental health promotion, prevention and treatment, client health logs, field notes and observations) was the primary method of data collection.

The qualitative research explored clients' experiences of PHC service delivery and whether it helped with the prevention, treatment and management of their depression and their health and wellbeing. Staff views and reflections about their practice in terms of the work they do responding to depression among individuals and in the community were also gathered, and led to improved understandings of the implementation of CPHC in responding to mental health in PHC. The qualitative analysis explored the ways power was negotiated during client and staff interactions, whether this resulted in clients feeling more empowered to manage their depression and what structures were in place to encourage community empowerment. The use of multiple methods and a case study design formed a picture of what each PHC service was doing in relation to depression. This approach was flexible and was able to manage the range and complexity of the interactions undertaken within the services and allowed for contextual changes during this project.

1.4 Terms used in the thesis

The following paragraphs outline the intended interpretation of commonly used terms in this thesis. The clarification of terms CPHC and PHC are given, as well as primary medical care, empowerment and the reasons for the choice of the term 'client' are outlined. Depression is defined in the next chapter on page 28.

Comprehensive Primary Health Care and Primary Health Care

In Australia the terms '*Comprehensive Primary Health Care*' and '*Primary Health Care*' are contested (Baum, 2016; Hurley, Baum, Johns, & Labonte, 2010; Keleher, 2007; McDonald, Powell Davies, Cumming, & Fort Harris, 2007). For the purposes of this thesis the definition of CPHC is taken from the Declaration of Alma Ata (World Health Organisation, 1978) that is based on a social view of health and incorporates important elements of equity of access, collaboration across sectors beyond health and client and community empowerment and participation in services. Thus, the Alma Ata conception of CPHC focuses on the process of empowerment and increasing control over all those influences which impact on health (World Health Organisation, 1978). CPHC has only been partially implemented in most countries around the world (Baum et al., 2016). Walsh and Warren (1979) in response to the Declaration of Alma Ata proposed a more narrow approach known as selective PHC arguing CPHC was too costly and unrealistic. Selective PHC which is based on a biomedical view of health, focuses on targeted interventions to high risk groups but is missing many of the key elements of CPHC such as the emphasis on social and economic factors and the involvement of other sectors beyond health. In Australia, there are various models of primary health care (PHC). Federally-funded general practice, State-funded multi-disciplinary PHC and Aboriginal community-controlled services all provide PHC services. In this thesis, PHC refers to the sector generally and "selective PHC" is used to distinguish it from comprehensive approaches to PHC which will be referred to as CPHC.

Primary Medical Care

The term *primary medical care* is used to refer to the care delivered by general practitioners

(GPs) mainly through privately-owned medical practices in Australia. Primary medical care is based on a disease-orientated medical model where the major focus is on diagnosing and treating disease, although there is also some preventive care, including immunisation, lifestyle advice, some health screening and provision of health information.

Empowerment

This thesis defines empowerment in the context of health services and refers to ‘the ability of people to gain understanding and control over personal, social, economic and political forces in order to take action to improve their life situations’ (Segal, 1998, p. 37). Within the context of health care there are many terms used to refer to empowerment – enablement, participation involvement, engagement, however empowerment is regarded as the more comprehensive concept (Fumagalli, Radaelli, Lettieri, Bertele, & Masella, 2015) and so was chosen as the term used in this thesis.

‘Client’ versus ‘patient’

There are many terms used to distinguish the relationship between those who provide services and those who are in receipt of services. Documents such as South Australia’s Mental Health and Wellbeing Policy (2010-2015) that guide the delivery of mental health services use the term ‘consumer’ (Government of South Australia, 2010) but there is ongoing debate about what service recipients should be called. McLaughlin (2012) critically considers the terms: ‘client’, ‘patient’, ‘customer’, ‘consumer’, ‘expert by experience’ and ‘service user’ and finds all these terms inadequate. The term ‘patient’ tends to be the term used by doctors and seems to identify the person as ill and ‘client’, which tends to be preferred by allied health professionals (Australian Community Health Association, 1992), has been challenged as it emphasises passivity (McLaughlin, et al., 2012). The term ‘customer’ or ‘consumer’ is linked to marketisation that implies a more financial or economic transaction, where they are purchasing or consuming services.

In deciding what term to use in this thesis, the literature above as well as research by Lloyd et al (1992) that surveyed recipients of mental health services and their preference between the terms patient, client or consumer were considered. In Lloyd et al.’s study ‘client’ was the preferred term by respondents and importantly, preference of terms was found to be context-dependent (Australian Community Health Association, 1992). People at inpatient settings preferred the term patient while those in the community settings preferred the terms client or consumer. Additionally, participants accessing a PHC service not involved in this study who attended group interviews to pilot the proposed client interview question guide and client health log were asked what term they preferred. The majority preferred the term ‘client’ and so this was the term used in this thesis.

NHMRC project

The NHMRC project is the term used in this thesis to refer to the larger five-year NHMRC project titled: *‘Evaluating the effectiveness of comprehensive primary health care in local communities’* to which this PhD thesis contributes.

The Southgate Model for Comprehensive Primary Health Care: Depression

The NHMRC project developed a program logic model that links mechanisms underpinning CPHC, responses to depression in CPHC models, service qualities and the possible short and long term health outcomes under a number of favourable contextual factors (see Appendix A). This model was used as a framework in which to assess the extent to which the client journeys .provided evidence of the services implementing CPHC principles. It provided a useful way of evaluating the PHC response to depression that allowed for local context to be taken into consideration. In particular, key mechanisms underpinning this model such as accessible, locally delivered, community driven, mix of direct care, prevention and promotion, multidisciplinary teamwork, intersectoral collaboration and cultural respect were aspects of a CPHC model for depression that were of interest. This model is referred to ‘The Southgate Model’ in this thesis.

Equity

In this thesis the term ‘equity’ is frequently used. Health equity refers to inequalities that are avoidable and unfair or unjust, and incorporates access to the determinants of good health and access to health services as well as equity in health outcomes (Commission on Social Determinants of Health, 2008). Health equity is a core principle underpinning CPHC but is often confused with equality (differences in health status between populations). CPHC, which is underpinned by equity and social justice, is the overarching theoretical framework used in this thesis, and hence equity is a critical consideration in this research.

Four PHC case study models

This study utilised four metropolitan case study sites which were State-funded multidisciplinary PHC services. The names of these services have been de-identified and in this thesis and are referred to as the Orange service, Green service, Blue service and the Aboriginal health service. These sites were chosen because they represented both long standing and emerging models of PHC delivery in Australia. The effectiveness of these four case study models is examined in relation to how they responded to depression among individuals and the community.

1.5 Outline of chapters

This thesis is structured into ten chapters. The following chapter (chapter 2) provides a review of the literature relevant to this thesis that establishes the importance of the research topic. Chapter 3 outlines the research design, approach and case study methodology undertaken and presents how the data was collected and analysed. Chapter 4 outlines the South Australian historical and reform context in which this study took place and provides a description of the four PHC services which were the case study sites. Chapter 5 outlines the range of responses to depression offered by the PHC services (research question 1), how the services worked with clients experiencing depression and with the broader community regarding the prevention of mental illness and promotion of good mental health as well as how they worked with other agencies. Client journeys, which were assessed against a CPHC theoretical framework, are presented from each of the PHC services which give an indication of the different pathways taken by clients accessing services for depression. Chapters 6-7 provide an analysis of the qualitative findings from interviews with clients and interviews with staff and service managers (research question 2 and 3). Chapter 8 explores the concept of power and the extent to which it featured in service delivery (research question 4). The links between clients' experiences of empowerment and processes of empowerment and disempowerment are presented along with staff views and reflections about how this concept featured in their work. Chapter 9 provides a summary and integration of both qualitative and quantitative findings. The discussion focuses on the system constraints and enablers that support or detract from CPHC service delivery for responding to depression at a community and individual level (research question 5). Finally, chapter 10 concludes this thesis with consideration of what this study means for CPHC practice and theory and the role of power in shaping PHC. It also details policy recommendations and avenues for further research.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This provides an overview of the literature relevant to this thesis. It provides a context to this study and outlines how it will expand upon existing literature. The following section outlines how the literature review was conducted and then provides a summary of the literature in the key areas that are relevant to this thesis. As this study was about the implementation of CPHC within PHC services for people with depression, literature was included on depression, mental health service delivery that includes treatment, prevention and promotion, mental health reform and , primary health care, social determinants of mental health, comprehensive primary health care (CPHC) that incorporates principles of empowerment and theories of power.. The chapter starts with depression, a prevalent chronic condition in Australia, and the impact of the social determinants of mental health. Key concepts that have guided mental health service delivery and mental health reforms in Australia are then highlighted, including and a recovery approach, the need for mental health promotion, prevention and treatment and acknowledgement of the social determinants of mental health. The discussion then turns to the potential of CPHC as an effective service delivery model to respond to depression.

The literature was reviewed applying a narrative approach and using a thematic analysis. A number of electronic data bases were selected: Scopus, Web of Science, ProQuest (health and medicine, social sciences) and Informit (health, social sciences and Aboriginal and Torres Strait Islander people). Searches sought literature published between 2007 to 2017 on depression and mental health, individual care, population health approach, health promotion, community empowerment, counselling, treatment outcome, social determinants of health, equity, housing, employment, empowerment, social isolation, discrimination, racism, poverty, primary health care, comprehensive primary health care, case studies, patient journey, patient pathway, referral pathway, patient care pathway. Literature was sorted and filtered based on key components of the Southgate model. (see p. 332). Literature was regularly updated throughout the research period from 2011 to 2013.

2.2 Depression – a chronic disease

Depression is the term used to refer to a group of depressive disorders that is characterised by the ‘presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual’s capacity to function’ (American Psychiatric Association, 2013, p. 155). Depressive disorders range in chronicity from mild to moderate and severe, for example persistent depressive disorder (dysthymia), the more chronic form of depression is diagnosed when symptoms have persisted for at least 2 years. Depression can occur in isolation, in a single episode or in combination with anxiety, personality disorders, bipolar disorders and substance abuse (American Psychiatric Association, 2013).

Over the past decade depression has become viewed as a prevalent chronic condition due to its episodic nature and symptoms that reoccur over time causing significant disability (Rost, Nutting, Smith, Elliott, & Dickinson, 2002; Tylee & Walters, 2007). Depression is one of the most prevalent mental illnesses (Australian Institute of Health and Welfare, 2014) and approximately 6.2% of the population experience depression (Australian Institute of Health and Welfare, 2014). There are no data available on the prevalence of depression in South Australia. Depression is more common in females than males. The effects of depression result in a loss in productivity and poor quality of life (Simon, Chisholm, Treglia, Bushnell, & Group, 2002; Strine, Chapman, Kobau, Balluz, & Mokdad, 2004). Treatment for depression is through counselling, commonly cognitive-behaviour therapy, interpersonal therapy or acceptance and commitment therapy and antidepressant medication. Evidence suggests that a combination of counselling and medication is more beneficial than counselling or medication alone (Parikh et al., 2009).

Depression is common in those with chronic physical conditions (Australian Institute of Health and Welfare, 2014). People with mental health problems have a greater number of physical health problems (Gunn et al., 2010; Whiteford & Groves, 2009b). The 2007 NSMHWB, the latest survey data available at this time reports higher rates of mental disorders in those with a National Health Priority Area health problem (i.e. diabetes, cancer, asthma, coronary heart disease, stroke or arthritis) in comparison to those without these disorders.

Social determinants of depression

Health is influenced by much more than the existence of biomedical contributions such as physical and psychological symptoms and is determined by a person's social and economic environment and their experiences of health care. Mental illness occurs more often in some social groups than others (Elliot & Masters, 2009). Depression is more common among those with lower socioeconomic status, those with insecure employment or those unemployed (Taylor, Page, & Morrell, 2004; Wilkinson & Marmot, 2003; Wilkinson & Pickett, 2006, 2007). Social exclusion and limited social support are associated with greater mental illness (Morgan, Burns, Fitzpatrick, Pinfold, & Priebe, 2007). Social exclusion is a multidimensional concept broader than poverty and for people with mental illness is frequently contributed to by a societal stigma around mental illness (Morgan, et al., 2007). Mental illness and psychological distress is also related to aging (Vink, Aartsen, & Schoevers, 2008), work and life stressors (Cole, Ibrahim, Shannon, Scott, & Eyles, 2002) and traumatic life experiences (Dailey, Humphreys, Rankin, & Lee, 2011; Slopen, Williams, Fitzmaurice, & Gilman, 2011).

Aboriginal and Torres Strait Islander people are relatively over-represented in the mental health system (Kowanko, de Crespigny, Murray, & Groenkjaer, 2003). Despite there being a lack of reliable data and population estimates on the prevalence of mental disorders within the Aboriginal and Torres Strait Islander population (Collinson & Copolov, 2004; Hunter, 2002; Langharhne, Glennen, & Austin, 2002); they have twice the level of psychological distress as measured by the K10 (Australian Institute of Health and Welfare, 2011), increased risk of death from suicide and a higher use of mental health services and hospital utilisation for mental health disorders and alcohol and drug diagnoses compared to non-Indigenous people (Emden, Kowanko, de Crespigny, & Murray, 2005; Roxbee & Wallace, 2003; Ypinazar, Margolis, Haswell-Elkins, & Tsey, 2007).

The social determinants of Aboriginal health are an important issue and in this study, one of the PHC services is an Aboriginal health service. Aboriginal and Torres Strait Islander people generally experience poorer health outcomes and have significantly poorer quality of life, lower life expectancy and less equality of opportunity compared to their non-Aboriginal counterparts (Australian Institute of Health and Welfare, 2008; Kowanko, et al., 2003; Tsey et al., 2010; Vos, Barker, Stanley, & Lopez, 2007).

Aboriginal health needs to be considered within the context of grief, despair and powerlessness spanning generations as a result of colonisation and discriminatory government policies where racism occurred interpersonally and institutionally across all sectors in Australia (Durey, 2010; Tsey, et al., 2010). The legacy of colonisation has resulted in ‘collective trauma’ which comprises ‘the structural effects of disrupting families and communities; the loss of parenting skills as a result of institutionalisation; patterns of emotional response resulting in the absence of warmth and intimacy in childhood; the carryover of physical and sexual abuse; the loss of Indigenous knowledge, language and traditions and the systematic devaluing of Indigenous identity’ (King, Smith, & Gracey, 2009, p. 78).

Aboriginal and Torres Strait Islander cultural views of health are holistic and emphasise the importance of wellbeing where land, food and health are key components (King, et al., 2009). Mainstream mental health services are argued to be at odds with Indigenous views of health and have failed to meet their mental health needs (Vicary & Bishop, 2005). Internationally researchers have argued one-to-one clinical treatment is not the best fit for Aboriginal people because of their different beliefs regarding the healing of individuals and the healing of families and communities (Thomas & Bellefeuille, 2006). Furthermore, Vicary & Bishop (2005) found many Aboriginal and Torres Strait Islander people distrust the Western mental health system, discouraging family members attending mainstream services due to the stigma of being mentally ill and concern of involuntary hospitalisation and medication.

2.3 Good mental health practice: treatment, prevention and promotion

Given the prevalence of depression and extent of psychological disability a population health approach has been applied by many governments around the world to mental health practice that acknowledges the role that social, cultural and economic factors play in influencing mental health and wellbeing and mental ill health (Hunter Institute of Mental Health, 2015).

In keeping with a CPHC approach this thesis considers the full range of treatment, prevention and promotion as key components that underpin good mental health practice which is consistent with federal and state policies on mental health that are outlined in this section. These components are important to outline as the extent to which these best practice responses to depression are evident at a selection of case study PHC services was examined in this thesis.

Mrazek & Haggerty’s (1994) continuum of mental health interventions is a commonly used model in Australia. It proposes a comprehensive approach where activities are aimed at populations or groups and individuals. It has been adapted by the Hunter Institute of Mental Health (2015) to incorporate prevention and promotion (figure 2.1) and shows the broad scope for intervention that includes universal, selective and indicated preventive action. Universal interventions are those targeting healthy populations, for example mental health programs in schools and workplaces. Selective interventions are aimed at vulnerable sub-groups of the population who are at risk, for example supportive relationships for young people and pregnant teenagers. Indicated interventions target those at high risk who have symptoms of mental illness, and focus on enhancing an individual’s coping strategies (Hunter Institute of Mental Health, 2015).

Figure 2.1: Prevention First Framework (Hunter Institute of Mental Health, 2015)

removed due to copyright restrictions

see http://s3-ap-southeast-2.amazonaws.com/everymind/assets/Uploads/EM-0026-Prevention-First-Framework.pdf

International momentum from the World Health Organisation (WHO) in addressing mental health promotion and prevention of mental disorders has brought ongoing mental health system reforms in Australia (Parham, 2005).Australian governments, both federal and state, have made a strong commitment to mental health reform as a national priority, placing an emphasis on acknowledging the social determinants of health and the promotion of good mental health and prevention of mental illness. A number of National Mental Health Plans (the first commencing in 1992 and the latest in 2009) have been developed by the Australian government to guide mental health reform. The first National Mental Health Plan moved care from psychiatric hospitals into the community and subsequent plans included a focus on mental health promotion, prevention and early intervention and highlighted the need for better coordination with social care sectors (Australian Health Ministers, 2003).

More recently, the Roadmap for National Mental Health Reform (2012-2022) emphasises the importance of supporting and maintaining good mental health through tackling the social determinants of health to lessen the burden of mental health issues and mental illness (Council of Australian Governments, 2012).

At a state level, South Australia’s Mental Health and Wellbeing Policy (2010-2015) (Government of South Australia, 2010), which is yet to be updated, outlines a number of principles that underline good mental health practice. These are:

- People that engage in the mental health system will have their individual rights protected
- The goal of mental health care is to promote recovery
- Mental health care is consumer-centred and culturally appropriate
- A whole of community, whole of government approach that promotes social inclusion and community participation will promote positive mental health
- Prevention and early intervention are prioritised in all areas of health promotion and service delivery
- Consumer and carer participation at all levels of policy, planning, service development and evaluation
- Mental health care is accessible, evidence-based and meets the highest possible standards of safety and quality regardless of age, gender, cultural background or geographical

location
- Resources for mental health are used wisely.

Both the Roadmap for National Mental Health Reform (2012-2022) and South Australia's Mental Health and Wellbeing Policy (2010-2015) recognise the complex and inter-related nature of the social determinants of health and wellbeing that can impact on a person's mental health. These policy documents also emphasise that prevention and health promotion as well as community participation and empowerment are important to mental health practice. These principles of good mental health practice being promoted in Australia are congruent with key characteristics of a CPHC model of service delivery. These reforms have a social view of health that defines health broadly and considers the person as a whole which is in contrast to a biomedical model view.

Both these federal and state policies emphasise and support an individual's potential for recovery. A recovery approach was established in the 1980s and has become widespread through most western countries (Whitley & Campbell, 2014). This approach views recovery as improving individual's ability to cope, building supportive relationships, empowerment and social integration. These policies emphasise that recovery-orientated approaches can be implemented across the spectrum of interventions for mental health (Commonwealth of Australia, 2013). There is evidence that at the treatment end of the spectrum mental health services that use a recovery approach can reduce the negative impact of stigma felt by those that experience mental illness (Corrigan, 2002; Verhaeghe, Bracke, & Bruynooghe, 2008).

Recovery is defined as *"a person's own unique and personal journey to create a fulfilling, hopeful and contributing life and achieve his or her own aspirations, despite the difficulties or limitations that can result from the experience of mental illness. It does not necessarily mean the elimination of symptoms or a return to a person's pre-illness state"* (Government of South Australia, 2010, p. 5). A recovery approach is relevant to this thesis as it is a framework that supports the empowerment of people with mental illness and has an emphasis on mental health promotion by promoting well-being and considering an individual's social environment (Ramon, Healy, & Renouf, 2007). A recovery approach seeks to address the social determinants of health that impact on the wellbeing of people with mental health problems such as employment, education, housing, income, social inclusion, stigma, discrimination, trauma and socioeconomic hardship and thus has some overlap with CPHC principles. A recovery approach is viewed as an alternative to the biomedical model which focuses on 'pathology, deficits and dependency' (Commonwealth of Australia, 2013, p. 11); it contests established ideologies of professional power (Perkins & Slade, 2012).

Despite the policy emphasis on recovery it is unknown the extent to which it has been implemented among mental health practitioners within PHC. There are differing views of recovery and there are problems with terminology (Davidson & Roe, 2007; Ramon, et al., 2007). Some medical model interpretations of recovery focus on clinical understandings of illness and the absence of symptoms, for example improved functioning and symptom management (Crowe, Deane, Oades, Caputi, & Morland, 2006) an approach that has been termed 'clinical recovery' (Slade, 2010). Other interpretations emphasise regaining control over aspects of personal and social life and have been referred to as 'personal recovery' (Slade, 2010). The term 'recovery' is problematic for some practitioners as it suggests full recovery and may offer false hope and disappointment (Davidson & Roe, 2007). The extent to which recovery approaches align with CPHC approaches has not been examined and this thesis provides an opportunity to examine these concepts in practice.

Good mental health practice that includes treatment, prevention and promotion is clearly present to some extent in the policies described above. These components of good mental health practice are strongly aligned with those that underpin a CPHC model of service delivery. Appendix A shows a program logic model developed as part of the NHMRC study that displays key elements of a CPHC model for depression that includes treatment, early intervention/prevention and promotion activities. A CPHC model that is underpinned by principles of social justice and equity was the overarching theoretical framework used in this study.

Similarly, the Ottawa Charter for Health Promotion that came after Alma Ata also aligns with these components of good mental health practice. The Ottawa Charter marks the commencement of the new public health movement. Both CPHC and the Ottawa Charter present an agenda and offer a holistic approach that emphasises a broad understanding of health as an alternative to the biomedical model, a focus on communities as well as individuals, working across sectors and an emphasis on community participation, health promotion and tackling the social determinants of health (World Health Organisation, 1978, 1986). CPHC and the Ottawa Charter have been important historically to the development of good mental health practice and are discussed further below.

Internationally, CPHC has not been fully implemented by western countries and in the lead up to the Ottawa Charter there were concerns that health promotion was being limited to lifestyle and behavioural approaches (Baum, 2016). The Ottawa Charter emerged at a time where it built on the World Health Organisation's (WHO) goal to achieve Health for All by the Year 2000 by the promotion of CPHC, and a number of social movements such as the consumer movement, feminism and community development (Baum, 2016).

The Ottawa Charter for Health Promotion sets out five strategies, two of which reflect goals of mental health promotion. These are 'strengthening community action' and 'development of personal skills'. For example, activities and programs directed at reducing social inequality and building social capital have been shown to have a positive effect on mental health (World Health Organisation, 2004). Over the last three decades a number of WHO health promotion conferences have developed the idea of health promotion (Baum, 2016). In Australia, the approach to improving mental health promotion and prevention of mental illness has involved the development of a comprehensive population health approach at a national, regional and community level.

Prevention and promotion strategies are more cost-effective than treatment only approaches (Hunter Institute of Mental Health, 2015). There is strong evidence for the effectiveness of mental health promotion and prevention in reducing individual and social impacts of poor mental health and in having a positive effect on mental health outcomes (Commonwealth Department of Health & Aged Care, 2000; Council of Australian Governments, 2007; Herrman, Shekhar, & Moodie, 2005; Jane-Llopis, Barry, Hosman, & Patel, 2005; World Health Organization, 2004a; Zechmeister, Kilian, McDaid, & MHEEN group, 2008). Successful strategies and activities that achieve positive mental health include: improving social and economic factors impacting on health such as poor housing and unemployment, making workplaces more health promoting and reducing stigma and discrimination associated with having a mental illness.

beyondblue is a mental health promotion campaign informing the community on common signs and symptoms of depression. An evaluation of this strategy found greater awareness of depression in the community and discrimination against people with mental illness (Australian Health Ministers, 2003) as well as improved mental health literacy in the community (Dumesnil & Verger, 2009).

Good mental health practice therefore involves looking at the whole person and having an understanding of how social and economic factors influence health. Barry (2007) argues mental health services need to *'embrace promotion and prevention activities as well as treatment and rehabilitation services'* (Barry, 2007, p. 6). However, mental health services have struggled to make a shift to a social view of health and mental health promotion has a history of being overlooked as an essential element of health promotion (Wahlbeck, 2015).

A number of researchers have documented barriers toward reorientating mental health services towards promotion and prevention (Jorm, 2012; Wahlbeck, 2015). Mental health information systems can tend to be aligned to hospital data rather than capturing community-based mental health service provision (Wahlbeck, 2015). Thomas and Morris (2016) point to challenges such as the prioritisation of treatment, a lack of training on how to develop 'multiple-way partnerships and communities for health', and a lack of infrastructure to support promotion and prevention. Other challenges relating to implementation include tensions from within the health system between 'treatment' and 'prevention' with clients and practitioners expressing dissatisfaction that mental health services are poorly funded (Jorm, 2012).

A recent national review of Mental Health Programme and Services (National Mental Health Commission, 2014) found there was substantial spending on mental health but that many people do not receive the support they need when they need it and recommended investment in prevention and early intervention. The federal government's response to this review emphasised treatment and the aim of including prevention and early intervention strategies but fears have been expressed that this may be rhetoric rather than reality (Australian Government

Department of Health, 2015; McGorry & Hamilton, 2016; National Mental Health Commission, 2014).

One of the strategies set out in the Ottawa Charter is building healthy public policy through linking with sectors beyond health to encourage healthier and more equitable living and working conditions (World Health Organization, 2004b). A fragmented Australian mental health system has meant there has been little progress in engaging stakeholders from social care sectors, something promoted by national mental health strategies over the years (Banfield et al., 2012) (Parham, 2005). The Partners in Recovery (PIR) initiative (initially run by Medicare Locals but now being moved to the National Disability Insurance Scheme) has recently made progress in engaging with multiple agencies across different sectors (e.g. housing, employment) to assist those with severe mental illness that also have complex needs (Brophy, Hodges, Halloran, Grigg, & Swift, 2014). The PIR initiative is based on a collaborative, person-centred holistic model that has utilises a recovery approach and emphasises the importance of empowerment. The National Mental Health Commission’s National Report Card argued for more holistic approaches to mental illness (National Mental Health Commission, 2014).

It is clear from the literature that important aspects of good mental health practice include prevention, the promotion of good mental health and a recovery approach, and these also concord closely with CPHC principles. The extent to which practitioners from four case study PHC services utilise a CPHC approach to mental illness that incorporates prevention, promotion and treatment and engagement with social sectors among individuals and the community was of interest in this study. In particular, the approach to depression, a serious and common mental illness is examined.

2.3.1 Treatment of depression

The treatment of depression is argued to be best managed using chronic disease management models where principles of chronic disease self-management are used (Andrews, 2001; Tylee & Walters, 2007). Andrews (2001) argues that managing depression using a model of practice where clients seek help only when felt necessary, or during an acute phase, is not appropriate for an episodic lifelong condition. Despite the evidence of the chronicity of depression, it has not been given the same priority as chronic physical health conditions as evidenced by mental health conditions being accorded insufficient health care resources in high income countries (Cassano & Fava, 2002; Moussavi et al., 2007; Thornicroft, 2011).

The treatment of depression has focused on organisational and educational strategies targeting health professionals to improve identification and management of depression in general practice (Bower et al., 2012{Sikorski, 2012 #2057)}. Educational strategies include guidelines targeting health practitioners, consultation-liaison, with an educative role for practitioners working more closely with non-specialist clinicians.

CPHC with its focus on multidisciplinary practice has the potential to cope with the chronic and complex nature of depression and problems of comorbidity while also taking into account an individuals' social circumstances. Hickie & McGorry (2007) and Gilbody et al (2006) argue that depression should be treated using multidisciplinary collaborative care rather than individual episodic care where principles of self-management are incorporated. There is considerable evidence that treating depression using collaborative care and self-management approaches is more effective (Hickie & McGorry, 2007; Woltmann et al., 2012). Collaborative care is when more than one discipline of health professionals work collaboratively together (Gilbody, et al., 2006). Collaborative care is used interchangeably with collaborative practice, care coordination, coordinated care and patient-centred care and all use similar definitions and refer to similar practices, that is, collaborative practice (Jones & Delany, 2014). Furthermore, Jones & Delany (2014, p. 12) provide the following definition for collaborative mental health practice: *'a code of practice enacted by multidisciplinary workers to establish an accessible communication and care framework with clients, their families, carers and other key stakeholders whose purpose is to facilitate consensus based on egalitarian principles of inclusivity, respect, equality to provide quality holistic care'.* This definition is relevant as the extent to which four case study PHC services utilise collaborative mental health care practice is examined.

Battersby et al (2010) argue collaborative practice ought to draw on the concept of an *enabling* society which is suggested as a way to improve people's ability to meet their own needs and successfully manage their chronic physical condition. This concept is relevant to depression when it is considered a chronic condition. Within the context of health care enablement refers to patient empowerment, self-management support (SMS) and where clients are involved in making decisions about the planning and management of their condition (Battersby, et al., 2010). Enablement is a person's *'ability to understand better, or cope with, or participate in, or have greater responsibility for, their own care*' (Haughney, Cotton, Rosen, Morrison, & Price, 2007). Battersby et al (2010) describe twelve evidence-based principles that are linked to improved enablement and self-management. The integration of enablement and self-management principles into routine treatment has been a challenge (Battersby, et al., 2010) and chronic disease management models for the treatment of depression represent an ideal rather than actual practice. These enablement principles are directed at individuals rather having a broader social approach targeting groups and communities. The Ottawa Charter defines enablement more broadly as 'taking action through partnership with individuals or groups to empower them, through the mobilisation of human and material resources, to promote and protect their health' (World Health Organisation, 1998, p. 7). This broader social approach directed at individuals and the community is a key component of a social view of health that underpins CPHC. The section below will discuss current mental health practice in Australia and explains where PHC services are placed within the health system.

2.4 Wider context of current mental health practice in Australia

Care and support for people with mental illness is provided by state and federal governments and by a combination of GPs, multidisciplinary PHC services (in some states), private psychologists and psychiatrists, social workers, allied health workers and public mental health services in the community. The appropriate treatment of depression is disputed amongst these practitioners and there are professional debates and scepticism regarding best practice and professional training and underlying philosophies among practitioners (Battersby, et al., 2010; Fairlamb & Muir-Cochrane, 2007). PHC services are part of this complex system and have an important role in mental health service provision. PHC services operate outside of fee-for-service primary medical care and parallel to government-funded mental health services and private mental health providers such as psychologists and psychiatrists.

Treatment of mental illness in the community has been inadequate, leading to a decades of considerable mental health system reform and an increased investment in the treatment of depression by the Australian government (Rosenberg et al., 2015; Senate Select Committee on Mental Health, 2006). In 2002-2003, the Mental Health Council of Australia conducted a nation-wide review of mental health services, consulting service users and service providers concluding that community-based systems failed to provide adequate services for people with mental illness. The review found that these services were 'characterised by: restricted access; variable quality; poor continuity; lack of support for recovery from illness; or protection against human rights abuses' (Groom, Hickie, & Davenport, 2003, p. 1). Twelve years on and reviews have been consistent in concluding the continued failure of Australia's mental health system and the failure of consecutive governments to provide an adequate community-based model of care promised following the deregulation and closure of psychiatric institutions (Griffiths, Mendoza, & Carron-Arthur, 2015).

> Primary medical care that is based on an individualistic biomedical model that focuses on episodic care has dominated the treatment of depression in Australia and internationally (Andrews, 2008; Deacon, 2013; Whitty & Gilbody, 2005). The next paragraphs provide an overview of the relevant literature on primary medical care in relation to depression giving context to this study.

Starfield and Shi (2002) who argue that the stronger a country's network of primary medical care providers, the lower care costs and generally the better the health of the population. Also, primary medical care, in contrast to specialty care (medical care provided by specialists) has advantages in that it improves health, prevents illness and death and leads to more equitable distribution of health in populations (Starfield, Shi, & Macinko, 2005). Despite the continued dominance of primary medical care in Australia there are a number of shortcomings to this community-based model of care that have led to mental health system reforms (Reifels et al., 2013)

Meeting the needs of chronically ill patients requires improvements in primary medical care delivery systems to include health promotion and disease prevention, the employment of allied health staff and a multidisciplinary teamwork approach (Barr et al., 2003; Hung et al., 2007; Schmittdiel, Shortell, Rundall, Bodenheimer, & Selby, 2006). Within primary medical care, health promotion opportunities are limited and short consultation times mean this community-based model is unable to provide a holistic approach that is recommended in the National

Roadmap to mental health that includes health promotion and prevention other than lifestyle risk advice and disease screening. There is little time to focus on social issues or gain an understanding of issues leading to depression. Additionally, primary medical models are unlikely to have the capacity to tackle the complex issues of the determinants of health or to contribute to advocacy and activism that can lead to social change, a key distinction between CPHC and fee-for-service general practice (DeVoe et al., 2016).

Federal and state governments have funded initiatives aimed at strengthening GP integration into the wider health system. The Commonwealth's General Practice Reform Strategy was a major structural reform with Divisions of General Practice were established in 1992. These regional associations of GPs coordinated local primary medical care services to increase the quality of care and health outcomes for local communities (Smith & Sibthorpe, 2007). Between 2011-2012 Divisions of General Practice became Medicare Locals that aimed to coordinate services in local areas and improve access and integration to services provided by general practice and allied health. These structural reforms are discussed further in chapter 4.

In Australia and South Australia there has been a shift in focus to incorporate prevention and health promotion strategies into primary medical care, which is more aligned to a CPHC model of service delivery. Other reform initiatives have included an interest in reducing costs, improving access and service quality and promoting private GPs to collaborate and support the wider health system (Fletcher et al., 2009; Harris et al., 2011). This has encouraged the integration of GPs with other PHC services in the community. However, progress toward integration is still limited with financial or business interests being a barrier to improved integration and ideological differences amongst GPs and community health centres who work across different sectors and have little shared accountability (Powell Davies et al., 2008). In South Australia, limited links were found between GPs and local PHC services with the main barriers being communication problems, referral pathways, access and availability of services (Wiese, Jolley, Freeman, Baum, & Kidd, 2010).

Around the world health systems have been plagued with challenges such as responding to the needs of individuals and populations while also reducing costs and being more efficient. Duckett (2014) argues health care has a number of 'wicked problems' that are not easy to solve.

There has been a focus on strengthening health systems both internationally (World Health Organisation, 2007) and nationally (Dwyer, 2004) as the way to support a healthy and equitable society. Too many health systems are inadequate and inequitable or are accessible to only a small proportion of the population. Treatment is prioritised and people often don't have access to affordable forms of prevention when they need it (World Health Organisation, 2007). Likewise, the World Health Report (World Health Organisation, 2008) reiterated the failure of health systems to respond to people's needs and the challenges of globalisation, reaffirming an agenda of a renewal of CPHC.

GPs are usually the first point of contact for people experiencing depression and can refer patients to PHC services, but more often refer to private psychologists (Whiteford, 2008). This referral pathway has become increasingly common since the introduction of Better Outcomes in Mental Health Care (BOiMHC) and the Access to Psychiatrists, Psychologists and General Practitioners program ('ATAPS') in 2006 (Fletcher et al., 2008). BOiMHC and ATAPS are discussed further in chapter 4 but briefly these programs include mechanisms where GPs can refer individuals with depression and anxiety disorders to allied health professionals (mainly psychologists) for six sessions of evidence-based care (cognitive behavioural therapy, CBT), with the option of more sessions if needed (Fletcher, et al., 2008).

Evaluations have concluded that these programs have provided increased access and improved management of depression (Pirkis et al., 2010). However, concerns have been raised about their focus on individualised medical care and the lack of incentives for co-location of services which has been regarded internationally as an important way of promoting collaboration among service providers which is more effective in treating depression than individual episodic care (Hickie & McGorry, 2007). The ATAPS and BOiMHC programs focus on acute, episodic treatment and have a biomedical orientation. A biomedical model underpins 'primary care' or 'primary medical care' which has dominated service delivery in Australia and globally (Baum, et al., 2016). There have been calls to strengthen health systems to become more equitable and dilemmas of having a cost effective system that is also responsive to people's needs have been debated. CPHC has been proposed as a model that is cost effective and responsive to individuals and communities.

2.5 Comprehensive Primary Health Care (CPHC)

The WHO has played a central role in promoting public health and developing public health policy worldwide (Earle, 2007). One of the most significant landmarks was the Declaration of Alma Ata (World Health Organisation, 1978) introducing the concept of ‘health for all’ and articulating CPHC as a model of health service delivery more likely to achieve high levels of health and recognise the social determinants of health to promote health and address health inequities (Earle, 2007).

A CPHC model of service delivery as envisaged in the Alma Ata Declaration would provide: “universal accessibility and coverage on the basis of need, vertical comprehensiveness with respect to access to secondary and tertiary services, horizontal comprehensiveness with emphasis on disease prevention and health promotion, active community and individual involvement in health services with an aim of self-reliance, engagement in intersectoral actions on the determinants of health and use of appropriate technology and cost- effectiveness in relation to available resources” (World Health Organisation, 1978)

The Declaration stated that a CPHC system “addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly”. It “should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need” (World Health Organisation, 1978). CPHC is both a model of community-based health service delivery and a philosophy of care (Keleher, 2001; Wass, 2000).

CPHC has been interpreted differently by different countries. It has rarely been fully implemented by any nation. Medically focused selective primary health care (PHC) with its individualised care and disease-based approach has dominated rather than what was envisaged in the 1978 Declaration of Alma Ata (Baum, 2008). Selective PHC emphasises measurable medically and behaviourally defined goals, and positions medical interventions as central to improving the health status of individuals. Selective PHC targets delivery of care to high risk groups rather than striving for universality, and has less capacity to address structural causes of ill health. This model of care retreats from issues of community involvement, equity and social action that form the basis of CPHC (Baum, 2008; Wass, 2000).

In Australia, PHC based on CPHC principles is delivered through a range of services such as Aboriginal community controlled health services, community health services, women’s health services and youth health services. PHC in South Australian has a long history dating back to 1973 when the Australian Community Health Program (ACHP) was introduced leading to the establishment of community health centres in the 1970s and 1980s (Warin, Baum, Kalucy, Murray, & Veale, 2000). The ACHP was a novel program that aimed for all Australians to have access to basic health services. An important feature of this program was community health services which were responsible for the health of the local community in any given area. The ACHP foreshadowed many aspects of the Alma Ata Declaration with an emphasis on reorientating health services, building community capacity to action upon health issues, promoting good mental health and encouraging and supporting self-help, (Baum, Fry, & Lennie, 1992). The ACHP established community health centres mainly in Victoria, South Australia, the Northern Territory, the Australian Capital Territory and Queensland. Primary medical practice is an essential component of PHC but in Australia most GPs and what was originally termed community health developed in parallel. Some of these community health centres included GPs but many did not as community health was seen as a threat to medical power and the medical model and some GPs were cautious about the emphasis placed on other health professionals (Raftery, 1995).

People that access community health services are often the most disadvantaged members of society, including older people, and people with physical and mental illnesses (Freeman et al., 2011). Community health services that developed under the ACHP operated on a social model of health, a conceptual framework based on the knowledge that improvements in health and wellbeing will only be achieved when direct effort is taken towards addressing the social, economic and environmental determinants of health (Willis, Reynolds, & Keleher, 2012). In a CPHC system, community health services are seen as an important part of the health sector, not an optional service or a service that responds to crises, but where there is a focus on key features such as building a long term relationship with the community that encourages empowerment, equitable access, partnership, is client-focused and encompasses a range of multi-disciplinary services (Baum, et al., 1992). These key features are particularly important in addressing mental health and for the recovery of mental illness. Below, the potential of CPHC in addressing depression is considered. Core values and principles underpinning CPHC such as equity and empowerment are discussed. The extent to which these principles are evident in the response to depression at a selection of PHC services is examined in this thesis.

2.5.1 CPHC as a model of service delivery for depression

CPHC offers a comprehensive approach to meet the needs of people experiencing a chronic condition such as depression. Its focus on prevention and disease management as well as treatment and rehabilitation is particularly important given that depression can be a reoccurring, preventable condition. Importantly, under a CPHC model, health care is tailored to the client and their family, where clients have an active role in promoting personal health such as increasing physical activity, reducing tobacco use and limiting unhealthy nutrition. A CPHC approach is consistent with the WHO’s Innovative Care for Chronic Conditions Framework (World Health Organisation, 2002) that recognises that depression is a chronic disease and argues for health care systems to be reorientated to include principles of CPHC like prevention and early detection, and capacity for extended and regular contact with health practitioners who are part of the response to depression. This framework maintains that health care systems based on an acute, episodic model are not effective for people experiencing depression.

CPHC has the potential to provide greater management of chronic conditions. A study in Canada compared three different models of selective PHC delivery to investigate the quality of chronic physical disease care being delivered. Models included:

1) Fee-for-service, where GPs received the majority of payment through fee for service billing, 2) Blended capitation, where GPs receive payment for comprehensive care as well as through fee-for-service and are given incentives for specific PHC services such as smoking cessation counselling and diabetes care and 3) Community health centres encompassing multidisciplinary teams which were community-governed and GPs are paid a fixed annual salary. The study found community health centres provided a higher quality of care that can benefit the management of chronic conditions such as diabetes and offer an alternative delivery system than the fee-for-service model (Liddy, Singh, Hogg, Dahrouge, & Taljaard,

2011).

A renewal of CPHC was called for in the World Health Report (2008) titled, *‘Primary Health Care - Now More Than Ever’*. This report revisits the vision of CPHC, its values and principles for guiding the development of health systems. Among other recommendations, it calls for service delivery reforms to orient health services towards people’s needs and expectations so they are socially relevant and responsive.

Health services that are responsive to people’s needs are referred to as ‘patient-centred’ (Jackson, Oelke, Besner, & Harrison, 2012) and is congruent with self-management and a recovery approach to mental illness. Even though the term patient-centred has been around for some time, orientating health services towards people’s needs is a challenge due to a biomedical dominated health system with its focus on acute, episodic care in which it is more difficult to take into account the social and economic circumstances of people’s lives. A CPHC system as defined in the Declaration of Alma Ata, that is underpinned by principles of equity and social justice that are key to health improvements should be able to overcome this issue. For example, within a CPHC system there is great capacity for practitioners to be involved in both planned and opportunistic mental health promotion through regular contact with individuals in their community. Through the promotion of good mental health with clients and advocacy on behalf of their community, practitioners are well placed to support both individual needs as well as influence the policies and programs that have an impact on the health of the community.

The potential benefits of CPHC are apparent but there is limited literature regarding its effectiveness as a health care delivery system in relation to depression and client perceptions of CPHC service provision. The majority of studies have focused on clients with severe mental illness in acute mental health services. For example, Onken et al (2002) investigated client perspectives on recovery for those using state and local mental health systems but focused on those with severe mental illness and did not investigate CPHC specifically. Noble et al (2004) conducted a review of client and carer perspectives about mental health care but again the majority of the studies in this review were focused on clients with severe mental illnesses in acute settings.

Evidence suggests community-based models of mental health that offer a range of services are associated with lower suicide rates compared to traditional hospital-based treatment (Wahlbeck, 2015). However, some researchers (Patel et al., 2013) and clients using community mental health services have expressed the need for integration of mental health and primary medical care (Wahlbeck, 2015).

There is little literature that describes mental health services within CPHC and in particular, on depression. Earlier research by Muir-Cochrane (2001) described case management practices in a group of community mental health nurses where a commitment to PHC involved client-centred approaches and an emphasis on health promotion. The only study that describes mental health being delivered in a CPHC context in Australia is by Fairlamb and Muir-Cochrane (2007) who outline advantages and challenges experienced when mental health service delivery is changed from a medical model to an innovative model using a CPHC framework. Within this framework there was recognition of the social, economic and physical determinants of health and acknowledgement of the role of factors such as housing and homelessness, employment and family relationships influence mental health. The service used a recovery approach which was applied across the spectrum of interventions for mental health from promotion, prevention, treatment (Figure 2.1) and aimed to promote individual power by using a comprehensive assessment form that shares power in the assessment process.

Challenges and barriers to implementing the model were described. For example, there were criticisms from mental health care providers from traditional medical model mental health philosophies that workers without mental health training may not detect acute signs of mental distress needing hospital admission. Also there were inadequate data collection systems to capture the frequent consultations and close working relationships developed among team members that minimised the risk of mental distress being unrecognised. Additionally there were minimal information systems to collect data on promotion and prevention work being undertaken. Neither the mental health promotion and prevention work carried out as part of this model nor the experiences of clients were reported in this study. This thesis will build on research by Fairlamb and Muir-Cochrane by investigating mental health promotion and prevention activities offered at four PHC services and will explore clients' experiences of the services they received within a CPHC model of service delivery.

Research has largely focused on specific aspects of CPHC. A review by Hurley & Baum (2007) found Australia evaluations mainly focused on small components, or locally based programs and projects carried out in CPHC, rather than services or policies as a whole. Individual components of CPHC such as provision of equitable access and community involvement and participation, and interdisciplinary collaboration (Sicotte, D'Amour, & Moreault, 2002) have been consistently evaluated while others such as action on social determinants or incorporation of a rights-based approach are less commonly included (Hurley & Baum, 2007). More recently, a review by Rule (2014) et al on the effectiveness of CPHC found studies have focused on quality, access and equity of access but have lacked the development of measurements to evaluate these components. Rule et al (2014) point to an approach by Wong et al (2011) where they developed and applied a logic model framework to evaluate CPHC that is based on local context.

This study will also apply a logic model developed for the NHMRC study (Lawless, Freeman, Bentley, Baum, & Jolley, 2014) which as discussed earlier is based on evidence-based practice and was guided by consultation with practitioners and managers. This thesis will contribute understanding about operation and outcomes of CPHC delivery systems in relation to depression. Although this research is looking at a component of CPHC, namely its response to a specific disease, depression, it examines the response to depression at a whole of service level and the way responses to depression play out across the spectrum of interventions for mental health. It has been argued in order to have this holistic approach a CPHC service delivery model needs to operate within a supportive context so that this system is able to target local community need (Lawless, et al., 2014). The next section will introduce the concept of empowerment, a tenet of CPHC, its importance to the treatment and recovery of depression and the theories of power used in this thesis.

2.6 Empowerment and health

Empowerment, is an important principle of CPHC underpinning how PHC services address depression and a key mechanism aiding the prevention, treatment and recovery of depression (Anderson, 2007; Schulrerg, 2001; Wallerstein, 2006). This thesis will examine the opportunities and barriers to individual and community empowerment in a CPHC model of service delivery.

Empowerment is widely described by a number of relevant disciplines including those in social and community work (Freire, 1971; McKnight, 1985; Turner, 2011) and health promotion and education (Laverack, 2009; Nutbeam, 2000; Wallerstein, 2006). This section looks at the way health-related disciplines understand empowerment. Numerous definitions of empowerment exist but there is little agreement on this concept (Fumagalli, et al., 2015; Kennedy, Hardiker, & Staniland, 2015; Tew, 2005). It has been argued empowerment is more easily understood by its absence: ‘powerless, helplessness, hopelessness, alienation, victimisation, subordination, oppression, paternalism, loss of a sense of control over one’s life and dependency’ (Gibson, 1991, p. 355). Empowerment is expressed through coping skills, supportive relationships, self-esteem, support systems, community organisation and community participation (Gibson, 1991).

Some researchers have argued community participation and the importance of empowerment through collective action are key components to improve health (Wallerstein, 2006) which connect with a social model of health that emphasises the importance of human rights and greater equity (Solar & Irwin, 2010). The empowerment approach targets individuals as well as social, environmental and political dimensions of the problem. Thus, empowerment according to Wallerstein (2006) embodies a broad process that includes prevention, community connectedness, self-development, increased quality of life and social justice.

The 2008 Report from the World Health Organisation’s Commission on the Social Determinants of Health points to the central idea that individuals and communities that are empowered are much healthier that those who are not (Commission on Social Determinants of Health, 2008). Evidence supports the contention that empowerment improves health outcomes and feeling in control of life situations has a positive impact on health and well-being (Segal, 1998; Wallerstein, 2006) such as being more confident and experiencing greater quality of life (Linhorst, Hamilton, Young, & Eckert, 2002).

Outcomes and benefits which occur among individuals and groups or communities include individuals/groups with increased autonomy, power and control and improvements in health status through the promotion of healthy behaviours leading to improved physical health

(Finfgeld, 2004). Several researchers argue mental health services that use an empowering approach is associated with reduced perceived stigma (Corrigan, 2002; Jensen & Wadkins, 2007; Verhaeghe, et al., 2008). Empowerment strategies have been successful in empowering youth. Health outcomes include collective efficacy, stronger bonds and relationships with others and greater participation in organised events such as youth action on changes to policy and improved mental health and school achievements (Wallerstein, 2006). Empowerment depends therefore not only on individual agency but leadership and a supportive context under which to operate.

The extent to which health systems promote and support empowerment is of particular interest as one of the research questions is concerned with system constraints and enablers that support or detract from CPHC service delivery. Health promotion and participation are key components that facilitate greater control over health. There is little literature on how health systems support empowerment. This is partly due to the lack of accepted tools for the measurement of individual and community empowerment (Segal, 1998). Bravo et al (2015) in qualitative interviews with stakeholders in the United Kingdom (clients, health managers, health service researchers) found health priorities, policies, culture and political context were important factors influencing empowerment.

Segal (1998) points to a number of strategies for a health system to promote empowerment of clients and communities. Among other strategies the importance of the flow of information to individuals is highlighted along with training for workers and agencies to adopt a service delivery approach that enables individuals and communities to have a more active role in defining their own health care needs, service delivery planning and support for staff to encourage individual and group empowerment. Empowerment therefore plays an important role in mental health and recovery.

2.7 Empowerment and mental health

In the past, people with severe mental illness have been dis-empowered (Carling, 1995; Linhorst, et al., 2002) and it is acknowledged that the treatment and process of mental health care for people with mental illness can contribute to this (Baker & Stevenson, 2000). There are various definitions of empowerment in the context of mental health and commonly they emphasise client choice and control (Linhorst, et al., 2002). Empowerment is referred to as both an outcome and a process (Labonte, 1990; Linhorst, et al., 2002; Oakley & Kahssay, 1999; Schulz & Nakamoto, 2013); and can be examined at individual (psychological), organisational (group) and community (political action) levels (Laverack, 2004). Individual approaches to empowerment have dominated but the importance of also supporting and encouraging community empowerment is discussed below.

Individuals are empowered by decisions they make and by being active in the process. Linhorst (2006, p. 5) describes the process of empowerment as “that which prepares people to participate more effectively in an activity that increases their power, control, or influence”. Empowerment is central to recovery approaches to mental illness. Policy documents outlined earlier such as the Roadmap for Mental Health Reforms (Council of Australian Governments, 2012) and the National framework for recovery-orientated mental health services (Commonwealth of Australia, 2013) highlight the importance of a recovery approach that is responsive and adaptable to individuals and the community.

Key to a recovery approach is including individuals with mental illness in their treatment through shared decision making regarding treatment planning and activities and choice around goal setting (Coulter & Elwyn, 2002; Loh, Leonhart, Wills, Simon, & Harter, 2007; Pearson, 2002; Perestelo-Perez, Gonzalez-Lorenzo, Perez-Ramos, Rivero-Santana, & Serrano-Aguilar, 2011; Schulrerg, 2001). Client involvement has an empowering effect and is linked to a strengths-based approach (Tambuyzer & Van Audenove, 2013). Other examples in the mental health literature of empowering practices for people with mental health problems include support groups, programs run by clients in the community, being involved on committees and advisory boards in mental health organisations and participation in program evaluation (Carling, 1995; Davidson et al., 1999; Linhorst, Eckert, Hamilton, & Young, 2001; Linhorst, et al., 2002). More recent literature argues the need for inclusive respectful services but also emphasises client empowerment involves the right to acceptable and accessible services (Wahlbeck, 2015).

A Canadian study investigating clients with severe mental illness participating in community mental health programs where there was a change from a medical model to an empowerment approach, found important elements that helped facilitate client empowerment. These included facilitating access to valued resources such as accommodation, and life skills training (cooking and budgeting) and community integration. For example, the organisations supported clients to have greater involvement in community activities such as through volunteer roles, being active on committees, and employed casually within the organisations (Nelson, Lord, & Ochocka, 2001). Research on the empowerment process has found that with a supportive community and through collective action, clients can shift from being relatively powerless to gaining power (Baxter & Diehl, 1998; Lord & Hutchinson, 1993; Nelson, et al., 2001; Young & Ensing, 1999). Shifts in power are improved through knowledge and awareness, gaining skills, and supportive relationships and community contexts (Nelson, et al., 2001). Additionally, research investigating PHC services in South Africa found community participation led to more culturally competent services and enhanced empowerment for individuals with common mental illnesses such as depression (Petersen, Baillie, & Bhana, 2012).

Kermode et al (2007) found poor mental health was associated with social and socioeconomic determinants. Empowerment was connected to income and education, reductions in discrimination and the promotion of good mental health among individuals and the community. Nelson et al (2001) along with others (Labonte, 1992; Solar & Irwin, 2010) argue empowerment is unlikely to occur without improvements in these life conditions. This represents a holistic view of mental health and is aligned with how mental health is viewed in a CPHC model of service delivery. An understanding of the processes that contribute to health inequities involves an examination of theoretical accounts of power that explain how power operates at different levels. The next section will outline the key theories of power employed in this thesis.

2.8 Theories of power

Multiple theories influencing power have been applied to examine the influence of power in the health care environment (Kennedy, et al., 2015). In this thesis, power is viewed as a complex multidimensional concept that acknowledges different forms and levels of power and adopts a political model of the concept and practice of empowerment that is embedded in collective action. This study draws upon the theories of Labonte, Lukes and Foucault which were used as both a conceptual definition of power but also provided a framework to analyse the power dynamics within the context of PHC services. A four-dimensional model developed by Hardy (1994) is presented which incorporates these theories and shows the different ways power features, providing a comprehensive approach and a deep analysis of the power dynamics within CPHC services. This model of power is used as a lens to examine empowerment practices within the case study sites. These three theories are outlined below.

Labonte's (1994) conceptualisation of power features two important elements: "power over" and "power with". Labonte (1994) emphasises the tension between the two. "Power over" takes the form of 'one person or group having control over others; the resources or decisions that influence their lives and health' (Laverack, 2007, p. 9). A practitioner may influence a client to change their beliefs, attitudes and behaviours is an example in the context of health services. In comparison, "power with" respects the views of the client and considers them within the broader context of their lives. Where "power over" seeks to inform or instruct clients regarding health behaviours or risks, "power with" considers what the client brings in relation to their knowledge and that of the community.

Lukes (2005) proposes that "power over" has three dimensions that are hidden from direct observation. These dimensions present different ways individuals, groups or services can exert "power over". Labonte's interpretations of power are theoretically compatible with Lukes (2005) three dimensions of power. Both theorists emphasise sovereign power that can be possessed by someone in the decision-making process. Lukes theory helps us to recognise how power plays out within organisations such as PHC services. The three dimensions of power are outlined below.

In the first dimension, power is expressed when a number of resources are used to influence decisions that are made. Non-decision making is relevant in Lukes second dimension of power and was apparent when researchers questioned the assumption that non-participation in decision-making was an indication of satisfaction and consensus (Hardy & Leiba-O'Sullivan, 1998; Lukes, 2005). This line of questioning led researchers to realise that conflict can be present even when it has not been communicated. As Hardy & Leiba-O'Sullivan (1998, p. 455) explain 'non-decision-making is typically associated with attempts by dominant groups to protect the status quo’. Here power is exerted by the powerful so that agendas are controlled and options may not be considered. The first two dimensions of power are therefore concerned with how power plays out within the process in which decisions are made as a specific way to reach outcomes.

The third dimension is where power is manipulated so that social groups are ‘denied entry into the political process’ and may accept the status quo without conflict (Lukes, 2005). This may be through individuals’ decisions, or through the operation of organisational practices. Lukes explains this third dimension of power as acknowledging the circumstances in which *possible matters* are hidden, by social forces, institutional policies or through decisions made…‘this can occur in the absence of actual observable conflict, which may have been successfully averted’ (Lukes, 2005, p. 28).

Power is also exerted by avoiding criticisms – by influencing perceptions, and preferences so that the status quo is maintained as there is no alternative. In this way, power is not just about observable conflict, the results of decisions made or issues that are suppressed. Lukes argues the study of power must also look at why objections are not voiced, why conflict and opposition does not arise as this could be due to power. In this aspect Lukes’ theory on power is representative of critical theory which consider power as ideological, economic and structural. As Hardy and Leiba-O’Sullivan (Hardy & Leiba-O'Sullivan, 1998, p. 456) explain critical theorists seek to expose ‘how power, concealed in the legitimate status-quo trappings of society’s structures, rules, class mechanisms, and cultures, prevents conflict from arising’. Conflicts may be latent rather than manifest where those who are subject to power are unaware of their interests or do not express them. Lukes refers to the concept of latent conflict where the interests of A (who is exercising the power) is in conflict with the interests of B, who is excluded.

Hardy (1994) builds on Lukes (2005) by proposing an additional fourth dimension incorporating the critical perspective of Foucault which is outlined below. Both Lukes and Foucault agree that there are covert forms of power but Foucault (2003) disputes the notion of sovereign power that Labonte and Lukes’ emphasise. Foucault rejects the idea that power can be possessed by someone and used to produce particular outcomes. Foucault (2003) outlines the following key principles of power: power is not a possession but a relation; power is not necessarily repressive but productive; power can only be made sense of through its connection to forms of knowledge and discursive practices and any relation of power can be resisted. Although there is disagreement between Lukes and Foucault in regard to sovereign power both theorists add useful concepts to explore. These understandings of power will be applied to examine the opportunities for and barriers to empowerment at these PHC services. The application of these theories enables an exploration of the different conceptions of power and presents a way of making visible the elements and forces through which power is maintained and how power operates and is mobilised in an institutional space such as a PHC service.

Foucault is interested in productive practices of power, the constraints and effects they generate and how power relations can be both coercive and productive. Foucault argues individuals are increasingly subject to 'disciplinary power', a web of power relations that is hidden and invisible. This power operates through bodies and spaces and involves people, institutions, bureaucracies and cultural fields within the state (Foucault, 1977)..

Foucault argues disciplinary power moulds individuals through intense training and surveillance and they are manipulated into ways of practicing that suit the economic and social interests of the state (Foucault, 1977). Foucault argues at a deeper level, power is entrenched in the system; it constricts what and how we see and think that reduces our ability to resist (Foucault, 1977). In this study, PHC services represent social institutions and the use of Foucault's view of power allows the exploration of the role of power and the ways disciplinary power is manifested and embedded within PHC services.

These theories of power are relevant in considering the unequal distribution of power in society and highlight that any action to reduce health inequities will require a change of power distribution to the advantage of those from low socioeconomic groups. One influential approach is that which describes changes in power or empowerment occurring at a number of levels, from the individual or "micro-level" to the social or "macro-level" which give rise to collective action. The process of changing power distribution is called empowerment in this theoretical approach. The next section will outline these different levels.

2.9 Levels of empowerment

A number of theorists (Israel, Checkoway, Schulz, & Zimmerman, 1994; Laverack, 2004; Masterson & Owen, 2006; Nelson, et al., 2001) describe empowerment occurring at two interacting levels: an individual (micro level) where empowerment occurs between individuals that have social networks such as friends, family, health practitioners; and at community (political action) (macro levels) where people with similar needs work together through large-scale action. Individual empowerment is explained first.

Individual (micro) level of empowerment

Individualistic models of empowerment, which most closely reflect the way empowerment is most often understood in the health field are referred to as psychological and consumerist (Rhodes, Holland, & Hartnoll, 1991). The psychological model describes power as an individual quality generated within a person through personal growth, increased self-esteem and problem solving skills.

An alternative theory is the consumerist model which involves self-care, self-determination and gaining personal control (Ghaye, 2000). This model emphasises individuals accepting responsibility for their own health and social circumstances. Anderson (1996) argues this model places responsibility away from service providers to individuals and raises an important critique of challenging how those living in poverty and social exclusion are able to change power differences and obtain resources to enable greater responsibility for their health and wellbeing.

Psychological and consumerists models represent depoliticised models of empowerment. They are limited by their individual focus and fail to consider organisational, cultural and political contexts, the resources available to those individuals and how to address the lack of resources (Anderson, 1996). When empowerment is conceptualised as a multi-level construct (which is argued in this thesis), where micro-levels of empowerment are supported and reinforced through structural approaches such as collective action, a more critical approach is ensured by considering organisational, social, cultural and political factors at play.

Social (macro) level of empowerment

In comparison to individual empowerment, macro levels of empowerment have received much less consideration in the health field. At the macro level of empowerment, approaches include: socio-structural change and collective community action. Socio-structural change occurs through legislative, policy, financial and organisational processes that result in equal opportunities. Organisational level empowerment in the context of health services includes shared leadership between clients and practitioners and management. For clients, this may include being involved in decisions made within an organisation. For practitioners working in health services, empowered organisations are democratically run and processes are developed that enable workers to have a sense of control over their work and are able to contribute to work processes and practices (Baum, 2016).

Collective community action is the outcome when there has been a transfer of power. It is an approach that builds the capacity of people to create change in their communities regarding issues that are important to the group. Community action may be initiated by the community or encouraged through community development approaches and includes being involved in decision making so that people have a sense of ownership and control regarding their community This results in community empowerment when individuals and communities are enabled to predict, control and participate in their own environment (Eng, Salmom, & Mullan, 1992) and relates to the term ‘enabling’, discussed earlier. Aboriginal and Torres Strait Islander people who have been oppressed by colonisation in Australia are an example of a group where power relationships are in urgent need of attention. Health services play an important role in enabling a transformation process whereby practitioners facilitate conditions and opportunities for individual and community empowerment (Labonte, 1990).

Collective action is a form of resistance where group works together on an issue or issues to effect change and is consistent with Lukes’ and Foucault’s analysis of power who both assert that power can be resisted. It is in Lukes’ third dimension of power that equity groups with less power can mobilise as a way of resistance, challenging the status quo and raising political awareness (Hardy & Leiba-O'Sullivan, 1998). However, in the fourth dimension Foucault draws attention to the limitations of resistance. For example, Foucault argues there will always be power relations inherent in the system that are unable to be controlled or escaped. Dominant discourses are seen as the reality and alternative discourses are hard to imagine. Existing power relations are reinforced making resistance unlikely. Similarly, in Lukes’ third dimension he points to how power can take covert forms and why resistance does not occur because groups may not be aware they have any serious grievances.

Empowerment continuum

In considering empowerment as a multi-level construct, Labonte (1992) proposes “The Empowerment Continuum” as a model of professional practice that describes how power is facilitated through a range of activities from working with individuals and small groups to facilitating coalitions and political action (figure 2.2). Labonte (1992) considers empowerment as a dynamic process occurring along a continuum where individual power and changes in power relations between different social groups progresses to more structured forms of social and collective action. Within this multilevel framework, Lukes and Foucault’s theories of power help to identify where power is concealed. Both Lukes and Foucault emphasise power is limitless and argue against depoliticised models of empowerment that endeavour to empower individuals without considering their social, cultural and economic environment (Foucault, 1977; Lukes, 2005). Solar and Irwin (2010, p. 59) emphasise the role of the state ‘for creating spaces and conditions of participation that can enable vulnerable and marginalised communities to achieve increased control over the material, social and political determinants of their own well-being’. This requires governments to support a social view of health that supports empowerment, however a biomedical model has dominated (Doyal, 1979; Navarro & Shi, 2001).

Figure 2.2 Labonte’s empowerment continuum

Removed due to copyright restrictions

See Labonte,R. (1992). Heart health inequalities in Canada: Models, theory and planning. *Health Promotion International 7*(2), 119-127. doi: 10.1093/heapro/7.2.119

Frequent terms such as medical model and biomedicine have been used to refer to an underlying principle of ‘medicalisation’ (Illich, 1975) which is focused on biomedical knowledge , individualism, the body and truth (Foucault, 1973). Theories by Lukes and Foucault are directly relevant to analysing how medical power is exerted so that policies that align with the medical model dominate over other views of health. The medical model promotes individualism, a reliance on individual responsibility and human agency.

The biomedical model with its ideology of individualism proposes individuals have the opportunity and the onus to take responsibility for their health and to make decisions about how to lead their life (Beck & Beck-Gernsheim, 2002). However, this approach is less able to address the effects of the inequities brought about through the social determinants of health. Azetsop and Rennie (2010) argue market-driven medicine is used to justify the reliance on individual responsibility and autonomy and contributes to a culture in which wellbeing and health promotion are no longer a feature of practice. The domination of health care delivery by market forces has been shown to lead to inequity of access for those who are sick and can’t afford to pay (or co-pay) for services or have the money to pay private health insurance premiums (Solar & Irwin, 2010). Neoliberalism, a philosophy that prioritises economic considerations in the development of public policy underpins individualism and is discussed below.

2.12 Neoliberalism

A basic principle of neoliberalism or economic rationalism as it has been referred to in Australia (Pusey, 1991), is that the free market is the best means to organise economic trade and within this context of open competition there is greater efficiency. Neoliberalism began in the 1970s and 1980s with economic policies introduced by Margaret Thatcher in the United Kingdom and Ronald Reagan in the United States (Jones, Parker, & Ten Bos, 2005). Policies commonly linked to neo-liberalism have been free trade for goods and services, deregulation, privatisation and reductions in government spending to areas such as health, welfare, housing, education and transport to enable the role of the private sector in the economy (Baum, 2014; Harvey, 2005; Jones, et al., 2005).

A key feature of neo-liberalism has been the infiltration of private sector management practices and procedures into the public service. This has caused a number of changes to traditional public bureaucracy such as strategic planning, an orientation towards goals and results, budgeting with health budgets primarily directed to hospitals and biomedical research, an emphasis on throughput, employment offered through contract basis or fixed term and an emphasis on reducing costs (Baum, Begin, Houweling, & Taylor, 2009; Germov, 2005). These changes are commonly associated with managerialism, which is underpinned by neoliberalism.

Germov (2005) points to managerialism in Australia in the health sector which has typically adopted a ‘centralised-decentralisation’ arrangement with state governments having centralised control over strategic planning and public policy, the allocation of resources and performance measures while the delivery of services and day to day management has been decentralised and is the responsibility of individual services. Research by Pusey (1991; 2010) found neo-liberalism in Australia has caused a reorientation of tasks and priorities of the state where public policy has been reduced to ‘a narrowly conceived ideology of maximum feasible market and business penetration into as many areas of the nation’s life as possible (Pusey, et al., 2010, p. 135). The dominance of these policies has in turn shaped health reform (Sanders, Baum, Benos, & Legge, 2011).

These social determinants of mental illness are rising in countries where neoliberal policies of market-orientation are a feature. Despite claims to the contrary, neoliberal policies have resulted in increases in poverty and inequality due to insecure employment and departure from state responsibility for social provision (Schrecker, Chapman, Labonté, & De Vogli, 2010), adversely effecting health and quality of life (Sawyer, 2008). In particular neoliberal policies have been found to influence risky self-management practices and poor health outcomes for those with depression (Brijnath & Antoniades, 2016). The effects on service delivery and response to individuals and the community within the context of neoliberalism will be discussed later in this thesis.

2.13 Conclusion

This chapter has highlighted the widespread prevalence of depression and the importance of addressing depression among individuals and the community. The potential benefits of a CPHC approach in the provision of good mental health that includes prevention, promotion and treatment were explored. Models of service delivery that are underpinned by a social view of health that focus on empowerment and equity are needed. To date, a biomedical model of health care that has a focus on primary medical care and neoliberalism has challenged more comprehensive approaches to addressing mental health and mental illness. The next chapter outlines the methods employed to examine how four PHC services addressed depression and the extent to which equity and empowerment were a feature.

CHAPTER 3 METHODOLOGY

3.1 Introduction

The theoretical perspectives that inform the research design and describes the methods of data collection and analysis is the focus of this chapter. The paragraphs below provide an overview of how this study was conducted, followed by background information in relation to how this project commenced. A discussion of the perspectives that underpin the research approach and details of the research design and methods selected are then outlined, followed by an explanation of the processes involved in undertaking this research.

The aim of this project was to examine the extent to which four case study PHC services responded to depression and complemented CPHC in their responses to depression in individuals and the community. A critical inquiry approach (Harrington, 2005) was adopted to examine key principles of CPHC such as equity and empowerment. A descriptive multiple-case study design was used, whereby a number of cases were studied jointly in order to investigate a phenomenon within their real-life context (Stake, 2005). The cases in this study were four South Australian government-funded multidisciplinary PHC services. A multiple-case study design offered an approach that was holistic and flexible and able to manage the range and complexity of interactions undertaken within PHC while also allowing for the contextual changes that occurred during the project. The wider policy, bureaucratic and service organisational context related to PHC and mental health was particularly important (Yin, 2009) and was monitored and documented throughout the project. This policy context is outlined in chapter 4 along with a description of the cases, the PHC services and chapter 5 builds on this description by outlining the range of responses to depression offered.

This study drew upon a range of methods to explore the response of four PHC services in addressing depression in the community and in individuals who accessed these services. Quantitative and qualitative methods were used and data were collected in two stages during 2012 to 2013. In stage 1 quantitative data were collected which informed the selection of participants for further investigation using qualitative methods in stage 2.

The first stage focused on client journeys through the case study services and used case tracking to identify steps in that journey. Case management data for clients with depression were gathered from practitioners in each of the four PHC services via self-complete questionnaire or interview. The second stage involved an in-depth exploration of participants' experiences on their journey through these services. Staff views and reflections about their practice, the opportunities and barriers to individual and community empowerment and what system constraints and enablers support and detract from CPHC delivery were explored. As discussed in the literature review, this research explored how these PHC services incorporated principles of social justice, equity and empowerment in the way they worked with individuals and the community. These principles are grounded in CPHC philosophy, which further informed the research methodology and methods. The four PHC services were used to compare common themes across each site to examine their alignment to CPHC, their response to depression and the extent to which they were able to incorporate equity and take into account clients' social determinants of health.

3.2 Situating this research

This PhD was conducted as part of a larger five-year NHMRC funded project titled: *'Evaluating the effectiveness of comprehensive primary health care in local communities'*. My three supervisors were all core researchers on this larger project (Baum and Lawless were Chief Investigators, Freeman was the project manager). The NHMRC project commenced in 2009 and examined the effectiveness of Primary Health Care in local communities.

These sites were chosen as they represented both long standing and emerging models of primary health care delivery in Australia. The services involved are listed below. All but three wished to be de-identified and have been given pseudonyms.

- Orange service
- Green Service
- Blue service
- Aboriginal health service
- Central Australian Aboriginal Congress (located in Alice Springs)
- SHine SA

One service withdrew from the broader NHMRC study and my PhD research (due to significant organisational change, concern over staff workloads, and a change in manager) prior to the PhD research commencing. It was at this stage that the Blue service was approached and agreed to participate. The services that contributed data to this PhD and the contextual environment in which they operate are described in more detail in chapter 4.

The NHMRC project had a number of aims. The aims that relate to this PhD were to:

1) Examine the effectiveness of PHC services using a variety of methods

2) Identify the strengths and weaknesses in the operation of PHC services in relation to people who experience depression and diabetes.

The PhD project contributed to the second of the above aims and focused on people who experience depression. The services listed above were involved in the PhD project as they were already part of the NHMRC project. However, SHine SA was not included in the depression element of work because of their focus on sexual and reproductive health. Further, Central Australian Aboriginal Congress was excluded from the PhD project because of its remote location and the practical difficulties and travel costs that would be associated with the data collection.

This research was guided by a personal and professional commitment to social justice values which informed the research methodology and methods. These values are based on my background and experience working in child protection and community health research in Victoria and Adelaide. I am a white, middle class Australian who is relatively well educated and has a certain amount of privilege in Australian society. My background is that I was born in South Africa and even though I came to live in Australia from an early age, I grew up hearing of the serious political, social and health challenges faced by Indigenous peoples of South Africa from my father who had lived there all his life. My interest in community health and social justice has stemmed from working in child protection system in Dandenong, a very low socio-economic suburb in Victoria and seeing firsthand the difficulties and struggles and system barriers experienced by families and the role that housing, living conditions, employment, and drug and alcohol addiction have on people’s health. Also my experience working at research institutes in Melbourne and Adelaide extended my interest in PHC where I’ve been able to work with others who also hold social justice values and a commitment to equity.

The NHMRC project developed a program logic model for depression, the Southgate Model which was used as a framework to guide this thesis and is explained below.

3.2.1 Southgate Model for Comprehensive Primary Health Care: Depression

To provide a framework for the complex nature of this project, an evidence-based program logic model of CPHC activities was developed prior to the commencement of this PhD. Between May 2012 to February 2013 the NHMRC project research team in collaboration with the PHC services adapted this model to examine depression (referred to as the Southgate Model) in order to evaluate the effectiveness of a CPHC model (Lawless, et al., 2014). The Southgate Model (Appendix A) is a program logic model that details the links between activities for depression and the possible short and long term health outcomes developed. The model was developed through a detailed process of collating evidence-based literature on best practice activities for depression, the combined experiences of the research team, interviews and workshops with PHC staff, managers, executives and departmental funders. This model that outlines CPHC as a theory of practice and service delivery and was the overarching theoretical framework used to analyse client journeys and assess the extent to which the PHC services were implementing a CPHC response to depression.

This model was developed to show how the values of social justice, equity, empowerment and a social view of health inform CPHC. This framework displays service qualities and activities that good mental health practice would involve in a CPHC model of service delivery are how they are likely to lead to desired individual and population health outcomes. These mechanisms are dependent on a number of favourable contextual influences in which the model operates within, shown at the bottom of this model.

3.2.2 Health Services Research

This research was undertaken within the field of health services research. It engaged health service practitioners and local communities at four state government-funded PHC services. Lomas (2001) describes health services research as a multidisciplinary field of inquiry encompassing interdisciplinary approaches from health and social sciences and utilising a variety of different methodologies. Health services research examines how health services operate and is relevant to a broad audience that includes: managers of health services, health professionals and policy makers (Lomas, 2001).

Common features of health services research given by Lomas (2001) are:

- Assembly of an inter-disciplinary team skilled in a variety of methodologies
- Gathering feedback from non-researchers in health services to prioritise the research agenda.
- Linking with non-researchers during the conduct of the research to keep them informed and to keep them relevant and ‘on-track’
- Communicating and disseminating the findings in ways that are relevant to non-researchers who can use the findings to inform health service decision-making.

In order to gain input from non-researchers, the PhD project and the NHMRC project consulted extensively with PHC service managers and practitioners who saw clients with depression at the study sites. Some PHC service managers were Associate Investigators on the NHMRC project and there was a project advisory group. There were multiple meetings at each site to negotiate and gain feedback on the data collection methods. Once data collection had been established at each site, regular phone calls and meetings were held to discuss progress, monitor and negotiate workload issues and to keep staff informed about the research.

This study used both quantitative and qualitative methods. Although there have been tensions associated with combining quantitative and qualitative methods (Crotty, 1998; Morgan, 1998) there is broad acceptance of the value of using both methods (Creswell, 2009). One of the main arguments against mixing the two methodologies comes from conflict between different philosophical paradigms about how knowledge is generated. Prior to discussing the methodology of this study, it is important to address these deeper issues and to explain the epistemological framework within which this study utilised quantitative and qualitative data.

3.3 Epistemology, Ontology and combining research methods

Disputes regarding the use of quantitative versus qualitative approaches to social research are the result of fundamental differences about the nature of knowledge and understanding (Morgan, 1998). Whilst qualitative research is based on the principal of subjectivity, often informed by a constructionist, interpretive epistemological position, quantitative research rests on the principle of objectivity and takes a positivist epistemological stance. Consequently, tensions arise when using quantitative and qualitative data as the two philosophies are often associated with being opposite and incompatible (Abusabha & Woelfel, 2003; Crotty, 1998). Prior to outlining the epistemological basis of this research and how it influences the methods chosen, it is useful to consider the different epistemological paradigms and why it was useful to combine these methods in this study.

Different epistemological stances provide different philosophical groundings for deciding what kind of knowledge is possible and ways of knowing the world. An objectivist epistemology assumes that meaningful reality exists apart from the operation of any consciousness. Objectivism takes an outside, 'objective' view to discover the truth about a subject. In contrast, constructionism argues that meaning cannot be discovered in a way that is independent of human consciousness, but is socially constructed (Crotty, 1998). However, to say reality is socially constructed does not mean that it is not real. Crotty (1998) points out that constructionism is epistemologically compatible with realism, an ontological position that argues that external reality does exist independently of humans. A realist ontology views reality as being influenced by social, political, economic and cultural factors over time. This study adopted a constructivist epistemology and a realist ontology and the discussion below centres on its value, the strengths of this approach and why it is useful for investigating CPHC.

Essentially, in utilising a constructivist paradigm and a realist ontology, it is proposed that an external reality does exist, but can't be understood meaningfully in a way that is independent of human consciousness. Knowledge and meaning of reality is always *constructed* from the interaction between the external 'object' of knowledge and the subject's (the researcher's) conscious ways of knowing through their own beliefs and values. That is, all knowledge is dependent on human understanding, and so, therefore presents a limited and partial view of reality rather than being truly 'objective'. The researcher is seen as part of the reality being researched.

This study applied a constructionist epistemology, and a realist ontology which allowed in-depth exploration of client experiences and understandings of PHC service delivery and an in-depth exploration of staff views and reflections about their practice in this model of service delivery. A constructionist position was adopted that argues behaviour is shaped by knowledge and social interaction but also takes a critical view whereby power relations and social context are also important factors. Critical forms of research that call into question commonly held values and assumptions about the world are central to a constructionist epistemology. Taken-for-granted assumptions about the world are questioned through an understanding of the influences of power, equity and social context on the interactions that occur (Burr, 2003). This research used an approach where some methods of a constructionist position were used but also took a critical theoretical perspective that acknowledged the normative view of CPHC that has a set values and principles upon which it is based. This led to examining and critiquing models of PHC being used by the four case study sites and the extent to which these models aligned with principles of CPHC. Of particular interested was the effect of power relations and equity evident in these models. The recommendations from this research have the potential to improve the quality of care and inform service planning and practice.

In combining constructionism with realism this study argued for a particular view of CPHC. As previously discussed in chapter 2, this thesis interprets CPHC as a philosophy of health care and health promotion as conceived by the Alma Ata Declaration (World Health Organisation, 1978) that embodies a number of principles and values such as social justice, community empowerment and participation that provide the basis for CPHC activities. These concepts are concerned with a society that is based on equality and solidarity, the interaction between people and how power and participation are negotiated. The unequal distribution of power was considered in the previous chapter. In this research it was important to gain an understanding of the power relations that exist within models of PHC and the work the case study PHC services undertook to support clients' social determinants of health through empowerment of individuals and the community.

The use of quantitative and qualitative methods was complementary and offered a way of furthering our knowledge of the implementation of CPHC and the extent PHC services responded to depression. Combining these methods provided a means of examining how models of service delivery at four PHC services aligned with CPHC as a philosophy of care and health promotion.. The broader work the services did to support clients such as advocacy and the work done towards tackling the social determinants of health that is implied in a CPHC model was a particular focus.

Some social scientists argue that using quantitative methods can bring useful understandings to constructionist research. Using a constructionist approach, quantitative data was interpreted using a subjective or qualitative judgement (Abusabha & Woelfel, 2003; Crotty, 1998). The use of a constructionist approach using mixed methods as ‘tools’ to gain further knowledge provided a thorough way of understanding the range of CPHC strategies offered by the PHC case study sites. The quantitative data provided a description of what was happening at the four PHC services, how the PHC services worked with clients and other agencies as well as the different pathways for clients using these services. The quantitative data was complemented with in-depth qualitative findings from a smaller group of clients and staff from each PHC service. The use of both methods offered a flexible approach that was important to understand the complicated dynamics of CPHC and was able to cope with the complex social, economic, political environmental context of this research. The approach taken to combining quantitative and qualitative methods is outlined below.

3.3.1 Approach to the use of quantitative and qualitative methods

This study utilised a Priority-Sequence Model (Morgan, 1998) whereby one method complemented the other without disregarding epistemological assumptions. Morgan argues when using a Priority-Sequence Model, a number of decisions are made regarding which method will be the principal method, and which will form the complementary method and whether one will act as a preliminary or a follow-up to the principal method.

In this study, the principal method was qualitative through in-depth interviews, field notes and observations and the complementary method was quantitative through the case tracking of clients with depression and the use of an empowerment tool, the Patient Enablement Instrument (PEI) which was used to collect information on how empowered clients felt. This preliminary quantitative data contributed toward answering the following research question:

‘What are the range of responses to depression offered in a CPHC model of service delivery in terms of mental health promotion, prevention of depression and treatment and rehabilitation for people with depression, including what are the client journeys through the CPHC services?'

The quantitative data did not address the remaining sub-questions listed in chapter 1 relating to client experiences and understandings of CPHC service delivery, staff views and reflections about their practice in this model, opportunities and barriers to individual and community empowerment and the system constraints and enablers that support or detract from CPHC. The qualitative investigation explored these aspects through in-depth interviews with clients and staff. The next section discusses the theoretical perspectives that underpin this research and shaped the research questions, methodologies and interpretability of the research findings.

3.3.2 Theoretical Perspective: Critical Theory

This research is informed by a critical theoretical perspective within a constructionist methodology and a realist ontology. Research that draws on a critical theoretical perspective focuses on critiquing and understanding inequities in society in a way that contributes to bringing about change. Critical forms of research emphasise the unequal distribution of power and privilege that some social groups in society hold over others (Kincheloe & McLaren, 2000). This form of inquiry fitted comfortably with CPHC with its core principles of equity and empowerment and this research sought to produce findings that could be used to improve consideration of equity and empowerment in health services. The next section will discuss how equity and a social view of health were used as a lens to shape this research, and following this, empowerment will be discussed.

This research accepts that social justice is a key principle of CPHC and examined in a critical way the extent to which the four PHC case study sites were able to consider equity and clients' social determinants of health in their practice. As seen in the Southgate Model, CPHC is based on a social model of health. This model of health recognises the impact that social, physical, economic and cultural aspects of the environment have on the health of the community. It recognises the role that factors such as housing, and homelessness, employment and family relationships influence mental health. It acknowledges that individuals do not choose to have bad health but rather there are political and social structures that determine access to the determinants of good health and access to health care services (Baum, 2016).

CPHC has struggled to be fully implemented in Australia and from the outset of this study the four PHC services were not operating according to the interpretation of CPHC outlined in the Declaration of Alma Ata. Rather than providing universal access to the whole population, an ideal of CPHC, the four PHC case study services in this study targeted low socio-economic groups in the community who were marginalised and most in need. These people are often unemployed and are either seeking work or couldn’t work due to their physical and/or mental illness.

This research adopted a social view of health which formed part of the theoretical lens that guided the study, and shaped this research by looking at how the four PHC services work towards addressing the broader determinants of health. In qualitative interviews with clients and staff, questions were asked about what work they do with clients regarding their social, physical and economic determinants of health and whether they were involved in health advocacy work. As discussion earlier in chapter 2, a social view of health is a contrast to the disease-orientated biomedical model of health (Baum, 2016). It is well documented that one of the main criticisms of lifestyle behaviour change approaches and a limitation of the biomedical model is the focus on the individual with the exclusion of any recognition of the social and environmental context.

The methodology applied in this study placed importance on the role of power and social context. This study used the concept of empowerment which is viewed as a process and an outcome which guided and shaped this research and became a focus in terms of the way individual and community empowerment can be supported among the PHC services. It sought to understand the empowerment of individuals accessing the four PHC services and the extent to which staff were supported to use an empowerment approach. For example, this study investigated whether staff at the four case study PHC services worked from an empowerment model using a partnership approach with clients or whether they were using an approach implying “power over” (Labonte, 1994). A power-over approach used by staff would endorse disempowering notions about mental illness such as defining and shaping solutions for them which are likely to undermine collaborative relationships (Corrigan, 2002; Labonte, 1994). The theories of Labonte, Lukes and Foucault were used as a conceptual definition of power and provided a framework to assess how power plays out among these PHC services.

This research sought to uncover the meanings staff have of empowerment and whether they see empowering clients as part of their role. For clients, it sought to explore how they felt about the services received and what understandings they attach to their experiences of PHC service delivery. This research is interested in whether clients had more confidence to manage their depression and looked at contributing factors in their life, for example, their background, housing, employment and domestic violence.

3.4 Research Design

A descriptive multiple case study design was used in this PhD project. As a research design, case studies are used in a number of ways, to explore individual, group, organisational, social and political phenomena (Yin, 2009). There are a number of advantages to using case studies: a) it helps researchers to understand a complex social environment, b) it allows researchers to study real life events and to retain the holistic and meaningful characteristics of the social environment and c) it provides the ability to use a wide variety of methods – in this research, interviews, questionnaires, focus groups, audits and observations. The use of multiple methods built a picture of what each PHC service was doing in relation to depression. Yin (2009) maintains the use of mixed methods provides a richer and stronger array of data than could be accomplished by using a single method alone.

CPHC operates within a complex social environment which involves the interaction of a large number of people within and outside the service. CPHC offers a wide range of activities including clinical treatment, self-help clinics and health promotion groups, community development, social action, policy advocacy and coalition building. An approach to research that is holistic and flexible was needed to deal with the complex nature of this project. Case study research is able to manage the range and complexity of the interactions undertaken in CPHC and allows for contextual changes to be accounted for during this research project.

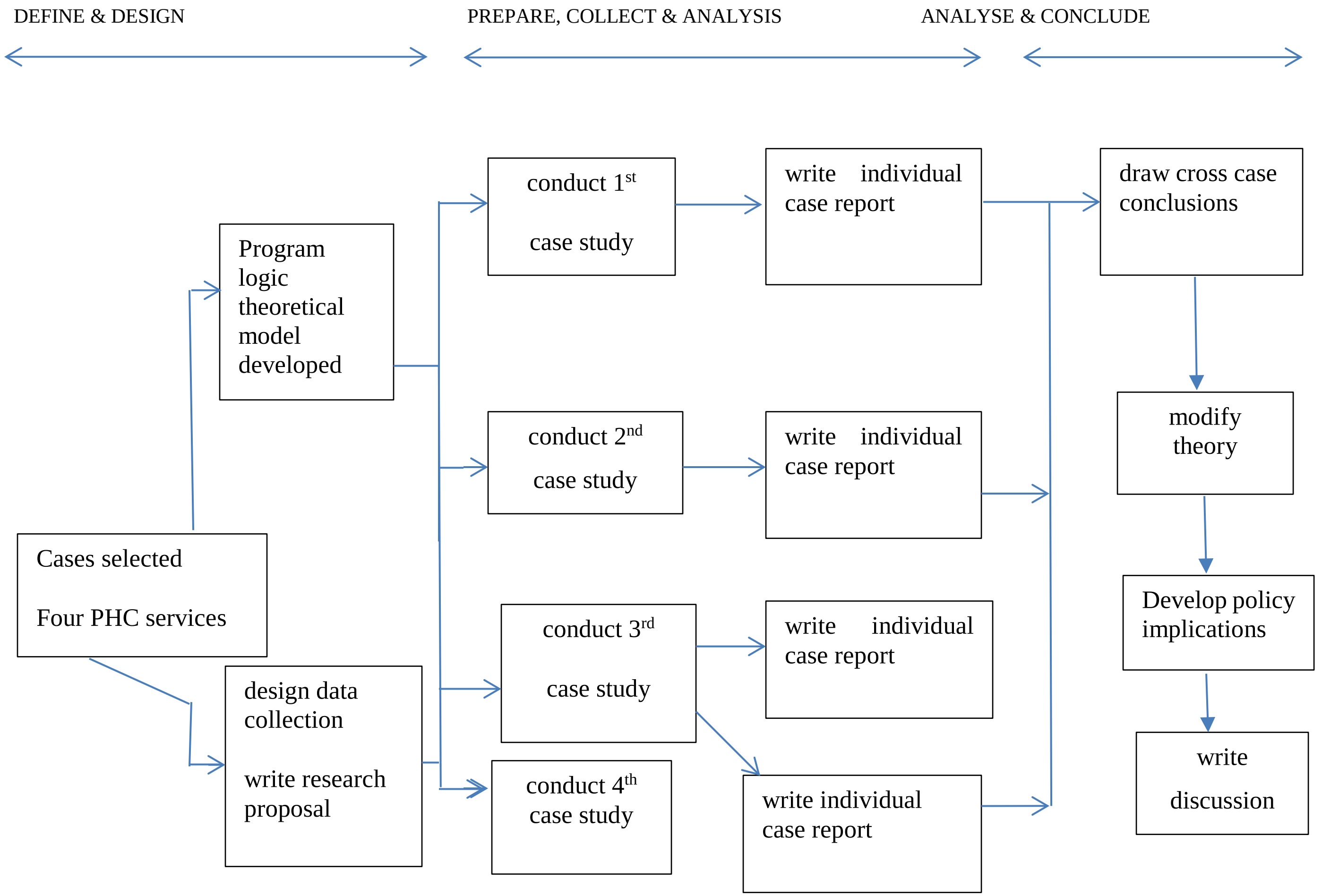
The NHMRC study was based on a collaborative partnership with the PHC services involved who were partners in the funding application and the services had an ongoing relationship with the research team during their participation in this five-year study. As outlined above, four of the PHC services involved in the NHMRC study were identified as case study sites and were used in this PhD. They were selected for the broader NHMRC study as they represented different models of PHC practice, which these case study sites represented at the time the NHMRC proposal was written in 2008.

This PhD was based on a descriptive multiple case study design methodology (Yin, 2009) to examine the extent to which the case study PHC services were implementing a CPHC model of service delivery in their response to depression among individuals and the community. A multiple-case design was chosen over a single-case design as the evidence is considered more compelling and overall more robust, and allowed the examination of services operating in different community contexts – for example, the Aboriginal health service’s focus on the local Aboriginal and Torres Strait Islander community, and the different geographic communities served by the remaining services.

Figure 3.1 below displays the important steps taken in the case study design. The PHC study sites were selected as cases, followed by theory development (the NHMRC study developed the Southgate Model) and data collection design and development of a research proposal. Yin (2009) emphasises the importance of incorporating theory prior to collecting any case study data as an essential step in the case study design phase. The Southgate Model was the theoretical framework that the case study sites were assessed against. Data collection at each case study site then commenced with each study site being written up as an individual case report. Client journeys were documented from those that accessed services for depression at the study sites. This was part of the NHMRC project design which also gathered client journeys for clients with diabetes. Conclusions were drawn from the multiple cases, theory reviewed and modified, policy implications were developed and the discussion written. A key to case study methodology is a description of the cases and the boundaries or constraints of these cases. To allow sufficient space for the description of the cases and documentation of the wider policy context that the PHC services operated within and the extensive changes that occurred leading up to and during the study period, a description is provided in chapter 4. In terms of boundaries, the cases were discrete, identifiable services with dedicated staff that were employed within a local health network with clear organisational boundaries within the broader health system. This research particularly focused on mental health staff and multi-disciplinary colleagues and the services they provided. The case data collection period was 2012 to the end of 2013. The scope of this PhD was limited to the examination of the services’ response to depression and was unable to consider their response to other mental illnesses. In addition, clients often did not have an official diagnosis of depression. Staff estimated that all clients had mild to moderate depression but did not identify which clients had mild and which had moderate depression. The PHC services were reliant on state government funding therefore the wider policy context also constrained the way the PHC services could respond to depression and this is outlined in chapter 4.

.

Figure 3.1 Steps taken in the multiple case study design



3.4.1 Ethics approval

Ethics approval received from the Southern Adelaide Clinical Human Research Ethics Committee (SAC HREC), Aboriginal Health Research Ethics Committee (AHREC) and SA Health Human Research Ethics Committee (SA Health HREC).

3.5 Method

In this study, the concept of a client journey is used to map clients experience through the health service over time. The idea of a patient journey has become widespread as the prevalence of chronic illnesses and multiple health problems have increased in frequency (Leeder, 2007). The result has been a change in the way people interact with health services, from relatively 'short and sharp encounters' to more people commencing journeys that may take years or decades of care (Leeder, 2007). There is increasing recognition that the health care journey itself, not only at the beginning (first symptoms, seeking help, getting a diagnosis) but also the process and experiences along the way, are important for health care outcomes (Doherty, Benbow, Craig, & Smith, 2009; Lapsley & Groves, 2004).

A patient journey has had increased attention in health services research and service design. However, the concept of patient journeys varies and different terms tend to be used interchangeably (Campbell, Watson, Gibson, Husband, & Bremner, 2004). Common terms used are 'patient journey', 'patient pathway', referral pathway, 'patient care pathway' and 'personal journey'. These terms are different from 'integrated care pathways, care pathways or care protocols which outline an agreed plan developed by a multidisciplinary team and may include client or carer involvement of anticipated care or client satisfaction feedback (Campbell, et al., 2004; Deacon, 2013; Hugo, 2001). As mentioned in chapter 1 this thesis uses the term 'client' as the research took place in services based in the community (American Psychiatric Association, 2013).

Case tracking methods allow the construction of client journeys by tracking individuals for a period of time from when they start seeing a health professional at a service to when they finish. It involves the use of multiple methods, using quantitative and qualitative data from a number of sources (Tomison & Goddard, 1999). Case tracking methods have been used to understand case management of child protection (Cassano & Fava, 2002; Tomison & Goddard, 1999;

Toumbourou et al., 2007; Whiteford & Groves, 2009a; World Health Organisation, 1999), and in health settings, including in hospitals (Jorm, Korten, Jacomb, Christensen, & Henderson, 1999), following hospital discharge (Barnes & Bowl, 2001) and outpatient clinics (Jorm, Christensen, & Griffiths, 2006). Common methods include the use of one or more of the following sources: auditing electronic records, interviews with clients, carers, and health practitioners, direct observation and health logs. Using a combination of these methods has been termed 'walking the patient journey' (Jorm, et al., 1999) as it presents a comprehensive picture of what is happening for clients and as well as including practitioner perspectives. However, very few studies do combine methods to establish client journeys. Studies that have been successful in generating client journeys often rely on single sources of information. For example, Oliver et al (2006) used client recall through telephone interviews to map the journeys of clients with rheumatoid arthritis and Richards et al (2005) extracted data from local National Health Service sites to describe pathways through stepped care services for clients with depression and anxiety.

Typical of case study design, the data collection, which was part of the NHMRC project, drew on many sources of information to gain an in-depth understanding of each case, the PHC services (Creswell, 2013). Table 3.1 lists the different methods employed such as interviews, questionnaires, group interviews, site audits and observations. I collected all the data for this PhD except for the set of interviews I have termed the 'NHMRC staff and manager interviews and the site audits, which were established for the services to self-complete prior to my PhD. Multi-method case tracking was applied to understand client journeys in PHC. Use of multiple methods achieves a more thorough picture of the client journey that includes service data, client perspectives and health logs and gave insight into how each PHC service responded to depression and whether they were adopting a CPHC approach. Comparisons were made between the four PHC services.

Quantitative methods were: case tracking clients with depression accessing one to one and group services and a Patient Enablement Instrument. Qualitative methods were: group interview with clients with depression, in-depth client interviews, client health logs, semi-structured interviews with staff who provided one-to-one services to clients with depression, semi-structured interviews with staff and service managers, audit of each PHC service on mental health promotion, prevention, treatment and recovery of depression, field notes and observations of each PHC service. Use of all of these different methods enabled me to act as an 'interpretive bricoleur’ (Denzin & Lincoln, 2011) using an interactive interpretive process guided by my own social justice values.

Table 3.1: Methods used at each case study site

Methods	Number collected at the Green service	Number collected at the Aboriginal Health Service	Number collected at the Blue service	Number collected at the Orange service
Case tracking client with depression over 12 months	35	18	20	13
Semi-structured client interviews	7	6	3	5
Client health log	7	6	3	5
Semi-structured interviews with staff involved in one to one services	2	2	6	2
NHMRC project staff and manager semi-structured interviews	7	4	4	1
Patient Enablement Instrument	7	6	3	5
Audit on mental health promotion, prevention, treatment and recovery of depression	3	3	3	3
Group interview with clients experiencing depression (pilot methods)	5			

Field notes and observations were taken throughout data collection

3.5.1 Overview of case tracking and client interview methods

This study adopted and piloted case tracking methods adapted from Tomison and Goddard (1999) to track the journeys of clients that accessed care for depression at each of the services over a 12 month period. Tomison and Goddard (1999) developed this case tracking method in their study of the Victorian child protection system where child protection case management and decision making models were developed. One key difference was that Tomison and Goddard tracked cases across multiple organisations, whereas we tracked clients seeing multiple professionals at one service. Referrals made to other services were made note of but this study was unable to track clients at these services due to the complex ethical and service approvals that would have had to be gathered to pursue this. While the general principle of Tomison and Goddard's case tracking method was followed, this study developed its own questionnaires comprising open and close-ended questions and provided a range of flexible options to collect this data from staff. As client perspectives were central to the research questions, client interviews and client health care logs were added to complement the case tracking. This log was adapted from health diaries used by Veale (1996) in her research investigating general practice utilisation in Australia. Health logs were a useful way of supplementing data captured during client interviews and have been used in other studies documenting client journeys (Barnes & Bowl, 2001). This multi-method design was used to provide the multiple perspectives necessary to 'walk the client journey' (Jorm, et al., 1999).

3.5.2 Definition and inclusion criteria for depression

Clients to be tracked came from external referrals (typically from GPs), internal referrals from other sections of the service, or were self-referred to the counselling team at the service. Few clients had a formal diagnosis of depression. Therefore, it was important to develop a working definition and inclusion criteria for "clients with depression." A draft definition and inclusion criterion for depression was developed and circulated for feedback from other members of the NHMRC study team. This was then presented to one of the NHMRC project chief investigators, a psychiatrist, who also gave feedback. Finally, the definition and inclusion criterion was presented to health service staff during meetings at each of the services. Staff at the four PHC services agreed with the definition for "clients with depression" and agreed to use the following criteria.

3.5.3 System for identifying clients with depression

A client was eligible to participate in case tracking if:

- The client had been diagnosed with depression by a GP, psychologist, or psychiatrist
- The client had been prescribed and was currently taking antidepressants for depression OR
- The health worker assessed the person to be depressed based on the inclusion criterion for "clients with depression".

3.5.4 Inclusion criteria for "clients with depression"

The client has depressed mood and/or loss of interest or pleasure in the last two weeks **and has** five or more of the following symptoms:

- Depressed mood most of the day
- Less interest or pleasure in all activities
- Weight loss or gain (when not dieting)
- Sleeping difficulties
- Slowed or fastened movements
- Tiredness or loss of energy
- Feeling worthless
- Difficulty concentrating
- Thoughts of death (Inclusion criteria from Beyond Blue www.beyondblue.org.au)

3.5.5 Criteria for tracking cases of depression

Clients were case tracked if:

- They were using the health service for depression for the first time. This was regardless of how long they had experienced depression, or whether they'd used other unrelated aspects of this health service AND
- They were receiving either one to one services for depression and accessing other promotion and prevention services which assist them in managing their depression (e.g. community gardens, exercise groups).

3.6 Stage 1: Case tracking methods

Prior to the case tracking commencing, meetings were held at each service to gain feedback on feasibility, consider staff workloads and gain approval from managers for staff to be involved. A ‘champion’ – a key contact person, was identified at each PHC service for depression to liaise with researchers and help organise the research at their site. Staff that saw clients for depression (one to one self-management support, counselling and/or other group work such as community gardens, exercise groups, or diabetes education groups) at the four sites were invited to participate in the study. Staff recorded the number of times per month they saw clients with depression. Clients were tracked for a period of 12 months or until they stopped using the health service.

Staff agreeing to participate chose how to provide the data to the researchers: electronic questionnaires returned via email, mailed paper questionnaires or monthly interview with myself where questionnaires were completed together for all the clients they had seen for depression in the last month. The majority of staff opted to complete the questionnaires during a monthly face-to-face interview. These interviews were usually scheduled every 4 weeks but sometimes stretched out to eight weeks due to staff rescheduling for various reasons such as high workload, added pressure of their service being audited, annual leave or the commencement of the new ePAS electronic system (Blue service). At one service a staff member started completing questionnaires but left the service when their contract was not renewed.

The staff questionnaires were designed by the NHMRC project staff to collect information on elements of comprehensiveness and drew on CPHC literature, and the program logic model developed as an evaluation framework (Lawless, et al., 2014). Both close-ended questions and open-ended questions were used to allow greater flexibility. The questions covered how the client came to use the service, relevant social determinants of health for each client (e.g. housing, employment situation), what internal or external services staff were aware clients had accessed, referrals made (health or social determinants of health-related), what contact they had with internal or external professionals. A final reflective section comprised questions on how the session went, what went well and what they could have done differently, and any issues or problems that they felt powerless to influence.

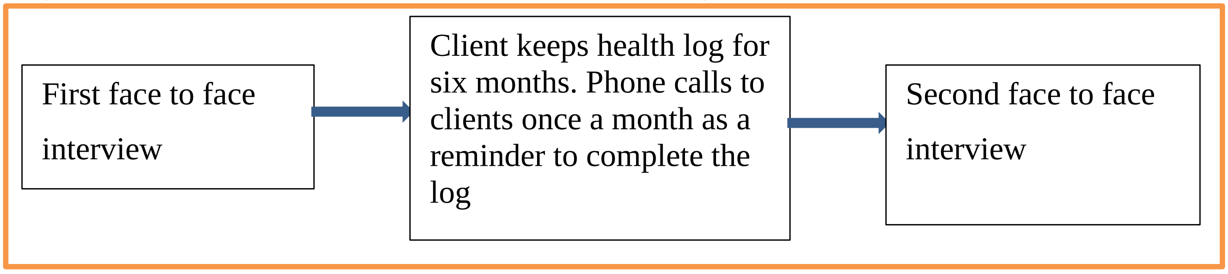
Staff were assigned an identification number that was attached to questionnaires to de-identify them. Clients were also de-identified through a code based on their date of birth and postcode of normal residential address. When a referral was made within the service, the newly involved worker also completed the questionnaire/interview each time they saw the client. This method captured when more than one worker was involved (either simultaneously or consecutively) and monitored the clients' pathway through the service.

Each client's journey was treated separately so individual client pathways through the service could be examined. The Orange, Green and Blue service tended to only see clients for a discrete period of time so the start of a clients' journey was the date they started seeing a health professional for depression. This was not necessarily the initial onset of their depression. At the Aboriginal PHC services clients were long term users of the service, therefore clients tracked were generally not new to the service.

3.7 Stage Two: Client interviews and health care log

Staff invited clients being tracked to participate in: i) a semi-structured interview early on in their journey (Appendix B), ii) to maintain a log of health care received for six months – from the PHC service or from other services, iii) a second interview covering their experience of receiving health care in the intervening six months (Appendix C). Six months was chosen to allow a significant period of time to study clients' experiences, while not wanting to reduce data completeness, or participant engagement and retention that a longer time frame may have risked. Practitioners were initially asked to purposefully sample to maximise diversity to aim for a range of age, gender, and living circumstances when inviting clients with depression to the interview component of the research. However, due to the lower than anticipated number of clients with depression accessing the services, practitioners were asked to invite all clients with depression that were being tracked to participate in the interviews. Practitioners raised concerns about inviting clients to participate in the interview component during their first appointment with a new client. Therefore, practitioners negotiated to invite clients into the Stage 2 component when a rapport had been established and they felt comfortable asking clients. Figure 3.2 below shows the data collection process for client interviews and health logs.

Figure 3.2: Process for client interviews and health log



Clients chose how they wanted to complete the health log. The different options catered for different literacy levels and for clients where English was a second language. Options included: 1) a table shown below (table 3.2) where clients recorded short responses about the nature and their experience of the interaction with the health services they accessed or 2) a pictorial log displaying a number of pictured boxes that clients could tick to record what services they received each month (Appendix D). Clients could also choose to complete the log on the computer or verbally discuss the information over the phone when telephoned each month.

Table 3.2: Client Health Log

Date of visit	Health service and health professional seen	Self-referral or referral from health professional	Type of contact (phone or home visit)	Problem or reason for visit	Outcome	Comments

This log and method was adapted from health diaries used by Veale (1996) (table 3.3) in her research investigating general practice utilisation in Australia. In the development of this health log, the NHMRC project team identified the health diary used by Veale as a way that clients could record and remember what services they had used in the six month period that were then discussed in the second semi-structured interview. Table 3.3 below shows how Veale's Health Diary was adapted to fit this research. The pictorial log (Appendix D) was developed by a NHMRC project team member based at the Central Australian Aboriginal Congress to suit the Aboriginal population accessing this service. The pictorial log was used for this PhD project as it suited the Aboriginal population that accessed the Aboriginal health service and provided an option to clients with differing literacy levels and where English was a second language.

Table 3.3: Health Diary used by Veale (1996).

Date of visit	Centre or Doctor	Was this first choice	Problem/reason for visit	Comments

A semi-structured interview guide was used that included open-ended questions to explore the assessments clients attached to their experiences of CPHC service delivery. Clients were asked to comment on the nature and their experience of services received, perceptions of PHC service delivery, whether it helped their depression, and how it has linked with other relevant services they may also have accessed.

During the second interview, the client's health log was discussed as a way of exploring the meanings they attached to their experiences of the services and what services they also accessed in the community. The interview questions addressed some of the service qualities that had already been identified in the NHMRC study such as holism and accessibility. A social view of health underpins CPHC, and so was part of theoretical framework that guided these questions such as whether they had received help or advocacy in relation to housing, employment or legal issues which correspond to the determinants of health.

Empowerment was explored in detail in these interviews. This research sought to critically assess the extent to which the four PHC services were using an empowerment approach. The semi-structured interviews with clients explored the meanings clients had of the concept of empowerment and what opportunities and barriers there were to individual and community empowerment.

Other questions addressed satisfaction, any difficulties with access, perceptions of improvements in health and wellbeing and any other benefits of their interactions with the service. The use of an interview guide ensured that clients were asked the same questions (Minichiello, Aroni, & Hays, 2008). Clients were encouraged to expand on topics that were relevant to their experiences as recommended by Loftland (1971) and Patton (1990). The interviews took place at a convenient time and location and were audio recorded and transcribed.

3.7.1 Patient Enablement Instrument

In the developing the methods of this PhD a way of investigating clients' empowerment was sought that could be used during the first and second client interviews. During a NHMRC project meeting a psychiatrist, who was also a chief investigator on the NHMRC project suggested an empowerment tool, the Patient Enablement Instrument (PEI) (Appendix E) (Howie, Heaney, Maxwell, & Walker, 1998). This measure was used during the first semi-structured interview to investigate client's level of empowerment in relation to the services they had accessed for depression. It was repeated during the second semi-structured interview to assess whether clients' levels of empowerment had changed over time. The PEI comprises six questions asking how clients felt about their health as a result of the care received at the health service.

As mentioned in chapter 2, 'enablement' is used interchangeably with empowerment. The PEI was deemed appropriate to pilot as a tool to assess empowerment. However, the wording of the questions that make up the PEI was changed slightly from 'As a result of your visit to the doctor today' to 'As a result of all the care you have received at (health service). This enabled the care they received at a particular health service to be captured.

It could be argued that this is an ‘objective’ measure used in positivistic biomedical research which takes a different approach to viewing the world than the constructionist view taken in this research. However, it was also used as a way of facilitating discussion with clients to understand their subjective meanings of their personal experiences of PHC service delivery on their journey through the health service. After reflecting on whether the PEI was appropriate to use, it seemed a way of breaking down the concept of empowerment for clients in order to get at views they had of empowerment and PHC. Other advantages of this measure were the shared approach for all clients which could be examined over time. Therefore, some form of standardisation was needed, although it is acknowledged that therefore meaning was not left to be totally constructed by clients. During the client interviews, the PEI was left to after the open-ended questions so as to not define empowerment for clients before they described their definition of it.

3.7.2 Informed consent and withdrawal criterion

Clients were provided with an information sheet and signed a consent form. Participation was voluntary and clients could choose not to answer any question they didn’t feel comfortable with. Clients were provided with a small reimbursement of $30 for the stage 1 interview and $50 for the stage 2 interview. This amount paid for their time and any travel costs. Clients chose where they wanted to meet; this was typically at the PHC service and they had the option of bringing along a support person.

3.8 Piloting client interview questions and client health log methods

The client interview questions and health log were piloted with a group of clients with depression from another PHC service that was not involved in this PhD or the NHMRC project to gain feedback on these methods. The section below outlines the process.

3.8.1 Recruitment for pilot

Another service not involved in the project was chosen to pilot the client interview questions and health log with a group of clients that had just completed a six-week mental health promotion group called “Getting Out of the Black Hole”. The practitioner that ran this group agreed to invite clients and nine gave their consent to be contacted about participating. It was explained that the purpose of the group interview was not to answer the questions contained in the client interview guide but to provide feedback on the questions, the language used and whether any important issues for them had been missed.

Seven clients were able to be contacted and agreed to participate. Three clients participated in one group interview and so another group interview was conducted where two clients participated (two didn’t turn up on the day). Two group interviews were chosen rather than one focus group due to the low numbers and to enable specific feedback to be gathered on the wording of client interview questions and health log methods. Participants overall were happy with the client interview questions but suggested ensuring that terminology used in the interview guide that referred to depression was consistent with clients’ own beliefs about their mental health. To respond to this suggestion, practitioners were consulted regarding the preferred language used by clients prior to attending client interviews.

3.8.2 Informed consent and withdrawal criterion for pilot

Clients were provided with an information sheet and signed a consent form. Participation was voluntary and they could leave at any time. A small reimbursement of $20 was provided to those that participated and taxi vouchers were offered if transport was difficult.

3.9 Audit on mental health promotion, prevention, treatment and recovery of depression

To assess mental health promotion, prevention of depression, treatment and rehabilitation yearly audits were conducted at each site. The NHMRC project developed the audit template (Appendix F) and each PHC service contributed relevant information. The audit included routinely collected service data on workforce, resources, changes in funding, activities and services provided, client numbers and the partnerships and collaborations they had with other agencies e.g. beyondblue and other mental health services. The audits documented changes that occurred over the duration of the project so that the extent to which the PHC services were adopting a CPHC approach could be assessed. As discussed earlier in this chapter the wider context in which this study took place was important to document as this had an impact on this research. These audits provided a way of documenting some of the contextual changes such as changes to funding and changes to policies. NHMRC project meetings, case tracking interviews with staff and field notes and observations kept in a research journal were other ways that contextual changes were documented.

3.10 Semi-structured interviews with staff involved in one-to-one services

Semi-structured interviews were conducted with staff involved in one-to-one services for clients with depression at each of the four PHC services. All staff involved in service delivery relating to adult mental health were invited to participate. Using a constructionist approach, a flexible interview guide was used that included open ended questions so that staff could construct meanings of their practice in a CPHC model of service delivery in terms of the work they do with individuals and the community. Semi-structured interviews explored what meanings staff attached to empowerment, whether it was part of their role and if so, what was done to support it. In promoting open discussion and to maintain confidentiality, separate interviews with staff were chosen over focus groups. Staff were given an information sheet and signed a consent form. As they worked for the public sector they were not allowed to receive a reimbursement for participating.

3.11 NHMRC semi-structured interviews with staff and service managers

As part of the NHMRC project, structured in-depth interviews were held with a selection of staff including managers and practitioners working at the four PHC services as well as South Australian Department of Health staff. A number of interviews were conducted with managers, practitioners and South Australian Department of Health staff in the first year of the project and were repeated in the final year of the NHMRC project. Specific questions on depression were included in the interviews carried out in the final year of the NHMRC project. This data was accessed and analysed for this thesis.

3.12 Field notes and observations

A critical approach to this research meant that a reflective research practice was adopted so that ‘objective’ truths are questioned and the subjective nature of my experience as a researcher recognised. This research accepted that meaning is open to numerous interpretations. It is not fixed and will change in different contexts. To assist with being reflective a journal was kept where field notes and observations (Appendix G) were documented throughout the project during interviews with staff, clients and visits to the health services. This information provided valuable data that added to the results and contributed to the context.

3.13 Analysis

The study yielded both quantitative and qualitative data. Quantitative data came from the PEI and case tracking questionnaires. Data from the PEI were analysed using SPSS software. The percentage of clients empowered to manage their depression during the six months between the first and second interviews was compared across the four PHC services and Wilcoxon signed ranks tests were undertaken to test for statistical significance.

Case tracking questionnaires were imported into Excel and grouped by de-identified client codes. This information along with any referrals were mapped onto a flowchart in Microsoft Word. Any qualitative reflections and comments from staff were added as annotations on the client journey diagrams. When client journeys were documented a framework of questions were developed (see Appendix H) examining evidence for different comprehensive PHC attributes such as advocacy, action on social determinants of health, and multi-disciplinary care. This data was reported using descriptive statistical analysis such as totals, means and ranges to allow comparisons to be made between the services.

The Southgate Model which describes a CPHC response to depression was used as a framework to analyse the client journeys and examine evidence for services’ implementation of CPHC in response to depression. Miles and Huberman’s (2014) approach to developing matrices in tabular form with defined rows and columns were applied to compare service responses to depression and alignment of these responses using the evaluation framework, the Southgate Model. The use of matrices condensed qualitative data into a few pages that could be easily viewed and enabled detailed analysis of response patterns to be examined within and between the services. Within-case and cross-case analysis (Creswell, 2013; Miles, et al., 2014) was applied where the range of responses offered by these PHC services to individuals with depression and the community are documented using the key themes of the Southgate Model (see chapter 5). Cross-case analysis (Creswell, 2013) then followed (see chapters 6, 7 and 8) with thematic analysis applied across cases. Matrices were used to compare and contrast these themes and interpret (Miles, et al., 2014) short and long term consequences as well as the extent of CPHC implementation among these PHC services.

Client interview data and reflective comments from the case tracking questionnaire were analysed in QSR Nvivo using thematic analysis guided by the key service qualities and mechanisms underpinning a CPHC approach outlined earlier in the Southgate Model. Analysis of client interview data was guided by the ‘Framework’ method (Ritchie & Spencer, 1994). The analysis proceeded through a number of stages. First, the analysis began with familiarisation by reading transcripts and listening to audio recordings to gain an overview of the data. Simultaneously, the process of ‘identifying a thematic framework’ began where key themes were identified. These themes were entered into Nvivo and familiarisation continued with the rest of the transcripts. During this stage meetings were held with the NHMRC research team to discuss the thematic framework and reach agreement on emergent themes. ‘Indexing’ or coding of the whole data set then took place according to the thematic framework. Charts were developed where data was ‘lifted’ from the transcripts to a table in Microsoft Word with headings according to core themes and based on the research questions. Interpretation and mapping then took place where client perceptions and experiences at the PHC services were compared and contrasted. These charts where interpreted alongside the client journeys, field notes and observations and took into consideration contextual factors in order to seek explanations and interpret the data set as a whole. Clients were given pseudonyms to assure anonymity.

This chapter has outlined the contribution this PhD made to the broader NHMRC project and discussed its positioning within the field of health services research. A constructionist epistemology, and realist ontology was applied which was further informed by a critical inquiry approach. The research design was outlined as well as the methods of data collection and analysis. The contextual environment in which this study took place is discussed in the following chapter.

CHAPTER 4: HEALTH CARE SYSTEM REFORM IN SOUTH AUSTRALIA

4.1 Introduction

This chapter outlines the broader policy and reform context in which the cases operated using a variety of sources and describes the way this context changed and shaped the cases (the PHC services). A description of the scope and profile of the four PHC services and the impact these reforms had on service delivery is outlined. Descriptive data is also provided to give insight into the general nature of the cases. Firstly, an overview of the Australian and South Australian health system is included to highlight the complex nature of health service delivery structures that constitute the Australian health system. The chapter then describes health care system reform in Australia and significant structural reorganisations in South Australia dating from the 1970s to when data collection commenced for this study in 2012. The policy context and health system changes during the data collection period 2012 to 2013 is described briefly with a more detailed discussion included in the results chapters. During this time the demise of community health centres and the introduction of GP Plus centres (two of which were study sites), GP Plus Super Clinics (one was a study site), and the establishment of federally funded regional PHC organisations, Medicare Locals occurred. A new model of service delivery accompanied a change from community health centres to GP Plus centres. The wider policy environment in which these services operated constrained service delivery. A holistic approach to mental health that included promotion, prevention and early intervention was no longer supported signifying a narrow interpretation of PHC with a focus on chronic disease and preventing hospital admissions.

4.2 The Australian health system – an overview

The Australian health system is a complicated mix of federal and state/territory funded services. The term ‘health system’ is used here to describe the network of organisations, institutions and resources whose primary focus is to improve health. In the case of the Australian health system various smaller systems, organisations and services intersect to differing degrees that can result in duplication and disputes. Responsibilities are spilt between federal, state/territory and local governments, and between the government and non-government sectors that provide some form of health care (Biggs, 2013). The following sections outline the role of these different levels of government.

4.2.1 The Australian Government’s role in health care

The Australian health system is unique in that there is a mix of provision of both public and private funds shared between states, the federal (Duckett & Willcox, 2015) and local governments (Davies, Perkins, McDonald, & Williams, 2009). In general, the federal government is primarily responsible for the funding of public healthcare that occurs outside public hospitals, subsidising fee for service rebates (for example General Practitioners, GPs) under Medicare, Australia’s national health insurance scheme (Davies, et al., 2009). States and territories are largely responsible for the direct provision of services such as public hospitals and public health and primary health care services, which includes mental health services, using a combination of federal government funding and revenue raised by state and territory taxes. These services are either provided directly or contracted to non-government organisations. The role of local government differs and can include community nurses and public health services such as the removal of rubbish.

Health system funding from the federal government to the states is negotiated every five years through the National Health Care Agreement, with the current agreement running from 2012-2017. These agreements define the objectives, outcomes and performance indicators for the state health system, and define and clarify the roles and responsibilities that guide the federal, states and territories in the delivery of services across the health sector. The private sector has a considerable role in the provision of health care and includes private medical practitioners including psychiatrists, private hospitals, pathology services and pharmacies (Palmer & Short, 2010). In 2012-13, 41% of hospital admissions occurred in private hospitals in Australia (Australian Institute of Health and Welfare, 2014). Private health insurance is heavily subsidised by the public tax system and usually covers private hospital, dental and allied health, although recently the health insurance industry is developing an increasing role in primary health care through recent collaboration with Primary Health Networks (Public Health Association of Australia & Australian Healthcare and Hospitals Association, 2014).

The Australian Government via the Department of Health (DOH)[1] provides funding for health services within the Australian public health system, subsidising pharmaceutical drugs

---

[1] Department of Health and Ageing up until September 2013 when it changed to Department of Health

on the Pharmaceutical Benefits Scheme and subsidising a range of services such as nursing homes and domiciliary nursing. In addition, the Australian Government contributes financially to a range of national community health activities such as the Aboriginal Health Close the Gap program (Holland, 2016), the National Mental Health Strategy (described later in this chapter), (Australian Government Department of Health, 2014) and Headspace, the provision of multidisciplinary care for young people with mental health and substance abuse problems (Duckett & Willcox, 2015).

The federal government funds general practice through Medicare. The majority of GPs are based in private practice provide services on a fee for service basis. The services provided by GPs include diagnosing and treating illness (both chronic and acute), referring patients to consultants, hospitals, allied health professionals, and local health services such as the four PHC services in this study. In Australia, GPs typically take the lead in diagnosing and treating depression (Duckett & Willcox, 2015). A CPHC model would normally include primary medical care as an essential component however, these funding arrangements meant that GPs operated in parallel to PHC services in this study.

The federal government and its policy decisions have an important impact on the state health system and local health services. This includes, for example the funding of Divisions of General Practice across Australia from 1992 to 2011 as outlined in chapter 2 to build capacity among local primary medical care services (Smith & Sibthorpe, 2007). In 2011 the Rudd/Gillard Commonwealth established new health services, Medicare Locals in communities across Australia. These organisations replaced the Divisions of General Practice and had a direct impact on the study sites. The SA government argued the creation of Medicare Locals led to duplication of counselling services and subsequently decided to reduce its role. This duplication was cited by the South Australian government in its decision to reduce its role in mental health service provision and health promotion, which affected all of the PHC case study sites (McCann, 2012). This policy contributed another source of reform initiatives and an additional layer of complexity to the context and will be discussed in more detail later in this chapter.

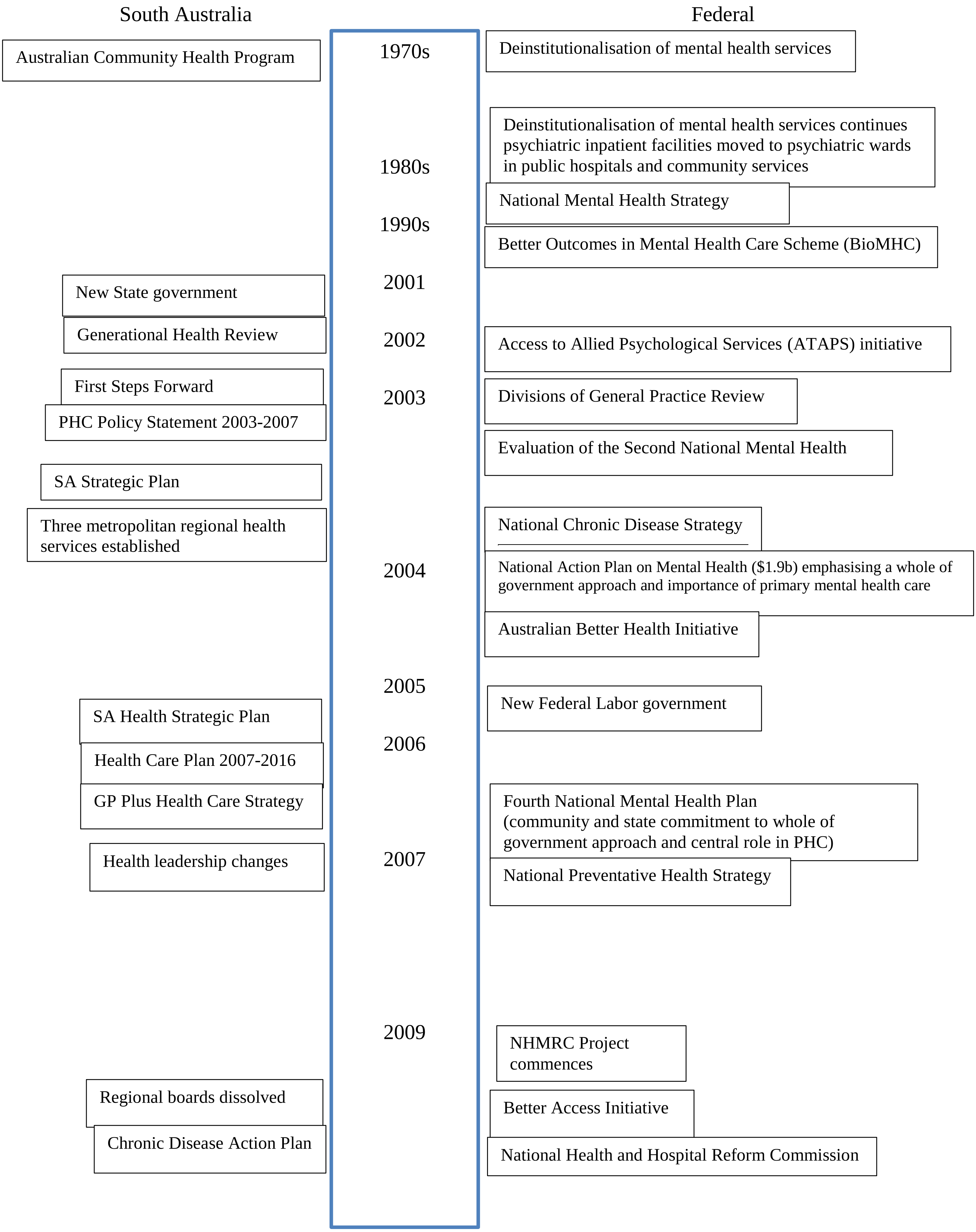
4.3 The South Australian Health system

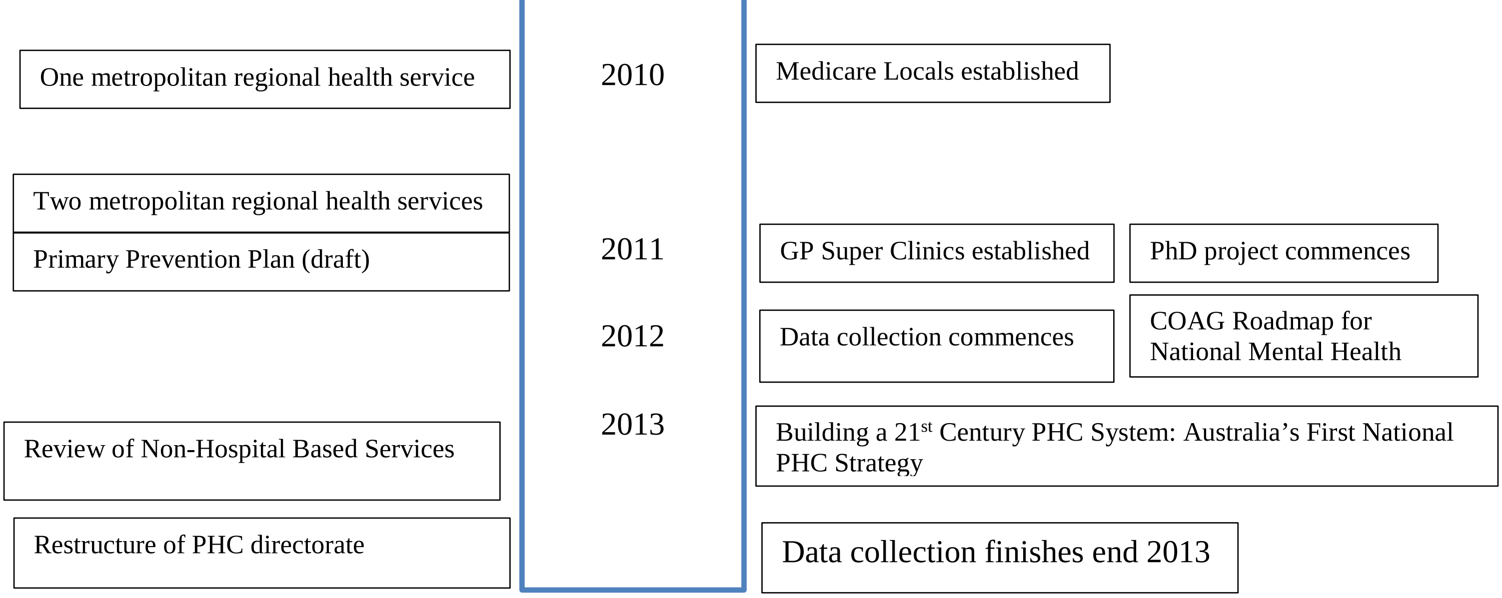
The South Australian state government has direct responsibility for hospitals (including psychiatric) as well as funding the multi-disciplinary PHC services in this study, and most community health activities. In South Australia, the Department of Health and Ageing (SA Health) is the central agency with policy, planning, funding and administrative responsibilities during the data collection period of this study.

This study took place during a time of considerable change in the PHC system in South Australia. There have been a number of changes in terms of regionalisation models and responsibilities in the health system over the last twelve years. Up until recently, there has been a trend toward regionalised governance where there has been decentralisation and delegation of authority in the administration of health services. These changes are shown in figure 4.1 but regionalisation dates back earlier to 1995 when the South Australian Health Commission was replaced by the Department of Health and two regions were created; Adelaide metropolitan and rural/remote South Australia. All rural services were categorised into a single division in consideration of the strong partnerships built in rural towns (Duckett & Willcox, 2015). The metropolitan area was subsequently divided into two separate regions and then three metropolitan regional health services Northern, Central and Southern were established in 2004. Dwyer (2004) argues these changes were focused on improving accountability of hospitals and other services and were politically driven and based on financial and health goals such as the need to limit health spending.

From 2010 there was a focus on greater centralisation of governance within SA Health with further regionalisation where the Northern, Central and Southern regions became one metropolitan regional health service. The four PHC services in this study became part of the Adelaide Health Service. In 2011, the Adelaide Health Service was restructured again into three Local Health Networks, the Central, Northern and Southern Adelaide Local Health Networks The policy context and health system changes during the data collection period 2012 to 2013 are described in the results chapters of this thesis.

Figure 4.1: Federal and state PHC sector and mental health policy changes (adapted from Jolley et al (2014).





4.4 Community health services – the Australian Community Health Program

CPHC in South Australia has a long history dating back to 1973 when the Whitlam government introduced the Australian Community Health Program (ACHP) leading to the establishment of community health centres in the 1970s and 1980s across Australia. The Commonwealth had flexible funding arrangements in place to encourage the states to take up the program. Consequently, the program developed differently around Australia. In South Australia and Victoria local committee management governance structures developed which were unique to community health centres in these states. Following a change in government in 1976, the program ceased and responsibility was transferred to the States. Community health centres in South Australian and Victoria were the most successful in continuing (Duckett & Willcox, 2015; Warin, et al., 2000).

Throughout metropolitan Adelaide community health centres and women's health centres provided treatment, prevention and health promotion activities (Lawless & Baum, 2014). In this study two of the PHC services, the Green and Blue services, were founded under the ACHP. The other two services in this study, the Orange service and the Aboriginal health service were established later on but in the same spirit as the centres developed under the ACHP.

The ACHP was an innovative program that sought to improve access to health services for all Australians (Hospitals and Health Services Commission, 1973). These services were based on a social model of health and foreshadowed principles outlined in the WHO Declaration of Alma Ata (World Health Organisation, 1978) and the Ottawa Charter in the 1980s (World Health Organisation, 1986) such as equity, health promotion, and community participation, and had a population focus. As a result, health promotion activities were an important feature of these community health centres as well as these centres being responsible for the health of the local community in a given area. These services comprised multidisciplinary teams providing a range of medical and nursing services, health promotion and prevention activities with a focus on community development and advocacy/social action on social and environmental issues of concern to the community (Baum, 2016). They provided mental health services that focused on treatment, health promotion, and prevention and also a range of services such as physiotherapy, nutrition and dietetics, counselling, and included programs such as financial counselling and drug and alcohol programs (Swerissen, Macmillan, Biuso, & Tilgner, 2001). In South Australia, the first CHC were driven by GPs enabling primary medical care to be delivered within a multidisciplinary context (Australian Government Department of Health & Ageing, 2005; Baum, Kalucy, Lawless, Barton, & Steven, 1996; Copeman, Sangster, & Lennie, 1990) however many did not have GPs largely due to concerns their income would become salaried and some were cautious about the emphasis the ACHP placed on other health professionals (Raftery, 1995).

The ACHP foreshadowed many aspects of the Alma Ata Declaration that would come five years later (1978) with an emphasis on reorientating health services, building community capacity to act on health issues, enhancing supportive local places for health and encouraging social inclusion and self-help behaviours (Baum, et al., 1992). During the 1980 and 1990s community health services in South Australia continued to operated strongly from PHC principles (Baum, et al., 1992) however, from the 2000s’ onwards these services have faced a reorientation away from PHC principles and community health and participation. The next section will discuss the PHC re-organisation, policy responses and the impact of health system change on these services over the last decade and a half.

4.5 Primary Health Care reorganisation and Australian policy responses

This study occurred during a time of considerable health system reorganisation in Australia that had a direct impact on the study sites involved in this project. The main health sector changes at a state and federal level from 1970s to 2013 are outlined in Figure 4.1. To provide some context to this study the following section will discuss the PHC reorganisation and federal and state government responses leading up to 2011 when this PhD project commenced. The Adelaide Affirmation was released by SA Health in 2003 reaffirmed its commitment to PHC as outlined by the Declaration of Alma-Ata (Government of South Australia, 2003a) but little action followed as there was a shift to more selective approaches to PHC that focused on chronic disease (Lawless & Baum, 2014). At the same time the Generational Health Review (GHR), the first major overall review of the South Australian health system since the 1970s commenced. The aim of the GHR was to deliver a framework that would guide the South Australian health care system for the next 20 years. The GHR concluded:

> “The present health system is under stress with increasing budget and demand pressures. It is not sustainable into the next generation on grounds of quality of care, efficiency and equity” (Government of South Australia, 2003a, p. 1).

This review concluded that the current system was not sustainable, arguing the PHC system needed to be improved and advocated for a shift in focus towards strengthening the PHC system through health promotion, illness prevention and early prevention, rather than providing more resources into the acute care sector (Government of South Australia, 2003a). SA Health’s response to the GHR, First Steps Forward (Government of South Australia, 2003b) was released in 2003 outlining SA Health’s intent to strengthen PHC and increase prevention, early intervention and health promotion. The SA Health PHC Policy Statement was released in 2003 recognising a PHC approach but there was a lack of implementation planning and resources to invest in PHC. Additionally, in 2006 the Health Minister changed was a change of Health Minister the policy lost support (Jolley, et al., 2014).

Despite reviews and policy shifts by 2007 the focus still remained on selective PHC and physical chronic diseases. For example, the SA Health Strategic Plan 2007-2016 provided statements supporting a PHC approach but focused on clinical treatment for individuals and health promotion was largely directed to information about healthy lifestyle choices by individuals. The release of the GP Plus Health Care Strategy in 2007 led to a number of structural changes to the PHC system in South Australia which further transferred the balance to medical and clinical interventions. These changes and their impact on the study are discussed in the next section.

4.6 Project period 2011 to 2013

The GP Plus Health Care Strategy was still relatively new at the commencement of the NHMRC study in 2009 and structural changes such as the establishment of new GP Plus centres and GP Super clinics to the PHC landscape occurred between 2011 and 2012, just prior to data collection commencing in 2012 for this PhD project. The beginning of the project saw a supportive policy environment within SA Health where there was an emphasis on PHC services incorporating health promotion, primary prevention, community participation and community development principles although as discussed earlier there was an increased focus on the health of individuals and chronic disease. Over the duration of this study there was an erosion of these key principles of CPHC which saw an end to a holistic approach to mental health offered by the PHC services (see chapter 7 where this evidence is presented).

4.6.1 Structural changes to the PHC system in South Australia

There were significant structural changes to the PHC landscape within South Australia during the time of this study. The Australian government's health service reorganisation positioned primary medical care as being central in the management of chronic diseases. Concerns were raised about the rising prevalence of chronic diseases and GPs' capacity to meet the growing chronic disease burden. The GP Plus Health Care Strategy was launched by SA Health to strengthen PHC services (Government of South Australia, 2007). The new GP Plus Health Care centres aimed to improve connections between GPs and other health providers and improve chronic disease through the prioritisation of population health needs.

The emphasis on improving access to GPs continued through the establishment of federally funded GP Super Clinics in 2010-2011. The GP Super Clinics program objectives have many similarities to the GP Plus Health Care Strategy in that both emphasise the need to enhance access to GPs and strengthen PHC, the need to reduce the rates of avoidable hospital admissions and have a focus on chronic disease prevention and management (Australian Government Department of Health and Ageing, 2010; Government of South Australia, 2007). The Federal government and SA Health have a shared approach to facilitating the provision of General Practice and Allied Health services within each of the SA GP Super Clinic sites (Australian Government Department of Health and Ageing, 2010). In South Australia there are three GP Super Clinics and four GP Plus Health Care Centres currently in operation. The co-location of medical and allied health services in GP Plus Super Clinics and GP Plus Health Care Centres is intended to provide the opportunity for clients to access more integrated health care. One of the case study services (Blue service) was located in a GP Plus Super Clinic.

One of the goals of these changes was that clients would have access to a range of services provided by multidisciplinary teams with the potential to improve the client journey by providing ongoing person-centred care all at the same location (Australian Government Department of Health and Ageing, 2010; Government of South Australia, 2007). Duckett (2015) has documented coordination and service delivery problems when multiple agencies are involved. The complex nature of the problems of some clients means there are sometimes a range of professionals all with different training, different orientations and different emphases in treatment. Along with these provider differences there are also rivalries over skills and training and ideological differences between those in the public or not-for-profit sector and those in the private sector (private practice) (Swerissen, et al., 2001). Fuller et al (2011) reviewed service linkages in primary mental health care and found a number of key factors affecting linkages, such as team problem solving, staff characteristics, capacity and support, physical infrastructure and leadership. One of the PHC services in this study is a GP Plus Health Care Centre (Green service) and community mental health teams that provide treatment for those with more severe mental illnesses are co-located within these new PHC services. It is unknown what the integration with these services is like and what effect this has on the client journey.

A key component of the structural reforms, independent to the GP Plus strategy and GP Super Clinics is the introduction of a national network of federally funded PHC organisations, Medicare Locals, established in July 2011-2012 by the Labor Government. Medicare Locals replaced Divisions of General Practice and had a role in coordinating services in local areas and improving quality, integration of and access to services provided by general practice and allied health. At two of the study sites, (Green and Blue services, a GP Plus Health Care centre and GP Super Clinic respectively), Medicare Local staff provided psychological counselling through the Access to Allied Psychological Services (ATAPS) initiative and were co-located in the same building. Medicare Locals were also responsible for the Headspace program and the Partners in Recovery (PIR) initiative which supports people who experience severe mental illness and have complex needs by collaborating with multiple sectors. Towards the end of this study a national review of Medicare Locals was announced by the Abbott Coalition Government and in 2015, after this research had concluded, Medicare Locals ceased operating and were replaced with Primary Health Networks. These Primary Health Networks are commissioners rather than providers of services and differ from the Medicare Locals which provided some mental health services.

4.6.2 Review of Non-Hospital Based Services

In 2012 Warren McCann was commissioned by SA Health to undertake a Review of Non-Hospital Based Services (McCann, 2012) in South Australia driven by the increasing state health expenditure and the introduction of Medicare Locals into the PHC landscape. This included a review of activities provided at South Australian PHC services such as GP Plus and GP Super Clinics. The Government response to this review (Government of South Australia, 2013) resulted in the cessation of funding to health promotion, disease prevention and community capacity-building programs. Services were reorientated toward physical chronic disease management, signalling the end of a holistic approach to mental health which includes the promotion of good mental health, prevention and early intervention. From July 2013, groups such as Mindfulness, Moving through Depression, a pre-chronic conditions program called ‘Do it for Life’ and a Healthy Eating and Lifestyle Group stopped operating. Services were reorientated to one-to-one work with individuals on the management of chronic disease and the avoidance of hospital admissions, indicating a more narrow approach to PHC. Some mental health staff at these services either ceased employment or were reoriented towards provided mental health support for people with chronic physical health conditions. These changes occurred during the middle of this research that resulted in considerable stress for staff. In documenting the changes during the course of the project it became clear the health system was a changing system rather than a stable system. The mental health system has also undergone considerable changes ranging from the 1970s when deinstitutionalisation of mental health services commenced in South Australia to more recent reforms such as the Better Access Initiative aimed at improving access to psychological services. The next section will give an overview of mental health care in Australia and its reorganisation as well as Australian policy responses.

4.6.3 Mental health service delivery and reforms

The provision of mental health services in Australia has been traditionally funded by state/territory governments. In South Australia mental health services range from hospitalisation and supported residential care to hospital-based outpatient services, triage mental health services, community mental health care services, and treatment provided by specialists such as psychologists and psychiatrists where referral can be through GPs or via self-referral.

The commencement of current models of mental health service delivery began with deinstitutionalisation of mental health services in South Australia in the early 1970s where patients were moved from psychiatric institutions into the community (Palmer & Short, 2010). During this time a number of community services were established such as community mental health centres, outpatient care services for those recently diagnosed, community housing and state-funded day hospitals. Older people, people with drug and alcohol problems and those with an intellectual disability were also moved to separate services (Willis, et al., 2012). State governments also began providing psychological services for children with the understanding that mental illness could be prevented. Deinstitutionalisation continued in the 1980s when inpatient facilities from psychiatric hospitals were moved to psychiatric wards in general hospitals and community services continued to be established for those with chronic mental illness so they could live outside psychiatric hospitals (Willis, et al., 2012). This led to the closure of psychiatric hospitals and the emphasis on provision of care in the community which was supported by policies at a state and national level.

Rosenberg et al (2009) argue the process of deinstitutionalisation in the 1970s and 1980s was underfunded leading to service gaps for those with severe mental illness. There was inadequate development of services available in the community and a shortage of supportive housing options that occurred at a time when there was an increase in the Australian population (Whiteford & Buckingham, 2005). As a result there have been major reforms to the mental health system over the last two decades (Duckett & Willcox, 2015).

Further reforms commenced in 1992 when the first National Mental Health Strategy was adopted and the updated National Mental Health Plans were released in 1998 and 2003. Following this in 2009 was the National Mental Health Policy 2008 and the Fourth National Mental Health Plan (Willis, et al., 2012) (see figure 4.1 documenting reforms to mental health services).

The aims of the first National Mental Health Strategy were to shift service delivery from psychiatric hospitals to general hospitals and the community, to improve the connections between government support services and non-government organisations and to develop consistent mental health legislation across Australia. The second and third National Mental Health Plans differed as mental health promotion, prevention and early intervention, development of a partnership approach and an emphasis on consumer and carer participation, research and service evaluation were introduced (Australian Health Ministers, 2003). The National Mental Health Policy 2008 and the fourth National Mental Health Plan introduced a recovery approach to mental health, emphasising the promotion of mental health in the community and social inclusion strategies such as promoting access to education, employment and housing (Department of Health and Ageing, 2009). A recovery approach shows some overlap with the social view of health that underpins CPHC.

Mental health reform has also saw a change in policy direction with a number of federally funded initiatives aimed at improving access to psychological services. The Access to Allied Psychological Services (ATAPS) initiative, a component of the Better Outcomes in Mental Health Care (BOiMHC) program established in 2003 provided short term psychological services for people experiencing mental health problems with funding being administered through Divisions of General Practice and then Medicare Locals who were part of the PHC landscape during this study.

Complementing the BOiMHC program is the federally funded Better Access Program which commenced in 2006 and was a major investment to mental health services with the aim to improve access to mental health services. This program subsidised Medicare, the national health insurance scheme, to enable people with mental health problems to access low cost treatment through private psychologists and other allied mental health specialists (appropriately trained social workers and occupational therapists) after the development of a Mental Health Treatment Plan by a GP. However, this program has been critisised for its traditional individual fee-for-service structure that has an emphasis on individualised medical care or as Hickie and McGorry (2007) refer to *'more commonly isolated, disorganised and episodic care'* rather than collaborative care models described in chapter 1 as multifaceted interventions, where a number of professionals within the service work together collaboratively which has been more effective in the treatment of depression. Hickie and McGorry (2007) point out another weakness in the Better Access program is the lack of incentives for co-location of services that may improve access to services (Rumball-Smith et al., 2014). The four PHC services in this study comprised of co-located multidisciplinary services having the potential to provide collaborative care. However, Better Access and ATAPS are aimed at GPs referring to private practitioners rather than these public services. Therefore there are public and private systems operating in parallel.

Accompanying these reforms was the development of a range of community services such as community mental health teams that have a role in assessing, monitoring and supporting people to live in the community, to supported accommodation provided by residential services and outpatient departments and clinics providing services for people with chronic mental illness. The National Mental Health Strategy (Department of Health and Ageing, 2009) argued for there to be a combination of government-funded community mental health services and services by non-government organisations (NGOs) (Willis, et al., 2012). This has led to a large number of NGOs providing mental health services in the community. Additionally, the Council of Australian Governments (COAG) released the Roadmap for National Mental Health Reform 2012-2022 outlining a number of priorities such as person-centered approaches, improving mental health and social and emotional wellbeing, the prevention of mental illness, early detection and intervention, improving access to services and supports and improving the social and economic participation of people living with a mental illness.

4.7 PHC services – scope and profile

Australian PHC comprises of general practice, primary health care services (or community health centres (CHC) in other states except South Australia), private allied health providers and Aboriginal Community Controlled health services. Primary medical care is usually provided through general practice, although some CHC and Aboriginal Community Controlled health services provide GP services.

The four case study PHC services in this study were once CHC operating from a social model of health where there was a combination of prevention, health promotion, community development and treatment and support provided to individuals. The health system reorganisation outlined in this chapter resulted in a gradual move away from CPHC service delivery. The following section provides a description of the four PHC services.

4.7.1 Description of the four PHC services

Orange service

The Orange service is located in a purpose built two storey building that opened at the end of 2010 when the service merged with a local PHC service and became a GP Plus Health Care Centre under the GP Plus Health Care Strategy (Government of South Australia, 2007). The service receives revenue through South Australian government funds and is located in an area that experiences a high level of socioeconomic disadvantage compared to the rest of Adelaide according to SEIFA indexes (Socio economic Indexes for Areas), an index of disadvantage devised by the Australian Bureau of Statistics for census data (Australian Bureau of Statistics, 2011).

Staff employed at this service in 2012 included a manager, administration staff, social workers, nurses, dieticians, lifestyle advisor, a PHC nurse and a visiting exercise physiologist. These staff had moved from a local PHC service which had philosophical origins based on a social model of health and grounded in principles of equity and participation. There were two social workers (one full time and one part time) that worked at the Orange service. In 2012, the manager estimated that staff spent approximately 75% of their time on one to one appointments with clients and 25% of their time running health promotion and support groups (service audit 2012). Staff that moved there had been involved in community development work but since the move no longer spent any time on community development activities and there were few examples of community partnerships and networks apart from some collaboration with the co-located GP, and referrals to Anglicare. The GP clinic was co-located in the building to address the shortage of GPs in the area (Government of South Australia, 2007). This is consistent with the GP Plus Health Care Strategy with its focus on improving connections between GPs and on people with chronic diseases and those at risk of developing a chronic disease. A number of other services were also co-located, for example a breast screening service and a service aimed to help people with management of chronic physical disease.

In June 2013, there was significant restructure of the PHC directorate in the region. Rather than staff reporting to the service manager they now reported to a director and discipline-specific manager based at a local hospital. As a result, the service manager no longer had responsibility for staff working at the service and took on the role of building facility manager. There was an addition of a social worker that commenced and worked between the Orange service and the local hospital. This represented a stronger alliance to the acute sector where they were able to engage with individuals who were already sick rather than working with the community on early intervention and prevention of mental illness as well as promoting good mental health.

In July 2013 as a result of the South Australian Government’s response to the Review of Non-Hospital Based Services most of the health promotion programs developed to target people vulnerable to mental health problems ceased. There was a continued shift in focus to chronic diseases and servicing the chronic disease clinics from the local hospital such as the Diabetes, Coronary, Cancer, and Respiratory clinics.

Green service

As for the Orange service, the Green service is managed and funded through the state government and is located within a GP Plus Health Care Centre. The service originally was a community health centre formed in the 1970s under the Australian Community Health Program and had a long legacy of working with the community using a community development approach on a range of issues such as domestic violence, and maternal and child health.

In 2010, the service was renamed and relocated to a new GP Plus Health Care Centre site, five km away from its original site. There were 36 staff (22.1 FTE) employed including: managers, administration staff, nurses, lifestyle advisors, project officers, dieticians, podiatrists, social workers, psychologist, crèche staff and under the early childhood teams there were speech pathologists, occupational therapists and a psychologist (service audit, 2010). Staff provided a range of services such as the treatment and prevention of chronic conditions, healthy weight, domestic violence, treatment of mental health problems and promotion of good mental health, early childhood services, healthy ageing and support for clients residing in supported residential facilities. A roof-top community garden was established to replace the community garden at the old site, particularly for clients residing in supported residential facilities.

During 2010 and 2011 the service manager approximated 60% of staff time was directed to one to one treatment with clients, 30% of their time was facilitating health promotion and support groups and 10% of their time was directed to community activity. There was an annual budget of $1.7 million. Service provision was constrained due to budget cuts and there was a feeling of uncertainty in the health system in early 2013 with a move away from permanent positions to short term contracts. This directly affected mental health service provision as the only psychologist (for the adult team) was placed on a short term contract with no guarantee of renewal. As a result, this staff member subsequently left for another position. This left one full time social worker and then at the beginning of 2013 another social worker was employed part time but only to provide one-to-one counselling to clients.

In July 2013, following the Review of Non-Hospital Based Services, the Green service lost a number of the project officers and lifestyle advisor staff who left or were redeployed to other areas. Health promotion services, including mental health promotion and support groups, healthy weight services, domestic violence support group and community garden ceased. There was no funding available to advertise the range of services available to the community and staff were no longer allowed to be involved in community partnerships and networks such as a regional domestic violence working group. It was estimated by the service manager that most of staff time was spent working one to one with individual client's (75%) with less group work (20%) and very little community work (5%). During the end of 2013, activity based funding, whereby the service receives more funding for treating more clients was being introduced and there was increased emphasis and pressure on staff to see a greater number of clients per week. There was also a move away from the terminology of primary health care with the local health network instead staff used a new term ‘intermediate care’ (see chapter 7).

Blue service

The Blue service is a state-managed PHC service that is in a jointly state and federally funded GP Plus Super Clinic. Similar to the Green service, the Blue service was established under the ACHP and was at one stage the largest community health service in South Australia (Lawless & Baum, 2014). For example, in 1986, there were 100 staff and administration staff employed there. The service operated as a regional base for community health services in the broader area and coordinated a number of outreach centres in surrounding locations within the region (Lawless & Baum, 2014). The passage from Baum et al (1996, p. 23) below gives an indication how the service operated.

> *Community health would provide services in a social, community health context, with a population focus and included a range of services from one-to-one direct client service, therapeutic groups and group education programs, community involvement initiatives and importantly health promotion….[Blue service] has been established in a social health model that was just beginning to take off in South Australia at the time.*

In 2012 this community health service was renamed and relocated to the new GP Plus Super Clinic site 100 metres down the road from its original site and adjacent to a local hospital. Staff employed included: managers, administration staff, nurses, lifestyle advisors, dieticians, podiatrists, social workers, psychologist, and crèche staff. In the early childhood team there were speech pathologists, a social worker, occupational therapists and a psychologist. Staff provided a range of allied health services such as psychology, podiatry and nutrition, counselling and support, chronic disease support and early childhood and family support. A number of other services were co-located within the building such as drug and alcohol services, a sexual health service and a GP clinic. There was a greater number of staff offering services for adults with mental health problems compared to the other three services. There were four social workers and two psychologists. In 2012 it was estimated by the service manager that 30% of staff time was spent working one to one with individual client's, 30% of time was spent on running groups or and 30% of staff time was spent working out in the community (the additional 10% of staff time was spent on administration).

The Blue service was also affected in 2013 by the Review of Non-Hospital Based Services and therapeutic groups and group education programs such as mental health promotion and support groups important for combating social isolation and aiding in the recovery of depression were no longer provided to the community. An example is the singing group that had been operating at the service for a long time ceased.

In a similar situation to the Green service, there was no funding available to advertise the services available to the community and staff were discouraged from being involved in community partnerships and networks, however there were some collaborations with the co-located GP and referrals made to Anglicare. In July 2013 the co-located GP clinic ceased consulting, possibly due to a lack of patients which had also occurred a year earlier at another GP Plus Super Clinic within metropolitan Adelaide.

Towards the end of 2013 the Blue service was trialling a new electronic reporting system that was focused on individual client care, and as at the Green service there was an emphasis on activity based funding and increased pressure from management to see a greater number of clients per week. By the end of 2013 which signified the end of data collection, staff reported largely working one-to-one with clients. There were no groups running and staff were discouraged from working in the community that had previously included attending meetings with other community services in the region, supporting clients to attend community services and advocating for broader social change on issues such as domestic violence and raising community awareness of mental health.

Aboriginal Health Service

The Aboriginal health service is managed by the South Australian government. It commenced operation in 2001and covers a large geographical area with two different site locations approximately 20km apart. One of the sites was co-located with the Blue service and the service was divided up into two different teams, the family clinic providing support with social issues and the health team providing clinical services such as medical treatment from a GP and nurses.

In 2010, the service received COAG Close the Gap funding bringing the annual budget to $1.1m and by 2011 the service employed 16.8 FTE staff. All staff were Aboriginal and included a manger, a team leader, Aboriginal health workers, lifestyle advisors, a mental health nurse, a transport officer, a data project officer, youth worker, children's services worker, community support worker, maternal infant care worker and a receptionist. The service offered a range of health promotion groups such as a Mums and Bubs groups, a Men's Group, Women's Group, as well as a community lunch operating weekly for community members and other local service providers. The service also provided a number of one-to-one services such as healthy lifestyle advice, case management, referral and advocacy, home visitation and a service providing transportation to and from the service as well as to specialist appointments.

In 2010, the site that was co-located moved into a new building next door to the where the new GP Plus Super Clinic was being built. However, the building did not have any common area that could be used for the community lunch program and another venue for this needed to be found.

At the other site, in 2010 the previously co-located Green service relocated 5km away and as a result the manager of the Green service reported a weakened relationship between the two services. In 2012, the Aboriginal health service received COAG funding and developed an Aboriginal health workforce training centre that provided workshops for community members on computer skills, budgeting and job application skills.

In 2013, a number of positions were lost as a result of a reduction in COAG funding. This occurred at the same time as the Review of Non-Hospital Based Services and resulted in further losses in health promotion positions and programs. For example, the team leader, data project officer, tackling tobacco coordinator, community support worker and pharmacy support worker positions were lost due to contracts ending, redeployments to other health services and resignations. Health promotion programs such as the tobacco cessation, healthy lifestyle programs and the youth group ceased. The Men’s Group and Women’s Group, and Mums and Bubs Group ceased as well as annual camps, and the community lunch program was reduced from weekly to monthly. The service was further restricted from organising community events such as NAIDOC week or other celebrations that it has done in the past.

After July 2013 the team was restructured and the family clinic and the health team merged to form one team. Some Aboriginal health workers became Aboriginal clinical health workers working in clinical care. The service shifted focus to seeing those with chronic physical conditions and early childhood. Apart from treatment for mental health problems through the GP, the service ceased providing case management and support to those with mental health problems unless they had a chronic physical condition. Home visiting was heavily reduced and the service shifted service delivery to an appointment system and there was less flexibility to see people walking in to the service. Below, descriptive data on client pathways and contributing factors to depression provides an overview of the general nature of the services.

4.7.2 Client pathways into the PHC services

Clients were referred to the health services for management of depression via: 1) referral by a GP, 2) self-referral, 3) internal referral from other health professionals, 4) internal referral from a health promotion group, 5) external referral from another agency (see table 4.1).

The majority of clients had referred themselves to the services except at the Orange service, where there were no self-referrals. At the Orange service, clients were mainly referred from other health professionals working within the health service; this was either to a one to one service or a health promotion and support group. At the Green service the impact of co-location with a mental health agency was evident with five referrals received from this agency who saw clients with moderate to severe mental illness. These clients were referred to the Green service to see a social worker. There was an agreement between the two services whereby the co-located mental health agency could refer clients to the Green service. At the

Aboriginal health service, a third of the clients tracked were referred from an external agency, commonly from a local hospital (the mental health ward or the emergency department).

Table 4.1: Client referral pathways into the health services

Health Service	GP	Self-referral	Internal referral from other health professional	Internal referral from health promotion/support group	External referral from another agency	Total
Green	5	18	3 (1 bariatric – for those at risk of obesity-related co-morbidities, 1 podiatry, 1 early childhood team)	0	9 (5 co-located community mental health service, 1 youth service, 1 child youth health, 1 GP Plus service, 1 women's legal service)	35
Orange	2	0	6 (2 dietician, 1 social worker, 1 speech pathology, 2 diabetes nurse)	3 (2 Do it For Life program, 1 HELP - Health Eating and Lifestyle program)	2 (1 social worker from local hospital, 1 occupational therapist from local hospital)	13
Blue	2	11	3 (1 dietician, 2 early childhood team)	2 (1 Cancer Support Group, 1 Lifestyle advisor, Do it For Life program)	2 (1 Green service, 1 Speech Pathology – local Children's Centre)	20
Aboriginal health service	1	10	1 (diabetes nurse)	0	6 (5 local hospital, 1 co-located community mental health service)	18

4.7.3 Contributing factors to clients' depression

Staff through informal assessment reported the factors they considered to be contributing to clients' depression. They reported a variety of factors (table 4.2) identifying multiple contributors for each individual. There was no difference in reporting contributing factors between the different health practitioners that completed staff case tracking interviews or questionnaires. At the Green service, common contributing factors for those accessing services for depression were childhood trauma, domestic violence and/or relationship stressors such as a marriage/relationship breakup. At the Orange service, eight out of thirteen clients had a physical health concern that was contributing to their depression (table 5.4). This may explain why the majority of referrals to social work at the Orange service were from other health professionals working within the service with clients regarding their physical health. Common contributing factors at the Blue service were marriage/relationship breakup/relationship stressors, parenting stressors, physical health concerns, being a single parent and being socially isolated. At the Aboriginal health service, a large number of clients had drug and alcohol problems, were experiencing housing difficulties or were homeless and had physical health concerns.

Table 4.2: Factors contributing to client's depression

Contributing Factors	**Green service**	**Orange service**	**Blue service**	**Aboriginal health service**
Unemployment	6	3	2	7
Drug and Alcohol	4	0	2	11
Childhood Trauma	10	1	2	0
Criminal Court Proceedings	0	0	0	4
Domestic Violence	11	0	4	2
Employment	0	1	1	0
Family History of Depression	0	1	1	0

Family Stressors	8	2	2	3
Grief and Loss	6	0	4	1
Housing	2	1	3	12
Marriage/relationship break up /relationship stressors	11	2	5	3
Other Mental Illness	5	1	1	2
Parenting Stressors	3	1	6	1
Physical Health	2	8	7	9
Postnatal depression	1	0	1	1
Single Parent	6	1	6	2
Socially Isolated	3	4	5	4
Financial Difficulties	0	3	1	5

4.8 Conclusion

This chapter described the scope and profile of the four case study PHC services and provided an overview of the bureaucratic and service organisational context in which this study took place. It describes the way in which this context changed and constrained the service characteristics. At the beginning of the study, there was a positive policy environment within SA Health that supported PHC services incorporating health promotion, primary prevention, community participation and community development principles. Over the course of this study there were considerable changes and reorganisation and reorientation of PHC in South Australia. As a result at these services, there was a move away from a broader social view of health envisaged by a comprehensive model of PHC. The effect of these changes impacted heavily on the services response to depression in terms of what services were offered which is explored through client journeys in the next chapter.

CHAPTER 5: CLIENT JOURNEYS WITHIN FOUR PHC SERVICES

5.1 Introduction

The following chapter presents a description of how the four PHC services worked with clients experiencing depression and how they worked with other agencies. The quantitative analysis presented in this chapter is the principal analysis, although a small number of qualitative reflections from staff regarding their work with clients is also included to deepen understanding of the quantitative data. Client journeys are presented from each of the services giving an indication of the different pathways taken by clients accessing services for depression. Client journeys were assessed against the Southgate Model (see chapter 3), a framework based on a CPHC response to depression. 86 client journeys were included in the analysis and example client journeys are included in the appendices (Appendices I-N). Examining key themes of this model such as accessible, mix of treatment, prevention and promotion, multidisciplinary teamwork, intersectoral collaboration, advocacy and cultural respect enabled an assessment of how comprehensive the services were in their response to depression among individuals. The extent to which the services addressed depression in the community is considered in chapter 7. A number of guiding questions (Appendix H) were developed based on these themes and were used to analyse the client journeys across the four PHC services. This chapter answers the first research question, ‘What are the range of responses offered in a PHC model of service delivery in terms of mental health promotion, prevention of depression and treatment and rehabilitation for people with depression’.

Details of the sample are provided first, followed by an overview of the service delivery models at the four PHC services. The client journeys are discussed related to the key themes of the Southgate Model and the extent they featured at the services. The chapter concludes with a summary and brief discussion of the findings.

5.2 Details of the sample

Clients were tracked for a period of 12 months by 1) meeting with health service staff individually to collect the case tracking data, or; 2) staff completing questionnaires and sending them via mail or electronically. At three of the PHC services, the majority of staff chose to meet with the researcher which provided detailed information into the case management of clients with depression. At the other PHC service staff completed questionnaires and posted them to the researcher.

Twelve staff were invited to participate in tracking clients. At the Green service, there were three staff members who agreed to participate, however, one staff member never returned any questionnaires and another staff member left shortly after commencement as their contact was not renewed. At the Orange service, only one of the four social workers approached participated in tracking. At Blue service and the Aboriginal health service four staff members provided tracking data.

A total of 86 clients were tracked from the four PHC services. Table 5.1 below shows the number of clients tracked from each health service.

Table 5.1: The number of clients tracked at each PHC service

Health Service	**Total Number of clients tracked**	**Male**	**Female**	**Average age and range**
Green	35	6 (17%)	29 (83%)	46 (23-67 years)
Orange	13	1 (8%)	12 (92%)	51 (38-66 years)
Blue	20	3 (15%)	17 (85%)	43 (29-65 years)
Aboriginal health service	18	6 (33%)	12 (67%)	38 (24-64 years)
All sites	**86**	**16 (19%)**	**70 (81%)**	**44.5 (23-67years**

Before describing the client journey through these PHC services it is useful to outline the different service delivery models and policies in place.

5.3 Details of service delivery among the PHC services

Various configurations of activities and services for clients with depression were provided at the four sites as shown in tables 5.2 and 5.3. The Green, Blue and Orange service employed social workers and psychologists who provided one to one counselling and health promotion/support and prevention services up until July 2013. At the services mental health staff reported that for clients that assessed services for depression, it was typically of a mild to moderate nature. At the Aboriginal health service, Aboriginal health workers and a mental health nurse provided home visits to clients. Staff at this service did not report on the severity of clients' depression. Provision of GP services at the four sites varied. At the Aboriginal health service there was a GP but the service didn't provide counselling. During the first six months of data collection a GP and a GP practice were co-located at the Orange and Blue services. After this time both the GP and the GP practice relocated to another site. At the Green service there were no GPs available within the building although there was a walk in clinic in the building next to the health service.

Table 5.2: Service delivery models at the four PHC service.

PHC service	**Model of service delivery**	**Key practitioners**	**Home visits provided**	**Limit on number of sessions**
Green, Blue and Orange	One to one counselling using a variety of treatment approaches: mindfulness, acceptance and commitment therapy, cognitive behavioural therapy (CBT), narrative therapy, supportive counselling Health promotion and support groups *(until July 2013)*	Green service – One Psychologist for the first three months of data collection and two social workers. Orange service - Two social workers (no psychologist), Blue service – Two psychologists, three social workers	No	Unlimited access to appointments at Green, Blue and Orange service but *after July 2013 strictly 6-8 sessions at the Green service*
Aboriginal health service	Holistic and culturally respectful service. Clients typically saw a PHC nurse first, then the GP and were referred to internal and external services as needed. Services such as home visiting, medication delivery, Men's group,	Mental health nurse, PHC Nurse, GP, mental health worker, Aboriginal health worker, clinical Aboriginal health workers, lifestyle	Yes (until July 2013)	Unlimited access to appointments

	Women's group, Men's camps, transportation to specialist appointments, advocacy, Stay Strong Plan (a mental health care planning tool focusing on wellbeing, Menzies School of Health Research, 2008) were provided. Health promotion and support groups *(until July 2013)*	advisors		

5.4 Multidisciplinary teamwork

Multidisciplinary teamwork concerns different disciplines supporting clients' needs, and ensuring good communication amongst staff so that clients receive integrated and holistic care. Multidisciplinary teamwork was assessed in the following ways, the number of disciplines clients saw, what internal and external referrals were made, what internal communication occurred between staff during their care for a client, and the extent to which staff considered client's physical health by communicating with GPs, private psychologists, psychiatric services and other health services.

5.4.1 Internal referral processes in the response to depression

Multidisciplinary teamwork enabled by co-location is a key component of a CPHC model and the extent to which it featured among the PHC services through internal referral processes, internal referrals made and communication with other practitioners was compared. Multidisciplinary teamwork was more evident at the Aboriginal health service and the Orange service. At the Aboriginal health service all 18 clients tracked saw three or more other professionals within the health service (see table 5.3). This in part reflects assessment processes whereby all clients were first seen by the PHC Nurse and then the GP, and then referred to other workers as required. The role of the PHC nurse at the Aboriginal health service was an integral part of the response to depression which was different to the other three PHC services who had PHC nurses but rarely saw clients with depression.

At the Orange service, a large proportion, eight of the 13 clients (61.5%) tracked saw a social worker plus one other professional working within the health service. This included either a dietician, respiratory nurse, speech pathologist, diabetes nurse or chronic conditions nurse. This might be due to the clients at this service having more chronic physical conditions and needing to see other health professionals.

The number of health professionals seen by clients at the Green and Blue services was similar. The majority of clients accessing counselling at these services saw one health professional, a social worker or a psychologist. This may be as a result of their depression being mild and they didn't need to see other health professionals.

Table 5.3: Number of internal professionals seen

Health Service	Number of clients	Number of internal professionals seen	Who clients saw
Green	27	1	social worker
	6	2	social worker **plus one other professional**: chronic disease team, dietician, podiatrist, lifestyle adviser, speech pathologist, PHC Nurse
	2	1	psychologist
	2	3	social worker **plus two other professionals:** podiatrist, lifestyle adviser, dietician, PHC nurse
	1	5	social worker **plus four other professionals:** Bariatric team – nurse, psychologist, doctor, lifestyle adviser
Orange	3	1	social worker
	8	2	social worker **plus one other professionals:** dietician, respiratory nurse, speech pathologist, diabetes nurse, chronic conditions nurse
	2	3	social worker **plus two other professionals:** respiratory nurse, PHC nurse, chronic conditions nurse, dietician
Blue	5	1	social worker
	5	2	social worker **plus one other professional:**

			psychologist, speech pathologist, early childhood team, Cancer Support Group Leader, Dietician
	1	3	social worker **plus two other professionals:** dietician, PHC nurse
	6	1	psychologist
	3	2	psychologist **plus one other professional:** PHC nurse, early childhood team, lifestyle adviser
Aboriginal health service	2	3	PHC nurse, GP, mental health nurse
	8	4	GP, PHC nurse, mental health nurse, Aboriginal clinical health worker
	5	5	GP, PHC nurse, mental health nurse, Aboriginal clinical health worker, Men's group leader
	3	6	GP, PHC Nurse, mental health nurse, Aboriginal clinical health worker, 'Tackling Tobacco' worker, Men's Group leader

5.4.2 Internal Referrals

The number of referrals made within a health service varied greatly among the four PHC services. Overall, there tended to be very few internal referrals made by social workers and psychologists at the Green, and Blue services. Table 5.4 below shows that at the Green service, among the 35 clients that were tracked, internal referrals were made for 5.7% of clients. At the Blue service, internal referrals were made for 25% of clients. At the Orange service, 46% of clients received an internal referral whereas at the Aboriginal health service. all of the 18 clients tracked at the Aboriginal health service had internal referrals made for them and there was a total of 37 internal referrals made overall and a range of between one and four internal referrals made per client. This suggests clients at the Aboriginal health service may be receiving a more comprehensive service, addressing their physical health as well as social and emotional problems.

Table 5.4: Total number of internal referrals at the four PHC services

Health Service	Total number of internal referrals	Number of clients with an internal referral	Range of internal referrals per client	Total number of clients tracked	Percentage of clients receiving an internal referral
Green	5	2	0-3	35	5.7
Orange	10	6	0-3	13	46
Blue	5	5	0-2	20	25
Aboriginal health service	37	18	1-4	18	100

5.4.3 External health referrals

The extent to which the four PHC services made external referrals to services in the community as well as informal referrals or suggestions to access particular services was examined. There was very little evidence of external health referrals at the Orange and Green services (table 5.5). At the Blue service five clients had an external health referral, for example to: an acute inpatient facility for women experiencing significant mental illness, to an emergency mental health service and to a community-based not for profit organisation delivering services to those with mental illness and their carers.

The Aboriginal health service had evidence of the greatest number of external health referrals, 27 referrals for 14 clients. A common referral was to: Medicare Local for psychological counselling and indicates the central role for GPs and PHC nurses at this service for providing referral to treatment for depression. This was not an option at the other services who did not have a GP based within the service.

Other common referrals at the Aboriginal health service were to the Care Coordination & Supplementary Services program, dental check-ups, drug and alcohol counselling, community mental health services and to specialists at a local hospital. PHC workers from the Aboriginal health service reported that for some of the clients tracked, when a referral to the Medicare Local for psychological counselling was made a number of clients did not attend. It is not known whether there was a breakdown at some point in the referral, whether the client needed to but didn't contact the Medicare Local or whether the Medicare Local couldn't contact the client and no first appointment was ever made. It was also reported that dental and podiatry appointments made for one client were not attended. Referrals to GPs are discussed in a later in this section.

Table 5.5: Number of external health referrals at the four PHC Services

Health Service	**Number of External Health referrals**	**Number of clients that had an external health referral**	**External health referrals**	**External health referral suggestions**
Green	4	3		**Client 12** – 2 suggestions – Lifeline, ACIS **Client 15** – 1 suggestion – hypnosis **Client 19** – 1 suggestion – GP for Mental Health Plan
Orange	2	2	**Client 2** – 1 external referral – GP re Mental Health Plan and sick certificate	**Client 7** – suggestion to contact a local GP – gave numbers
Blue	11	5	**Client 11** – 2 external referrals – acute mental health service, mental health assessment and crisis service **Client 14** – 1 external referral – sexual health counselling **Client 17** – 1 external referral – women's health service **Client 18** – 1 external referral – mental health support service **Client 20** – 1 external referrals – mental health assessment and crisis service,	**Client 18** – 2 suggestions – mental health support group, 1 suggestion to see GP Osteoporosis **Client 20** – 2 suggestions to see GP regarding depression and GP at Shine SA
Aboriginal health service	27	14	**Client 2** – 1 external referral – Medicare Local psychological counselling **Client 3** – 3 external referrals – Medicare Local psychological counselling, mental health assessment and crisis service, community mental health service **Client 5 –** 1 external referral – Non-government health service psychological counselling **Client 6 –** 1 external referral	**Client 4** – 1 suggestion Medicare Local psychological counselling **Client 5** – 1 suggestion drug and alcohol counselling **Client 16** – 1 suggestion drug and alcohol counselling

			Medicare Local psychological counselling **Client 8** -1 external referral - Dental **Client 9** – 4 external referrals – Medicare Local psychological counselling and CCSS (Care Co-ordination and Supplementary Services) program, Domiciliary Care, FMC Specialist **Client 10 –** 1 external referral – FMC psychiatric assessment **Client 11** – 3 external referrals – Ophthalmologist, Medicare Local psychological counselling and CCSS program **Client 12** – 2 external referrals Medicare Local psychological counselling and Headspace **Client 13** – 2 external referrals Dental, Podiatry **Client 15** – 1 external referral drug and alcohol counselling **Client 16** – 2 external referrals FMC cardiac specialist, IMVS for regular blood tests **Client 17** – 1 external referral – – community mental health service **Client 18** – 1 external referral - Dental	

5.4.4 Internal Communication

Among the clients tracked, there was little indication of internal discussions/case conferences between staff regarding clients at the Green, Orange and Blue services. Table 5.6 shows the Orange and Blue services had the least number of internal discussions/case conferences regarding a client. There were two specific instances of internal discussions for one client at the Orange service with the GP, showing the importance of co-location. There were also two internal discussions between the Early Childhood team for two clients at the Blue service who appeared to work closely with one social worker as there were several joint appointments. However, there was no evidence of communication between health professionals within the health service that referred clients to counselling.

As discussed in the last chapter, the majority of clients at the Orange service (eight out of thirteen, refer to table 4.1) were referred to counselling from either a health promotion/support group or from another health professional within the health service. However, the case tracking found no evidence of communication between the mental health worker and the health professionals that referred clients to counselling. The mental health worker at the Orange service chose to complete questionnaires rather than meet individually or discuss over the phone so the question relating to this in the questionnaire may have been misinterpreted.

At the Green service there was evidence of a greater number of internal discussions/case conferences compared to the Orange and Blue services (N=14) but this was for only three clients. Examples included two case reviews between a social worker and dietician and another client journey showed communication between a social worker and the Bariatric team; however the qualitative reflections from the social worker indicated tension regarding a difference in professional judgement over how the client was progressing. There were also examples where clients were referred from within the health service but there did not appear to be any communication with the social worker. The Aboriginal health service was recorded as having the highest number of internal discussions/case conferences regarding their clients. There were 26 internal discussions for nine clients.

Table 5.6: Number of internal discussions/case conferences within a health service

Health Service	Total Number of internal discussions/case conferences	Number of clients with internal discussions/case conference	Total number of clients tracked
Green	14	3	35
Orange	2	1	13
Blue	2	2	20
Aboriginal health service	26	9	18

5.4.5 External Communication

There was strong communication with external services at the Aboriginal health service (table 5.7). This included phone calls, meetings/case conferences with services also working with clients such as drug and alcohol services, housing support services, a community mental health service and for one client there were joint home visits with staff from a community mental health rehabilitation centre also working with this client. The strong communication between staff at the Aboriginal health service and external agencies is intended to ensured services were not fragmented, that there was a partnership approach where all parties were involved and kept informed particularly when dealing with broader complex issues such as housing.

In contrast at the Green, Orange and Blue services communication with other services was not as evident. At the Blue service, staff communicated with other agencies for one in five (20%) of the clients tracked and at the Orange and Green services 15 per cent and 11 per cent respectively. The majority of social workers and psychologists at the Green, Orange and Blue services seemed to provide one to one counselling services to clients with very little communication with other services that were also working with clients. At the Green service there was four clients that had some communication between the social worker and mental health staff at a co-located community mental health service, which might reflect a difference in severity of depression amongst these clients and therefore the need for this communication. This co-located service had referred these clients to the Green service and were continuing to working with them. This co-located service sees clients with moderate mental illnesses. Evidence for the differences in external communication amongst the services is captured in chapter 8 which highlights the restricted way staff were able to practice limiting their capacity to attend meetings with external agencies.

Table 5.7: Number of discussions/case conferences with other services at the four PHC services

Health Service	Number of external discussions	Number of clients where there was external discussions	Percentage of clients where there was external communication	Number of clients where there was no external discussions
Green	9	4	11%	31

Orange	2	2	15%	11
Blue	8	4	20%	16
Aboriginal health service	32	12	67%	6

At the Green service a number of clients were referred to counselling by a co-located community mental health service who also continued to work with these clients over the case tracking period. However, the communication between the two services was variable. For two clients there was no evidence of communication between the social worker/psychologist and the community mental health service (Appendix L) while for three clients there was some evidence of communications and informal meetings between the social worker and this service (Appendix M).

5.4.6 Communication with GPs, private psychological and psychiatric services

Overall, there was very little indication of PHC workers at the Green, Orange and Blue service considering or making suggestions regarding a client's physical health and little evidence of workers communicating with a client's GP. Seven clients across the Orange, Green and Blue services were all referred to the service by their GP but there was no indication of any communication back to the doctor regarding client progress. The psychologist at the Green service noted that three clients were seeing a GP regularly to monitor anti-depressant medication, but for most workers it was evident during case tracking interviews that they were unaware of the other services clients may also be accessing for their depression. The only evidence of communication back to the doctor across the four health services was a letter that was sent to a GP by a social worker. This is consistent with research by Wiese et al (2010) who investigated how GPs and PHC services work together and found GPs did not feel they were keep updated by PHC practitioners about their clients.

An interesting example was at the Blue service where at the start of case tracking the social worker suggested the client see a GP but the client declined stating that she didn't want to rely on medication. Eight months later this client became very depressed and was admitted to an acute facility for a voluntary mental health stay. Here she was prescribed anti-depressants and suggested that she access a GP to manage her medication.

Information was collected on whether clients were also accessing private psychological and psychiatric counselling (table 5.8). Only a small number of clients at the Green, Orange and Blue service also saw a private psychologist or psychiatrist. None of the clients tracked at the Aboriginal health service were seeing a private psychologist or psychiatrist.

Table 5.8 Number of clients accessing private psychological services at the four PHC services

Health Service	Number of clients accessing private psychological services	Number of clients tracked
Green	2	35
Orange	3	13
Blue	4	20
Aboriginal health service	0	18

Among the client journeys there was no communication between private psychologists/psychiatrists and mental health staff at the four PHC services. An exception was a social worker at the Green service that advocated for Mia's children to be bulk billed which is discussed further in the advocacy section in this chapter.

5.5 Health Promotion and Support groups

In a CPHC model health promotion, and disease prevention are important. Results suggest health promotion and support groups were little utilised in the Green and Blue services compared to the Orange and Aboriginal health service. Timing of data collection may explain some of this difference. Case tracking at the Orange service commenced in July 2012 when many of the health promotion programs were still in operation and had not yet been affected the Government's response to the McCann Review which led to withdrawal of funding for health promotion. This may explain the larger proportion of clients attending health promotion groups/support at the Orange service compared to those attending groups at the Green and Blue services where case tracking commenced later, October 2012 and January 2013 respectively. The changed health promotion environment appears to have made a difference to external referrals except at the Blue service where clients were referred to health promotion/support groups offered in the community after they stopped being provided at the health service. Although the case tracking questionnaire did not ask about preventive and health promotion advice offered in one to one sessions, two client journeys from the Blue service did capture health promotion work such as talking about quitting smoking and diet and healthy eating.

In contrast, at the Green, Orange and Aboriginal health services there were very few referrals or suggestions made to clients to attend groups in the community after they ceased running at the health services (see table 5.11 – Other sector referrals and suggestions, later in this chapter). Among the client journeys there are several examples where clients were reported to be socially isolated but were not linked into social supports or encouraged to attend groups or courses in the community (Appendix J).

At the Aboriginal health service the case tracking data suggests that just under half of the clients, eight out of the 18 clients tracked (44%) also attended health promotion groups. Table 5.9 shows that clients were more likely to attend more than one group, commonly the Men's Group or Women's Group and the community lunch that each ran fortnightly.

Table 5.9: Number of clients attending health promotion/support groups

Health Service	**Number of Clients attending Health Promotion/Support Group**	**Group attended**
Green	3 (35)	Client 22 – Mindfulness Yoga Client 23 – 'The Dad Factor' Client 33 – Mindfulness Yoga, Domestic Violence, Moving through Depression
Orange	5 (13)	Client 2 – Cheap and Easy Eats Client 7 – Mindfulness Group Client 10 – Do it For Life Client 11 – Healthy Eating and Lifestyle Group (HELP), Moving Toward Wellness, Mindfulness Group

		Client 13 – Do it For Life
Blue	1 (20) 3 attended external groups suggested by Social Worker/Psychologist	Client 6 – Cancer Support Group Client 14 – Circle of Security (external) Client 17 – Domestic Violence Legal Group (external) Client 18 – GROW (mental health group) (external)
Aboriginal health service	8 (18)	Client 4 – Women's Group Client 5 – Women's Group and Nunga Lunch Client 8 – Men's Group, Nunga Lunch Client 9 – Men's Group, Nunga Lunch Client 11 – Men's Group Client 14 – Men's Group, community lunch Client 15 – Men's Group, community lunch Client 18 – Men's Group, community lunch

5.6 Accessible

The extent to which therapeutic counselling was accessible to clients at the four PHC services and well any barriers to access were examined.

5.6.1 Number of Client Contacts per month

Best practice guidelines recommend mild to moderate depression is treated through therapeutic counselling and psychotherapy (eight to twelve sessions) that is provided for 12 weeks in the first instance (Clarke, 2011; Ellis & Smith, 2002), i.e., about four appointments per month. The majority of clients attended an average of one appointment a month at the four PHC services as shown in table 5.10. At the Green service, 12 of the 35 clients tracked were recorded as attending an average of two appointments a month compared to five clients at the Blue service and the Aboriginal health service. At the Orange service, four clients attended appointments on average every six to eight weeks whereas at the Aboriginal health service more clients had three, four and five average appointments a month. These appointments dealt with other health conditions as well as depression. Although the service did not offer therapeutic counselling, the frequent contact is consistent with beyondblue ‘Keeping Strong’ depression guidelines for Aboriginal and Torres Strait Islander people (Beyondblue). When individual client journeys are examined across the four PHC services it was common for clients to be seen two to three times in one month with appointments then becoming more spread out to monthly appointments. This is probably representative of clients needing more support from PHC workers when they first start using the health service but seems very little contact for clients with mild to moderate depression and is not in accordance with recommended guidelines.

Table 5.10: Average Number of client contacts

Health Service	Appointments every 6-8 weeks	Appointments monthly	Two appointments a month	Three appointments a month	Four appointments a month	Five appointments a month
Green	2	19	12	2	0	0
Orange	4	7	2	0	0	0
Blue	1	13	5	1	0	0
Aboriginal health service	1	6	5	3	2	1

5.6.2 Barriers to accessing services for depression

Whilst the data above shows that most clients had regular appointments there was restricted access to counselling at the Green service due to a change in the service delivery model in April 2013. For example below is a comment that a PHC worker reported when asked to reflect on any issues or problems they felt powerless to influence:

“This is the last session with this client due to pressure from higher management to limit the number of sessions offered to clients – there is a focus on seeing more people over a shorter

period of time". Mental health practitioner, Green service.

A number of client journeys showed clients being diverted to services for depression that were operating in parallel. For example after six appointments with the social worker it was suggested to Gary that he see his GP regarding a Mental Health Plan in order to access further counselling.

While there were no limits to the number of appointments available to clients at the other three study sites there were other barriers. For example at the Orange service there was a tendency for clients to stop attending the health service due to declining physical health. At the Blue service one client walked out of the health service after waiting a long time for her appointment. The social worker was unable to contact her and it appears that she didn't return to the health service during the case tracking period.

The lack of access to the crèche based near the Blue service was a barrier cited by two clients. For Barbara, three face-to-face appointments were scheduled with the social worker and the remaining six were conducted over the phone which the social worker reported were at times difficult due to the clients' child being in the background.

There were few barriers to accessing services evident among the client journeys from the Aboriginal health service. One client did not return to the health service as they feared family and community members would find out about their depression. This client did not return to the health service during the 12-month case tracking period. In the four health services there was no evidence from staff reflections about their practice that they took action to address these barriers. These barriers to access may have contributed to the low number of client contacts discussed in the previous section and also the low number of internal referrals particularly at the Green service but also evident at the Blue and Orange service as discussed below.

5.7 Intersectoral collaboration

The extent to which the services collaborated with other sectors in the community was examined.

5.8 ‘Other’ Sector Referrals

There were a range of ‘other’ sector referrals or suggestions made by PHC workers to clients to access other services in the community (see table 5.11). Across the four PHC services ‘other’ sector referrals commonly included referrals or suggestions to housing support agencies or Housing SA regarding accommodation, domestic violence support and legal services, income support through the Australian government (Centrelink) and suggestions to attend groups offered at local community centres, for example: a cooking group, domestic violence support groups and parenting groups.

The Green service had the lowest number (11%) of ‘other’ sector referrals/ suggestions made by the social worker or psychologist. These were typically to local services in the community such as their local council, library, the police and Centrelink. These referrals might reflect the differences in severity of depression between clients and their differing needs. At the Aboriginal health service 33% of clients tracked had ‘other’ sector referrals/suggestions. Similarly, these referrals were for housing support, legal services, Centrelink and one was to a childcare centre.

At the Orange service, 31% of clients tracked had ‘other’ sector referrals/suggestions. These were to community support services for home help and food vouchers, Centrelink, financial counselling and suggestions to look at the local service directory for volunteer work and access to community services. The Blue service had the highest number of ‘other’ sector referrals (45%) for the clients tracked. The majority of these were suggestions to attend domestic violence and legal support services in the community and groups offered at local community centres on parenting, social support and career pathways. All but one of these ‘other’ sector referrals were made by social workers indicating that among the clients tracked at the Blue service there was a tendency for social workers to make a greater number of other sector referrals/suggestions for their clients.

Table 5.11: Number of ‘other’ sector referrals/suggestions at the four PHC services

Health Service	**Total number of clients tracked**	**Number of Other Sector referrals**	**Number of clients with Other Sector referrals**	**Other Sector Referrals**	**Other Sector Suggestions**
Green	35	10	(11%)	**Client 19** – 1 referral - Housing Support Agencies **Client 24** – 2 referrals – Family Safety Framework, DV Crisis Service **Client 33** – 1 referral – Family Safety Framework	**Client 14** – 1 suggestion – Housing SA regarding accommodation **Client 33** – 5 suggestions – Local Government, Local Library, Police, Corrections Social Worker (re son), Centrelink (re son)
Orange	13	7		**Client 5** – 1 referral – community support service for home help **Client 6** – 1 referral – Financial counselling – help making an appointment	**Client 2** – 2 suggestions – Anglicare and Salvation Army for food vouchers **Client 6** – 1 suggestion – Centrelink – not able to work **Client 9** – 2 suggestions – Volunteering Services and Community Services Directory
Blue	20	21	9	**Client 1** – 2 referrals – Housing Support services **Client 3** – 1 referral to Community Service – ‘Who’s in Charge’ parenting group **Client 18**- 2 referrals Cooking group at a local Community Centre and Personal Helpers and Mentors service	**Client 5** – 2 suggestions to do voluntary work or attend a community group **Client 6** – 2 suggestions to access a local community service -Over 50s Club **Client 8** – 1 suggestion Centrelink for financial assistance **Client 11** – 2 suggestions Legal Advice Helpline and a parenting group at a Children’s Centre **Client 17** – 4 suggestions Family Violence support service, Domestic Violence Helpline, Domestic Violence Legal Group, Making a Difference (MAD) Support Group (for clients’ daughter) **Client 20** – 5 suggestions Women’s Legal Services, , Next Steps Workshops career pathway program, Parenting Teenagers course, Women’s self-care group

Aboriginal health service	18	10	6	**Client 3** – 1 referral – Childcare centre **Client 5** – 2 referrals- Housing Support Agencies – **Client 6** – 2 referrals – Housing Support agencies and Boarding Houses –, Indigenous Solicitor **Client 7** – 1 referral – Housing Support agencies **Client 11** – 1 referral – Centrelink – housing **Client 17** – 3 referrals – Aboriginal Legal Rights, Housing SA – bond, Centrelink – rental assistance	

5.10 Advocacy

There were a range of examples of client advocacy reported at the four PHC services. The Aboriginal health service had the most examples of advocacy due to the greater need among clients using this service. Examples included:

- supporting clients in their application for housing, rent and bond in advance
- verifying that clients were sick and were not able to look for work (for Centrelink)
- an application for disability support pension
- supporting and promoting clients' rights during case conferences with other agencies also working with a particular client,
- assisting clients to access food parcels or financial help,
- liaising with a childcare agency and advocating for a client to have access to extra childcare days
- liaising with the public advocate on behalf of a client to access money
- liaising with a private psychologist to negotiate bulk billing for a clients' children.

Suggestions made by PHC workers for clients to attend a particular service such as Centrelink were not included as examples of advocacy. Examples of advocacy were only counted where the PHC worker had specifically reported that they had advocated for a client.

The Orange service had the lowest number of examples of client advocacy with examples of a referral for home help and assistance in making an appointment for financial counselling (table 5.12). At the Blue service, among the clients tracked, social workers tended to provide more advocacy for their clients than psychologists.

Table 5.12: Number of examples of individual client advocacy at the four PHC services.

Health Service	**Number of examples of advocacy**	**Number of clients receiving advocacy by PHC workers**
Green	6	3
Orange	2	2
Blue	10	4
Aboriginal health service	42	10

5.10.1 Transport

The Aboriginal health service was the only health service that provided transport for clients to attend health appointments and community events. There was no evidence of the other health services providing transport, taxi vouchers or public transport tickets to clients to help them access appointments, even for those struggling financially. At the Blue service one of the social workers took a flexible approach to treatment and conducted counselling sessions over the phone to clients that had difficulty getting to the health service.

5.10.2 Number of social issues addressed

The client journeys showed PHC workers helping clients with a number of social issues. Table 5.13 shows among the clients tracked, the number of social issues addressed across the four PHC services and the number of clients that had help with social issues. The Aboriginal health service addressed the largest number of social issues with 24 social issues for 10 clients being addressed. This included help with a variety of issues such as Centrelink applications for housing, financial assistance and disability support pension, moving house, accessing food assistance and access to legal services. Among the client’s tracked at the Blue service, PHC workers helped to address 12 social issues for eight clients. These social issues included help with housing, social isolation; access to legal support services, parenting support and information on work employment courses. The Orange and Green service recorded the lowest number of help with social issues with four and three social issues addressed respectively among three clients at the Orange service and one client at the Green service. At the Orange service these social issues included accessing food assistance, Centrelink application for financial assistance and assistance making an appointment for financial counselling. At the Green service help with social issues included negotiating with a private psychologist to bulk bill counselling for one client’s children, parenting support and Centrelink payments for the client’s child.

Table 5.13 Number of social issues addressed at the four PHC services

Health Service	**Number of social issues addressed**	**Number of clients that had help with social issues**	**Social issues addressed**
Green	3	1	Cost of psychological counselling for children who could no longer access a publically funded mental health services (Social Worker negotiated with private psychologist for client to be bulk billed) Parenting issues and support with parenting Centrelink – payments for clients’ son
Orange	4	3	Provided information of where to access food vouchers Organised access to home help through a community support service as (client has a terminal illness) Centrelink – client unable to work due to physical health Assisted making an appointments for financial counselling
Blue	12	8	Phone calls to housing agencies as client is homeless – client accesses accommodation at a boarding house through a community support service Social isolation – social worker suggested she access a community centre, Over 50s Club Centrelink – suggested to apply for financial assistance (for two clients) Suggestion to seek legal advice and information provided on legal support

			services (for three clients) Parenting issues – attendance at a Parenting group (for three clients) Intervention order – supported client’s application Provided information on finding work employment courses
Aboriginal health service	24	10	Help to access a washing machine Help to access extra child care days Parenting issues – referral to a parenting group Access to food assistance Transportation to appear in court (two clients) Phone calls to housing agencies as unstable accommodation – possible eviction. Case conference with public housing agency and issue resolved (five clients) Transportation to chemist to collect money owing to recently deceased partner Provided phone numbers so client could access an Indigenous solicitor/ organised a solicitor (two clients) Help with banking Centrelink – application for Disability Support pension (two clients) Centrelink – housing and financial assistance (three clients) Public housing agency – support with new accommodation Organised truck hire as client moving house Organised house repairs Helped client access legal services

5.11 Cultural Respect

The way the services considers a client’s cultural background was examined. Client journeys from the Aboriginal health service suggested that clients’ were treated with respect. Their culture was taken into account as the health service encouraged clients to attend Close the Gap Day and organised transport for them. At the other services the majority were Caucasian. There was a Lebanese client and an Aboriginal client tracked at the Green service. One was culturally discriminated against while on a train and this formed the focus of some of the sessions with the social worker. The psychologist at the Green service reflected on her practice for one of these clients stating she *‘could have spent more time discussing his cultural background, will do this next time’*.

5.12 Summary

This chapter provided an analysis of the client journeys for those accessing services for depression at the four PHC services including a description of how staff worked with clients and other agencies. Clients using these services had mild to moderate depression and had different levels of need. This was reflected in the client journeys at the four PHC services. The level of need was more evident at the Aboriginal health service where there were greater referrals and communication to external services, although this may also reflect the service was more comprehensive. Overall, the client journeys highlight a range of different pathways for clients accessing services for depression at the four PHC services. The client journeys from the Aboriginal health service and some of the client journeys from the Orange service showed some comprehensive aspects prior to health system reforms.

Co-location of services seemed to support multidisciplinary care. At the Aboriginal health service, having a GP within the health service meant clients' physical health as well as their mental health was considered. Internal collaboration and communication was a strength of this service and the client journeys showed the way the GPs worked with the mental health staff, the integral role of PHC nurses and a number of staff collaborations internally and externally to the health service. For example there were regular meetings and case conferences with other support services working with clients to coordinate service delivery. Another strength was their responsiveness to clients. There were many examples of ways in which the service tailored service delivery so that it was based on clients' individual needs and considered their social and economic circumstances. This included transportation to financial counselling, home visits and encouraging attendance at health promotion/support groups to promote community connection. However, a shortcoming was the service lacked mental health counsellors on site and had to refer clients externally to a mainstream service which many clients felt uncomfortable attending.

At the Green and Blue services and for some of the client journeys at the Orange service, the journeys showed a partially implemented PHC approach that didn't match CPHC ideals of intersectoral collaboration and the inclusion of mental health promotion and prevention services. The Blue service was the only service to refer clients to health promotion and support groups in the community. Overall, PHC workers at the Green, Orange and Blue services mostly worked one-to-one with clients in isolation from other professionals at the service with only a few examples of internal referrals and communication within these health services and external health referrals and communication with other agencies. This interaction might be expected if the majority of clients had mild depression.

There were a number of examples of advocacy and help with social issues among the four PHC services, particularly an emphasis at the Aboriginal health service showing that this seems to be an important aspect of their work. At the Blue service where there was a range of social workers and psychologists that participated in tracking clients, it appears that social workers tended to advocate more for their clients compared to psychologists, however it may also be that those clients who require advocacy are referred to social workers rather than psychologists.

This chapter provided a snapshot of the client journeys through four PHC services for people experiencing depression and gives an indication of how PHC services worked with clients and other agencies. In order to consider the personal experiences as a result of these client journeys (which were not measured by the case tracking questionnaire), and the implications for mental health service delivery, the following chapters (6-8) provide an analysis of the qualitative data from in-depth interviews with clients and staff.

CHAPTER 6: CLIENT EXPERIENCES OF TREATMENT FOR DEPRESSION AND STAFF VIEWS ON THEIR PRACTICE AT FOUR PHC SERVICES

6.1 Introduction

This chapter focuses on the treatment end of the CPHC continuum. It examines clients' perspectives and reflections on the treatment they received for depression at the case study PHC services as well as staff views and reflections on their practice. Individual's experiences and staff reflections were examined in the context of each case study service and by comparing the responses between the case study services using matrices (Miles, et al., 2014), which built on the client journeys presented in the previous chapter. This triangulation of data enabled a holistic analysis (Creswell, 2013) of how the case study PHC services responded to the treatment of depression and the extent they used a CPHC approach. Key findings in this chapter are the presentation of clients' individual perspectives on social and economic issues that have affected their mental health and shows the need for CPHC responses to depression. Client and staff perspectives on the prevention of depression in the community including health promotion activities, advocacy and community development work are discussed in chapter 7.

The analysis in the next two chapters is based on in-depth interviews with clients accessing the four PHC services for depression. Clients' were asked about their experiences of one-to-one services they accessed, the perceived changes in their health and wellbeing and how the service helped treat, manage and aid them in the recovery of their depression. The client journeys presented in the previous chapter showed the different pathways for clients accessing services for depression and that a CPHC model was only partially being implemented.

The views and reflections from dedicated mental health staff working with adults experiencing depression (social workers and psychologists) and allied health staff (dieticians, occupational therapists, lifestyle advisors, speech pathologists and Aboriginal health workers) also working with clients experiencing depression are explored. PHC service managers and regional executives provided further contextual perspectives highlighting a number of barriers for responding to depression.

This chapter starts with a description of the qualitative samples for the client and staff interviews. Participants' backgrounds are presented together with the services they accessed at each health service followed by a discussion on how their life circumstances impacted on their depression. Referral pathways and the different models of service delivery are discussed followed by client's commencement at the health services. The approach to CPHC and participants' experiences and staff reflections are then discussed starting with the Aboriginal health service that used a different model of service delivery compared to the other services. Client experiences and staff reflections are then discussed for the Orange, Green and Blue services, followed by barriers to access and the changes experienced by participants.

6.2 Description of the qualitative samples

6.2.1 Client sample

Practitioners at the four PHC services tracking clients with depression were asked to invite clients who were just beginning their interaction with the service to participate in two in-depth interviews. At the Aboriginal health service there was often long term engagement with clients on a range of issues which meant there was not the same turnover of clients that was evident at the other services. Therefore, the clients were not necessarily new to this service.

Twenty-one participants that were accessing services for depression at the four PHC services were interviewed for this study. Table 6.1 below gives a summary of the number of participants in each of the four PHC services.

Table 6.1: Number of participants from the four PHC services

PHC Service	Orange	Green	Blue	Aboriginal health service
Number participants invited	6	7	7	12
Number agreed to participate	5	7	3	6
Couldn’t be contacted	0	0	1	2
Withdrew/Declined to participate	1	1	3	4
Male	0	1	1	10
Female	6	6	6	2
Average age and range	51 years (45-60 years)	44 years (28-65 years)	42 years (33-56 years)	45 years (25-64 years)
Ethnicity	All Caucasian	1 non-English speaking	All Caucasian	Aboriginal
Employment status	All received a pension from Centrelink	2 employed 5 received a pension from Centrelink	1 employed 2 received a pension from Centrelink	1 employed 5 received a pension from Centrelink
Housing	2 living in own home 3 private rental	4 living in own home 2 renting privately 1 public housing	1 living in own home 2 renting privately	All lived in public housing
Total Number of clients interviewed	5	7	3	6

The majority of participants at the Orange, Green and Blue services were female and Caucasian. At the Aboriginal health service the majority of participants were male, possible because there were two male mental health workers and no female mental health workers. Participants had an age range of 42 to 51 years. 19% of participants were employed and 81% received a pension from Centrelink. All participants at the Aboriginal health service were living in public housing whereas at the other three services participants were either renting privately or buying/owned their own home.

There were several reasons for the low numbers of client participants which have been discussed in chapter 5. These included the new PHC infrastructure and location of GP Plus and GP Super Clinics and the restriction on advertising the new location of these PHC services to the community and GPs. Also a number of staff worked part time or were on very short term contracts (e.g. 3 months) and declined to participate in the study.

6.2.2 Staff sample

The staff sample included mental health and allied health staff working with adults at the four PHC services and other staff such as regional executives and managers. In this chapter to differentiate between the two groups of staff interviewed, the interviews with allied health staff and regional executives and managers are referred to as 'general staff' and the other group will be referred to as 'mental health staff' that included social workers or psychologists working with adults. Twelve mental health staff and sixteen general staff working at the four PHC services were interviewed for this study. Table 6.2 provides a summary of the staff interviewed at each PHC service and their positions.

Table 6.2: Number of staff interviewed at each PHC service and their positions

	Number of staff interviewed			
	Orange	**Green**	**Blue**	**Aboriginal health service**
Mental health staff interviewed that saw adult clients	2 social worker	2 social worker	4 social worker 2 psychologist	2 Aboriginal mental health workers
General staff interviewed	1 regional executive manager	1 dietician 1 lifestyle advisor (Do it For Life program) 1 manager PHC services 1 occupational therapist (early childhood team) 1 psychologist (early childhood team) 1 SRF Nurse 1 regional executive manager	1 manager PHC services 1 PHC nurse 1 psychologist (early childhood team) 1 regional executive manager	2 Clinical Aboriginal health worker 1 Aboriginal Maternal and Infant Care Practitioner 1 Manager Aboriginal health service
Totals	2 mental health staff 1 generic staff	2 mental health staff interviewed 7 generic staff interviewed	6 mental health staff 4 generic staff	2 Aboriginal mental health workers 4 generic staff

*Mental health staff working in the early childhood team were included in the general staff interviews as they didn't deal directly with clients with depression

6.3 Participant backgrounds

The following section presents an analysis of client experiences of depression, services and recovery. To give a sense of participants' individual experiences, key aspects of their background are presented in table form including a short descriptive account of the services they received. Analysis then moves from description to interpretation - comparing and contrasting the experiences across services, identifying common themes or patterns and explanations for these.

6.3.1 Summaries of client background, commencement and services provided

Tables 6.3-6.6 provide a brief summary of how each participant commenced at the different service, the activities they accessed and the services they received. Information is drawn from individual client journeys to provide concrete examples of the services and activities they experienced. These data were used to provide an assessment within the cases and enabled comparisons to be made between the services. Pseudonyms are used to ensure anonymity.

Table 6.3 – Summary of participants' background and services provided by Orange service

PHC service	**Pseudonym**	**Contributors to depression**	**Commencement at PHC service**	**Services provided**
Orange	Elaine	Living in poverty due to repayment of a large loan left by her son Poor physical health – Diabetes, recent triple bypass operation, Asthma Childhood sexual abuse	Health professional at local hospital referred to Cheap Easy Eats cooking group	One to one counselling with social worker, One to one diabetes education, exercise physiologist, podiatry, Cheap and easy eats*, Respiratory nurse, GP (co-located at health service), Milk provided on one occasion when short, Provided information for local support services in the community to access food vouchers, Organised application to receive subsidy for incontinence pads, Helped organise replacement batteries for blood pressure machine, Information provided on free legal service, Information provided about a craft group
	Elise	Recent marriage separation, past abuse issues, back injury unable to work	Health professional at local hospital referred to 'Do it for life' one to one program	'Do it for Life' program *, one to one counselling with social worker
	Ella	Poor physical health – Diabetes, Asthma,	Health professional at local hospital referred to	Consultations with dietician, - referral to social worker

		needs to have gall bladder removed, obese, past uterine cancer, unstable housing, family stressors	Dietician to help with healthy eating and weight loss	One to one counselling with social worker, Suggested to go through public housing instead of private rental
	Eloise	Poor physical health, family stressors – five children and grandchild on the way, all living with her, sole parent as husband working away	Health professional at local hospital referred to ‘Do it for life’ one to one program	‘Do it for Life’ program* (3 months only due to funding ceased) One to one counselling with social worker
	Emily	Poor physical health – pre-diabetic, arthritis – can’t work, recent cancer in kidney, family stressors	GP referred to Healthy Eating and Lifestyle group as pre-diabetic	Healthy Eating and Lifestyle group, Cheap and easy eats*, ‘Do it for life’ program*, Consultation with exercise physiologist, Mindfulness group, Consultation with dietician, One to one counselling with social worker, Information provided about an exercise group in community and water aerobics group (couldn’t attend due to the gno longer being offered)

*Cheap and easy eats was a nutrition and cooking program

*’Do it for life’ program was lifestyle advice for people at risk of chronic diseases

Table 6.4 – Summary of participants’ background and services provided by Green service

PHC service	**Pseudonym**	**Contributors to depression**	**Commencement at PHC service**	**Services provided**
Green	Madeline	Recent marriage separation – living apart from children, difficult childhood – Mother an alcoholic, unstable housing, socially isolated	Health professional at mental health service (ISMH) referral to social work	One to one counselling with social worker, Suggested go through public housing instead of private rental
	Maggie	Relationship issues, domestic violence, low self-esteem, parenting issues, physical health issues – kidney disease, childhood sexual assault	Self-referral – recommended by local women’s health service	One to one counselling with social worker, Suggested relationship counselling Provided with information of support services for daughter with challenging behaviours
	Margaret	Childhood abuse and sexual assault, grief and loss over Mother’s death as a teenager, domestic violence	Self-referral - recommended by local women’s health service	One to one counselling with social worker
	Margot	Has other mental health issues – Bipolar, Grief and loss from father’s death, family	Self-referral recommend by a friend	One to one counselling with social worker

		issues – conflict with daughter, legal battle with her brother over property after the death of her father, moving her mother into a nursing home		
	Marlene	Recently gave birth to third child (has three children under five years old), husband lost license and can't drive	Self-referral recommend by a friend	One to one counselling with social worker
	Matthew	Other mental health issues – PTSD as a result of a physical assault, borderline personality disorder, Dyslexic, single parent to newborn, carer for elderly mother, socially isolated	Self-referral recommended by a friend	One to one counselling with social worker
	Mia	Single parent to five children, domestic violence – history of chronic abuse, child with difficult, abusive behaviour, socially isolated, living in poverty	External referral from GP	Has attended service for 3 years and accessed one to one counselling with social worker, Mindfulness group, Domestic violence group, Advocacy provided – support letter for housing application for larger house, recommended Suggested private psychologist for children as too old to access child and adolescent mental health service , spoke to private psychologist and negotiated for client to be bulk billed, Referral for Family Safety Framework, Suggested access community supports such as local government, police, Corrections Social Worker (for son)

Table 6.5 – Summary of participants' background and services provided by Blue service

PHC service	**Pseudonym**	**Contributors to depression**	**Commencement at PHC service**	**Services provided**
Blue	Natalie	Single parent to two young children, recent relationship breakdown, socially isolated	Self-referral, recommended by a friend	One to one counselling with psychologist, External referral to Circle of Security group, Referral to sexual health service
	Nicole	Mother of two young children both have a disability, socially isolated, family history of depression	Self-referral, recommended by a family member	One to one counselling with psychologist, Internal referral to Dietician
	Noelene	Ongoing family distress regarding her brother's recent jail sentence, recent marriage break up, physical health problems –possible	Self-referral	One to one counselling with psychologist

		knee surgery, increased role in supporting her elderly parents		

Table 6.6 – Summary of participants' background and services provided from the Aboriginal health service

PHC service	**Pseudonym**	**Contributors to depression**	**Commencement at PHC service**	**Services provided**
Aboriginal health service	Aaron	Poor physical health – ongoing pain issues, alcohol addiction, socially isolated, racial discrimination, grief and loss – not able to see children from a previous relationship, living in poverty	Internal referral from GP	Home visits from Mental health nurse and Aboriginal health worker – social and emotional support, medication delivery, mental state examination, medical appointments with GP and health checks with nurse, referral to cardiac specialist. Men's group, community lunch, transport provided to attend appointments at health service and to go to chemist to collect medication, external health appointments, community events e.g. Close the Gap Day. Suggested to access counselling and is thinking about it. Linked into Close the Gap scheme to access medications for free
	Adam	Poor physical health – heart failure, alcohol addiction, socially isolated, grief and loss - family issues – just starting to see son after 20 years, racial discrimination, stigma – as a result struggles to use public transport, living in poverty – often no money for transport, struggles to pay bills, family often come to stay unexpectedly	Self-referral	Home visits from Mental health nurse and Aboriginal health worker – social and emotional support, mental state examination, medication delivery, medical appointments with GP and health checks with nurse, Men's group, community lunch, transport provided to attend appointments at health service, to go to chemist to collect medication, attend community events e.g Close the Gap Day and external health appointments, suggested to access counselling and referral to drug and alcohol service , support letter for Centrelink, help with financial distress – negotiated with electricity and gas companies regarding payment of bills, attended housing trust appointments to advocate on behalf of client. Linked into Close the Gap scheme to access medications for free
	Alex	Unstable housing – only short term, alcohol addiction, diabetes, socially isolated, stigma and racial discrimination as a result struggles to use public transport, intellectual disability, living in poverty	External referral from local hospital – mental health ward	Home visits from Mental health nurse and Aboriginal health worker – social and emotional support, mental state examination, medication delivery, medical appointments with GP and health checks with nurse, Men's group, community lunch, transport provided to attend appointments at health service, to go to chemist to collect medication, attend community events e.g. Close the Gap Day and to get to external health appointments, referral to a drug and alcohol service, attended case conferences with clients to advocate on his behalf. Linked into Close the Gap scheme to access medications for free, provided information for local support services in the community to access food vouchers
	Alfred	Poor physical health – chronic back pain –spinal cord operation, heart condition, alcohol addiction, heavy	Self-referral	Home visits from Mental health nurse and Aboriginal health worker – social and emotional support, mental state examination, medication delivery, medical appointments with GP and health checks with nurse, Men's group, community lunch, transport provided to

		smoker, socially isolated, grief and loss – multiple deaths in family, poor housing conditions – no heating or cooling, living in poverty, struggles to use public transport due to poor physical health		attend appointments at health service and specialist appointment at local hospital, to go to chemist to collect medication, attend community events e.g Close the Gap Day, external referral to Medicare Local for psychological counselling and Care Co-ordination & Supplementary Services (CCSS) program for new glasses, internal referral to Tackling Tobacco to help reduce smoking. Linked into Close the Gap scheme to access medications for free, assistance with payment of bills
	Anna	Poor physical health – heart condition, relationship issues – domestic violence, volatile relationship with neighbour, alcohol addiction, grief and loss – death of daughter and recent death of partner, unstable housing – possible eviction, living in poverty	Self-referral	Home visits from Mental health nurse and Aboriginal health worker – social and emotional support, mental state examination, medication delivery, medical appointments with GP and health checks with nurse, phone calls and home visits from Clinical Health workers regarding help with alcohol addiction and support with housing, referral to Anglicare for counselling, Women's group, community lunch, transport provided to attend appointments at health service, to Sobering Up Unit, to chemist to collect medications, to police station to take out restraining order on neighbour, attended case conference between Housing SA, SA police and local homeless service – Clinical health worker advocated for client. Linked into Domiciliary Care and Aboriginal Home Care who help with domestic chores, laundry and shopping
	Archie	Recently diagnosed with Diabetes, alcohol addiction, living in poverty – unemployed – financial pressures, grief and loss – parents both dead, socially isolated as most of his family he's close to are in Western Australia.	Internal referral from Diabetes clinic	Home visits from Mental health nurse and Aboriginal health worker – social and emotional support, mental state examination, medication delivery, medical appointments with GP and health checks with nurse, referral to Ophthalmology, Men's group, Diabetes clinic, community lunch, Tackling Tobacco - transport provided to attend appointments at health service, to go to chemist to collect medication, attend community events e.g. Close the Gap Day and to get to external health appointments, referral to a drug and alcohol service, referral to Medicare Local for psychological counselling and CCSS program to see a Podiatrist for his Diabetes (transport provided). Linked into Close the Gap scheme to access medications for free, provided advocacy for client regarding housing, linked into a chronic disease course and Diabetes Australia who helped him to manage his Diabetes, external referral to see a Dietician to learn more about eating healthier

6.4 Living with depression: Social aspects of people’s lives and the impact of the social determinants of health

An overarching theme emerging from participants’ accounts at all the services of their experience of depression was the way in which the broader context of participants’ everyday lives contributed to and shaped their personal experience of depression and their interactions with the services. It was evident from their accounts that their experiences of depression cannot be understood in isolation from their life circumstances. There were many examples given which illustrate the ways in which the social determinants of health had an impact on individual experiences.

Eight of the 21 participants from the four PHC services reported living in poverty; creating stress and sometimes constraining their ability to seek help. This is consistent with research findings which show a strong association between poverty and depression (Australian Bureau of Statistics, 2009; Draine, Salzer, Culhane, & Hadley, 2002; McLaughlin, et al., 2012). Participants spoke about not having enough money for the necessities of life. Some were unable to buy food and accessed food vouchers regularly or described times when they couldn’t afford to pay for gas and electricity. Anna’s partner had died six months ago and she was struggling to live on a pension once she had paid her bills:

> *‘I haven’t had anything to eat for about four days now. Got a little bit that I survive on, because another thing, I’ve never been by myself, I’ve been with my partner for 20 years, so I find that – all my housing stuff, electricity and all that, it takes a lot out of my pension, but I try and survive’* Anna (Aboriginal health service)

Alex (Aboriginal health service) accessed food vouchers from a local community organisation but was too embarrassed to seek help more than once a fortnight. Adam described times when he had no money to pay for public transport and that at times this prevented him from getting to appointments at the health service. Elaine attributed her depression to living in poverty after she was left with a large loan to repay.

Family pressures also featured in many accounts. Alfred reported family circumstances that made it hard for him to manage his depression and access counselling. His nephews often used the credit on his phone so he couldn’t use it to make appointments at the health service. Adam spoke of the stress of having family stay with him regularly. For example five people would soon be staying whilst his Aunt had an operation. He spoke of the financial stress of paying gas and electricity bills – in the previous year he had owed $1300 for utilities and was unable to pay, as a result gas and electricity were disconnected for a four month period.

Three participants described stress related to unstable housing and poor living conditions. Alex had to move out of his current house as it was only short term accommodation. Alfred had to move out for a short period due to a cockroach infestation.

Participants at all services commonly described family stressors and relationship issues including domestic violence as contributing to their depression. For example, Margot listed a series of events including conflict with her daughter, a legal battle with her brother over property after the death of her father, and moving her elderly mother into a nursing home. Noelene spoke of her increasing role in supporting her elderly parents and family distress regarding her brother’s recent jail sentence. Others mentioned relationship breakdowns, marriage separations, parenting stress and post-natal depression.

Stress related to caring was a theme in fifteen interviews which supports research that has found family caregivers have an increased risk of depression and anxiety (Schreiner, Morimoto, Arai, & Zarit, 2006). This is evident in the quote by Eloise below:

> *‘with five kids and a grandbaby on the way and they’re all living in my house and my husband works away all the time, yeah I felt like I was drowning in it. I wasn’t even coping with my own life, how was I supposed to cope with everybody else’s? You know, moving interstate – I was just ready to combust I think’* Eloise (Orange service)

Eight participants reported difficult childhoods, two were survivors of sexual assault and three had been in a domestic violence relationship in the past. Mia reported extreme domestic violence from her husband who was now in jail. She was a single parent of five children with no family support.

Five participants, all accessing the Aboriginal health service, described the impact of alcohol on family relationships and how this made their depression worse.

> *'Things that make it hard to manage my depression are having family members around that are depressed and on heavy medication and drink a bit, you know…drink a lot'* Archie (Aboriginal health service)

Ten of the 21 participants across the four PHC services were socially isolated and five spoke of withdrawing from health services such as counselling and appointments with their GP and psychiatrist. Withdrawing from services was particularly evident among participants from the Aboriginal health service. Three participants stated they did not like leaving their homes, disliked going shopping or were unable to use public transport as they couldn't cope with crowds of people. Alfred felt his depression made it hard for him to leave the house due to the stigma attached to mental illness.

> *'With depression, you find it hard to leave your house because you keep thinking everyone's going to look at you, they're talking about you. They think I'm psychotic, it stops me going out……I can't stand being around large groups of people, like on buses and trains.'* Alfred (Aboriginal health service)

Feeling socially isolated, the stigma associated with mental illness and experiences of racism were significant barriers to accessing other services for the Aboriginal people interviewed. Racism is recognised as a determinant of health for Indigenous populations and minority groups (Williams & Mohammed, 2009). Racism has a detrimental effect on the health and wellbeing of Aboriginal and Torres Strait Islander peoples and is associated with poor mental health, such as anxiety, depression and suicide risk (Priest, Paradies, Gunthorpe, Cairney, & Sayers, 2011). The Aboriginal health service took these experiences into account by helping clients navigate the health system through advocacy and facilitating access to other services. Tthe other three services did not provide assistance with navigation of services, although there was some evidence of advocacy which is discussed further in chapter 7.

Stressors in relation to physical health were common among participants which is consistent with research demonstrating that people with mental health problems have a greater number of physical health problems (Gunn, et al., 2010; Whiteford & Groves, 2009b). The majority of participants mentioned a number of different physical health concerns including kidney disease, uterine cancer, gall stones, arthritis, knee replacement and chronic back pain.

Of the 21 interviewed, twelve reported a chronic health condition as well as their depression however, only three felt their physical health was a contributor to their depression. There was a focus on chronic physical conditions at the Orange service. Four of the five clients had poor physical health, which was consistent with the service requirement to have or be at risk of developing a chronic condition. Archie (Aboriginal health service) had recently discovered he had diabetes at the age of 31. Alfred (Aboriginal health service) had undergone a spinal cord operation due to back pain and was therefore limited in his mobility. All participants at the Aboriginal health service had a chronic health condition, reflectinging research showing higher rates of chronic disease among Aboriginal people compared to non-Aboriginal counterparts (Tsey, et al., 2010) and illustrating the extent to which the social determinants of health such as discrimination, cultural fragmentation, and marginalisation, along with disadvantages such as gaining access to education, employment, income and housing play a role in influencing people’s vulnerability to poor health. Clients with chronic physical conditions were less of a feature at the Green and Blue services perhaps reflecting less medically focused service provision at these services.

Five participants at the Aboriginal health service attributed their depression to grief and loss of family members compared to two clients who expressed grief and loss at the Green service and none at the other two services. There is a known link between the high levels of grief and loss in communities and depression (Vicary & Westerman, 2004; Ypinazar, et al., 2007). Participants reported having multiple deaths in the family, often listing two or three close family members who had recently died.

The impact of the social determinants of health from family and relationship stressors through to housing issues and the effect on participants' lives and their experience of depression came through clearly in the interviews for all services. Good practice in mental health care acknowledges the need for action on the social determinants of health. A recovery approach acknowledges a person's social determinants and the impact of social inclusion, housing, education, employment, income, stigma and discrimination. Acknowledgement of the social determinants of health is a fundamental principle of CPHC. The ways in which the four PHC services considered and responded to these broader social issues in the treatment of individuals with depression is discussed in the next section.

6.5 Referral pathways and commencement at the services

Participants' commencement differed among the four services. Participants' explanations of how they started using the service were consistent with the client pathways described in chapter 5 and are shown in tables 6.3-6.6. The main pathways evident at the Green and Blue services were being informed by a friend or relative, or more formally by a health professional or other agency making a suggestion or referral.

Those who had access to social networks, friends, neighbours and relatives or were able to access support services in the community were linked into the PHC services. This was also reflected in the client journeys for Maggie, Margaret and Mia who rang a Women's health service or were able to get to their GP. Social networks such as family and friends have been found to be an important resource in accessing health services (Alam, Speed, & Beaver, 2012). Also those that accessed other services facilitated access to these PHC services. It suggests the importance of a PHC service maintaining links and collaborating with local providers so that clients are referred to PHC services.

All participants at the Orange service were referred by a health professional to the *'Do it For Life'* program, which helped people at high risk of developing chronic diseases to make lifestyle changes to improve nutrition and physical activity, reduce smoking, alcohol consumption and stress. An internal referral was then made from the *'Do it for Life'* worker to the social worker to access counselling. For example:

> *'I got sent to hospital and the cardiac sister there said "Well it's not your heart, it's one of these panic attacks"…so she referred me to the "Do it For Life" program and she's helping me with my lifestyle more. Then she thought it would go with [counsellors name], go hand in hand, emotional and healthy as a holistic approach.'* Eloise (Orange service)

This program was available at the Green and Blue services up until July 2013 but did not feature in the client journeys possibly indicating less emphasis on chronic disease at these two services compared to the Aboriginal health service and the Orange services.

At the Aboriginal Health service all participants described knowing about the health service through relatives that worked there and through their friends. The different pathways into the services either by word of mouth or through referrals primarily from other services or programs suggests the service was well known in the community. For participants that were socially isolated having the service recommended to them by a friend or family member, talking to their GP or health professional at a local hospital were important access points to all the PHC services. The variety of entry points described in the paragraphs above suggests that a CPHC service needs to have a number of different access points into a health service if it is to reach those in need with few resources. Providing outreach services such as staff attending community groups to promote the service and encourage attendance was only evident at the Blue service. Freeman et al (2011) argue(Freeman, et al., 2011) outreach services improve access to health care for those in the community (Freeman, et al., 2011). Other differences between the four PHC services were evident particularly in their approach to service delivery.

6.6 Models of service delivery

The Orange, Green and Blue services used a clinical one to one counselling model to respond to clients experiencing depression. Prior to policy changes in July 2013, there were a range of health promotion and support groups offered and these services (discussed in chapter 7). One-to-one counselling was offered typically using a variety of treatment approaches such as mindfulness, acceptance and commitment therapy, cognitive behavioural therapy and narrative therapy. These approaches to care and treatment activities are shown on the Southgate model. At the Aboriginal health service staff didn't use these therapies for clients experiencing depression as they did not employ social workers or psychologists. Up until July 2013, clients saw the PHC or mental health nurse and GP based at the health service for medication to treat their depression as well as other conditions. The mental health nurse conducted risk assessments and mental state examinations. The service used a holistic flexible approach to service delivery acknowledging the social and economic constraints faced by the clients that contributed to their depression. Home visits were conducted, transportation to appointments, medication delivery, support and help with housing and financial distress. This holistic approach is also evident in the Southgate model that considers social and economic factors that impact on clients. After July 2013, policy changes affected the services response to depression. In particular, the Aboriginal health service no longer responded to mental health issues. The mental health nurse role ceased and the position was converted to a PHC nurse role. All clients with mental health issues were referred to mainstream services. Those clients with depression who also had a chronic physical health condition continued to be seen by the service but the focus was on their physical health. Client's experiences of the services they received, the various approaches taken by the services and how this shaped their experiences is discussed further below.

6.6.1 Client experiences and staff reflections on treatment for depression at the PHC services

The services were assessed against key components of the Southgate Model. Table 6.7 provides a summary of the response to the treatment of depression at the four PHC services before and after July 2013 and their alignment with CPHC principles. Empowerment is not listed as a key component as it is discussed further in chapter 8. The following sections expand on table 6.7 by presenting a cross-case analysis that brings together findings from the client and staff interviews and the client journeys. There was minimal to no alignment with CPHC principals at the Green, Orange and Blue services regarding the treatment of depression. The Aboriginal health service had some alignment with CPHC principles such as culturally respectful, accessible, consideration of social and economic issues affecting clients and using a multidisciplinary approach. These key features were only evident up to July 2013 when policy changes took affect that reduced the services ability to respond in a comprehensive way to the treatment of depression.

Table 6. 7 Cross-case analysis of the PHC service response to the treatment of depression

Key components of a CPHC model	Green	Orange	Blue	Aboriginal health service
Culturally respectful	Unable to say only one client tracked Manager reported the building was not culturally safe	Unable to say	Unable to say	Yes
Accessible	Limited access	Restricted chronic disease focus before and after July 2013	Limited access	Yes, access up until July 2013 but limited as no counselling offered. After July 2013 access restricted to those with a chronic disease. Staff no longer had capacity to visit clients in their homes
Focus on situational factors causing stress	Yes, upon entering service but limited service response	Yes but limited to those with a chronic disease	Yes, upon entering service but limited service response	Yes up until July 2013 when there were service delivery was affected by policy changes
Multidisciplinary	Reduced during study period	Yes	Reduced during study period	Yes
Chronic disease focus	Yes	Yes	Yes	Yes
Alignment with CPHC principles	nil	minimal	nil	Some alignment

The impact of the social determinants of health on individual experiences of depression was touched on in the previous section. Poland, Frohlich & Cargo (2008) argue individual behaviour is shaped by 'layers of context' and the social environments where behaviours are developed and maintained need to be considered. The way in which these services tried to help individuals with depression in the context of their everyday lives, taking into consideration broader social contexts was of particular interest.

Accounts of the four services demonstrate distinct differences between the approach taken by the Aboriginal health service and the other three services. The experience from participants accessing the Aboriginal health service demonstrated the ways in which the service was responsive and flexible to their individual needs, incorporating an understanding of the social determinants of health particularly prior to policy changes and the service restructure. This was in contrast to the three other services which are discussed together in the section following this one. The approach taken by the Aboriginal health service is discussed first. How the services aligned with key components of CPHC listed in table 6.7 is discussed in these sections.

6.6.2 Aboriginal health service

The Aboriginal health service had a culturally respectful and flexible approach to service delivery where their culture was considered and they felt listened to without discrimination. This approach was valued by participants who felt cared for, they found the service to be helpful and understanding, and preferred the service to other GP practices where they felt the time, care and understanding wasn't the same. For example:

> *'helpful, understanding and they listen, they don't treat you any different'*
> *Aaron (Aboriginal health service)*

> *'Good, better than other GPs where you are in and out in less than five minutes' Alex (Aboriginal health service)*

Stigma, discrimination and social isolation contributed to and shaped the lives of participants from the Aboriginal health service and were intertwined with other social determinants of health such as education, housing, employment and income. The service provided them with a place that respected their culture and was welcoming. This was evident in Alfred's comment below:

> *'when I go shopping I don't like staying in there, people looking at me because it starts to muck with your mind and you think "Yeah, what are*

> *you looking at me for, man? and then you just want to get out. Whereas here, you don't really want to get out. You can get coffee, tea. The people who operate this service understand the culture, who we are, where we come from and what we're going through. Where as you go see someone else and they don't understand, they just believe what they read in the paper and then they put us in one basket'.* Alfred (Aboriginal health service)

"Respectful" was a common term used to describe the service among all Aboriginal participants. Adam thought there was a mutual understanding among clients and workers:

> *'Respectful, yeah they've been through it too. I understand them and they understand me too so, yeah, they know what you're going through'.* Adam (Aboriginal health service)

Aaron felt acknowledged and respected when he came in, he didn't feel judged as though staff were thinking, "Not Aaron again". Adam valued that the staff took the time to say hello when he entered the service and ask how he was. All participants from the Aboriginal health service described feeling connected to the health service as they had been attending the service for a long time.

Participants valued the flexibility of the approach taken in providing home visits and actively following up with clients they hadn't seen through these visits and phone calls. Five of the six Aboriginal clients were socially isolated, three had experienced stigma and discrimination due to mental ill health and three struggled to use public transport due to racism and discrimination experienced in the past. A service that provided a service delivery approach where clients were regularly visited in their homes and where practitioners 'checked-in' with them was important. This is evident in the following quote:

> *'They check up on me if I don't answer my phone. They pick me up for appointments, come around and keep me posted on when the lunches are, always checking on me which is good because some days I feel so depressed and they'll knock and we'll have a talk, a laugh and I feel*

> *better. This is important because sometimes it’s hard to leave the house. It’s good the way they keep in contact, don’t get that from other services’.* Alfred (Aboriginal health service)

Alfred’s client journey included a large number of home visits and appointments at the service with the doctor, PHC nurse and health worker. Transport was provided so he could get to appointments and other health services. This was typical of the ways in which the health service facilitated access for participants.

The multidisciplinary nature of the Aboriginal health service was a common aspect that was referred to by staff. Having a doctor on site enhanced multidisciplinary team work. Mental health workers confirmed that clients saw a nurse and then a GP when they came into the clinic. Clients experiencing depression were referred to the mental health nurse and there were six client journeys that showed meetings with the nurse, doctor, Aboriginal health workers and Aboriginal mental health workers regarding clients. However, mental health staff regarded the service response to depression as “ad hoc” as specific services to treat depression were lacking and this made it difficult to offer a service to clients with depression. One worker commented:

> *“I’ve found it quite difficult because we offer a service to clients with depression but we don’t have any direct access to psychiatrists so it’s always through the GP. If someone’s in crisis then we have to access the emergency department or triage line. The other thing is we didn’t really set up clinics where clients could come in one afternoon a week, it’s more ad hoc and chaotic”* Mental health worker, Aboriginal health service

General staff that saw clients with depression or at risk of depression referred clients to the GP at the clinic, or the mental health team when it existed. A referral was also made for the client to receive counselling either through the nearest Medicare Local or mainstream state PHC service. Internal referrals within the service were also a key aspect of service responses. An Aboriginal health worker gave the following example:

> *"I had a client and I was doing her observations and we were chatting. She started crying, she had a lot of other things going on and she gave me a little bit of a brief example of what was happening for her. I referred her to one of our community health workers"* Aboriginal health worker, Aboriginal health service

The role the service played in facilitating clients' access to health services and supporting clients to navigate the health system was particularly evident at the Aboriginal health service. All staff described working and information sharing with outside agencies such as Domiciliary care, aged care agencies, SA Housing, domestic violence services, Families SA, local hospitals and a local mental health service. However, there seemed to be limited links with other sectors to help with employment and training and staff reported collaboration with other agencies was becoming harder due to staff turnover and staff restrictions regarding face- to-face networking with other services.

> *"Things have changed, you don't get to network – it's like we can't get in the car and go to services and network anymore. It's a lot of emails, a lot of ringing instead of travel. To go face to face and meet other services it seems to me it's a big no-no now….It's hard to express yourself and try to tell the workers in the other services who you are"* Aboriginal health worker, Aboriginal health service

All participants at the Aboriginal health service described being referred to a number of different external services regarding their physical health and mental health such as referrals to specialists at local hospitals, Domiciliary Care, a Medicare Local for new glasses and for counselling, the Closing the Gap initiative to access free prescriptions, and were referred to the State drug and alcohol service for counselling.

Archie's client journey showed the service helped him access many of these services not only for his depression but also for his recently diagnosed diabetes. He described being provided information about Diabetes Australia who had explained to him how to manage his diabetes. One of the most helpful links had been the Close the Gap scheme where he received his medications free of charge. This was a 'big help' as he took many medications each day.

Archie’s experience shows the multidisciplinary teamwork practiced at the Aboriginal health service. The way staff at this service worked closely with each other and other health services was a common feature reported by clients. Having a GP based at the health service to consider physical health is particularly important. Ideally, a CPHC service would provide a range of services and would include medical services but this was only the case for the Aboriginal health service. Historically the integration of GPs and PHC service has been limited largely due to business interests of GPs and different ideologies between the two (Wiese, et al., 2010).

However Alex, who accessed many different services each week, described the services as separate and said he had to repeat information to different service providers, perhaps indicating the challenge for a health service to collaborate with multiple health services for clients with complex needs. He stated that although the services were separate, they were central in geographic location and were all nearby to the Aboriginal health service. Health workers from these services either came to him or he travelled to them via transport provided by the Aboriginal health service. He wasn’t able to use public transport due to past experiences of racism and discrimination described earlier. Alex described the services that worked with him as ‘helpers’ and stated the following:

> *‘It’s like a circle, I’m in the middle and they are based out around me, forming like a shield, stopping all the crap and bullshit coming in that I don’t need’* Alex (Aboriginal health service)

Mental health workers regarded the Aboriginal health service as an essential part of the broader health system:

> *“The Aboriginal health service I think it’s an essential part, it fits very well as a GP service and referring off to specialists. The thing about this place is it’s very flexible, you’ve got to be flexible with Indigenous people or communities”* Mental health worker

Having a service delivery approach that is responsive and flexible to individual needs was an important aspect of the Aboriginal health service that was consistent with client's views and reflections about the service. However, when the service restructured service delivery shifted to chronic physical disease management and the mental health team ceased to exist. One mental health worker reflected on the changes:

> *"It has changed around mental health because the mental health team had a registered nurse and an Aboriginal health worker, but this no longer exists from 1st July 2013 so the funding went elsewhere, our focus is just on chronic disease prevention and management".* Mental health worker, Aboriginal health team

A general staff member from the Aboriginal health team emphasised the limitations created by this policy change and noted the need for greater capacity and training among staff in recognising depression when it's often not identified by the client. For example:

> *"Well [the Aboriginal health service] should be doing a lot more, because I tell you it's ripe. It's that ripe, everything has a shadow of depression over it, especially those with chronic disease. We've got our mental health workers but they don't even have their own sessions, they're not even allowed to do that. They wait for the shit to hit then it's, "Where's our mental health workers? Aahh!" I think each worker needs to be more educated about depression because there are so many clients out there with depression, they [client] don't even tell you, they're not telling us, and you can see it"* Clinical Aboriginal health worker, Aboriginal health team.

Post July 2013 staff were no longer able to visit clients with depression in their homes and the service lost a lot of its flexibility to respond to the individual needs of clients.

The service initially provided a comprehensive response to depression incorporating a range of workers and activities but policy changes after July 2013 reduced the service response resulting in less alignment with CPHC. The Orange, Green and Blue services were also subject to the same policy changes post July 2013 and their response to depression also falls into two distinct periods. The section below discusses the response to depression at the

Orange, Green and Blue services both before and after policy changes in July 2013.

6.6.3 Orange, Green and Blue service

All participants from the Orange, Green and Blue services both before and after policy changes in July 2013 reported seeing a social worker or psychologist for one to one counselling which was consistent with information from client journeys. Overall, participants found the service safe and welcoming, providing descriptions such as ‘helpful’ and ‘supportive’. The services facilitated their understanding of their depression and encouraged individual empowerment, a key service quality in the Southgate Model by highlighting the areas in their life where they needed help. For example:

> *‘I found it really helpful, I always expected people to fix it [depression] for me and when they didn’t I was very disappointed and disillusioned. I’ve found with this service it’s about me trying to deal with it and fix it within myself, no one else can fix it for me, so it’s more about me dealing with situations more than someone dealing with it for me’* Eloise (Orange service)

All but one participant reported a positive connection with their practitioner which facilitated the therapeutic relationship; this made them feel validated and comfortable. For example:

> *‘Amazing, absolutely amazing, she was just extraordinary. The intake interview was very professional and I felt really validated by that, like I had been minimising it and that’s probably part of the reason it took me so long to get help’* Margaret (Green service)

A positive therapeutic relationship has been found to directly contribute to the recovery of depression (Zuroff & Blatt, 2006). Although a positive therapeutic relationship is not unique to CPHC it would seem ideal CPHC service qualities such as being culturally respectful (at the Aboriginal health service) and encouraging empowerment as described above provide a positive environment for the development of this relationship and were important features of these services and their response to the treatment of depression

A typical comment by those accessing the Green service was that the counselling sessions had been of more benefit to them that any other counselling they had received. This was evident in the following quote:

> *'I talked about some really intimate things that I hadn't talked to somebody about for 30 years but I felt so comfortable with her that I could do that. It was much better than talking to my psychiatrist, I don't talk to anything personal with him. He just gives me a script for my medication'* Maggie (Green service)

An exception was Elise (Orange service) who overall was happy with the counselling but reported a time when she felt uncomfortable and stopped attending the health service. It appears that an attempt was made to contact her by the health service but the message didn't reach her.

> *'There was a time I didn't feel comfortable and I stopped attending for a while, she told them to ring me but the message never came through but I got the nerve up and came back. We talked about something that I was really nervous to talk about – there are labels out there for schizophrenics and mental illness and I just went somewhere I wasn't comfortable and then got really nervous about coming back and seeing her again'* Elise (Orange service)

Another participant, Nicole reported a lack of empathy by the practitioner during the initial intake interview. She commented:

> *'He was probably a little too business-like and perhaps that's his way but there wasn't a great deal of empathy shown. I actually knew him from my step-father who has seen him and had been unhappy with him and he had said to my step-father on the first appointment, "Oh well, we'll have you all fixed up in four sessions" – that's not how it works'* Nicole (Blue service)

These examples raise the importance of CPHC services, like other services, having mechanisms in place to monitor quality. Those with limited resources may have no option but to remain with the therapist they receive or may give up on finding a counsellor. Feedback mechanisms were not uniform - participants had been asked to provide feedback regarding services received at the Green service but not at the Blue service. At the Orange service those who had attended health promotion and support groups had been asked to give feedback, however feedback was not sought on individual sessions. Health promotion and prevention activities are discussed further in the next chapter.

Multidisciplinary teamwork

An ideal of CPHC is its multidisciplinary approach incorporating a range of disciplines collaborating to care for a client. A multidisciplinary approach was evident at the Orange service both before and after policy changes in July 2013 where there was a focus on the management of chronic physical conditions. As shown in the client journeys, participants initially started using the service for their physical health and were then referred to a number of one to one services for their physical health and mental health. This included general staff such as dieticians, occupational therapists, lifestyle workers (in the *'Do it for Life'* program), early childhood psychologists and PHC nurses who contributed to the treatment of depression by recognising signs and symptoms and helping clients to gain support. This awareness of depression, identification and referral for treatment were enabling factors that enhanced the service response to depression.

A general staff member at the Green service that worked on the *'Do it for Life'* (DIFL) program funded prior to July 2013 felt able to address depression more directly in their role:

> *"One of the eligibility criteria for DIFL was stress so that was relatively common and in the course of working with clients that issue would come up with some of them. Obviously they're trying to change behaviours and if they've got another stress issue going on it impacts fairly strongly. So yeah, I'd like to think the program has some impact there"* General staff, Green service.

This comment reflects a way of working with clients that considers the broader social factors occurring in client's lives and the contribution of these other stressors on depression. This person's ability to address depression directly was an exception compared to reflections from other general staff whose primary role was identification and referral within the service or to external services.

The two social workers at the Orange service thought the multidisciplinary approach was a key aspect of the service that was valued by clients.

> *"So we have a level of autonomy and flexibility in terms of ways of working with people and have drawn on the resources of other allied health workers, which is often really helpful. There's a source of referral into social work, but also in terms of access to other disciplines, expertise that might be helpful for our clients. So working in that multidisciplinary model has been particularly good I think"* Social Worker, Orange service

The multidisciplinary work is conceptualised by this worker as cross referral and sharing of resources however, client quotes below suggest informal interdisciplinary case management. For example, Elaine provided examples of when her GP had been co-located at the Orange service and that this had facilitated communication between the social worker, the diabetes nurse and her GP.

> *'Well, my GP used to work in this building and they [social worker and diabetes nurse] would just pop in there and talk to him but I don't think this will happen now with whoever my new GP will be'* Elaine (Orange service)

Examples were also provided describing different practitioners communicating with each other regarding her health during a time when she was experiencing poor memory.

> *'[social worker] was sitting there and she asked me a question and I just couldn't remember, so she gets up and goes in to [diabetes nurse] office and then we transferred in there and we were all sitting in there talking about everything'* Elaine (Orange service)

In comparison at the Blue service Nicole's quote below highlights the potential of a multidisciplinary approach as you would expect it to operate in a CPHC service.

> *'What I'd really like is, and I guess what I thought I was getting when I came in, was that I would love if this was actually one service, but it's not. It seems to be quite segregated. The GP is a private and it's not linked at all with the other services, which I thought was odd. I'd love to come here and say this is where I go for everything, this is where I go for my psychology, my physical health and that my GP knows that I have these psych issues and that it's actually one linked service, but it's not. And the GP doesn't even bulk bill, so we go elsewhere'* Nicole (Blue service)

This quote illustrates lack of integration and collaboration at the Blue service and highlights that the presence of multiple disciplines doesn't necessarily lead to a multidisciplinary approach.

The majority of staff at the Blue and Green services reported there had been a reduction in multidisciplinary work after July 2013. A psychologist from the Blue service used the term 'cross-referral' rather than multidisciplinary:

> *"Well, it's pretty non-existent at the moment except in cross-referrals, so I refer to other social workers or nutritionists and so on, they refer to me, so in that sense it's multidisciplinary work because you'll both be seeing the same clients"* mental health worker, Blue service

When staff were not seeing clients they were based in another building so that rooms were available to be hired by other services. Staff were restricted in the information and resources they could access while seeing clients as they weren't allowed to keep filing cabinets in consultation rooms. A psychologist explained resources were often mailed to clients as it was hard to know what information clients may require. These restrictions were similar to those being imposed on staff at the Green service discussed earlier.

A social worker at the Green service also used the term cross referral seeing it as a key aspect of the service. The role of the Lifestyle advisor (DIFL program operating prior to July 2013) seemed to facilitate cross referrals. This program worked with clients at risk of developing chronic diseases and promoted a multidisciplinary approach where clients were referred to a dietician and an exercise physiologist. However, the approach seemed to comprise cross referrals between disciplines with little evidence of collaboration with other practitioners and external services regarding clients.

The other social worker at the Green service thought multidisciplinary teamwork had reduced after policy changes in July 2013 and reported the main collaborative work was with the early childhood team where the psychologist worked with the child and the social worker worked with the parent. The manager at the Green service gave insight into the reasons behind the reduction in multidisciplinary team work with co-located services in the building:

> *It's the thing that you do when you've done everything else that you're absolutely required to do…it depends on people's energy levels, which nobody's sitting around thinking what shall I do this week…The other thing it depends on is personality of the managers and then behind the managers, the directors, how much drive are they putting into working together. Some of the managers who were around when we all sat down and we all did the planning and we all had these exciting dreams for GP Plus have actually moved on and new people have come in with new directors behind them and there's been a bit more "actually that's not really our role". Everybody's getting pushed on their own KPIs and actually nobody has KPIs around collaboration.* Manager, Green service

This quote reflects the lack of priority on multidisciplinary teamwork in the Green service which stemmed from higher management and how this lack of priority for collaboration can filter down and affect staff in the services. It is unknown whether the reduced multidisciplinary approach at the Blue service was influenced by management or possibly due to staff being spread out between two different buildings. The co-location of a GP and the collaborative way staff worked with this clinic at the Orange and Aboriginal health services supported multidisciplinary teamwork.

Prioritisation of chronic physical conditions

After July 2013, all mental health staff and general staff from across the Orange, Green and Blue services thought the service response to depression had moved away from a CPHC model to a narrow clinical focus on chronic disease and one to one treatment. For example:

> *"It's more clinical and a very narrow definition of ill health. The people we will support in the future are going to be people with diabetes, cardiac disease or a respiratory disorder. As far as I'm aware, we will still help them with issues like depression or domestic violence but they will have to have a pre-existing condition"*
> Mental health worker, Blue service

The Green and Blue service saw anyone that had depression; a chronic physical condition was not a prerequisite as it was at the Orange service. Often clients at the Orange, Green and Blue services had experienced domestic violence, relationship stressors or breakdown or stress as a result of being a caregiver. Key roles for mental health staff at the Orange, Green and Blue services were providing one to one support and education to those presenting with depression. Additionally, the majority of mental health staff from the Green and Blue services emphasised the importance of acknowledging situational factors causing stress such as relationship breakdown, housing, financial difficulties and social isolation. While staff at the Orange service also acknowledged these factors experienced by clients the prerequisite to have a chronic disease resulted in the service having little capacity to help clients with situational factors that did not have a chronic condition.

Barriers to access

A service that is accessible is a key mechanism of a CPHC approach through the provision of services that are available, affordable, acceptable and that engage the local community (Freeman et al., 2016). Both before and after July 2013 clients reported barriers to accessing the PHC services due to availability issues such as a lack of after-hours services (Blue service) and after July 2013, limits on the number of appointments available to clients (Green service). Both staff and clients reported childcare availability was a barrier to access. As noted above service policy at Orange service acted to restrict access to those presenting with a chronic physical condition in addition to depression.

Nicole’s account of her experiences at the Blue service capture a number of these barriers. Limited availability meant she found it difficult to attend appointments.

> *‘The intake interview was only between nine in the morning and one in the afternoon and where I worked I didn’t have a recess break, and lunch started at 12.40pm, so it only gave me 20 minutes that I could call. So in the end I had to wait until school holidays to even get in for an intake interview, so I found it difficult to access in that way…Even now I find that very difficult, [psychologist’s name] only works – and apparently her hours have just been cut I found out at my last appointment- so she only works out of hours once a fortnight, but I’m talking a four o’clock appointment. It’s still within business hours, so there’s only that one day a fortnight that I can access her without having to miss work, so that’s quite challenging”* Nicole (Blue service).

Having missed an appointment due to injury she wasn’t able to get another appointment for three weeks, so it was six weeks between appointments which was too long and she found it difficult to cope during that time.

Nicole often had to bring her two young children to appointments because she didn’t have anyone to take care of them. She found this difficult and felt this limited what she could discuss with the psychologist. She was not aware that there was a crèche at the health service and this wasn’t presented as an option to her.

There were examples of services responding flexibly to increase access. Margaret who also worked full time, found the Green service accessible, because of the flexibility of the social worker who took into consideration her hours of employment and met with her at eight o’clock in the morning so she could still get to work on time. Despite this worker’s flexibility, the manager of the Green service noted that the goal of providing longer after-hours access such as opening late two nights a week and a Saturday morning had not been achieved.

At the Blue service intake hours were restricted to those that work during the day and there didn’t seem to be as much flexibility as there was at the Green service. Information about the crèche was not passed on as an option to Nicole and a general staff member confirmed there had been a reduction in the availability of the crèche resulting in a long waiting list and is maybe why information about the crèche was not passed on. Furthermore, Nicole’s quote mentions a reduction in her psychologists’ hours of work. This was due to the considerable change and health system re-organisation that was occurring during this research. Reduced funding to health services and a focus on chronic diseases in which depression was not included limited the services ability to provide a service accessible to all. These examples illustrate the way policy changes impacted on staff and clients.

A major barrier identified by five participants from the Green service was the limit on the number of appointments they were able to access that took effect after July 2013. During the study period the Green service changed its model of service so that any counselling provided was counselling that was limited to six to eight sessions.

All participants at the Green service were very anxious about whether they would cope without the counselling. They were all socially isolated and three were unsure where to go now for their depression and what other services were available to them in the community. For example, Margot was worried that she wouldn’t be able to cope without support. Her quote below indicates she is aware of services being reduced in the community and was worried whether a service would be available and whether she was able to access the service again in the future if her depression worsened. She stated the following:

> *‘I’m just wondering if this will be a thing that I’m able to source. If anything should happen in the future because I know how many services have been cut back and I would hate to think that mental illness is one thing that has been cut in particular. Plenty of places have gone. We’ve*

> *got people who have nowhere to go so this kind of service is essential as far as I'm concerned'* Margot (Green service)

It appears a consequence of the changes at the Green service were to raise anxiety in already vulnerable people and there was little done by this service to support clients in this transition. Mental health workers at this service confirmed the aim of this policy change was to achieve throughput.

> *"In the future we will be expected to give less of a service, because the times will be cut down, it will be how we churn people through. So the longer term more in-depth work, we just won't have time to do that. I don't know where people will get that"* Mental health worker, Green service

A limit on the number of counselling sessions was only noted at the Green service however the Green service early childhood team had been quarantined from the changes and the difference in staff perceptions about the service they provide is stark.

> *"one thing that's really lovely about this service, is that I feel we've been able to work with clients to be able to respond to the need and to not say it has to fit within that little tick box, and that basically "you need to be cured by the end of your six sessions or whatever, because that's all we're able to offer"* General staff, Green service

Participants' inability to continue to access counselling was a significant barrier to managing their depression. If CPHC principles were enacted services for depression would be readily available, the service would be flexible and responsive to clients' needs and would have an active role in engaging the community to raise awareness about depression.

For Madeline there was also a barrier of affordability in accessing counselling through a private psychologist. She stated:

> *'Maybe if we could have more appointments if we need more. I don't mind*

> *paying the gap between Medicare and all that, that's fine, but not when a person's on Centrelink benefits and you've got no money but you've got depression and you can't speak to someone unless you go and take an overdose and are hospitalised. But [counsellor's name] was good, she gave me an extra two that I needed.* Madeline (Green service)

This quote reads as though she doesn't mind paying the gap but actually reflects her own situation and her pathway into the Green service – her experience of poverty and her struggle to access mental health services not only when she lived in the country but also when she moved to Adelaide. She had in fact previously taken an overdose and was hospitalised. She described going to several GPs before she was successfully able to acquire a mental health plan.

A general staff member raised the same potential barrier for people wanting to obtain a mental health plan through their GP to access counselling through ATAPS funding:

> *"If a person has a GP who's fairly switched on to be able to pull together a mental health plan and refer them on for services through a private psychologist through the Medicare funding, that would be a good thing, but I don't know that all GPs are switched on enough to be able to do that, or that they are even open to the idea that psychology could be a useful thing. I certainly have that experience of talking to clients and knowing friends who have actually raised "we'd like to get a mental health care plan" and not being supported by their GPs to do that"* General staff, Green service

This gatekeeping emphasises the importance of services enabling clients to self-refer. The affordability of these services is an issue. It is unlikely those most vulnerable are able to afford these services as there is often a considerable gap to pay whereas an advantage for all the case study PHC services and one of the factors staff identified as enhancing the response to depression was that services are free. Clients didn't need a mental health plan from their

GP to access the service, a requirement needed to access Medicare Local. A study by Meadows et al (2015) also shows that psychologists and psychiatrists are used less by people in disadvantaged areas, mainly because practitioners aren't practicing in these areas.

There was a lack of certainty after July 2013 regarding whether PHC services would continue to see clients with depression who didn't have a chronic physical condition which was confirmed by a manager from the Green service. If these PHC services don't provide a service for those with 'only depression' a lot of people are denied resources that could help them recover. Managers from the Green and Blue service and one regional executive confirmed the lack of certainty regarding where PHC services fit amongst the health system and were questioning the duplication of services operating in parallel to other systems such as Medicare Locals who provide counselling funded by ATAPS. For example:

> *"It's a bit unclear whether we'll be allowed to keep doing that, if we're taking generic depression. If you're depressed because you've got a chronic disease that's all right, but if they're depressed because of domestic violence and that sort of stuff and again in comes down to what they're going to fund…the ATAPS service is going great guns and so I think the other thing we'd need to take into consideration is what we would be providing would be a duplication of a service that our colleagues at Medicare Local are providing"* Manager, Blue service

Two mental health workers (Blue and Green service) also identified the duplication from other services:

> *"There's more competition, Medicare Locals is one, Headspace is another…the [name of service] Psychology clinic is here…all Medicare Local referrals are from the GP and is referred using a mental health plan. So GPs have always referred to us but now they're getting paid to refer - So the referrals go to Medicare Local because they're getting paid to do a medicalised care plan."* Psychologist, Blue service

Mental health staff felt that a lot of the work that would come to these PHC services now goes to Medicare Locals who also use a clinical one-to-one service delivery model signifying selective PHC rather than comprehensive primary health care that would also offer promotion and primary prevention activities. However, the case study PHC services were also using a selective PHC model particularly after funding cuts to health promotion and prevention activities in July 2013 (chapter 7). The staff perspective that services such as Medicare Locals and Headspace are competition does not sit easily with a CPHC approach where practitioners would collaborate with other service providers.

A regional executive had a similar view that counselling services offered to clients with ‘only depression’ didn’t fit with the current chronic disease focus of PHC services.

> *“I’m not sure that it’s necessarily the best fit with the way our chronic disease services are moving versus more traditional medical health services. They’re very much standalone. We have services that are very disease integrated model approach and then we have counselling services, people presenting with depression not necessarily associated in any way with the remainder of the service. Certainly, when it forms a significant component as it often does with people with a chronic condition and disabling disease, I see it as a strong role. I think there are better ways of delivering a service for clients suffering long-term depression than in the services we provide”* Regional executive

However, the services this regional executive had in mind for the long-term treatment of depression were not apparent.

It is clear the case study services were operating under difficult and constrained circumstances. The uncertainty regarding where services for depression are placed within the health system and policy decisions dictated who received services, how many sessions they received and what supports could be provided to facilitate access. This was particularly evident at the Green and Blue services and at the Orange and Aboriginal health services where those with or at risk of developing chronic conditions were prioritised. For clients this produced considerable anxiety and was a significant barrier to managing their depression. Further barriers are discussed in the next section.

Barriers to managing depression

Participants in all services identified a number of barriers that impacted on the management of their depression. For Aboriginal clients barriers such as family issues, poor physical health and discrimination experienced at mainstream services were consistent with the social determinants of health that had contributed to their depression mentioned earlier in this chapter. The perspectives of staff and managers provided further insight into these barriers. Staff confirmed client views that mainstream services were not culturally respectful and highlighted the important issue of developing trust and the tension between staff and management after policy changes in July 2013 regarding their inability to provide a supportive relationship with clients that involved listening to client's stressors and linking them into support services. These barriers are outlined below.

A participant's mood and how they were coping emotionally affected whether they would read information provided. For example:

> *If they leave you with information and I feel depressed, I won't read it. I just put it away somewhere and think, you know, one day I'll go pick it up and say yeah, I should have read this'.* Alfred (Aboriginal health service)

Others such as Madeline (Green service) stated a barrier to managing her depression was her lack of confidence. This was a typical comment also from others, for example Natalie (Blue service) made a comment that the biggest barrier to receiving information was her capacity to act on it.

> *'It wasn't so much the information that was given to me, it was how I could put it into practice in my life and with the emotional state that I was in. So yeah, it wasn't so much the information, it was where I was at'* Natalie

> (Blue service)

The capacity of staff at these services to continue to working with clients until they are in a position to act on this information is important and was emphasised by staff at the Green service were there was the barrier of restricted access. At the Orange and Blue services, staff were able to work with clients for a longer period. Similarly, at the Aboriginal health service, where staff had an ongoing relationship with clients, reminding them of this information and suggesting support services regularly was a strategy used.

The majority of Aboriginal clients were referred to external health services (Medicare Local) for psychological counselling or drug and alcohol counselling however; only one participant followed through with the counselling. Archie reported he hadn't attended due to family issues, three had not attended due to poor physical health and Adam declined the referral due to reluctance to telling his story again. Archie explains in the quote below that he did not attend due to family reasons.

> *'Drug and alcohol counselling, that was only a couple of times I went there. Yeah, didn't go too well. Just family issues and then after I lost my mother, brothers, just the family, you know, that was doing my head in a bit. I had a lot going on at the time, I was looking after my brother, he was in an accident as well. So yeah, I was looking after him at the same time, trying to be everything to everyone, you know.'* Archie (Aboriginal health service)

Grief and loss, combined with a very stressful time meant that Archie wasn't able to attend counselling. Poor physical health and the challenge of managing another chronic condition was a barrier to accessing counselling for three participants. Archie found managing his diabetes and having low energy made it hard to get to appointments. For example:

> *'When it comes up, I don't know, I'm doing something, or I'm not around, or I just couldn't be stuffed. When you got diabetes, you know, I've got low vitamin D, I've got to take Vitamin D everyday'* Archie (Aboriginal health service)

For Archie the acceptability of counselling through mainstream services was a barrier. He describes being referred to a non-Aboriginal counsellor, separate from the health service. This was a barrier as he didn't like accessing other services as he felt he was treated differently and there wasn't the same level of understanding of his culture as there was at the Aboriginal health service.

> *'They hooked me up with counselling but I never went to it. I missed it a couple of times, but I think it's outside. They hooked me up with someone outside, yeah'* Archie (Aboriginal health service)

The issue of (mis)trust and the stigma and discrimination Aboriginal clients felt at mainstream services was a key theme that posed a significant barrier to the treatment and recovery of depression. General and mental health staff identified similar barriers that mainstream services were not culturally respectful and lacked an understanding of Aboriginal culture. Mental health staff reported in the past they could attend appointments with clients to act as cultural brokers but they were no longer supported by the service to do this.

At the Green service, the Manager also thought the service wasn't culturally respectful:

> *"I don't think this centre is particularly safe or friendly for Aboriginal clients. It's just a little bit more clinical. A little bit more professional. The gap between the main front door and the reception is actually quite a long and exposed walk for people, and we don't have the Aboriginal flags and we don't have the things that would make Aboriginal people feel especially welcome to this service unfortunately"*
> Manager, Green service

Observations made at the Orange and Blue services are consistent with this comment. Both the Orange and Blue services were very clinical and lacked Aboriginal posters or the employment of Aboriginal staff that may contribute to Aboriginal people feeling more welcome and these services and being perceived as more accessible.

The need for mainstream services to continue to attempt to contact potential Aboriginal clients and to include home visits in their service delivery model was stressed. Aboriginal health staff thought mainstream services often failed to engage with Aboriginal clients and that they didn't try to re-contact clients if they had initially been unsuccessful. An Aboriginal health worker reflected on the stigma and discrimination felt by many Aboriginal clients accessing mainstream services:

> *"Clients often won't go there because it's a non-Aboriginal service that they're going into and a lot of the Aboriginal blokes they're feeling bad enough already, the same as everybody else that has depression but there's a double edged sword that they're feeling that they don't fit in, that they'll be judged when they go there because they're Aboriginal"* Clinical Aboriginal health worker

There was (mis)trust of mainstream services in the context of past colonisation and ongoing stigma, racism and discrimination experienced by clients who were reluctant to use these services. Trust in health practitioners and in the health system has been shown to be important in increasing client's health seeking behaviours, following through with treatment and are more likely to utilise health services (Meyer, Ward, Coveney, & Rogers, 2008).

The lack of Aboriginal counsellors in mainstream services was identified by one mental health worker and two general staff as problematic.

> *"There's no Aboriginal social workers. I do, unfortunately think that's a barrier. Yes, definitely and that's why a lot of our clients are happy just to talk to us. That's my experience with my clients. I've got a client that has been ringing me in the last couple of days and I'm not even community, but she wants me, she trusts me. So I have to see if I'm allowed, days when I'm quiet, you know? Because it does take a long time to build that trust with them, it really does."* Aboriginal health worker

Both general staff and mental health staff reported that clients were happy to talk to them. However, when the Aboriginal service was restructured after July 2013 to focus on chronic physical disease there was a lack of clarity and tension between staff and management regarding the extent to which staff were allowed to talk to clients about their mental health and wellbeing and therefore respond to their needs. Three staff (two general and one mental health worker) didn't know whether they could have a supportive role and listen to clients' stressors as shown in the quote above. In contrast, the two mental health staff had been directed by management that listening to clients' concerns was not part of their role and that they were no longer allowed to conduct home visits:

> *"…you get rapped over the knuckles because we did a home visit just to see how someone is and talk some sense into them, chat, take their blood pressure, check their glucose and just have a chat, say okay, you need some counselling"* Aboriginal mental health worker

> *"We're not counsellors here and we get told we can't sit here and just talk to them – but we're not talking, we're just giving them an ear. But we've been told that we can't be doing that either. It's only sitting there listening, it's not actually giving them advice, and it's just being that person there for them to talk to, to let it all out to. They come in and just want a yarn if they're depressed".* Aboriginal health worker

The inability of staff to continue to provide this supportive role was perceived as a significant barrier to good mental health care. Staff had built trusting relationships with clients and acknowledged that this trust often takes time to develop. It would make sense for staff to be able to provide support and listen to clients' concerns to facilitated linking clients into support services but staff were no longer supported to provide a responsive and flexible approach to service delivery.

Adam described having depression for over 20 years and had been admitted to a number of different institutions. The thought of explaining his depression to someone new stopped him from accessing counselling

> *'They wanted me to see someone a counsellor but I've had a lot of family business lately and I don't want to keep going back to a different person telling the same story over and over and over. You should be talking to the same person and that's even making me more depressed, telling the same story over. I said "No, I don't really feel like talking to someone again, telling my problems all over again, it's already in my files, just read it". So I just get up and go for my little walks, I got family members in the neighbourhood I go and visit them and have a yarn you know?'* Adam (Aboriginal health service)

These descriptions highlight the significant challenges faced by participants when the Aboriginal services became less comprehensive that made it more difficult for them to manage their depression. The examples above at the Aboriginal health service and in the previous section that discussed barriers to access at the at Orange, Green and Blue services show how heavily restricted they were in their response to clients, from staff capacity to attend appointments with clients to even being able to listen to client's needs.

6.6.4 Changes

Participants reported a number of important personal changes within themselves and in their lives in the six months between the first and second interviews. Interview transcripts were analysed for changes and improvements in health and wellbeing. Cross-case analysis indicated there were five common changes and benefits among participants. These changes and benefits were compared with the services' alignment with CPHC principles (see table 6.8).

Table 6.8 Changes and improvements to health and wellbeing among participants at the four PHC services after July 2013

Changes	Orange	Green	Blue	Aboriginal Health service
Recovery	3	2	1	0
Improvements in depression	5	5	3	1
Greater management of depression	5	5	3	1

Enhanced life skills, improved ability to manage work and relationships	3	2	1	0
Improved self-confidence/self-esteem, more assertive	3	4	0	1
Improved physical health and wellbeing	2	1	0	3
Reduced alcohol/cigarette intake	0	0	0	4
Total clients interviewed	5	7	3	6
Alignment with CPHC principles	minimal alignment	nil	nil	partial alignment

All participants at the Green, Blue and Orange service and one participant from the Aboriginal health service (14 participants) reported a change in how they perceived situations which had led to recovery and improvements and greater management of depression over time. For example, Ella explained:

> *“It’s actually made me realise that the problems that led to my depression are not actually my problems. Its circumstances and family history and that sort of thing that’s beyond my control. They’ve helped me to figure out why I’ve stayed big, it was attention seeking and since I’ve discovered that, I’m able to start dealing with it”* Ella (Orange service)

Of the 14 that reported improved management of depression, seven reported more self-care activities such as going for walks; two reported a more positive outlook on life and were planning for the future. One participant, Archie (Aboriginal health service) had gained employment, one had commenced studying, and one was considering further studies. Elise talked about the change in her depression in the following statement as well as her plans for further study:

> *‘Well, I get up, I eat now, I have interests I haven’t done for years, I have new interests, and I’ve met new people. I’m interested in studying. I can’t do nursing anymore because of my back, no one will employ me, so I*

> *want to do psychology, or counselling or something along those lines'*
> Elise (Orange service)

Five out of the six participants from the Aboriginal health service reported no change in their depression in the six months from the initial interview to the final interview, possibly due to the fact that their social determinants of health hadn't changed during this time. Descriptions of their depression were either 'the same', or 'up and down'. They attributed their depression to other ongoing stressful issues impacting their lives that have been mentioned earlier such as housing, family issues, physical health problems, smoking and alcohol, grief and loss of friends and family members. The clients at the Aboriginal health service had lower incomes, poor or unstable housing, experienced grief and loss and racism and discrimination more than clients at the Orange, Green and Blue services. This complexity was evident in the client journeys at the Aboriginal health service. Even though this service had the most alignment to CPHC principles compared to the Orange, Green and Blue services, it would seem the extent of clients' social determinants of health and the services' lack of capacity to respond to them, particularly after July 2013 had an impact on client's perceptions of their health, management of their depression and their self-esteem. An important factor to consider is the Aboriginal health service did not have counselling on site and clients did not feel comfortable accessing counselling through mainstream services they were referred to whereas the Orange, Green and Blue services all offered counselling.

Six participants felt the counselling had enhanced their life skills and improved their ability to manage work, friendships and family relationships. Strategies had been discussed to help manage stressful situations at work, and how to deal with family and friends which had led to improved work attendance and personal relationships.

Eight participants reported improved self confidence and self-esteem. Maggie described being more assertive. She stated:

> *"I'm stronger in my work; I'm actually a lot more resilient in my work. At home I'm more assertive with my partner, I don't let him bully me anymore which has been a huge shift and he's got more respect for me"*

Maggie (Green service)

Six reported improved physical health and well-being. Participants described eating healthier and exercising more since they started using the service. Ella (Orange service) who was also seeing the dietician had lost over five kilograms.

A common change among participants at the Aboriginal health service was reduced alcohol and cigarette intake. Four of the six participants reporting reductions since they commenced using the service. They had attended a smoking reduction program (‘Tackling Tobacco’) and reported receiving information on the importance of minimising alcohol consumption. The extent and importance of these changes within participants such as recovery and improved management of depression and greater self-confidence reflects the effectiveness of these case study services for people experiencing depression. The Orange, Green and Blue services were effective in helping clients to manage their depression. These three service provided counselling. Management and recovery of depression was not as evident at the Aboriginal health service. The lack of Aboriginal counsellors and coping with complex situational stressors may explain the lack of change among Aboriginal clients.

6.7 Conclusion

This chapter described participants’ experiences of and staff reflections on the treatment of depression and the extent to which the four PHC services implemented a CPHC response. Key findings from the cross case analysis indicated there was a reduced capacity among these PHC services to provide a comprehensive response to the treatment of depression among individuals after July 2013 when policy changes took effect. In particular, accessibility issues were evident and a reduction in multidisciplinary approach at two of the services. A partially implemented model that focused on chronic physical disease and cross referrals between practitioners was evident. A CPHC response to the treatment of depression where there is universal access for all clients and where practitioners can work in a collaborative multidisciplinary way seen in the Southgate Model was constrained under the policy environment and pressures from management to focus on throughput. The extent to which these services provided a holistic approach that included prevention and the promotion of good mental health in the community is discussed in the next chapter.

CHAPTER 7: CLIENT AND STAFF REFLECTIONS ON RESPONSIVENESS TO COMMUNITY NEEDS, PREVENTION AND HEALTH PROMOTION OFFERED AT FOUR PHC SERVICES

7.1 Introduction

A key mechanism of CPHC is a holistic approach that strives for a mix of treatment, prevention and health promotion activities. While the last chapter examined individual care the focus of this chapter is on the range of responses to mental health and depression that were offered to the community. The extent to which the four PHC services were able to deliver prevention and health promotion activities, advocacy and consider client's social and economic circumstances as well as respond to community needs is considered. The political and bureaucratic context played a key role in shaping the case study services and so influenced the views and reflections of clients and staff.

7.2 Staff and client reflections on the services response to mental health and depression in the community

The following section presents an analysis of client views and staff reflections about how the four case study services responded to depression in the community and how this response changed over the course of this project. Table 7.3 below provides a matrix of the PHC services response comparing the extent of key mechanisms outlined in the Southgate Model. The discussion below the table describes how well the services appear to have performed based on the analysis of data from the client and staff interviews and client journeys. Key mechanisms included how responsive the services were to community needs, how holistic the services were in terms of help with physical and mental health, use of a multidisciplinary approach and consideration given to clients social determinants of health. Other mechanisms included whether the services were culturally respectful, used by those most in need as well as how effective the services were regarding the promotion of good mental health and prevention of depression in the community as well as whether clients were able to manage their depression as a result of the services they received. The services' responses to depression in the period after July 2013, that include the one to one services presented in the last chapter and the community responses in this chapter are compared and rated against the key activities and service qualities of good mental health practice.

Table 7.1: Matrix of the PHC service response featuring comparative performance regarding key mechanisms of good mental health practice post July 2013.

PHC service	Aboriginal health service	Orange	Green	Blue
Responsive to community needs and priority populations	High level of need for treatment of depression, prevention of mental illness and promotion of mental health given the extent of the social determinants of health (in chapter 6) Restricted access– only focused on those with chronic physical conditions Health promotion /prevention programs no longer offered	High level of need for treatment of depression, prevention of mental illness and promotion of mental health given the extent of the social determinants of health (in chapter 6) Restricted access – only focused on those with chronic physical conditions Health promotion /prevention programs no longer offered	High level of need for treatment of depression, prevention of mental illness and promotion of mental health given the extent of the social determinants of health (chapter 6). Service sees clients with depression as a result of domestic violence issues, relationship breakdown, parenting stressors but threat of restricted access in future to focus on those with chronic physical conditions Restricted access – limited counselling sessions available to clients Health promotion /prevention programs no longer offered	High level of need for treatment of depression, prevention of mental illness and promotion of mental health given the extent of the social determinants of health (chapter 6). Still seeing clients with depression as a result of domestic violence issues, relationship breakdown, Parenting stressors but threat of restricted of access in future to focus on those with chronic physical conditions Health promotion /prevention programs no longer offered

Holistic	Multidisciplinary approach used by staff. Some help with addressing social determinants of health but reduced capacity due to the focus on chronic physical conditions	Multidisciplinary prior to policy changes. Reduced consideration of social determinants of health due to focus on chronic physical conditions	Reduced consideration of social determinants of health due to clinical focus. Reduced multidisciplinary approach	Reduced consideration of social determinants of health due to clinical focus Reduced multidisciplinary approach
Universal and used by those most in need	Those with 'only depression' marginalised, no transport provided, no home visits, therefore harder to access the service	Those with 'only depression' marginalised, no transport provided, no community development or outreach support provided to the community Service could only see those that could get themselves to the service	Staff no longer supported to provide outreach service to the community or community development work to encourage hard to reach groups into the service Service could only see those that could get themselves to the service	Staff no longer supported to provide outreach service to the community or community development work to encourage hard to reach groups into the service Service could only see those that could get themselves to the service
Effective	Improvements in physical health and reduction in smoking/alcohol among some clients evident from chapter 6. Reorientation of mental health care to Medicare Locals however the majority of clients did not feel comfortable attending this mainstream service and did not follow through with the referral for counselling Staff not supported to attend mainstream services with clients	Improved management of depression among clients (evident in chapter 6) Not effective in the promotion of good mental health or prevention of depression in the community as groups and community development work not possible	Improved management of depression among clients (evident in chapter 6) Possible reorientation of mental health care to Medicare Locals Not effective in the promotion of good mental health or prevention of depression in the community as groups and community development work not possible	Improved management of depression among clients (evident in chapter 6) Possible reorientation of mental health care to Medicare Locals Not effective in the promotion of good mental health or prevention of depression in the community as groups and community development work not possible

	Not effective in the promotion of good mental health or prevention of depression in the community as groups and community development work was not possible			
Culturally respectful	Considered culturally appropriate by clients accessing this service and staff working at the service	Unable to say, all clients tracked were Caucasian however an absence of culturally friendly posters, encouraging social inclusion. The building was very clinical and imposing with an exposed reception area	Unable to say, all clients tracked were Caucasian however an absence of culturally friendly posters, encouraging social inclusion. The building was very clinical and imposing with an exposed reception area	Unable to say, all clients tracked were Caucasian however an absence of culturally friendly posters encouraging social inclusion. The building was very clinical and imposing with an exposed reception area
Short term effects	The service is only responsive to those who are able to get to the service. Reduced service scope to help with the social determinants of health	The service is only responsive to those who are able to get to the service Reduced service scope to help with the social determinants of health	The service is only responsive to those who are able to get to the service Reduced service scope to help with the social determinants of health	The service is only responsive to those who are able to get to the service Reduced service scope to help with the social determinants of health
Long term consequences	Service lacks capacity to prevent depression in the community	Service lacks capacity to prevent depression in the community	Service lacks capacity to prevent depression in the community	Service lacks capacity to prevent depression in the community

For the majority of the service qualities the four PHC services performed poorly in their community response to depression. There was a focus on short term treatment for individuals at these services rather than a focus on achieving long term benefits for the community. A number of barriers were identified and overall, staff found it very difficult to identify any enabling factors that enhanced the way the services' responded. The Aboriginal health service is discussed first followed by the Orange, Green and Blue services.

7.2.1 Aboriginal health service

At the beginning of this study a CPHC approach that incorporates treatment as well as prevention, health promotion and acknowledgement of the complexity of the social and economic contexts that impact on clients' lives was much more evident at the Aboriginal health service. Although at the beginning of this study the service was not operating from a fully implemented CPHC model, it incorporated important aspects consistent with the Southgate Model that aimed to reduce depression in the community, promote greater health and wellbeing and contribute to greater health equity. The changes in the way the service responded to depression as a result of both the state government's response to the Review of Non-Hospital related services and the reduction in Close the Gap funding influenced client and staff views. Clients access to health promotion and support groups are discussed first followed by the extent to which the service considered their social determinants of health.

Health promotion and support groups

When this study commenced in 2011 the Aboriginal health service addressed participants' social isolation by encouraging community connection through health promotion and support groups such as Men's group/Women's group, community lunches, Tackling Tobacco group, and a Family Wellness group. All participants from the Aboriginal health service had attended two or more of these groups. They had positive experiences and felt supported and understood. For example:

> *'A lot of us at the Men's group are going through anxiety and depression, having a group to talk and hear other people's experiences is good. There is support and understanding for what each individual is*

> *going through. It is helpful to hear what others are going through'*
> Aaron (Aboriginal health service)

This gave them a chance to connect with family and friends and helped to reduce social isolation. For example:

> *'Just getting out more, going to different classes, weekend camps, it's helpful talking to others and good to see my family, cousins, nephews coming to groups and that. Go to the groups they help me with things that have come up – help me with a bill or housing trust'* Aaron (Aboriginal health service)

These groups played an important role in addressing depression in the community by giving clients a chance to share their feelings and experiences of depression with others. While the groups were operating, participants at the Aboriginal health service found they helped manage their depression and stress and in the absence of these groups they missed the opportunity to socialise and connect with the community.

Staff reported that clinical workload was prioritised over mental health prevention and promotion and there lacked a coordinated approach with a strategic plan.

> *"The barrier is the clinical need; it depends on the clinical workload. If I have a big clinical workload I won't be able to do the prevention or promotion work"*Mental health worker, Aboriginal health service

When the service restructured and funding cuts that occurred in July 2013 the only prevention and promotion work was with individual clients who had a chronic physical condition during one to one sessions. Examples provided were promoting healthy lifestyles, monitoring clients' mental state and trying to identify those at risk of depression early so that support could be put in place. This included help with financial distress or housing problems. A mental health worker estimated that only one fifth of their time was spent on health promotion and prevention work which they thought was inadequate and there was dissatisfaction among all mental health staff and general staff regarding these restrictions and the lack of groups available to offer the community. A mental health worker stated:

> *"Yeah, always more [mental health prevention and promotion] could be done, not satisfied with it, the system sucks".* Aboriginal mental health worker

When participants were asked what the health service could do to prevent people becoming depressed and what they could do to help those with depression in the community a theme that emerged was the tension between agency versus structure. As discussed in chapter 2, advocates of agency believe people have the capacity to choose their behaviour regardless of structural influences whereas a social determinants of health view tempers this by also seeing people's behaviour as being shaped by living circumstances, employment and socioeconomic status.

All participants at the Aboriginal health service thought an individual's agency was dependent on their ability to address their depression. They stated that people shouldn't feel embarrassed to talk, that they should be more open and not let pride get in the way. For example, Adam stated:

> *'They mustn't feel embarrassed to talk. That's the only way you're going*
> *to get sort of self-aware. Well the people are a bit frightened to talk*
> *about it, see, because when they talk about it they get more upset, so*
> *yeah, pride; yeah'*
>
> *Interviewer: 'What could the workers here do for them, then?'*
>
> *'Then it's up to that person, you know, just to take the next step'* Adam (Aboriginal health service)

Aaron also stated that people need to be more open:

> *'I don't know how they're going to help reduce it, it's just more people have got to be more open. They've got to talk about it, how they're depressed and stressed and all that. You talk to some other people and they don't want to hear it. Like saying, that's not their problem, it's not their issue, but at least here, like yeah, they sit down and they'll listen to you.* Aaron (Aboriginal health service)

Aaron explained that when he had opened up to others outside the health service he had not received a positive response; they did not want to know about his problems. At the Aboriginal health service though prior to July 2013, he felt listened to, signifying the importance of having someone to talk to and having his feelings acknowledged.

Alfred thought that there wasn't anything you could do to prevent depression:

> *'I don't think there's any way to prevent someone from getting depressed. But to handle it see I mean you can't look at someone and go "I've got to help that guy, he's going to get depression". Because you can't, you don't know when it's going to hit. It's only when it hits you that you suddenly realise; you know I've got a problem'.* Alfred (Aboriginal health service)

While participants thought it was largely up to an individual to address their depression, all participants thought that health promotion and support groups offered prior to July 2013 at the Aboriginal health service should be offered again as they helped with stress and the management of depression by connecting people with others in the community and provided an opportunity to discuss social issues that had arisen.

In the quote below, Alfred talks about his disappointment when these groups were defunded.

> *'The [groups] helped until I found out they weren't going to hire him [group leader] again. He could have helped and some pen-pusher in the government's got to cut it…and I'm thinking*

> *what for, if it works leave it. I don't know, some government people just don't consider how an Aboriginal people feels. When they started the groups it was totally different. More men came in to talk who were sad, they communicate with you. You can't go out there in that type of world as lot of them don't understand the cultural aspect of being Aboriginal'* Alfred, Aboriginal health service

The majority of clients reported greater social isolation as a result of these groups being defunded. The previous chapter revealed a lack of trust by Aboriginal clients of mainstream services. This quote highlights a lack of trust at a broader level with the government and the health system. This supports research by Ward and Coates (2006) who found mistrust constructed at both inter-personal and system-based levels within the community that lead to feelings of social exclusion.

An important aspect of the service prior to its restructure was the capacity of staff to help clients with social and economic factors impacting on their health. The next section will focus on how this approach changed over the period of this study.

Responding to the social determinants of health and community needs

Unique to CPHC is action on the social determinants of health through advocacy on issues that are risk factors for depression and intersectoral collaboration in order to improve health equity. Advocacy and cross-sector action can occur at a system level through policies that link different government sectors outside of health. Advocacy and action on social determinants among individuals to support their health in the context of their social circumstances was evident. Prior to policy changes five of the six participants practitioners helped with client's social determinants of health through individual advocacy. Workers advocated on behalf of clients regarding housing and/or financial assistance by attending meetings together or linking them with a support worker to help with financial distress. Alfred explained that sometimes the health service paid a portion of the bill and/or a payment system was organised where he could pay the amount gradually over time.

For Adam, workers negotiated payment of electricity and gas bills and attended housing trust appointments with him to help resolve issues. He stated:

> *'If we have to go and pay some bills or something, if the bill place is in the neighbourhood, they do that…..I had a housing trust appointment and they took me to the housing trust and that was one less problem I had.'*
>
> Adam (Aboriginal health service)

Help with social issues relieved stress and helped with the management of depression. These examples of advocacy reflect key principles of CPHC and although a health service can't directly address these social determinants of health, they can respond by advocating on behalf of clients for access to stable housing and utilities such as gas and electricity.

Staff considered the Aboriginal health service to be unique and one of the few culturally appropriate services that considered the health and wellbeing of the community by providing medical treatment, help with social and emotional needs and an understanding of the impact of social determinants of health. The two mental health staff acknowledged that being non-judgemental and having an understanding of Aboriginal culture and shared experiences were important areas that set the service apart from mainstream services. Key roles for the health service were providing acute health care to the community and an important aspect was providing social support for client's including help with housing, finances, income and food.

The role services played in facilitating clients' access to health and social services and supporting clients to navigate these systems was particularly evident at the Aboriginal health service. An approach that took into account the complexity of clients' lives was evident. Staff thought the service worked well with housing and social support services. Examples of advocacy included attending Centrelink with clients and assistance with application forms, and transport for clients to attend appointments (within the service and to other health and support services). In this way Aboriginal health workers acted as 'cultural brokers' with other health professionals, a finding also found in the NHMRC study (Freeman, et al., 2011).

All staff thought the service restructure would mean a focus on chronic physical conditions and there would be reduced capacity to help those without chronic conditions with social issues. An Aboriginal health worker noted:

> *"I don't think we'll be able to…no we've been asked to be clinically focussed, and the same with the community health workers you know, they can only do so much"* Aboriginal health worker, Aboriginal health service

Another general staff member stated:

> *"I don't know what's going to happen. But what we're told is that the stuff around drugs, alcohol, mental illness, family issues, child neglect is to be referred on to external agencies"* Aboriginal health worker, Aboriginal health service

As the service response narrowed and staff were restricted in their capacity to help with social factors, limitations were also placed on transport provided to clients. Again, only those with chronic physical conditions with an appointment at a medical service were eligible for transport and a requirement stipulated if clients missed the bus three times they were denied further access to transport. A worker explained the implications:

> *"The transport….there is no transport after one o'clock…and having to tell all the community that if they're not home when they're getting picked up for their appointment, that's one strike. Third strike they don't get any transport at all"*
> Aboriginal health worker, Aboriginal health service

A mental health worker elaborated on the implications:

> *"You have to have an appointment with the medical service and have a chronic disease to get transport. Now again, people who are disadvantaged they might find*

> *it hard to catch buses or they don't drive…and that lift got them straight to the dentist who is going to fix that problem for them. But it's been cut, and they just give up"* Aboriginal mental health worker, Aboriginal health service

The community need for transport and the lack of responsiveness on behalf of the health service posed a major barrier for many with depression that excluded them from accessing services.

Although the Aboriginal health service initially had a holistic approach that was responsive to community needs, during this study it appeared the service lost a lot of its flexibility in regards to clients with depression. The service was no longer able to reach out to clients to assist with social and economic issues or act as 'cultural brokers' with other health professionals. Table 7.1 below provides a summary of the barriers and enhancers to a community response to depression that were discussed in this section.

Table 7.2: Barriers and enhancers to a community response to depression at the Aboriginal health service

Barriers to responding to depression	**Enabling factors that enhance the response to depression**
Services were unable to provide programs that focused on prevention and promotion of good mental health because of South Australian health policy	Initially provision of prevention and health promotion that helped reduce social isolation providing community connection and support for mental health. Staff encouraged clients to attend these groups and community events such as NAIDOC week and provided transport that facilitated access
Reduced capacity to help with the social determinants of health, particularly for those with depression that didn't have a chronic physical condition	Initially had a holistic approach that considers the social determinants of health.
Restrictions to transport provided to clients	Services delivered that are culturally appropriate and respectful

Staff at the Orange, Green and Blue services reported similar restrictions and a narrowing of the response to depression. While these services are individual cases in this case study, they operated from similar models of service delivery and so are discussed together in the next section. Table 7.3 outlines the PHC service response at the Orange, Green and Blue services after the policy changes and compares key mechanisms of good mental health practice drawn from the Southgate Model.

7.2.2 Orange, Green and Blue services

The service delivery before the Review of Non-Hospital Based Services (McCann, 2012) is best captured at the Orange service given they started data collection earlier. There was a combination of one-to-one services and health promotion and support groups such as a cooking and nutrition program, an exercise group, diabetes education, mindfulness and lifestyle advice for clients at risk of chronic conditions. Client experiences and staff views regarding health promotion and support groups at the Orange service are discussed first followed by client experiences and staff views at the Green and Blue services.

Health promotion and support groups

Two participants at the Orange service discussed the benefit of listening to others experiences of depression and this influenced how they viewed their own health. For example, Emily who attended the Mindfulness group commented:

> *'Made me realise I'm not the only one that has these problems. There are other people out there and some of them are worse than I was, you know…it's made me think a lot clearer knowing the fact that there are other people that feel the same way as me'* Emily (Orange service)

Elaine had a similar experience to Emily in that she had been to a number of health promotion/support groups as well as one to one services. She found the groups encouraged her to get out of the house and connect with others in the community:

> *'I found it good because you meet other people and when you're with*

> *other people it takes your mind off yourself, and I think that's real good, yeah, very therapeutic'* Elaine (Orange service)

She initially used the Orange service for her physical health and was then referred to a number of other one-to-one services and health promotion/support groups for her physical and mental health. These experiences reflect key components of the Southgate Model in the balance of prevention, promotion and treatment, with practitioners referring clients to other services within the health service, demonstrating they were considering both physical and mental health.

Staff considered the provision of key characteristics such as one to one treatment and group and community work were important aspects of service delivery prior to July 2013. All mental health staff at the Blue service discussed the benefits for the community and the importance of community development work, supporting clients to attend groups at the service or externally and raising awareness about healthy lifestyles. Three mental health workers (Blue service) had been involved in working with the community to promote good mental health. For example, one worker described working with the local council and non-Government organisations and attending craft groups with clients where good mental health was promoted. Before July 2013 staff regarded the PHC services as the only ones delivering this style of service and when this health promotion work was ceased, staff were frustrated and disappointed at not being able to do this work.

As with the Aboriginal health service when the service response was restricted to treatment there were a number of shortcomings in how the service responded to depression. In addition to staff being restricted from group work and community development, management directed staff to be site-based and they were not allowed to make contact with those socially isolated in the community to increase awareness and encourage attendance at the health service. Therefore, there was insufficient access for those who were most vulnerable in the community. A social worker commented on the change in service delivery:

> *"In the past it was about prevention and there was more of a holistic approach*

> *whereas now it is more to do with hospital avoidance and the structures are probably going to be a lot more rigid focusing on certain diseases that we can offer services for rather than focusing on the general wellbeing of the community. The model is quite different now, there use to be different groups they were running, staff had a lot of opportunities to go out into the community but that's not happening"* Mental health worker, Orange service

All mental health staff thought there was a gap in the service response to depression at these PHC services.

> *"The group programs were a bit of a stepping point because people could come here for one-to-one sessions and then they could go to a group and it was quite a smallish step because they were coming here already"* Mental health worker, Blue service

A community development approach is a way a health service can help to provide 'a stepping point' to encourage disadvantaged people to use health services. For example, a community garden was provided by the Green service for those living with a mental illness. The garden provided many benefits to these clients such as socialising with others, learning about plants and how to grow and cook vegetables and importantly helped those coming to the garden to feel more comfortable with the service (Armstrong, 1994).

The Green service even went as far as restricting the availability of health promotion brochures in the rooms where they saw clients. Two mental health workers had been asked to keep rooms 'blank' so they could be hired out to other services and in the future there was a possibility that staff would need to relocate to another office while not consulting. The hiring out of consultation rooms to maximise income for the building had already occurred at the Blue service with negative reports from staff regarding a reduction in a multidisciplinary approach.

Four social workers at the Blue service struggled with only being able to offer one to one counselling following the model change and were questioning how effective their work was.

> *"It's much more clinical. I've been finding work a bit tricky at the moment and the conflict is in my ability to do good work. One of the things it's highlighted for me, because you know, I love group work and it's now only one to one work which is quite draining. Sometimes you don't get a lot of feedback like you do in a group…I think seeing one after another isn't very good practice really, so I struggle with that"* Mental health worker, Blue service

Research by Bell, Kulkarni and Dalton (1994) found that human service workers were less susceptible to burn out if they were provided with a range of roles such as community education, outreach, or advocacy for policy changes however; it was these roles that staff were no longer able to do, therefore potentially increasing staff chances of burnout at these services.

All mental health staff reported an emphasis on throughput at the Blue service. A social worker from this service noted that staff were monitored closely and had to see an increased number of clients a week, leaving little time for community development work:

> *"When you've got a diary full of clients, like I'm supposed to see 20 people in a week or let's say 15 people in a week, which is probably more realistic, there's not enough time to go out. And you know, I can easily see why people say, "Oh, no, I can't do that; I'll just cross that out and not go because I can't fit it in."* Mental health worker, Blue service

Staff missed the balance of work provided through group work and community development:

> *"I think one of the strong protective factors for preventing depression is that they are socially connected, rather than feel this sense of alienation and estrangement from their local community."* Mental health worker, Orange service

This comment acknowledges social isolation as a determinant of depression and highlights the important role PHC services could have in providing community connections for people to help prevent, manage or help with the recovery of depression. There is a significant gap that now exists within these PHC services in the promotion and prevention of mental health, community development and supporting clients to make connections in the community. A social worker at the Blue service emphasised that it was unrealistic to expect change to happen in clients without being able to support them to attend groups in the community.

> *"If I can't get out the door to go and meet with people or support them to attend a group, then it's a lot harder. It reinforces that expert model, come here, be fixed, go away and I'm the only one that can fix them. There a lot of pressure to fix them and send them off and it's just not realistic in terms of how change actually happens in my experience. It has to be based on what happens in the world and if we're not connected with what happens in the world, well what good are we?* Mental health worker, Blue service

A shift to a clinical 'expert' model was also evident at the Green and Orange services and neglects the consideration of a broader view of what is happening in people's lives, and lacks acknowledgement of the impact of social isolation and the importance in providing support to clients to attend groups in the community. This mental health worker described attending craft groups in the community with clients in their own time. It shows her commitment to CPHC principles. Clients' experiences of the PHC services helping with broader issues and advocating on their behalf is discussed in the next section along with staff views on the extent to which they were able to help with client's social determinants of health.

Responding to the social determinants of health and community needs

Another key principle unique to CPHC is contributing to greater health equity through action on the social determinants of health through advocacy and intersectoral collaboration and is an activity identified by health workers and shown in the Southgate model. Where advocating for clients was a feature at the Aboriginal health service for five of the six participants, at the Orange and Blue services there were no examples of such advocacy after July 2013.

Mia's experience of the Green service highlighted the importance of advocacy work and how it helped her family. There were two occasions when the service advocated on her behalf. One occasion involved liaising with a private psychologist to negotiate bulk billing for her children to access counselling for the domestic violence they had witnessed. Her children had attended the maximum 10 sessions with a psychologist that they could access through the Child and Adolescent Mental Health Service (CAMHS), after which Mia, a single mother of five children explained , they had to wait until the following year to access another 10 sessions as she couldn't afford to pay for further counselling. Mia was referred by the social worker at the Green service to a private psychologist for her children to receive counselling but described the financial barrier in accessing this service and how the social worker had negotiated for her to be bulk billed.

> *'It's expensive; you have to stop if you can't pay. I told my kids you have about 10 sessions and then you stop, next year you can have another 10, otherwise you have to pay. But she wrote down the name for a private psychologist and she said he would be perfect for your kids for anger management. But it's expensive, because I said to her its $85 an hour and I have five of them, so it's a lot of money. Only for people that are working, that have both the mother and father working, but if you're a single mum…..So [counsellor's name] she understands that, she talked to him, she said "leave it to me I will talk to them". They said to me I have to go to the doctor and get [a] referral from the doctor, a mental health plan, then that's fine. He said send them to him.'* Mia (Green service)

Mia also described being successful in her application for a larger house for her family since she started attending the health service. She explained that the service had helped her with this application by writing a support letter and that this had reduced her stress as the house was in a safer area. Mia was not new to the Green service and had been accessing the service for a much longer period of time compared to the other participants, perhaps reflecting a time when there was possibly more support for working to key principles of CPHC such as advocacy and intersectoral collaboration.

Mia’s experience was an exception and all mental health staff identified a change from looking at broader psychosocial issues to an emphasis on one to one treatment where they were based on site and were unable to reach those in the community who were most in need of their services. A social worker made the following comment:

> *“It’s [work on the social determinants of health] diminished is about all I can say because things around poverty, unemployment, lack of education, domestic violence, we don’t promote any of that, we don’t seek out those clients anymore…we use to go out and seek them out and organise programs, parenting programs for parents, get them involved in domestic violence groups, get them involved in some community development groups but now it’s around people with pre-existing diagnosis of chronic disease”* Mental health worker, Green service

Not only were the services not reaching out to community groups, there was the threat at the Green and Blue services that they would stop providing care for issues that may contribute to depression, such as domestic violence. It appears there was pressure to divert client’s care to other services operating in the community. For example:

> *“Well, you see they’re saying that a women with domestic violence can go straight to the domestic violence crisis service, they’re saying that someone that is suicidal can go to their doctor or can go to Lifeline or something…it’s all very ambiguous and up in the air at the moment”* Mental health worker, Green service

The Manager at the Green service confirmed they do very little work to address the social determinants of health and there had been a reduction in collaboration with sectors outside of health due to the focus on staff being based on site.

The client journeys highlighted that although there were links that brought participants into the Orange, Green and Blue services there was a lack of links and collaboration with services that connected participants to the community once they commenced treatment. Two participants (Orange service) were provided with suggestions to attend social groups and support services in the community such as help with food vouchers, a craft group and Legal Aid. However, others either had not been referred to any services or services were no longer operating due to funding uncertainty. Elise was looking for a social group but couldn't find any in the community.

> *'…and groups, there aren't many groups, I searched for things I'm interested in that you can join in, but yeah, – I couldn't find anything at the present that wasn't just sitting down and talking, just things I was interested in like Canasta where they do things like cards, you can't unless you go to the pub and play poker…Just to get out and mix, because once you feel like you're getting better it's well, what do I do now? Even [counsellor's name] got on the computer to try and find out what was going on around, and there isn't anything'.*
>
> Elise (Orange service)

Elise highlights the importance of accessing a social group to help recover from depression but was unable to find a group. A key component of CPHC service delivery is to help facilitate clients' access to other health care and social support services but Elise's quote shows the limited availability of these groups made worse by. SA Health policies.

The absence of links to services outside the health services was even more evident at the Green and Blue services. Two of the three participants at the Blue service and six of the seven participants at the Green service reported not being linked into services in the community. An exception was Natalie (Blue service) who was referred and attended a parenting group at another health service. Two participants were trying to find networks in the community to support them. Matthew who was dyslexic reported the Green service had not made any suggestions or referrals to other services in the community and this was something he was organising himself. He found a community-based support group to help people recover from mental illness. This group didn't seem suitable which is evident in the quote below:

> *‘I joined this Monday I did my first meeting at [Name of group]. I’m not sure how I’ll go there because it’s very structured and it’s all done from a book….I know I’m going to struggle trying to read it and they ask you questions from it and that’s when I’ll freak….That’s there because I need to try and get in place some people that I can say “would you like to go for a walk to [Suburb] and go and have a coffee or something”. There’re the things I’m desperately now trying to find. Some networks so that I can function outside of the house’* Matthew (Green service)

The lack of connection to other services seems unusual for a PHC service where you would expect a highly networked service providing a range of support from one-to-one treatment to health promotion groups. An important role for practitioners is to facilitate clients’ access to other health services by linking clients into services provided by other local providers in the community to best meet the needs of their clients. This suggests the services were not fulfilling this aspect of the Southgate Model.

Mental health and general staff saw a role in helping clients to improve social connectedness but staff found it difficult to maintain links with other services to refer clients to in order to improve their social support. A difficulty for staff with the change to a more clinical model was the difficulty maintaining relationships and links with other community services. Such links are important in making referrals for clients to attend community groups and to keep up to date with programs operating. However, adding to this, mental health workers emphasised that services in the community that offered groups often lacked a planned approach and described these groups as “sporadic” and “haphazard”.

> *“Usually different agencies have different programs more or less once a term but you know, also different priorities emerge and other things die away over time as well. So things have fashions, you know, there's the fashion for gardening programs and the fashion for cake decorating has come and gone but you can’t keep up to date with this if you don’t go out.”* Mental health worker, Blue service

The loss of community groups such as the Community Foodies program, Start Right Eat

Right program, and Obesity Prevention & Lifestyle program (OPAL) discussed in chapter 4 resulted in many community groups ceasing to operate, adding to the difficulty for staff to find groups to refer their clients to and may explain why many of the client journeys from the Orange, Green and Blue services lacked links to other services. A mental health worker from the Orange service confirmed they were trying to work out what support services were available in the community to refer clients.

One social worker at the Blue service noted that the relationships developed with practitioners from other services are important in providing *‘a net that hold clients’*. These links are important to make access to PHC services easier for clients with depression and was a common theme that mental health workers and client’s felt was needed. One social worker at the Blue service had many years’ experience working with services in the community and local government which helped to maintain links with these services. Three mental health workers (Blue and Green service) argued the need to go out and be known in the community otherwise they weren’t able to reach those most in need who were often isolated and lacked resources. Clients also felt that greater exposure was required by PHC services to educate the community as to what services were available and who could access them.

An overarching theme among all participants at the Green, Orange and Blue services was the need for these services to have greater exposure and improved communication with local communities to ensure that people knew what services were available and how they could be accessed. Participants felt the services were not known in the community. For example Elise stated the following:

> ‘*Well a lot of people I talk to don’t even know they do counselling here and it’s really hard to find a good counsellor… You don’t get told about them at the GP, it’s when you go over that someone will actually tell you what’s available out there. I didn’t find out about counsellors till I had a breakdown and saw a psychiatrist and I didn’t know there were people out there you could go and just talk to.’* Elise (Orange service)

Elise wasn't aware that counselling was offered at the Orange service and reported that it wasn't until she was in crisis that she found out she could access counselling services. In order to prevent depression in the community Elise thought GPs needed to play a role in recommending people speak to a counsellor earlier in their treatment rather than a referral to a psychiatrist when they are struggling to cope. She stated:

> *'I've seen quite a few doctors, different doctors and nobody's-- they wait till you can't cope and then send you to a psychiatrist where there's no need to go that far if you can talk about it'*. Elise (Orange service)

The Better Access program described earlier encourages GPs to refer to psychologists and psychiatrists. Elise's comment reflects the need for some GPs to take a proactive approach in considering the mental health of their clients.

Eloise commented that the service needs to be promoted so it is accessible to the community, particularly for those who can't afford to see a private psychiatrist:

> *I didn't know that this was here until someone at the [local hospital] told me about it so maybe it could be broadcast more. People should be made aware of what services are actually there for people who can't afford to spend $50 a visit at a psychiatrist's office because there'd be a lot of them and they just don't know, they're not made aware. And they don't know what questions to ask, so I think there should be more information in doctors' surgeries, maternity waiting rooms and things like that where people could find out about the service, but I never see any information around'* Eloise (Orange service)

Nicole thought the Blue service needed to be more transparent with the community to let people know there is counselling available:

> ‘*I think being more open and letting the community know that this service is available. I didn't know it was available…..It seems to be very hidden. I came across it through word of mouth, and so I think if people knew that the service was here, then it would be better utilised. It may be that they don't want it to be better utilised, because they don't want to fund it, I don't know. So that may be a strategic thing that they're doing’* Nicole (Blue service)

A CPHC service should be accessible to all in the community but this was not the case as there was a creaming or selection of individuals with chronic disease (at the Orange and Aboriginal health service) that have to capacity to get themselves to these health services.. Participants were not aware these services existed, there were no outreach services and they felt they had to be in crisis before they received any information and help. These barriers, summarised in table 7.2 make these services inaccessible to many in the community, particularly vulnerable people who are socially isolated and have limited resources.

Table 7.3: Barriers and enhancers to the service response to depression at the Orange, Green and Blue services

Barriers to responding to depression in the community	**Enabling factors that enhance the response to depression in the community**
SA Health no longer funded mental health prevention and promotion programs. Staff were not able to undertake broader advocacy work	Prior to July 2013 a range of health promotion/support groups were successful in helping people with depression
Services were unable to advertise or promote the service to the community	Staff commitment to CPHC principles
Lack of consideration of SDH, no outreach support provided to the community to encourage those most disadvantaged to attend the health service, no transported provided to clients	Staff with extensive experience in community development and links with other services
Direction from management that staff increase the number of clients they see a week. Staff unable to maintain links with other services in the community Clients are sourced from other health providers rather than the service being a primary access point themselves	Prior to July 2013, staff were involved in providing outreach support to the community such as talking to groups about domestic violence, healthy eating etc. The PHC services remained free for clients to access

7.3 Conclusion

This chapter has provided an analysis of client experiences and staff perspectives and reflections on the services’ community level response to depression highlighting considerable barriers in this response. The only positive result was the culturally respectful approach taken at the Aboriginal health service where clients felt comfortable and did not feel discriminated against. The community response to depression was inadequate given the lack of health promotion groups and the restrictions placed on staff in regards to remaining on site. The services were only accessible to those who had the means to get to the services. The services did not have capacity to reach out to those vulnerable groups that lack capacity to make it to these health services. This helps to explain why there was improved management of depression among clients at the Orange, Green and Blue services (evident in chapter 6) as these services had a more treatment focused approach offering counselling. After policy changes at the Aboriginal health service, a responsive flexible approach to depression was no longer evident. Home visits were no longer provided and transport was reduced to those with a chronic physical condition. The loss of health promotion and support groups offered through these services meant a community response to the prevention of depression was no longer possible. . There was restricted access for those with chronic physical conditions at the Orange service and treatment of chronic physical conditions was prioritised over mental health at the Aboriginal health service. There was the threat of this trend occurring at the Blue and Green services, indicating a shift of mental health services to Medicare Locals and other parallel services operating in the health system signifying that the state government is retreating from mental health service provision within its primary health care services.

CHAPTER 8: OPPORTUNITIES AND BARRIERS TO INDIVIDUAL AND COMMUNITY EMPOWERMENT IN A CPHC MODEL OF SERVICE DELIVERY

8.1 Introduction

The concept of empowerment, a particular focus of this thesis and the extent to which it featured in service delivery forms the focus of this chapter. Through a critical exploration of power, the chapter considers the links between clients' experiences of empowerment and processes of empowerment and disempowerment and staff views and reflections about how this concept featured in their work.

Power is considered here in a multi-level framework utilising Labonte's (1992) Empowerment Continuum (figure 8.1) where empowerment is seen as a dynamic process occurring along a continuum. Within this continuum supporting individuals' power and changes in power relations between different social groups can develop into more structured forms of social and collective action.

As explained in chapter 2, changes in power can occur among individuals, referred to as micro empowerment, and community or macro empowerment. This chapter seeks to reveal the opportunities for, and the barriers to, individual and community empowerment at these services in relation to mental health. The chapter begins by examining micro empowerment represented on Labonte's continuum as individual empowerment and small group development. The discussion then turns to macro empowerment that includes political action, coalition advocacy and community organisation. Small group development is also briefly discussed in the context of macro empowerment, as it can be a precursor to community organisation, coalition advocacy and political action.

Figure 8.1: The Empowerment Continuum (Labonte, 1992)

Removed due to copyright restrictions

See Labonte,R. (1992). Heart health inequalities in Canada: Models, theory and planning. *Health Promotion International 7*(2), 119-127. doi: 10.1093/heapro/7.2.119

8.2 Micro levels of empowerment

Micro levels of empowerment include individual empowerment and small group development. In the context of Labonte's continuum, the empowering work that CPHC services undertake begins with the individual through personal empowerment. Power is facilitated through developmental casework, enhancing personal perceptions of control and power and increased self-esteem. Individual empowerment may be a necessary precursor to collective empowerment, because clients with depression who feel little self-worth may be unlikely to have the confidence to contribute to collective action until they realise their ability to make a positive impact. The counselling provided at these PHC services had the potential to contribute significantly towards community organising and coalition advocacy (Baum, 2016). If the PHC services in this study were working to Labonte's continuum, while clients with depression were receiving counselling, they also would be actively participating at these services and attending a number of groups. However, staff had limited capacity to work to other forms of empowerment up the continuum and focused only on the individual. There were only two processes that enabled empowerment for clients, while there were many disempowering practices evident at these services.

The following section provides an analysis of individual processes and experiences of empowerment by clients incorporating both client experiences and staff views and reflections on how empowerment featured in their practice. The analysis begins with results from the Patient Enablement Instrument (PEI) used to investigate client's levels of empowerment. Following this, physical structural barriers evident at the Orange, Green and Blue services and staff disempowerment in relation to pursuing more structured forms of social and collective action are considered.

8.2.1 Client experiences of personal empowerment

Clients' levels of empowerment in relation to the services they accessed for depression at the start and end of their use of the health service was investigated using the PEI adapted from (Howie, et al., 1998). Clients were given this short questionnaire on two occasions; at the initial interview which refers to Time 1 and six months later, which refers to Time 2 (table 8.1). Twelve out of the 21 clients interviewed completed both the Time 1 and Time 2 questions. The table shows that clients from all services felt able to cope with life much better, had greater understanding of their depression, were able to cope with their depression and felt more confident about their health. There was no significant difference between time 1 and time 2 regarding clients ability to cope with life, understand their depression, cope with depression, ability to keep healthy and ability to help themselves. However, clients' confidence about their health was significantly improved from time 1 to time 2 (Wilcoxon Signed Ranks Test Z = -2.00, p=0.046).

Table 8.1: Percentage of clients more able to manage their depression at Time 1 and Time 2 at the four PHC services

"As a result of the care at this service do you feel you are…."	**Much better**		**Better**		**Same or less**	
	Time 1	**Time 2**	**Time 1**	**Time 2**	**Time 1**	**Time 2**
Able to cope with life						
Aboriginal Health Service	1 (20%)	1 (17%)	2 (40%)	3 (50%)	2 (40%)	2 (33%)
Orange Service	3 (100%)	5 (100%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Green Service	2 (100%)	6 (86%)	0 (0%)	1 (14%)	0 (0%)	0 (0%)
Blue service	2 (100%)	1 (33%)	0 (0%)	1 (33%)	0 (0%)	1 (33%)
Understand your depression						
Aboriginal Health Service	1 (20%)	3 (50%)	2 (40%)	3 (50%)	2 (40%)	0% (0%)
Orange Service	2 (67%)	4 (80%)	1 (33%)	1 (20%)	0 (0%)	0 (0%)
Green Service	2 (100%)	7 (100%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Blue service	1 (50%)	1 (33%)	1 (50%)	2 (67%)	0 (0%)	0 (0%)
Cope with your depression						
Aboriginal Health Service	1 (20%)	2 (33%)	2 (40%)	0 (0%)	2 (40%)	4 (67%)
Orange Service	3 (100%)	4 (80%)	0 (0%)	1 (20%)	0 (0%)	0(0%)
Green Service	1 (50%)	5 (71%)	1 (50%)	2 (29%)	0 (0%)	0 (0%)
Blue service	2 (100 %)	2 (67%)	0 (0%)	0 (0%)	0 (0%)	1 (33%)

Able to keep yourself healthy Aboriginal Health Service Orange Service Green Service Blue service	2 (40%) 2 (67%) 1 (50%) 0 (0%)	0 (0%) 4 (80%) 5 (71%) 0 (0%)	2 (40%) 1 (33%) 1 (50%) 1 (50%)	2 (33%) 1 (20%) 2 (29%) 3 (100%)	1 (20%) 0 (0%) 0 (0%) 1 (50%)	4 (67%) 0 (0%) 0 (0%) 0 (0%)
	Much more		More		Same or less	
Confident about your health Aboriginal Health Service Orange Service Green Service Blue service	0 (0%) 2 (67%) 1 (50%) 0 (0%)	2 (33%) 3 (60%) 6 (86%) 1 (33%)	5 (100%) 1 (33%0 1 (50%) 1 (50%)	3 (50%) 2 (40%) 1 (14%) 2 (67%)	0 (0%) 0 (0%) 0 (0%) 1 (50%)	1 (17%) 0 (0%) 0 (0%) 0 (0%)
Able to help yourself Aboriginal Health Service Orange Service Green Service Blue service	2 (40%) 3(100%) 1 (50%) 1 (50%)	2 (33%) 5 (100%) 5 (71%) 2 (67%)	2 (40%) 0 (0%) 1 (50%) 0 (0%)	3 (50%) 0 (0%) 2 (29%) 0 (0%)	1 (20%) 0 (0%) 0 (0%) 1 (50%)	1 (17%) 0 (0%) 0 (0%) 1 (33%)

These results should be treated with caution given the low number of clients completing time 1 and time 2 and the lack of a control group. Only one of the six tests yielded a significant difference, which may be the result of familywise error – a Bonferroni adjusted result would not be significant. This measure is also limited as it only gives an indication of client’s level of empowerment regarding the management of their depression on a particular day. In addition, it was not possible to say whether they may have got better in any case in the absence of a control group. Despite these limitations, this measure was a useful way of facilitating discussion with clients to understand their experiences of PHC service delivery.

As seen from chapter 6, six clients from across the Orange, Green and Blue services had recovered and all 13 reported improved management of their depression. Eight clients from the Orange, Green and Blue service had more self-confidence and self-esteem and described being more assertive. Staff at all four PHC services played a role in supporting clients’ personal empowerment through the management of depression in ways that enhanced their perceptions of control and power and through increasing their client's self-confidence and self-esteem. The following section provides an analysis of how individual processes of empowerment played out among the PHC services.

8.2.2 Processes of individual empowerment

Among the four PHC services there were a number of processes of individual empowerment. Potentially empowering strategies found at the micro level were: choice with goal setting, some participation in decision making regarding treatment activities, and self-help groups, such as health promotion and support groups that were available to those clients who used the service before July 2013. Staff incorporated these strategies into their work through developmental casework, a component of personal empowerment in Labonte's continuum. Clients received counselling for depression and prior to July 2013, some attended health promotion/support groups. Through counselling, clients' depression was tackled through the use of cognitive behavioural therapy (CBT), mindfulness, and acceptance and commitment therapy (ACT). These forms of therapy were used as they are developmental, skills-based models that seek to empower individuals (Halperin, Nathan, Drummond, & Castle, 2000; Hayes, Pistorello, & Levin, 2012) to manage their depression and promote recovery. As discussed in chapter 5, best practice guidelines recommend mild to moderate depression is treated through therapeutic counselling and psychotherapy (eight to twelve sessions) that is provided for 12 weeks in the first instance (Clarke, 2011; Ellis & Smith, 2002).

Working in partnership with clients and using therapies such as CBT, mindfulness and ACT assisted clients to feel empowered at the Orange, Green and Blue services:

> *"Using cognitive behavioural therapy or mindfulness….the client is actively involved so it's a collaborative form of therapy really which is kind of empowering in itself so I would look at myself as being a coach, coaching clients how to do it, so if they continue to use it, it gives them ongoing ability to make changes in their lives"* Mental health worker 4, Blue service

At two services (Green and Blue) there was a partnership approach where clients contributed to deciding the focus of the sessions. Three clients (two from the Green service and one from the Blue service) were involved in deciding the focus of sessions which enhanced their perception of personal control. Maggie provided an example:

> *"She'd say "Next week we can talk about this or next week we can talk about that and what do you want to focus on next week?" It would be my choice about what we wanted to focus on next week"* Maggie (Green service)

Margaret had a similar experience where she had a choice of what goals she wanted to discuss:

> *"The other thing she did that I really appreciated was she would ask me what had happened in the last week and I would be able to self-direct some of those sessions rather than me going in there and she's got an agenda. That was fantastic because then I could address the things that I'd been going over in my mind which were my goals"* Margaret (Green service)

Natalie (Blue service) also had a similar experience in being able to direct what was discussed during counselling sessions. This was different to her experience with psychologists she had seen in the past.

> *"She let me direct where I wanted things to go. I've seen psychologists in the past and they say "right, well let's start from here". But she let me direct what things I needed to deal with which was really helpful. She also let me guide sessions around what I felt I needed to be dealing with so it wasn't like previous counselling I've had in past years where the counsellor wanted to guide everything. It was 50/50, if I wasn't comfortable with something then [counsellor's name] wouldn't push it".*
> Natalie (Blue service)

These quotes suggest that this partnership approach enhanced personal perceptions of power and control, as seen in Labonte’s continuum. Clients contributed to deciding on the focus of sessions and goal setting. This gave them influence and personal control and practitioners appeared to be facilitating empowerment. This is an example of “power with” (Labonte, 1994) occurring as there may have been a small transfer of power to these clients.

At the Orange service, a supportive relationship with clients assisted them to feel more empowered. For example:

> *“I just think having a supportive relationship makes a huge difference to people. If they genuinely feel that someone takes an interest in them and cares about them, then I think they’re more inclined to take those steps to feeling more empowered in their lives”* Mental health worker, Orange service

This mental health worker acknowledged that part of this supportive role involved providing information to help clients navigate health systems and empower clients to make positive connections with other health service providers. Staff from the other services didn’t mention the potential role they played in helping clients navigate the health system. It is unknown if this was a feature across the Orange service as this worker was the only full time mental health worker interviewed. There were three other part time workers, all of whom declined to participate.

Only two mental health workers from the Blue service discussed encouraging social connection through support groups in the community to enhance individual empowerment. An important part of encouraging social connection for one worker was accompanying clients to these groups to help facilitate access. However, this was restricted by the directive to remain on site. This had a large impact on how they worked with clients and limited their ability to facilitate empowerment.

Staff from the four PHC services had an awareness of the power differentials that exist between clients and staff. Here a mental health worker acknowledges the power difference.

> *"There are therapists who say there's no power difference. I think that's a load of rubbish, because I think there's always a power difference. The mere fact that someone is coming to us for help is a difference in power because they're coming to someone that they deem has more knowledge and more experience….- that's what I've been trained to do. It doesn't mean that I'm better than them or more worthy than them, it just means in this particular aspect I've got more experience and knowledge. And you know, it's about accepting that and knowing that…it's about being aware of our own values, and not imposing those on our clients".* Mental health worker 1, Green service

Staff identified ways where clients were actively involved in their treatment and passive roles, where staff took a more direct approach. This direct approach often occurred at the Aboriginal health service where staff felt they had a monitoring role and took a 'problem solving' rather than a 'problem posing' approach. This is discussed in more detail below. The Orange, Green and Blue services are discussed first, followed by the Aboriginal health service.

At the Orange, Green and Blue services empowerment was limited to personal empowerment, shown on the left side of Labonte's continuum by improving client's sense of control through personal growth, assertiveness and increased self-confidence. Most staff identified client empowerment as being central in their work and that an expert approach, where the practitioner is the 'dominant expert' and the client is the 'passive patient' was not a model they were comfortable with.

Clients were encouraged to have an active role in identifying problems and coming up with possible solutions. Staff noted that sometimes it was difficult for clients to clarify what they needed and wanted out of counselling or struggled to identify possible solutions to problems. Staff tried to overcome this by suggesting options and inviting the client's opinion.

> *"If people are feeling very stuck and not able to name what the causes might be about, then it's the always about inviting opinion. If you are suggesting some options, not telling somebody what their issues are - so it still might be some practitioner contribution, but it's always presented in a way that "Could it be such and such?"* Mental health staff, Orange service

Offering and discussing options with clients was a way of facilitating empowering practice at these services. The approach taken at the Aboriginal health service was different and is discussed below.

8.2.3 Aboriginal empowerment

Empowerment for Aboriginal client's needs to be considered within the broader context of transgenerational powerlessness through colonisation, racism, social isolation and discrimination experienced in mainstream health care and social services. To respond to these experiences community-controlled health services have been established to give Aboriginal people a political voice and control over resources through community action and mobilisation (Anderson, 2007). While the Aboriginal health service is not a community-controlled service, it was established to counteract these broader experiences of powerlessness and to give the Aboriginal community access to health services where they feel their culture is respected.

Consistent with the Orange, Green and Blue services, the Aboriginal health service also had an individual focus on empowerment that focused on enhancing personal perceptions of control and power and improving client's self esteem , however there was an information-giving rather than self-empowerment approach as there were no counsellors based at the health service and no health promotion and support groups (after July 2013). The approach focused on providing information with the belief that this information would help clients and lead to behaviour change. While giving information is not disempowering in itself, it is when not linked to activities further along Labonte's continuum, an approach that builds towards community organising and coalition advocacy (Labonte, 1994). Organisational barriers prevented staff from acting on a broader conception of empowerment. For example, as service delivery narrowed in focus, the service withdrew from community events that may have facilitated community empowerment to the right of the continuum. Staff reported they were prevented from being able to run NAIDOC celebrations, organise camps and other reconciliation events as they had done in previous years due to a lack of time because of the redirection in service delivery to chronic physical conditions. This approach represents a major divergence from original perspectives on empowerment and key principles forming the basis of CPHC such as the importance of participation in health services, and a failure to consider the broader social and economic conditions impacting on individual's lives (De Vos et al., 2009; World Health Organisation, 1978). While the client journeys captured how the Aboriginal health service helped clients with social and economic factors such as housing and other support services, staff reported in interviews that were conducted six months later that service changes since had limited the extent they could now help with these issues.

There were different views on empowerment among staff at the Aboriginal health service and one staff member had a more directed approach compared to other staff at the service. Empowerment featured in his work in the following way:

> *"Just setting them up with things to do like getting their own medication, appointments, hoping they'll follow it through, talking them into treatment or whatever and that's empowering them to do that"* Aboriginal health worker, Aboriginal health service

This represents a more directed way of working with clients. This worker considered staff had a role in monitoring clients and checking up with them to see whether they had attended medical or counselling appointments and to remind them of appointments and confirm transport had been organised for the following day. For example:

> *"We just monitor, make sure they're following through with their dietician and counselling appointments"* Aboriginal mental health worker, Aboriginal health service

One perspective may be that staff checking in with clients may serve to diminish client control and promote ‘dependency’. Dependency is associated with disempowerment in the literature (Gibson, 1991; Lawn, Delany, Sweet, Battersby, & Skinner, 2013) and is used to describe how control is ‘played out’ during practitioner-client interactions. Dependency is a consequence of practitioners unintentionally exerting “power over” clients by controlling decisions that influence their lives and health (Lawn, et al., 2013). Alternatively, in considering the lived experience of Aboriginal people which includes racism and discrimination, a more direct approach taken by staff through checking in with clients through home visits and reminder calls was a way of providing assistance through structure and consistency. This approach was reported as encouraging improved management of clients’ health and helped to enhance individual control and power, a key component of personal empowerment in the continuum.

Another mental health worker reported empowerment was supported through clients developing independence, indicating a different approach:

> *“Just being aware of who’s responsible for what and identifying the stages of ill health and returning to good health. Not the fact that I’m everything for the client and just giving them the responsibility for their own health care and their own goals and obtaining those goals. Giving them some direction or some assistance in obtaining those goals but they’ve got to be the ones to do it, so identifying that all the way along”* Mental health worker, Aboriginal health service

Staff saw they had a role in helping clients identify problems and discuss solutions:

> *“They identify the problem and then we discuss solutions and ways of getting around those solutions and they will take what they want out of that conversation”* Mental health worker, Aboriginal health service

This way of working is consistent with the approach taken at the Orange and Green services of offering choices which contribute to them feeling more empowered. However, it represents a slightly more direct way of helping clients than that used at the Orange, Green and Blue services and is consistent with a directive approach where the practitioner ‘acts prescriptively, directing the behaviour of the patient wanting help’ (Fallowfield, 1988, p. 727).

There were different views among staff regarding this directed approach (as staff referred to it in interviews) shown in the two quotes below. The first quote is about a direct approach used in counselling sessions, whereas the second is about having a directed approach to encourage a client to go to a support group offered in the community.

At the Green service a mental health worker disagreed with this directed approach:

> *“I actually really disagree with directed counselling. So that’s not something I would do, and if I felt I was moving towards that, I would be having to stand back and look at my practice because for me it’s all about posing the questions to get them to explore and come to their own conclusions”* Mental health worker, Green service

At the Blue service a mental health worker noted that having a directed approach was sometimes needed to encourage clients to engage with different ideas. Thus they said:

> *“With one of my clients she didn’t actually see herself as depressed, whereas I actually thought she was very depressed but she wouldn’t engage with that idea at all. So maybe being a bit pushier with her in terms of, “Okay, well you know, go and try this support group and see what you think, and go and see what can happen when you get there, and you know nothing will change unless you make some sort of attempt to do that,” so maybe getting a little bit pushier and saying, “The first thing I’ll do next time we meet is ask you about what happened when you were there and how you felt afterwards”* Mental health worker, Blue service

This quote indicates the fine line between workers being encouraging and being too direct, when power-over occurs between the practitioner imposing ideas on clients who may struggle to attend support groups on their own. Labonte (1994) describes empowering practice as respecting the autonomy of the client, being culturally sensitive and giving consideration to the clients’ psychosocial and socio-environmental contexts. Any individual empowerment achieved at a personal level was overshadowed by processes of disempowerment and lack of control as a result of organisational structures and policies. This is discussed in the following section on processes of disempowerment.

8.2.4 Client experiences and processes of disempowerment

There were many processes of disempowerment within the PHC services despite staff efforts to empower clients. These processes of disempowerment are summarised in table 8.3 and client experiences of disempowerment and staff perspectives are discussed below. These processes are considered within the broader context of the health reforms occurring during this study.

Table 8.2: Disempowering processes among the health services

Disempowering processes
Restricted access to counselling appointments
Lack of access to health promotion and support groups
Transport and delivery of medication withdrawn (Aboriginal health service)
Shift to physical health focus - disease specific view of health excluded clients with mental illness
Waiting list- lack of communication with clients regarding when they will receive a service

While staff discussed the aim of empowering clients, their limited capacity was largely the result of organisational changes that served to restrict access to services and resources that would facilitate recovery.

The restricted access to counselling for clients at the Green service after July 2013 resulted in considerable uncertainty for clients, constraining clients’ choice and control. This restriction was not made clear to clients from the start and they could access the service in the future:

> *"It [limited number of sessions] just come up in conversation the last time we were talking, it was not made clear from the start. We were looking at booking a counselling session in and she was saying "Oh generally people have six to eight sessions and I remember thinking six to eight sessions is not really that much. I was happy to finish up but I think for some people it might be very frightening and could almost be a trigger to make some people more stressed out"* Marlene, Green service

Three clients at this service were distressed at being told that they could only access one or two more sessions and the perception of counselling services being 'pulled away" was a common statement among these clients.

> *"If you have six to eight counselling sessions and they say "that's all we are allowed to give you and we've given you the tools and you're alright now" it feels like something has been pulled away from you. Maybe if in a year's time and I'm in a similar place would I be able to ring and recontact the service?"* Margot, Green service

The restricted access to counselling served to constrain clients' choice and control and was a process that was disempowering for clients. The time pressure at this service had significant impact on the way staff worked with clients and their expectations for change. Browne et al (2012, p. 70) makes the point that 'working with populations whose health is so closely linked with social and economic conditions can seem slow or stagnant with respect to improvements in short and long term outcomes'. The social worker acknowledges in the quote below that the client needs long term counselling that they are not able to provide.

> *"This client has gained insight into her thinking but there is no movement in reframing and using mindfulness strategies, there is no perceptual change. This client needs long-term counselling and I can't offer this"* (Client journey) Mental health worker, Green service

However, in the quote below the client is described as “unresponsive” and not completely successful at achieving goals.

> *“Sessions have gone okay, but client is unresponsive to change, she wants her life to change but doesn’t want to do anything to change it”* Mental health worker, Green service

Under the time pressure of six to eight sessions it is unrealistic there would be enough time for clients to have progressed. Prior to July 2013 the service had been able to provide long term counselling and this organisational change failed to recognise the broader contexts influencing clients’ lives. In comparison, acknowledgement of social and economic factors were identified by a social worker at the Orange service who reported it was hard for clients to focus on specific issues when there was so many other factors impacting on their lives. This mental health worker stated the following:

> *“So often clients will be in a state of crisis or facing severe financial issues or homelessness and that undoubtedly impacts a lot on their capacity to manage their health issues, as well as engage meaningfully in a therapeutic process. Also transport and accessibility and not having enough money to catch a bus or having to weigh up whether they can afford their medications or go without food. So sometimes it’s either or, rather than both”* Mental health worker, Orange service

A social model of health where there is a focus on recovery of mental illness involves helping clients reclaim ‘aspects of ordinary life such as decent housing or employment opportunities’(Tew, 2005, p. 26). Supporting clients in this way contributes to personal empowerment and enhances individual perceptions of control as shown in the first dimension of Labonte’s continuum. However, as described earlier staff were restricted from providing this help and the Orange, Green and Blue services did not facilitate transport to attend health appointments like the Aboriginal health service did before the policy changes.

When health promotion and support groups ceased clients lacked an opportunity to access resources that would help with the recovery of depression and facilitate empowerment through improving social support and reducing social isolation. The manager at the Green service reflected on the benefits of the previous community garden project for individuals living in supported residential facilities.

> *"We did make a huge quality of life difference to those people who participated [in the community garden] and they've actually got very, very low quality of life and probably for lots of people participating in that garden was their social life. It was probably the only time that anyone really took an interest in them and that they actually got a decent meal and maybe had some fun"* Manager, Green service

When prevention programs such as the *'Do it For Life'* (DIFL) program ceased Eloise expressed disappointment at only being able to access three months of support rather than the six to 12 months she would have otherwise been entitled to. She stated the following:

> *"I'm a little bit disappointed they're taking [counsellors name] away because the DIFL program is ending in July. My support has been crammed into a few months and I'm a little bit disappointed with that but what I've learnt from here I think I'm on the right path but I think I would have liked to have stuck with her for the 12 months, but that option's taken away"* Eloise, Orange service

Likewise, at the Aboriginal health service clients lacked control over the cessation of promotion and prevention programs. The South Australian Government's decision to stop funding the Tackling Tobacco program was seen by clients as culturally insensitive, compromising personal empowerment through a lack of access to social connectedness activities.

Key components of empowering practice involve services being delivered in a supportive, non-controlling way (Labonte, 1994). The lack of groups represents a key component that is missing in regard to the services' ability to empower their clients. Labonte (1992) argues personal empowerment must be linked to the other four dimensions of empowerment along the continuum but there was no evidence of this in the case study services. The focus on one to one care meant individualism was the dominant paradigm after July 2013 and was a way the organisational power of these PHC services had the power to restrict access to valuable resources that would help in the recovery of depression.

At the Aboriginal health service the loss of a flexible approach facilitated client disempowerment. Examples are discussed below. For example after July 2013 the provision of transport discussed in the previous chapter was restricted to only those with a chronic physical condition. Staff were no longer able to use the vehicle described in the quote above. This served to exclude clients experiencing mental health problems, and treated mental health as a lesser priority than chronic physical conditions. Additionally, for those meeting this criteria, a new policy commenced stipulating if clients missed the bus three times they were denied further access. An Aboriginal health worker made the following comment:

> *"The government, it's like they're using our service now and treating our clients as numbers. You know they're not people. That's how I'm starting to feel sometimes……it's how they're putting it upon us that now we're treating our clients as numbers. Get them in; get them out…if you don't jump on the bus three times you get black marked! How do you get off the black mark? We're disadvantaged fellas, we have lots of issues, but "don't miss the bus three times, you're out"* Aboriginal health worker, Aboriginal health service

This comment shows the extent to which staff in their approach to empower clients were constrained by this policy. Wallerstein (2006) maintains successful approaches to empowerment need to take into consideration the lived experience of specific populations. The organisational policies commencing after July 2013 had limited consideration of people's lived experience. The lack of power from a staff perspective is also evident in that staff lacked autonomy and control over how the service treated clients. In chapter 6, Aboriginal clients discussed experiences of racism and stigma that made using public transport difficult. Clients were left to find their own way to appointments. The lack of transport posed a major barrier for many with depression and reduced their ability to access services.

In considering the transport difficulties experienced by many clients, the health service delivered medications to clients at their homes prior to July 2013. However, again after health reforms medications (anti-depressants, medications for chronic conditions) were no longer delivered to clients. A mental health worker stated the following:

> *"We've actually disempowered people from medication deliveries and taken over that side of their care. We're all in a good mind now too about disempowering people, we're aware of what we've done so we can now empower people, do the opposite to what we were doing before"* Mental health worker, Aboriginal health service

In considering the broader context of racism and discrimination and the challenging life experiences described earlier in this thesis, medication delivery could be seen as not dis-empowering clients but as a way of providing assistance to help enhance individual control and ability to cope with day to day challenges of life. Enhanced individual control is a key aspect to facilitating empowerment in Labonte's continuum and the cessation of medication delivery served to constrain perceptions of control and power among clients. There was a reduction in the frequency in which staff saw clients as a result. Aboriginal health workers felt medication delivery acted as a form of prevention and presented an opportunity to discuss with clients how they were coping. In the context of health reforms and funding being reduced from many services it is unknown to what extent management were interested in empowering clients and the extent to which this was undermined by concerns about cost cutting and concerns of cost-efficiency and effectiveness. There was no mention of empowerment being a priority or something staff should aim for in the South Australian health policy (Government of South Australia, 2009).

Furthermore, the long waiting list for counselling reported by staff at the Orange, Green and Blue services limited clients' personal empowerment. A social worker at the Green service reported that by the time a service was available and clients were contacted they often no longer needed a service. These services were constrained by the limited resources available to them.

Nicole felt she was left waiting for a service with no communication regarding when she was likely to receive help. Similarly, after she commenced counselling an internal referral was made to a dietician but again there was a lack of communication regarding when she would potentially be able to access this service.

> *"The other thing would be communication. When I was on the waiting list, there wasn't really any communication to say, well you have progressed in the queue and we expect it to be this long. [mental health worker] has recommended that I access the dietician, she told me that she put the request in probably four, five, six weeks ago, and I've had no communication at all.* Nicole, Blue service

Organisational decisions regarding how resources are allocated and priorities served to disempower clients who are left waiting to receive a service with no control over when this may be, whether they have progressed in the queue and when they could expect to receive a service. It should be noted that there were staff shortages at the Blue service, particularly dieticians contributed to the long waiting time to access this service

8.4 Staff disempowerment and physical structural barriers to empowerment

Labonte (1990) argues CPHC services should support their staff to work in empowering ways using politicised and advocacy-focused approaches but staff were not supported to do this. Many staff expressed a commitment to CPHC principles and were frustrated with these changes in service delivery and lack of autonomy. A social worker stated the following about the changes to service delivery:

> *"Well it's just much more clinical. I mean to me, the ethos is much more 'treat them, and get rid of them' really you know, 'get them in and get them out' you know, 'sort them out, get them through'. And I suppose for me it's a much more expert model idea of things that you can come and be fixed up and then go off and do your own thing. And I don't find that a terribly helpful model in terms of really making a difference to people"* Mental health worker 1, Blue service

Staff reported a change in their thinking about what practices are empowering and disempowering and that this had filtered down from management. They had been told by management their current practice which included visiting clients at home, medication delivery and attending appointments together with clients to advocate on their behalf was in fact disempowering. There was tension regarding empowering practice between staff and management indicated in the quote below where the Aboriginal health worker thought clients also "just need that one time". The quote indicates the power dynamics between staff and service managers where managers had overall say in what was empowering practice and the way they could work with clients.

> *"We're here to empower our people too, our community, but some [clients] just need that one time, to hold their hand, and then just give them a bit of…That's all going to stop. Just 'here you go, here's a number, ring them'. And that's it, so that's sad, how we've been told…that's what the community health workers have got to do. Unless …we get a complex one – they might be able to, but they've got to get approved first from the managers before, if it's okay to go and advocate for clients, or just take them to an appointment with like Families SA"* Aboriginal health worker, Aboriginal health service

Surveillance through Foucault's disciplinary power is relevant here. Foucault argues in modern society power is imposed upon individuals via the bureaucratic surveillance of populations where staff and clients were exposed to systems of power where visibility and monitoring of staff activities by management is a form of control (Foucault, 1977). Foucault likens this power as operating through capillary style; power relations circulate everywhere, through these PHC services and through society in a capillary fashion. In this case, it is particularly of concern because of the incompatibility between this strict control and surveillance, and the imperative to work in a culturally respectful way to meet the needs of the Aboriginal and Torres Strait Islander community. There has not been an easy relationship between the Aboriginal and Torres Strait community and the government and it is one that is entangled in the history of colonisation and dispossession. As a result Aboriginal people more generally are subject to considerable coercive power.

Staff lacked power and autonomy over service delivery decisions. Managers remained in control, stipulated how staff worked with clients which reduced their ability to empower clients. This supports both Laverack (2007) and Labonte (1994) who identify that many practitioners feel relatively powerless in their organisation due to the power that others, namely managers have over them in their workplace which can reduce their confidence to help clients. Schon (1983, p. 298) warns that when staff are not provided autonomy and legitimacy in their role there is greater difficulty in empowering clients due to not having ‘enough voice in the situation to be able to do so’. Some staff felt disempowered in their organisations due to managers restricting the way they worked with clients that conflicted with their own values and principles of practicing. This reduced their ability to empower clients. One mental health worker stated:

> *‘I always try to empower clients to make positive change, to find a voice. I don’t feel terribly empowered myself but…I suppose it’s all part of that whole picture thing though, helping people just to find a voice’* Mental health worker 3, Blue service

There were power struggles between staff and service managers in regard to the way they worked with clients and one mental health worker gave examples of resistance by pursuing their own professional beliefs and values in their practice. This fits with what Foucault refers to as micro-politics of power, where there was resistance by staff toward the institutional power of these PHC services and the broader SA Health system (Foucault, 1977).

> *I do [community and advocacy work], because I can't not do it. It's not right to just sit here. And so I do take people to appointments, I do take people, I help people to get to financial counsellors, or if I possibly can I help people to go to community things that they wouldn't go to if somebody didn't take them. So I do some of that. But I don't think it's a greatly desirable – it's not seen as being particularly desirable. I think that the workers here, there's a lot of really good workers who really try very hard to be as creative, and strengths based, and empowering as possible. But the system is very unsupportive really.'* Mental health worker 1, Blue service

In the context of health system reform, the work of Freeman et al (2017) based on data from the NHMRC study and the application of the concept of dilemmatic space is applicable. Dilemmatic space refers to the tension that occurs when reforms contradict professional values that staff have regarding the way they practice, potentially leading to staff burnout. Staff in their study responded to dilemmatic space through ignoring directives from management, or they did the work in their own time. This is consistent with the staff response in the quote above.

The tension between staff and service managers is shown in the following quote. The worker talks about negotiating with management to see clients longer than the restricted six to eight counselling sessions in place at the Green service.

> *'I think it's still preferred that I don't see them long term, but I can usually put up a pretty good argument and be listened to. I guess the barriers are there is always that constant tension around when it will change, when you will find it, how far we get into this work with this client, because if, you know, they've said business as usual, but if I do go along those lines of business as usual and get very deeply into work with a client and then they say okay we are changing practice now, that can actually be really dangerous. So that's a limitation. The ambiguity and lack of clarity around what's happening and when it will happen.* Mental health worker 1, Green service

This quote also shows the tension of the uncertainty of potential further changes to service delivery and the institutional power evident at this service that had ‘control over the policing of discourse – of defining what is acceptable and unacceptable’ forms of practice (Elliot & Masters, 2009). It was common for staff to refer to further changes such as the threat of only seeing those with a chronic physical condition at the Green service and not accepting self-referrals at the Green and Blue services, however, they were unaware when this would be happening. The tension in the health system is explained by Germov (2005) in his work on managerialism in the Australian public health sector. He refers to the Australian experience of managerialism where the government has centralised strategic control over public policies, resources and health services.

The Orange, Green and Blue services had all relocated to new multi-storey buildings in 2010 that were very different from the smaller community health centres that clients previously accessed. The change that occurred from community health centres (CHC) to GP Plus and GP Plus Super Clinics, shaped individual and community empowerment and health. Six mental health workers from the Orange, Green and Blue service thought the building in which the PHC service were located did not encourage community involvement. A mental health worker provided the following comment:

> *“I think a building of this design is foul in terms of supporting people and holding people. This building does not say, "You're really welcomed here, that this is a place for you." This building says, "This is an edifice of external power that you are a subject to." And you know, I read a phrase a while back about - health services needing to be temples of tenderness - I love that phrase, I think it's fantastic and I think this is not a temple of tenderness, this is get them in, get them out, f__k off. And you know, I mean that's an indication - like, in some ways that's a bit of a reflection of community's relationship to external power. You know, we can't be bothered with you, you're, you know, we're contained in this massive kind of, what would you call it? It's sort of kind of imposing and sort of almost repelling building because it’s so dominating”* Mental health worker, Blue service

The work of Freeman et al (2017) cited above also found the newly built PHC buildings were a physical embodiment of dilemmatic space that staff were experiencing. This is demonstrated in the quote above. These buildings were commonly described by staff as sterile and not welcoming as indicated by the comment made by another mental health worker:

> *"It is such an awful building, and we get lots of feedback about how sterile it is and you're always in a different room, which I think too can disrupt people that are quite sensitive to that sort of thing. Lots of people comment on it, "Oh, we haven't been into this room before," or, "Gosh, these seats are a bit shitty," or whatever. So I think all of that really impacts as well, and it's not very welcoming"* Mental health worker 1, Blue service

This comment is consistent with feedback that Nicole in chapter 6 gave about the Blue service that her counselling sessions were always in a different room and that she found this unsettling. In comparison, the Aboriginal health service also moved into a new single storey building in 2012. Staff were pleased to have their own building dedicated to Aboriginal health and only a few minor issues were identified such as struggles over space.

Drawing on the findings of Warin et al (2000) in their exploration of community perspectives and experiences of CHCs assists in explaining how issues of time and space in health services shape empowerment and impacts on community health. The CHCs in Warin's study operated according to principles of CPHC providing salaried doctors as well as nurses, social workers, psychologists, speech pathologists, physiotherapists and community development officers and actually did include the Green service when it was a CHC prior to the change to the GP Plus model.

Importantly within these CHCs some had spaces suitable for community meetings and small group work and there was a sense of community ownership that had a positive impact on individual and community health. For example the following quotes describe what was missing at the four PHC services even prior to reforms "*…large spaces for the many group activities, community and health promotion notice board and Community Corner (a space* *located at the entrance to the health centre staffed by community volunteers where anyone can sit down and have a cup of tea or coffee for a nominal donation)"* (Warin, et al., 2000, p. 1869)

"The importance of these 'non-clinical' and community orientated environments was highlighted by participants in the project, many frequently commented on the welcoming and inclusive environment of their health centre and the impact it had on their health experiences" (Warin, et al., 2000, p. 1869).

"…people felt as if they had ownership of the building" (Warin, et al., 2000, p. 1869).

In contrast, the four PHC services, who used to have some of these dimensions of space and connections to build a sense of community were now very different. There were no meeting rooms or spaces where community groups could meet or communal areas where clients could make a drink. The structural power of the buildings and spatial dimensions and the lack of community involvement and ownership at these services limited empowerment and was a barrier to community empowerment. The individual focus evident at the services and the impact of organisational policies on clients and staff left little room for macro empowerment which is examined in the next section.

8.5 Macro empowerment

There was a lack of community organisation, coalition advocacy and political action shown on the right side of Labonte's continuum within the four PHC services.

8.5.1 Community organisation, coalition advocacy and political action

Achieving macro empowerment is a complex issue for a CPHC service and there are a number of ways a service can support community empowerment. Practitioners may work with community groups in a way that acknowledges the complex and multiple adverse social determinants of access to health services and health outcomes. Practitioners also play an important role in encouraging and providing opportunities for groups to form coalitions to advocate for their concerns or to be involved in political action. This may involve lobbying for healthier public policies such as more public housing or affordability, or employment policies that leads to political action at local government or national levels. In this way, Labonte's continuum that outlines how power is facilitated through these activities has potential to benefit the whole community.

The majority of clients in this study had a chronic physical condition in addition to depression, lacked material resources such as decent housing and employment opportunities, were socially isolated, and were living in poverty (chapter 5). As outlined in chapter 2 people living in poverty are more likely to be socially excluded. Foucault maintains that individuals are viewed in a ‘gaze’ by society and that once they have been slotted into this category it is very hard to escape (Foucault, 1977). The disempowering stigma and discrimination toward those that experience mental illness are outside of the immediate control of staff and clients, limiting individual empowerment opportunities. Masterson and Owen (2006, pp. 25, 26) argue individuals that are socially and economically deprived ‘require empowerment wider than that offered by individual processes’ and that both individual and structural (macro) approaches are needed. This is congruent with Labonte’s continuum and argument that services and practitioners must work at the personal level as well as macro levels (Labonte, 1994).

The services were not conducive to support structural approaches that have the potential to lead to community empowerment. Many barriers were identified by staff (table 8.3) toward promoting community empowerment within the policies at the PHC services particularly after July 2013 but even at the start of this PhD in 2011 there were few opportunities for broader forms of empowerment. These barriers are discussed in detail below while drawing on examples of advocacy from these services in the past.

Table 8.3: Barriers to community empowerment

Barriers to community empowerment
Individual focus on treatment took precedence over interacting with the community
Lack of health promotion and support groups where staff can interact with community and where

there are opportunities for community organisation
Policies in place restricting staff to work in the community
No opportunities for community involvement in service planning, service delivery or management and to have a voice in decisions made at the health services.
PHC services did not have the mandate of a supportive policy environment to be responsive to local community
Reduced capacity for staff to advocate for clients

At the four PHC services the focus on the treatment of individuals shaped service delivery that took precedence over interactions with the local community that would potentially lead to collective action and community empowerment. There was no evidence of action directed at macro levels of empowerment at the PHC services. For example, the loss of prevention and promotion groups at these services meant there were no mechanisms in place that might enable local action on health issues or even to be involved and consulted in relation to changes occurring at these services. This was a significant barrier and not consistent with best practice where the integration of micro and macro is one of a number of strategies (Legge et al., 1996).

Policies at the PHC services over a number of years served to undermine community empowerment. There was no longer capacity for the community to be on boards of management and provide feedback regarding service delivery and planning. Staff were not supported to have an active role in the community representing a lost opportunity to serve in community building relationships. In Labonte's terms, staff lacked capacity at the community organisation level in regards to supporting local action on health issues, forming critical community groups that include dialogue between professionals and community members. This represents a move away from principles such as advocacy and taking into consideration the social determinants of health which form the foundations of CPHC. The following quote provides a common view among staff of their reduced capacity to work in the community and highlights the broader advocacy work they were once able to do.

> *"It's changed a lot in the last five years. A lot of my work was around advocating for*

> *community change around nutrition, and social opportunities for people. I was very actively involved until 30 June 2013 in a domestic violence community development network. So advocating for change in the broader community around more support for women and children who have been in domestic violence, and creating a less violent, or an environment that is more supportive of non-violence. A lot of work around that, and you just can't do it anymore"* Mental health worker 2, Blue service

Advocacy and action on determinants of good metal health, resilience programs and activities to reduce stigmatisation shown in the Southgate Model were impossible for staff to deliver within the constraints of the new service model. In the quote below the mental health worker reflects on the extent of the changes to their work.

> *"There's just masses of losses in the work. The lack of attention to community based work, to population health, to primary health, to the broader social determinants of health, the lack of attention to keeping people well, as opposed to managing their illness, it's just masses of impacts and masses of sadness around that. I can do really good work with people individually, but if that's all I do it's very limited"* Mental health worker 1, Blue service

Service changes imposed meant that decision after decision constrained staff ability to engage in macro forms of empowerment. For example, the restricted access to social connectedness activities, restricted advertising to the community of services available at the PHC services, and restrictions placed on staff from participating in community development work are illustrated in the following quotes.

> *"I can only see people one to one, there is pressure to see them in a particular way that I don't believe in, like here in the office, and tell them what to do, and send them away, and don't do any more than you have to, and certainly don't take them anywhere"* Mental Health worker 1, Blue service

> *"One of the things is it's harder to make proper connections if you're not allowed out the building. And if there aren't any meetings, or any forums, or networks that you are allowed to attend, it's much harder to actually build the relationships….if you don't have relationships with people, and if you are not allowed to build them, then you won't have them, or they won't be very good. The whole idea of referrals, I can refer people to things, but if I don't know the people there, it's a pretty cold referral and you want to give people warm referrals"* Mental health worker 2, Blue service

> *"The prevention work, well, it's not just funding cuts, it's also the perceptions and directions of management. You know, I don't know how far up the ladder that goes – but there's certainly a block that we don't do that work [prevention and promotion] anymore. Even the committees that I use to be on we're no longer allowed to do. …I was on the domestic violence action group, I chaired that"* Mental health worker 1, Green service

These quotes provide evidence of the number and variety of mechanisms and "regimes of practices" that acted to constrain staff, even the extent of where staff practiced was governed. These policies or "regimes of practices" stipulated by higher management lacked flexibility and as a result the four PHC services were much less responsive to local community needs. The power that management extended over these PHC services appeared to be the promulgation of a biomedical model of health which saw individuals as responsible for their health. This model dominated service delivery and meant the social view of health that had been more evident at the start of this study was no longer apparent. The implications of this biomedical focus are examined further in chapter 9.

There was surveillance and monitoring that staff experienced by management evident at the services. A typical quote was:

> *“I have regular emails; people have regular emails saying, ‘I notice you don’t have many clients booked, why not?’. That’s because they can see your diary electronically, so there is a lot more emphasis in impersonal performance checking, and a much more rigid kind of approach to the way the work is done”* Mental health worker, Green service

The lack of staff autonomy is explored further in section 8.3. Additionally, clients lacked a voice in planning and decision making regarding changes to all four PHC services. There was a mismatch between the rhetoric and practice of community participation at these PHC services stated by a general staff member at the Green service:

> *“There was planning [for community participation] when we first moved in but it didn’t eventuate to anything. I think that capacity building, community participation it’s all just rhetoric. I think on a practical level that doesn’t happen”* General staff member, Green service

The involvement of clients was limited to providing feedback about groups they had attended. Decision-making and participatory action at other levels within these services had already been heavily reduced before July 2013. At the Blue service a mental health worker reported after July 2013 there had been no feedback sought from clients due to the uncertainty of not knowing what they could offer. Another staff member from this service stated the following about previous community participation when the service was a community health centre (CHC):

> *“We used to have community people involved with planning and evaluation of group programs, there were some community reference groups that helped with planning half and whole day service planning. Community Foodies was an excellent example of community participation but these have all gone now”* Mental Health worker 1, Blue service

Community Foodies was a nutrition program that endeavoured to develop individual and community capacity to make healthier food selections by training and supporting volunteer community members ('Foodies') to become agents for change. This program provided a nexus between small group development and community organisation, improving social support and promoting personal behaviour change while also facilitating a critical community group with the potential to develop local actions on health issues important to the group.

These changes in the way community can be involved represents a major departure from original advocacy for community participation and community empowerment in CPHC as articulated in the Alma Ata Declaration (World Health Organisation, 1978). It is useful to consider what a CPHC service should be doing to include individuals and the local community and reflect on other examples from the past. Historically, the services made relatively strong attempts to engage in political advocacy. Examples of community organisation, coalition advocacy and political action were evident in a project run by a community health centre in the North of Adelaide called the Women in the North Domestic Violence. The project provided information, support and referral to women and aimed to increase awareness of domestic violence in the community. Women with direct experience of domestic violence were actively involved in planning and implementing and evaluation of the project (Baum, Cooke, & Murray, 1998).

Similarly, the Blue service had a long term involvement in the Healthy Cities initiative that included working on a range of environmental, safety, school-based, drug use and service access projects to improve the health of the community. The process of community empowerment involved the active participation and collaboration of all parties which was evident in the Healthy Cities initiative (Baum, Jolley, Hicks, Saint, & Parker, 2006) where there was collaboration and support of community members, local government, service staff and other local service providers. This initiative represented a community group that facilitated dialogue between professionals and community members - components of community organisation shown in Labonte’s continuum (figure 8.1).

Through this initiative, a commitment to participatory democracy, a characteristic of political action in Labonte's continuum was evident in the governance structures for the Blue service when it was a CHC with community members and staff involved through reference and executive committees that met quarterly (Baum, et al., 2006). These services (Green and Blue services) had their own boards with representation from community members who participated in decisions regarding health service delivery.

Key features of the Boards' mandate included being responsive to local community, community development activities described above and an approach that acknowledged the social and economic constraints faced by clients. The Southgate Model was developed based on evidence that prevention of mental illness and promotion of good mental health and wellbeing is supported through these strategies and would also include addressing known pre-cursors to depression such as alcohol abuse, violence, poverty and advocacy and action on these issues. Working in this way is based on evidence that community involvement strengthens community networks, relationships and support, promotes a stronger sense of community and develops self-esteem, confidence, and personal skills (Labonte, 1990) resulting in individuals feeling as though they have more control over their lives.

The structural changes in the service delivery model to GP Plus services and Super Clinics represented a departure from the service model of the previous CHCs and lacked many of these key features supporting community empowerment outlined above. As outlined in figure 4.1 in chapter 4, community boards of management were removed in 2004 and signalled the beginning of the shift to a more selective model. Similarly, prior to July 2013 there were already signs that health promotion was under threat such as the release of South Australia Health Strategic Plan 2007-2016 that focused heavily on clinical treatment of conditions and where health promotion was conceived largely as a lifestyle choices. This was part of the ongoing loss of processes and structures that support health services approaches to promote community empowerment.

8.5 Conclusion

This chapter examined power in a multi-dimensional framework to examine how it found expression at the four PHC services. In applying the ideas of Foucault, power was embedded in the system within which these PHC services operated constraining the way staff worked with clients. There was a narrow view of empowerment at an individual level indicating a depoliticised model of empowerment rather than broader forms of collective and political action. Some staff endeavoured to engage in empowering practices with clients however, their efforts were overshadowed by processes of disempowerment among these services. The analysis revealed power-over tendencies among staff constraining empowerment due to organisational policy decisions. Constraints on empowerment included a lack of access to prevention and promotion groups and there was no capacity for groups to come together to build a sense of community and develop individual self-esteem, confidence, and personal skills. Most staff were frustrated about the health reforms and the changes in service delivery, and lacked autonomy and power which in turn reduced their ability to empower clients. Some staff framed empowerment using a consumerist discourse which emphasised clients taking responsibility for their own health, with little acknowledgement of social and economic factors. Although the importance of organisations supporting staff in developing empowering practices has been argued (Labonte, 1990) there was no organisational commitment to empowerment and there was no support for staff in developing empowering practices such as organisation of community groups and political action on issues important to the community.

The way power played out among these PHC services represented a major divergence from original perspectives on empowerment such as community participation and action on the social determinants of health, key principles forming the basis of CPHC. The WHO (2010, p. 10) argues that the key to client empowerment in mental health is ‘the removal of formal and informal barriers and the transformation of power relations between individuals, communities, services and governments’. There were many barriers to empowerment at these services highlighting a retreat from a more empowering ways of working. The end result of these shortcomings is less prevention of mental ill health in the community, less promotion of positive mental health and individuals being less empowered to manage their mental health

CHAPTER 9: DISCUSSION

9.1 Introduction

This chapter provides an analysis of the main findings and integrates CPHC theory and practice to consider the central question of this thesis: How comprehensive are four case study PHC services in practice and to what extent do they align with CPHC in terms of their response to depression in individuals and the community? To answer this question, the following research questions guided the thesis:

1. What are the range of responses to depression offered in a PHC model of service delivery in terms of mental health promotion, prevention of depression and treatment and rehabilitation for people with depression including what are the client journeys through the PHC services?

2. What are client experiences and understandings of PHC service delivery and how do these help prevent/treat/manage/aid in the recovery of their depression and in their health and wellbeing in general?

3. What are staff views and reflections about their practice in PHC model of service delivery in terms of the work responding to depression among individuals and the community and how they see these services fit into the broader health system?

4. What are the opportunities and barriers to individual and community empowerment in a PHC model of service delivery in relation to mental health and especially prevention of depression?

5. What system constraints and enablers support or detract from CPHC service delivery for responding to depression in individuals and in the community?

These questions are addressed in this chapter by focusing on two main themes. The need for more holistic approaches to mental health that incorporate an empowerment approach and how neoliberal inspired reforms influence service delivery and act as a barrier to holistic approaches to mental health.

This thesis started with the proposition that CPHC provides a strong potential framework for responding to depression among individuals and in communities based on evidence that indicates good mental health practice includes health promotion, prevention and treatment of depression and that a holistic, whole of community approach is critical (Commonwealth Department of Health & Aged Care, 2000; Council of Australian Governments, 2007; Government of South Australia, 2010; Herrman, et al., 2005; Jané-Llopis, 2008; Jane-Llopis, et al., 2005; World Health Organization, 2004a; Zechmeister, et al., 2008). An empowerment approach that considers the context of people's lives and provides links to appropriate structural (employment, housing) and community supports is also important (Nelson, et al., 2001; Petersen, et al., 2012).

This thesis investigated the style of PHC over time (from 2011 to 2013) and the extent to which four case study PHC services' responded to depression in individuals and the community aligned with principles of CPHC. The Southgate Model discussed in chapter 2 was used as a framework to evaluate the comprehensiveness of four PHC services' approaches to depression and the analysis focused on key activities and service qualities of good mental health practice in a CPHC setting. Key activities and service qualities include: culturally respectful, universal access and used by those most in need, effective, holistic, responsive to community needs and priority populations and encouraging of community empowerment to undertake and sustain healthy behaviours. The extent to which these services took into account the social determinants of health in the planning and delivery of activities to address mental health and sought to develop the strengths of individuals and the communities through empowerment and community development approaches were of particular interest.

Another service quality, efficient also features in the Southgate Model; however, this research did not gather data on efficiency measures. The model positions the organisational and political context in which the PHC services operate as being particularly important and this thesis reflects on how the context affected the services' capacity to provide treatment, prevention of depression, and mental health promotion. The following section provides an overview of the key themes and outlines the structure of this chapter.

9.2 Overview of key themes emerging from the findings

In the study period the four case study services were not operating from a CPHC model but rather there were different models of PHC operating at these services representing a narrow selective approach to PHC aligned with a biomedical model compared to the more social view of health that was observed at the start of this study in 2011. This was largely a result of changes in the context in which these services were operating which resulted in considerable reorganisation in the health system at a state and federal level over the period of this study (see chapter 4). This research is not alone in being conducted during such changes – reorganisations and policy changes are an inherent factor in health services research (Lomas, 2001).

At the start of the NHMRC project the four PHC services had some features of a CPHC model however. Universal access was not evident at the services and there was minimal community participation. There was also a dualism with regard to physical and mental health where they were treated separately and PHC services operated in parallel to a number of other public and privately funded mental health services in the community.

Key findings of this study confirmed that the implementation of CPHC that supports empowering practice, is heavily reliant on a favourable socio-political context (Bravo, et al., 2015; Labonte et al., 2008) and the need for a more holistic approach to depression (Xiang, 2010). In this study health service reforms reflecting an ideology of neoliberalism made the implementation of a CPHC approach to depression difficult to achieve.

At the beginning of this study, the PHC services had a number of strengths for responding to depression that reflected the important role of PHC in responding to mental health, particularly in the community at a population level. However, over the duration of this study a shift to a narrower PHC model caused many threats to the implementation of CPHC within these PHC services resulting in less capacity to support community empowerment and less potential for action on equity. A key discussion point is the way the services could respond to depression when there was support for a social model of health versus the restrictions placed on these services under neoliberal reforms that threatened a comprehensive approach to mental health. The discussion then turns to what the findings from this study indicate would strengthen the different models of PHC provided so they are more aligned to CPHC, the threats to a more comprehensive approach and the limitations and strengths of this study.

9.3 Key features of CPHC for responding to depression among individuals and the community and alignment with PHC models

There is widespread prevalence of depression and other mental illnesses globally and little improvements in rates of death or disability over the last decade (McGorry & Hamilton, 2016). Rates of suicide are increasing (Australian Bureau of Statistics, 2016) and with the acknowledgement of a problematic mental health system in Australia (National Mental Health Commission, 2014), the importance of a comprehensive approach to mental health is urgently needed. There is potential for a comprehensive response to depression to be achieved through a CPHC model of service delivery. The following section outlines the key features of CPHC that are important in addressing mental health (figure 9.1). Some key features were present at the case study PHC services when the PhD project commenced, highlighting the important role that PHC has in responding to mental health in individuals and communities while other features were absent.

,

Figure 9.1: Strengths of the PHC services in responding to depression 2011-13

Strengths of the PHC services from 2011 to 2013

- Policy and management were initially supportive of a social model of health
- Holistic – encompassed mental health and physical health
- Whole of systems approach including health promotion, prevention, early intervention, treatment and support with recovery - leads to individual and community empowerment
- Advocacy and work on addressing the social determinants of health leads to individual and community empowerment
- Flexible and responsive to individuals and communities

- Community development, collective participatory mechanisms and involvement in service planning leads to community empowerment (not a feature at the PHC services)

In 2011 when this PhD commenced there were policy mandates and support from regional managers for a social model of health and this was reflected in the delivery of services. A combination of treatment, prevention and promotion activities was offered. These activities included: one to one counselling and small groups on mindfulness, cooking and healthy eating and exercise. These activities form a central aspect of comprehensiveness represented in the Southgate Model and shows the important role PHC services have in responding to depression among individuals and in the community.

Individual treatment under a CPHC model considers the whole person, providing holistic care that acknowledges the impact of social factors on health. Starfield (2011, p. 63) used the term ‘person-focused care’ which is consistent with this holistic approach and is ‘based on accumulated knowledge of people, which provides the basis for better recognition of health problems and needs over time and facilitates appropriate care for these needs in the context of other needs’. Examples of this approach at the PHC services included practitioners working with clients for an extended period of time, offering health promotion/prevention groups and there was intensive client support to integrate individuals that were socially isolated back into the community by attending local support groups together.

Importantly, recent mental health reforms call for a shift to holistic mental health care with prevention, early intervention and recovery based community support being particularly important (National Mental Health Commission, 2014). In 2011, PHC services had the capacity to provide prevention services. Prevention and health promotion groups were targeted to address known precursors to depression such as domestic violence and counselling, support for alcohol and tobacco addiction and parenting groups. Although primary medical care that is based on a biomedical model can also offer prevention and promotion, these activities are limited due to short consultation times and are likely to focus on lifestyle risk advice and screening. When a combination of treatment, health promotion, and prevention activities were offered in 2011, (Orange service), clients reported improved social connection, individual empowerment, improved management of depression and for some recovery. The PHC services demonstrated they were able to take into account the complexity of social and economic factors affecting clients, something primary medical care has struggled to have the capacity to do (DeVoe, et al., 2016).

In 2011, the Aboriginal health service operated from a more holistic model of service delivery that was 'responsive to community needs' and flexible, adapting organisational policies to client's social and economic context. For example, clients were visited in their homes and the service provided transport for clients to attend health appointments, health promotion/support groups and community events. Clients valued the flexible approach that facilitated access to the service and to social support services and encouraged community connection. The model of PHC evident at the Aboriginal health service facilitated access and community connections which is important for those with mental illness as the majority of clients were socially isolated and experienced stigma and discrimination that was a barrier to accessing services. An approach where cultural respect is embedded into organisational policies, and consideration is given to client's personal circumstances and experiences of racism and discrimination is important. This finding supports research by Cleweth, Smith & Sealey (2006) who found flexible service provision for Aboriginal clients such as in homes, parks and schools facilitated access and aligns with calls for PHC organisational policies to be flexible, dynamic and consider client's personal circumstances (Browne, et al., 2012).

This flexible approach is consistent with the provision of culturally competent care – a key dimension of an equity-focused PHC service described by Browne et al (2012, p. 2012) that recognises the 'cultural meaning of health and illness', people's experiences of racism, discrimination and marginalisation and the ways those experiences shape health, life opportunities, access to health care and quality of life'[2]. As discussed in chapter 6 there was not enough evidence to assess the extent to which culturally competent care was a feature at the Orange, Green and Blue services due to the majority of clients tracked being Caucasian

---

[2] Culturally competent care is the term used by Browne et al, 2012 and is also consistent with other terms such as culturally respectful and cultural sensitivity

however, one manager acknowledged that the service (Green service) could do a lot more to ensure cultural safety for clients.

The social determinants of mental health were outlined in chapter 2 and the role the PHC services had in 2011 in supporting and advocating for more supportive contexts aligns with a CPHC model. Advocacy can encourage individual and community empowerment (Labonte, 1990). Particularly when advocacy is targeted toward broader changes in the community that are risk factors for mental illness such as action to prevent domestic violence and access to affordable safe housing. At the PHC services practitioners supported clients with social and economic issues through advocacy to try and make their living conditions more supportive. Examples included help to access food and financial assistance, support letters and assistance in finding suitable housing, promoting client’s rights during joint meetings with other services and assisting clients to access legal services. This was an important finding given recent literature documenting the need for more comprehensive measures of PHC and ways of documenting advocacy, cultural sensitivity and equity (Levesque et al., 2012). Collective participatory mechanisms and involvement in service planning are also important for individual and community empowerment (Gurung, Derrett, Hill, & Gauld, 2016) and health and wellbeing (Wallerstein, 2006), however they did not feature at the PHC services during this study.

CPHC is unique in its scope to address physical and mental health. Mental health and physical health were treated separately at three of the PHC services. Only the Aboriginal health service addressed the comorbidity between depression and chronic disease so that both were dealt with in the same service. An approach where clients saw the PHC nurse/mental health nurse first and then the GP was important at this service and differed from the other study sites (particularly the Green and Blue services) where PHC nurses were employed but rarely involved in the client journeys. The key features of CPHC described above are important for a holistic response to depression. The ways in which CPHC can be strengthened is discussed in the next section.

9.4 How can the implementation of CPHC be supported and strengthened?

In order for the potential of a CPHC approach to mental health to be realised the different models of PHC evident at the services need to be strengthened to support the implementation of CPHC. There needs to be equal priority of health promotion, prevention and treatment with the capacity for practitioners to engage individuals and the community through community development strategies (Germov, 2009). It was evident from this study that CPHC can only be supported in a contextual environment where there is support for empowering practice and adequate funding and resources available for treatment, early intervention/prevention and promotion activities.

A holistic approach to preventing and treating depression has been advocated for involving psychological, physical, social and environmental needs to be taken into consideration (Xiang, 2010). This holistic approach was evident at the Aboriginal heath service in 2011 where GPs were part of the service but this was different at the other PHC services where physical health operated in parallel and there was little contact between practitioners and GPs.

Infrastructure to support community engagement and participation as well as a socio-political environment that supports equity, and recognises and takes action on the social determinants of health is also important (Baum, 2008; Solar & Irwin, 2010). Governance strategies such as community engagement and a shift in power towards local communities, community participation and community representation in health service planning is recommended (Gurung, et al., 2016). Community engagement is effective in engaging groups who may struggle to engage and navigate mental health services (Lamb et al., 2014). In Australia, community engagement strategies have improved access to GPs, antenatal care, childhood asthma, health promotion and anti-smoking programs (Cheng, Wahidi, Vasi, & Samuel, 2015). Collective efficacy is an important component to enhancing community engagement to address depression. Collective efficacy is the belief a group have in their capacity to improve a problem. Enhancing collective efficacy may be important in enhancing community engagement to address depression in the community (Chung et al., 2009). Small groups are an important mechanisms by which collective efficiency can be encouraged.

Health promotion and prevention groups that target lifestyle interventions such as reducing smoking and alcohol consumption, weight loss and healthy eating and physical activity have mixed results in terms of their effectiveness (Baum & Fisher, 2014; Harris et al., 2013; Laatikainen et al., 2007). In relation to this study, clients that attended health promotion and support groups reported benefits of social connection and these groups provided multiple entry points for clients to access services enabling greater equity of access. However, these small groups only target a proportion of the population and do little to address the risk factors across the broader population. For the implementation of CPHC to be strengthened strategies are needed that support these service's capacity to addressing depression as a public health issue. In addressing mental health an individual's everyday context is important to consider and greater links are needed to community support services such as housing, financial and employment agencies which have been shown to improve mental health (Petersen, et al., 2012).

Mental health promotion and participation are important mechanisms that help individuals gain greater control over their health and promote empowerment. Empowerment needs to be a goal that is given priority and made explicit by health services (Segal, 1998). Segal (1998) points to a number of ways health services can promote empowerment such as improving the exchange of information to individuals to encourage an active role in identifying their health needs and in service delivery planning. Effective governance structures that give power back to communities are important and are central to the implementation of CPHC (Baum, 2016).

South Australia, Victoria and some countries internationally (Lavoie & Dwyer, 2016; Rosato et al., 2008) have a strong history of providing CPHC that gives insight into how empowerment can become genuine. As discussed in chapter 2, CHCs, established by a Whitlam Labour government in the 1970s through the Australian Community Health program (ACHP) and were an example of a more comprehensive PHC response to mental and physical health issues. They were developed in a supportive political and ideological context very different from the context during this study. CHCs included a whole of system approach, with health promotion, prevention and treatment interacting and informing one another representing a holistic approach to mental health. Importantly in South Australia mechanisms such as decentralisation and community participation in service planning

(Raftery, 1995) were a feature different from the governance structures of the PHC services in this study that enabled CPHC at these CHCs, although never fully implemented as shown by progressive reviews of the ACHP (Australian Community Health Association, 1986, 1992).

CHCs had very different governance structures that facilitated community involvement and supported community empowerment. South Australia and Victoria had their own boards of management and a certain amount of budgetary control. These key features facilitated community participation, a key component to improve mental health. There was community representation on management and planning committees (Raftery, 1995) which gave local community a voice in the planning of these health services and gave CHCs the ability to advocate for community concerns (Baum, et al., 1992; Laris, 1995). The successes achieved by CHCs outlined in chapter 8 such as the Healthy Cities initiative and the State-wide Coalition of Domestic Violence services reflect the strong attempts at advocacy and engagement in political action to reduce health inequities that were more possible under the participatory governance structures of CHCs. Internationally, the Healthy Cities initiative (Ritsatakis, Ostergren, & Webster, 2015) and community mobilisation strategies (Women's groups in Nepal (Manandhar et al., 2004)) have been effective in promoting participation, building community capacity and empowering communities (National Mental Health Commission, 2014; Rosato, et al., 2008).

As a result of these differences in governance structures, CHCs enabled some shift of power from management to the community and Raftery (1995) observes their importance in placing community participation on the political agenda. In Raftery's (1995, p. 23) analysis of the ACHP she maintains CHCs were 'based on 'collectivist' ideology and supportive of public intervention to redistribute political and economic power'. In this way Raftery argues CHCs to some extent were successful in challenging the biomedical perspective of health that shaped professional and client behaviour. These defining features of CHCs such as their organisational structure that facilitated community participation, boards of management, and the ability to respond to community demand outlined above were important mechanisms that promoted empowerment and supported mental health but were missing from the services in this study. If boards of management were part of the organisational structure of the PHC services in this study it would be interesting to know whether or not they would have been influenced the shape of the reforms to be more supportive of CPHC through advocacy and political pressure.

More recent successes using a CPHC model are evident in Aboriginal Community Controlled Health sector which were first established in the Australian health system in 1971 (Freeman, et al., 2016) and stemmed from the Community Health Program (Bartlett & Boffa, 2005; Freeman, et al., 2016). Aboriginal Community Controlled health services have had a significant role in advocacy that has been important in addressing health inequities.

Despite the documented complex and rigid contractual requirements for Aboriginal services that can constrain the delivery of CPHC (Dwyer, Boulton, Lavoie, Tenbensel, & Cumming, 2014), community control would be a much more comprehensive and supportive model for mental health delivery rather than the centralised administration that featured at the PHC services in this study. For example, the NHMRC study included Central Australian Aboriginal Congress (Congress) as a case study site and found the service provided much more comprehensive ways of addressing mental health through prevention and early intervention programs (Freeman, et al., 2016). The service offered a number of groups addressing social and emotional wellbeing, suicide prevention, and support and education for those coping with mental illness. The service provided early intervention for young people at risk of suicide through delivery of the Headspace program and clearly operated from a broader view of health.

Key features of the Board’s mandate included being responsive to local community, community development activities described above and an approach that acknowledged the social and economic constraints faced by clients. The extent to which Congress worked with the community to addressing known pre-cursors to depression such as alcohol abuse, violence, poverty and advocacy and action on these issues was a defining feature. This approach is based on evidence that community involvement strengthens community networks, relationships and support, promotes a stronger sense of community and develops self-esteem, confidence, and personal skills (Labonte, 1990) resulting in individuals feeling as though they have more control over their lives.

Among the PHC services advocacy on behalf of clients was evident from some of the client journeys. Some examples included: writing letters to social support agencies to support improved housing, attending meetings with clients regarding legal support, organising for a private psychologist to bulk bill a client for their children's psychological treatment. This advocacy helped clients to navigate complex systems and bureaucracies to receive support which ultimately helped their health and wellbeing. This illustrates the importance of advocacy and has implications for the type of training needed for health practitioners that supports a key feature of CPHC implementation. With continuing health system reforms creating challenges in PHC workforce supply and variations in demands and role description (Douglas et al., 2009) away from a comprehensive approach, practitioners may need to be retrained in the importance of advocacy and consultative processes as well as the importance of community connections and linking with other support services depending on client needs. Health practitioners working in CPHC also need to be supported by senior management to conduct and have the capacity and mandate to carry out this broader work.

Over the duration of this study any provision there was by the state government toward a partially implemented social model of health disappeared and there was no longer the infrastructure to support many of the community connectedness activities, advocacy and the actions to prevent omental illness, even though its prevalence was growing. As a result any activities in the case study services to provide community wide initiatives aimed at preventing depression in the population was heavily reduced. This study suggests that when CPHC is not supported through policy and leadership the response to the mental health needs of clients and the community is constrained and there is less potential for equity. While the discussion above emphasises barriers to CPHC such as governance and staff skills a number of other threats to the implementation of CPHC were captured and are outlined below.

9.5 Threats to CPHC implementation

During this study the comprehensiveness of the PHC services was reduced and hence their potential to respond holistically to mental health. Figure 9.2 provides a summary of these threats and figure 9.3 shows what the selective PHC approach looked like at the sites by the end of this study. Selective PHC has been a major threat to CPHC since not long after the Alma Ata conference (Walsh & Warren, 1979) and has continued to impede the application of a social model of health (Keleher, 2001). Germov's (2009) work helps to explain the limits of selective PHC which emphasises disease control and is set up to support a medicalised society that disregards the role of social and psychological impacts on health. It also fails to acknowledge the multifaceted nature of health and illness as it discounts social, economic and structural factors such as poverty, discrimination and their influence on the physical and mental health of individuals and the role of the state from acting in these areas (Germov, 2009). The focus on physical health at the expense of prevention of mental illness and promotion of mental health was a key change that occurred during this study. A narrow PHC approach continues to prevail in Australia over CPHC despite broadening health inequities around the world (Ballie, Matthews, Brands, & Schierhout, 2013; Baum, et al., 2009; Wilson, 2012).

Figure 9.2 Threats to CPHC implementation in South Australia evident from staff and client interviews and client journeys

Threats to CPHC implementation

- Narrow interpretation, health system dominated by a biomedical model
- Vulnerable to neoliberalism, cost-cutting, relies heavily on a favourable socio-political environment
- Fragmentation of services
- Individualism emphasises treating individuals to the exclusion of health promotion, prevention and strategies designed to promote community empowerment
- Lack of co-ordination between state and federal governments

Under a narrow selective PHC approach many of the mechanisms and service qualities listed in the Southgate Model, such as holistic, accessible, community driven, mix of treatment, prevention and promotion and multidisciplinary teamwork were lost (shown in figure 9.3 by a strikethrough). Neoliberal driven management strategies were central to the policies directives, procedures and practices inherent in this selective PHC approach. To provide a conceptual framework the analysis draws upon Hardy's (1994) four dimensional model, described earlier in chapter 2 that utilises the theories of power by Lukes and Foucault. These theories are used as a lens to examine how power operated within the PHC services.

A feature of the study sites from the outset of this study was the centralised administration and governance which meant a loss of local control. Services were not responsive to community needs and had no flexibility to respond with specific policies and programs that were needed by the local community. As a result the services were providing a reactive service that is closely aligned with a biomedical model rather than a proactive service where they could be actively engaging with a community and reaching out to groups who may find it hard to access these services (Birks et al., 2010). Determining local community needs may make some contribution to reducing health inequities and helps to enable services to plan what PHC workforce is required to meet local need (Butler, Petterson, Bazemore, & Douglas, 2010).

Central to neoliberal rationalities is an emphasis on individual responsibility, a noted trend of governments in Australia (Fullagar & Gattuso, 2002) and Canada (Teghtsoonian, 2009) in their response to depression. At the Aboriginal health service initially there was flexibility in the response to depression but the changing policy environment came to emphasise individualism, a philosophy discussed earlier (chapter 2) whereby a focus on individual responsibility replaces recognition of the complex health issues and layers of context in Aboriginal clients. Kuipers et al (2014) note in order to take into account the complexity and contributing factors of Aboriginal health a response is needed where staff have the capacity to apply multiple strategies, work in different contexts and with many stakeholders. This approach was not possible under the narrow and restricted activities the PHC services were able to offer.

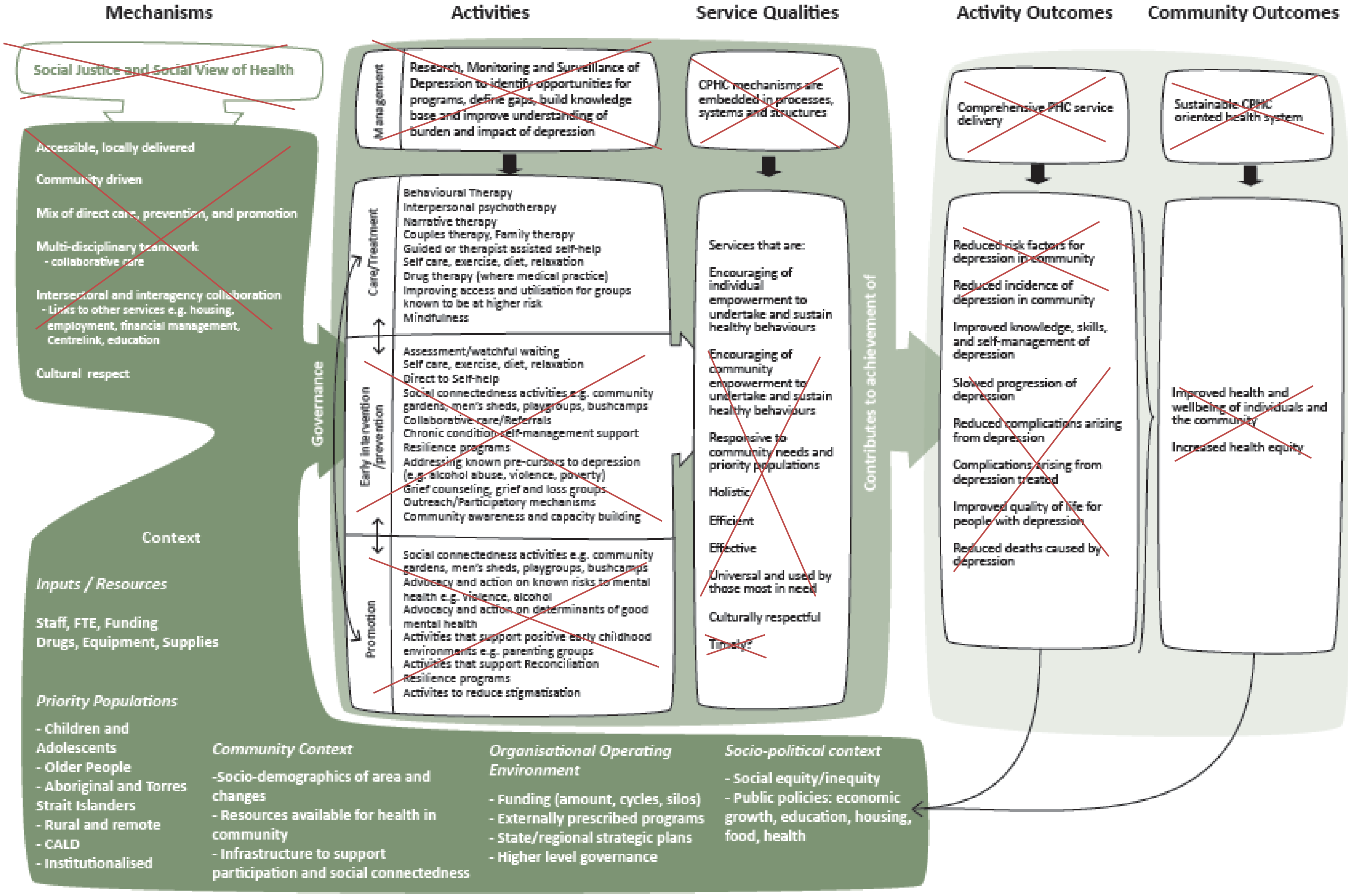
Responsibilisation (Rose, 1999) a term that refers to individuals having responsibility for experiences of mental illness rather than publically funded PHC services was evident at the Green service. For example, the policy mandate that limited clients to six to eight sessions would seem to indicate a strong message that they needed to take responsibility for their experiences of mental illness. Clients had to go on a waiting list for 12 months before they could access further counselling through the service. This finding resounds with research by Sawyer (2008) who point to the implications on the mental health system in Australia where neoliberalism has led to a narrowing of service delivery to clients. Service delivery was restricted for clients with depression and they were either excluded (Aboriginal health service) or directed to federally funded Medicare Locals for counselling.

Germov (2009) points to the propensity for ‘victim-blaming’ under the narrowed PHC response and this was a concern voiced by one practitioner, particularly with the loss of prevention and support groups that they believed could act to counteract victim blaming. As neoliberal reforms filtered through the PHC services staff had to establish new ways of working that limited their autonomy and their capacity to help with social and economic issues affecting clients’ lives. Their inability to carry out health promotion, prevention and support groups was contrary to the emphasis placed on this work and on the recognition of the social determinants of health in state (South Australia’s Mental Health and Wellbeing policy (2010-2015) (Government of South Australia, 2010) and federal (Roadmap for National Mental Health Reform) (Council of Australian Governments, 2012) policy documents (chapter 2). When the South Australian government reduced health promotion and advocacy work there was a disconnect between state and federal policy rhetoric that emphasised the importance of the social determinants of health, recovery and holistic approaches to mental health.

Policy mandates impacted heavily on the PHC services during this study and marked a change to a narrow definition of PHC that enforced a restricted way of responding to mental health, particularly population mental health. Staff from all services described a pressure from the state Department of Health and their regional health services to focus service delivery on one to one treatment of individuals with chronic physical disease with the aim of reducing hospital admissions. The focus on chronic disease was particularly evident at two of the services (Aboriginal health service and Orange service) who only saw clients with depression if they also had a chronic physical condition.

The neoliberal reforms became a form of social control where chronic disease became a ‘privileged space’ for treatment over mental illness. Rose (1998) and Sawyer (2008) have discussed social control in the context of community mental health care. Among the sites there was a stripping back of services to core business – the management and monitoring of chronic physical disease. Osborne’s (1994) analysis of Foucault’s book “Birth of the Clinic’ where he argues ‘medicine has become a privileged site’ and is extensively linked with the political response of the state resonates with this study. In Australia a political ideology of liberalism with its focus on individualism and competition has dominated under a neoliberal environment and is more likely to lead to inequity rather than a social democratic government like the Whitlam government with a central belief in state ownership rather than private property and sharing of economic resources (Germov, 2009). Take for example Cuba who has a medicalised health system but have had success in developing a CPHC model of care with free universal coverage and a focus on prevention, promotion and community participation and strong engagement between community members and services (Feinsilver, 2010). Cuba has maintained health indicators that are comparable to developed countries but at a much lower cost. The success of this model of care has much to do with political will and commitment to addressing health inequities. In western countries a social model of health has been overlooked given its complex interventions, the need for intersectoral collaboration and long term strategies that are harder to quantify than a biomedical model (Baum, et al., 2016).

Figure 9.3 Selective PHC approach at the four PHC services over the duration of the study



Mechanisms

~~Social Justice and Social View of Health~~

~~Accessible, locally delivered~~

~~Community driven~~

~~Mix of direct care, prevention, and promotion~~

~~Multi-disciplinary teamwork~~
~~- collaborative care~~

~~Intersectoral and interagency collaboration~~
~~- Links to other services e.g. housing, employment, financial management, Centrelink, education~~

Cultural respect

Activities

Management

~~Research, Monitoring and Surveillance of Depression to identify opportunities for programs, define gaps, build knowledge base and improve understanding of burden and impact of depression~~

Care/Treatment

Behavioural Therapy
Interpersonal psychotherapy
Narrative therapy
Couples therapy, Family therapy
Guided or therapist assisted self-help
Self care, exercise, diet, relaxation
Drug therapy (where medical practice)
Improving access and utilisation for groups known to be at higher risk
Mindfulness

Early intervention /prevention

~~Assessment/watchful waiting~~
~~Self care, exercise, diet, relaxation~~
~~Direct to Self-help~~
~~Social connectedness activities e.g. community gardens, men's sheds, playgroups, bushcamps~~
~~Collaborative care/Referrals~~
~~Chronic condition self-management support~~
~~Resilience programs~~
~~Addressing known pre-cursors to depression (e.g. alcohol abuse, violence, poverty)~~
~~Grief counseling, grief and loss groups~~
~~Outreach/Participatory mechanisms~~
~~Community awareness and capacity building~~

Promotion

~~Social connectedness activities e.g. community gardens, men's sheds, playgroups, bushcamps~~
~~Advocacy and action on known risks to mental health e.g. violence, alcohol~~
~~Advocacy and action on determinants of good mental health~~
~~Activities that support positive early childhood environments e.g. parenting groups~~
~~Activities that support Reconciliation~~
~~Resilience programs~~
~~Activites to reduce stigmatisation~~

Governance

Service Qualities

~~CPHC mechanisms are embedded in processes, systems and structures~~

Services that are:

Encouraging of individual empowerment to undertake and sustain healthy behaviours

~~Encouraging of community empowerment to undertake and sustain healthy behaviours~~

~~Responsive to community needs and priority populations~~

~~Holistic~~

~~Efficient~~

~~Effective~~

~~Universal and used by those most in need~~

Culturally respectful

~~Timely?~~

Contributes to achievement of

Activity Outcomes

~~Comprehensive PHC service delivery~~

~~Reduced risk factors for depression in community~~

~~Reduced incidence of depression in community~~

Improved knowledge, skills, and self-management of depression

~~Slowed progression of depression~~

~~Reduced complications arising from depression~~

~~Complications arising from depression treated~~

~~Improved quality of life for people with depression~~

~~Reduced deaths caused by depression~~

Community Outcomes

~~Sustainable CPHC oriented health system~~

~~Improved health and wellbeing of individuals and the community~~

~~Increased health equity~~

Context

Inputs / Resources

Staff, FTE, Funding
Drugs, Equipment, Supplies

Priority Populations

- Children and Adolescents
- Older People
- Aboriginal and Torres Strait Islanders
- Rural and remote
- CALD
- Institutionalised

Community Context

-Socio-demographics of area and changes
- Resources available for health in community
- Infrastructure to support participation and social connectedness

Organisational Operating Environment

- Funding (amount, cycles, silos)
- Externally prescribed programs
- State/regional strategic plans
- Higher level governance

Socio-political context

- Social equity/inequity
- Public policies: economic growth, education, housing, food, health

Selective PHC has a short term appeal to governments seeking to reduce costs where there is a focus on economic efficiency and short term goals and targets such as hospital avoidance. The short term treatment of depression rather than mid to long term goals of prevention and improvements in health equity, community empowerment and health and well-being featured in this study, which has been a trend noted by others (Baum, 2016; Labonte, et al., 2008; Sanders, et al., 2011).

Neoliberal driven policies create fragmentation of the health system, reduced co-ordination and services that are less effective and efficient (Labonte, et al., 2008). Services become governed by market competition and contractual obligations. Fragmentation and reduced coordination was a system feature evident throughout this study. Services for mental health are distributed across the health system and include hospitals, non-government services, psychiatrists, psychologists, GPs, social workers and PHNs (formerly Medicare Locals) all operating parallel to these PHC services. A key finding of this study was the lack of collaboration and coordination with these parallel services. Staff reported limited contact with psychiatrists or psychologists and GPs that clients saw. From the outset of this study communication and links between these services were already poor (Wiese, et al., 2010), however, the restructuring that occurred, the emphasis on throughput and the confinement of staff to their offices rather than building and maintaining networks in the community only discouraged collaboration with other practitioners. This finding resonates with those by Healy and Renouf (2005) who point to the changing role of community mental health workers who must manage higher and more complex caseloads making collaborative work difficult to achieve.

These type of changes – fragmentation and reduced coordination, an emphasis on throughput, efficiency and reducing costs and loss of collaborative partnerships, are typically driven by the dominant paradigm of neoliberal forms of governance directed by market-orientated reforms (Gardner & Barraclough, 2002; Solar & Irwin, 2010). Neoliberalism shaped the policy environment under which the four PHC services operated and directed de-politicised approaches to health that were limited in their individual focus and lack of consideration of social, economic contexts and their effect on health. A disease-focused model was evident that constrained the opportunity for policy action directed toward the implementation of a CPHC approach.

These market-orientated reforms prioritised efficiency above equity and there was restricted access to these PHC services under this approach. During this study, there was an emergence of a logic that stressed the most efficient use of resources. As a result, economic policy decisions and what is best economically for the state became priorities ahead of social policies and the health and well-being of individuals and the community (Baum, 2014). The McCann review and the Government’s response revealed the rationale for ceasing health promotion and prevention programs to reduce government expenditure on health care and was successful in shifting the focus away from a broader view of health. However the aim of the state government to reduce health costs may not be served by this approach as the lack of prevention and health promotion activities will likely result in greater prevalence of depression in the community.

Central to neoliberal reforms is managerialism, the implementation of private sector management strategies into public services (Baum, 2016). Germov (2009) discusses managerial strategies such as the use of performance measures and specific workplace guidelines and protocols. Managerialism was evident in this study in the specific work requirements staff were permitted to undertake. The concept of managerialism helped to explain the changes that occurred in this study. Managerialism undermined practitioner’s capacity to respond flexibly to clients’ needs and those of the community. Rather service delivery was based on priorities set by regional management such as individual care, hospital avoidance, and throughput of clients. Practitioners and service managers were re-positioned within these services by the rationalities of competition, accountability and surveillance, which shaped their practice. These findings revealed the different dimensions of power and its operation through these PHC services.

9.5.1 Dimensions of power at the PHC services

Hardy’s (1994) four dimensional model, described earlier in chapter 2 that utilises the theories of power developed by Lukes and Foucault is useful in demonstrating the ways aspects of power were concealed and why the scope for individual and community empowerment was limited at these services. The first dimension is about decision making and chapter 8 revealed how there may have been a small transfer of power to clients through shared decision making between clients and practitioners in counselling sessions. The second dimension of power is about non-decision making, where power is exercised by controlling agendas so that options may not be considered was also evident. Power was imposed by the state government and maintained by service managers who didn't have many options available to them as the agenda had already been determined at a higher level. The terms of service delivery or the 'rules and regulations' (Elliott, 2009, p. 75) had been established where there was fewer opportunities for clients and the community to oppose these changes. Lukes argues power is employed to prevent criticisms – by influencing perceptions, cognitions, and preferences so that the status quo is maintained (Lukes, 2005). This is an example of how power was used to ensure conflict from clients was minimised (Lukes, 2005). There was some conflict by the community regarding the cessation of the Community Foodies program but the lack of community participation and involvement in decision making and planning of these services were ways in which there were fewer opportunities for clients to access political processes to oppose the changes in service delivery.

Conflicts were latent (the third dimension of power) as clients did not have an opportunity to have a voice and be actively involved in decisions regarding service planning. The fourth dimension of Lukes' multidimensional model of power proposed by Hardy (1994) was evident where the interaction of knowledge and power within these PHC services came together to control people. This knowledge was based on a biomedical view of health that emphasised chronic physical disease and endorsed an individual responsibility for health over a social view of health.

Within this fourth dimension staff, clients and society as a whole are exposed to what Foucault (1977) terms 'disciplinary power', a 'web' of power relations that is hidden and invisible (Hardy & Leiba-O'Sullivan, 1998, p. 460). This power operated through these PHC services and shaped individuals through training and surveillance into subjects who were manipulated by managers within the system to suit the broader cost cutting agenda of the

South Australian Department of Health. Although staff reported extensive knowledge and experience working in PHC, a biomedical view of health stipulated the way they were able to respond to clients. For example, the computer system (Blue service) that staff used to document sessions with clients was largely clinical and hospital focused, moulding staff into considering clients in clinical terms. The surveillance of staff and clients was an example of Foucault's "simple instruments" of hierarchical surveillance (Foucault, 1977, p. 170), a technique that was used to monitor staff and made them visible through a "gaze". This "gaze" results in practitioners and clients being visible whilst shading the powerful state government who remain hidden.

The different models of PHC evident at the services at the end of this study brought with it an expanding and tightening web of power. The emphasis on medicalisation was symbolic in the new buildings the PHC services moved into at the beginning of this project that reinforced this web of power. PHC services in this study underwent a change to new multi-storey physical structures that conveyed power, were very clinical and contained no communal spaces for the community. Even the name of these structures, GP Plus and GP Plus Super clinics conveyed a biomedical model. The lack of communal spaces and the disciplinary power of these structures regulated the movement of clients through its space. The majority of staff felt the imposing, external power these buildings conveyed conflicted with being able to support clients and the community.

Networks of autonomous disciplinary power relations worked across different sites and constituted neo-liberal governmental techniques that operated upon practitioners, managers and clients and shaped services delivered. It is within this context of managerialism that Foucault's concept of governmentality is relevant. This concept is based on the understanding of autonomy and mobile power relations and the way in which power is diffused and dispersed (Foucault, 1977). The many policy directives resulted in practitioners and clients having to conform to the narrow PHC approach, to behave in a different way. Although there was tension between staff and management and the majority of staff were frustrated by the policy mandates and changes in service delivery, staff largely went about their roles within these services and were constrained by the web of governing techniques.

Not only was power diffused and managed centrally but there was a complex relationship between state and federal and non-government agencies entailing a range of political actors within this web. The challenge of federal-state divide and the division of responsibilities for mental health services has been widely discussed by a number of authors (Bennett, 2013; Duckett & Willcox, 2015). The difficulties this division creates in the provision of mental health care was evident among service managers and regional executive's narratives and played a significant role that complicated this fragmented system. The role of mental health services within the PHC services was questioned for those without a chronic physical condition when federally funded mental health services are also in operation. In line with a liberal ideology the state government seemed to be retreating from mental health provision at these PHC services. The services were being transformed to clinical PHC services where programs and activities to promote good mental health and prevention of mental illness in the community were lost.

This study has examined depression within the context of the different models of PHC in operation in South Australia. A key finding was the way neoliberal-inspired policy reforms threatened the implementation of comprehensive approaches to PHC. This chapter has outlined how the PHC services were more aligned to a comprehensive response to depression at the start of this study in 2011 when there was more state government support for a social view of health. The ways in which CPHC can be supported and strengthened though governance structures so that power can be transferred from managers to clients through community participation, health promotion and prevention is important to highlight. CPHC is potentially a strong framework to respond to depression among individuals and communities, however its implementation is heavily reliant on a social and politically supportive context. This chapter concludes with a discussion of the strengths and weaknesses of this study.

9.6 Study limits and strengths

A challenge of this research was the considerable restructure and reorientation in the South Australian PHC sector during the study period that impacted the four study sites. Such restructuring is not uncommon, but makes it difficult to undertake research in health services when service continuity is low, what is being studied is in flux, and staff turnover is high.

Engaging staff in this research was at times also problematic. Barriers included competing demands for staff, low morale, high levels of stress and staff turnover, and a number of staff that worked part time or on short term contracts (e.g. 3 months). Staff were less motivated to be involved in this research and some, particularly part time staff, declined to participate in the study.

There were challenges in applying the pilot case tracking methods. Staff were reluctant to invite clients into the interview component of the study during initial appointments as clients were considered too vulnerable and often very distressed. At some services, clients were seen for a short time and delaying the invitation to participate sometimes meant clients had finished counselling or did not return to the service. The case tracking sampling was largely able to avoid selection bias as all depression clients seen by practitioners were included. This was not possible for the client interviews, and selection biases may have been introduced by staff making judgements about which clients to ask to participate. At two of the services (Orange and Green) there were very few mental health workers employed, partly due to the reorientation of services towards physical chronic conditions which was part of the restructuring of services, and this reduced the ability to capture the work of a multi-disciplinary team.

There were some limitations in this study. The tension between studying CPHC as a holistic model and focusing on selected conditions (the broader project focused on diabetes as well as my contribution on depression) was a source of ongoing debate amongst investigators and partners in the project. The focus on selected conditions was seen as a way to provide practical examples of the practice and benefits of the implementation of CPHC, to aid in research translation, however, the risks in this approach, of not seeing the broader benefits of CPHC, and reinforcing a biomedical focus on diseases, were acknowledged. The research was envisioned as an action research project to provide key learnings to the case study sites to improve practice. However, reorganisation meant it was difficult to provide this feedback to the health services. Importantly, services were moving away from both mental health care and comprehensive PHC that endorsed aspects of a social view of health that this research aimed to capture - in some cases reducing organisational support and enthusiasm for the research.

Additionally, given this study looked at clients' experiences of the services they had received, this study could be vulnerable to response bias (Roulston & Shelton, 2015), where client's may be reluctant to criticise their PHC service. However, the study benefitted from data coming from a number of different sources where data comparisons were able to be made.

Furthermore, while staff did refer to client case notes to complete the case tracking questionnaires (Appendix S), gaps sometimes needed to be filled by relying on staff memory. As a result, there may have been some under reporting of information such as referrals. Despite these difficulties, the case tracking methods and client interviews were useful in generating descriptions of client journeys for individuals experiencing depression, highlighting client experiences of PHC and the broader work that comprises a comprehensive PHC model of service delivery.

The strengths of this research can be considered in light of criteria proposed by Guba & Lincoln (1989): credibility, transferability, dependability and confirmability. The credibility of this study was ensured by the involvement of service managers, staff and clients in key aspects of this study. Service managers of the PHC services were Associate Investigators and/or on a reference group for the NHMRC project. Staff at each of the services were consulted and assisted with the development of the case tracking methods. A group of clients with depression from another PHC service contributed to the development of a pilot client interview schedule that ensured use of language that was respectful.

Although the operation of CPHC is context-specific, there is some scope for transferability aided by the detailed description of the context in which this study took place. This enables others to take this context into account and judge for themselves if the findings apply to their context.

Dependability was enhanced by the utilisation of one interviewer for the staff and client interviews and the piloting of the client interview questions. This ensured interviews followed a similar process. An exception was the NHMRC staff and manager semi-structured interviews that were conducted as part of the NHMRC project and were shared amongst the research team.

The confirmability of the process was enhanced by the combination of data being used from a number of different sources. For example, client journeys were confirmed by clients during interviews, data was gathered through interviews with staff and managers as well as yearly audits conducted at each site that collected service data on workforce, resources, changes in funding, activities and services provided, client numbers and the partnerships and collaborations with other agencies. As a result, a strength of this study was examining the service response to depression over the care trajectory rather than focusing on a particular aspect of the implementation of CPHC.

The use of multi-method case tracking was a strength of this research that captured actions unique to CPHC. The use of this method was a thorough way of generating client journeys through service data, client perspectives and health logs. The client journeys and client interviews prior to policy reforms captured features of the PHC services that were aligned to a CPHC model of service delivery such as taking into account clients' social determinants of health and undertaking advocacy on their behalf. This was an important contribution as how health services respond to the challenges of clients' social determinants of health is rarely reported in the literature. These data are an important contribution given the need for innovative ways of measuring advocacy, cultural sensitivity, and equity (Levesque, et al., 2012).

The flexibility of the case tracking methods was a strength that enabled being responsive to practitioner needs and the changing organisational environment. This flexibility was important given the frequent reorganisation and reform in health care. Being flexible with practitioners' workloads was crucial to the success of gathering case tracking data and the construction of individual client journeys. Practitioner's chose how to provide the data, either electronic questionnaire, mailed paper questionnaires or monthly interview where questionnaires were completed together for all clients seen for depression in the last month.

The multi-method case tracking has not been used before in research of PHC services and offers a useful way of constructing client journeys for clients with depression that could be applied to research of other chronic conditions to examine client pathways through health services. This method can also be used by PHC services as an audit tool to examine the extent to which they are operating from a social view of health, and would provide a way of drawing attention to gaps in service delivery and coordination with other services. The inclusion of client perspectives was also very valuable given there is a lack of evidence about the experiences of people receiving multi-disciplinary PHC services over time, and health services research focusing on clinical aspects and outcomes may overlook the role played by clients' social determinants of health. This method has the potential to inform service planning and practice, with the potential to improve health system integration.

CHAPTER 10: CONCLUSION

10.1 Introduction

The focus of this thesis has been on the implementation of CPHC, an approach to service delivery and health promotion underpinned by a social view of health, community participation, empowerment, social justice, equity and action on the social determinants of health (Baum, 2016; World Health Organisation, 1978). In this thesis it has been argued that a PHC service that is aligned with a CPHC model offers a valuable approach to treating and preventing depression in individuals and communities. This research was undertaken using a critical inquiry approach to examine how comprehensive four case study PHC services were in practice and the extent to which they responded to depression in individuals and the community.

This study has considered mental health in multidisciplinary PHC services. The findings of this study have highlighted how CPHC as a model of service delivery and philosophy of care can be strengthened and the difficulty of implementing anything resembling a CPHC model in the neoliberal climate that was prevalent in the health sector in South Australia at the time of the study. In particular, this study has drawn attention to managerialism that underpins neoliberal health reforms and directed de-politicised approaches to PHC service delivery and constrained the opportunity for policy action that supports CPHC. Within this context there was less capacity to prevent and respond to depression and little scope to reduce health inequities in the community. This chapter concludes with consideration of CPHC policy and practice, implications of this study for mental health reform and the potential for further research.

10.2 CPHC and mental health

The results of this study provide important information about how the implementation of CPHC can be supported and strengthened with a particular focus on responding to mental health. There is little literature regarding the implementation of CPHC as a health care delivery system in practice in relation to depression and particularly client perspectives of PHC service provision. This study investigated the implementation of CPHC, a model of service delivery that is in the minority in Australia, running counter to the mainstream medical model. The extent to which four case study PHC services aligned with a CPHC model in terms of their response to depression in individuals and communities was examined. In South Australia there hasn’t been a consistent and similar model of CPHC. In this study there were different models of PHC operating at the four case study sites. The services were not operating from a CPHC model as it was being undermined by neoliberal health reforms promoting market-orientated competition between services, managerialism, fragmentation and economic efficiency that constrained its operation.

The different PHC models were more holistic prior to health reforms and client perspectives emphasised life events and the broader context of their lives which contributed to and shaped their personal experiences of depression and their interaction with services. Client perspectives confirmed the value of a holistic approach that considered physical health and helped manage their depression as well as helped with issues such as housing and social support. This study captured the importance of health promotion and support groups in reducing social isolation, helping clients to feel connected to the community and in gaining support and skills to manage their depression. These elements that underpin CPHC are consistent with a recovery approach to mental health that has been widely accepted in mental health policy both nationally and internationally (Kidd, Kenny, & McKinstry, 2014). As neoliberal health reforms became more pronounced enforcing restrictive practices for responding to depression, it was evident that this climate was not supportive of a recovery approach.

This research contributes new knowledge by examining how comprehensive four case study PHC services were in practice and the extent they aligned with a CPHC model regarding their response to depression. Research on CPHC has focused on implementation and outcomes of individual components of CPHC, for example work done to improve equity of access (Andrews, Simmons, Long, & Wilson, 2002; Braveman & Gruskin, 2003) and community participation (Manandhar, et al., 2004). Evaluations of CPHC in Australia and internationally have focused on small components, or reports on specific programs carried out in CPHC rather than looking at overall services (Hurley & Baum, 2007; Labonte, et al., 2008).

The overall service response to depression among the four PHC services and the spectrum of interventions offered for mental health were examined. The study provided an important contribution to research methods through the piloting of case tracking in PHC services. This study builds on research by Fairlamb and Muir-Cochrane (2007) who describe mental health being delivered in a CPHC context in Australia. Fairlamb and Muir (2007) document a model that recognises the social determinants of health and considers important factors such as housing, homelessness, employment and family relationships that influence mental health. This study confirms the consideration of these factors were an important element of service delivery for responding to depression. Fairlamb and Muir-Cochrane did not report on the mental health promotion and prevention work that was carried out or client experiences and the findings of this study make a significant contribution to this literature. This study supports the findings of Liddy et al (2011) who found community-governed community health centres made up of multidisciplinary health care teams where staff received a fixed salary provided a higher quality of care for chronic diseases such as diabetes than fee-for-service and blended-capitation models. For example, practitioners were more likely to following guidelines and provide more comprehensive care that included foot and eye examinations.

The findings from this research can be used to inform mental health policy and practice. In particular the role of health promotion and support groups and their importance for social connection and recovery of mental illness. Additionally, if good mental health practice is reflective of mental health policy that recognises the social and economic contexts of people’s lives as important, practitioners need to be provided training in advocacy and empowerment of individuals and the community. Additionally, practitioners need to be supported in ways that enable them to have the capacity to advocate for individuals and support broader forms of collective advocacy. With current mental health reforms some mental health services are commissioned through Primary Health Networks around Australia, the results of this study have important implications for the value of a social model of health that incorporates one to one treatment as well as group work.

10.3 Institutional constraints on the implementation of CPHC

This thesis offers findings which contribute to improved knowledge about the ways institutional barriers such as the broader sociological dominance of neo-liberalism and individualism shape health reforms and constrain the implementation of CPHC. Although CPHC has never been fully implemented by these services, there were features of the PHC services such as health promotion, prevention and treatment and advocacy that clients valued. This study highlighted what was lost at these PHC services under the influences of neoliberalism. Narrow and restrictive reforms threatened health outcomes by eroding the focus on communities, prevention, social and economic factors that affect health and lead to broadening health inequities. Promoting community engagement in health issues and building linkages to improve community health is a key challenge of an empowering approach. The narrow approach acted against collectivism, community participation, prevention, equity and improvements in the overall health and wellbeing of the community.

The results of this study support findings by Baum et al (2016), Sanders et al (2011) and Labonte et al (2008) documenting neoliberalism and individualism having an effect on health systems in western industrialised countries and the ongoing struggle for CPHC to be operationalised. The emphasis on chronic disease at the expense of a broader CPHC approach has been documented in Canada and elsewhere (Raphael, Curry-Stevens, & Bryant, 2008; Sanders, Stern, Struthers, Ngulube, & Onya, 2008). This research supports literature by Labonte et al (2008) regarding the globalisation of market-driven models of health systems that fail to consider the social determinants of health, equity and community participation. This implies the need to find ways to strengthen CPHC through mechanisms that promote greater equity such as infrastructure to support community participation and social connectedness and where there is an emphasis on clients, the context of their lives and the needs of the community.

10.4 Individual and community empowerment in CPHC

Empowerment is at the heart of CPHC (Labonte, 1992; World Health Organisation, 1978) yet there is little research on this topic and the role of power in shaping PHC has not been studied in detail. This study found that empowering practices were limited by the operation of selective PHC and the sociological dominance of neoliberalism which led to processes of disempowerment. Clients in this study were restricted and didn’t have access to services and support groups that would help manage their depression.

This study contributes important information about how individual empowerment can be enhanced by one to one support through counselling and group work where practitioners acknowledge power differences and where clients are able to direct sessions in a way that integrates practitioner expertise with client needs. However, under an unfavourable socio-political environment where there is an absence of structured ways for PHC services to support community empowerment within these PHC services the scope for empowerment is limited. Without mechanisms supporting community participation and clients' involvement in the planning of services there is a lack of potential to have any impact on the community in regards to preventing mental illness and empowering the community to address causes of ill health, or undertake and sustain healthy behaviours. An implication of this is the need to have structures in place that support empowerment of individuals, community participation and involvement in the planning of health services, and broader collective advocacy structures that enable staff to advocate for individuals as well as collective advocacy that can lead to community empowerment.

This thesis offers findings which contribute toward a detailed understanding of how power embedded within the health system operates within these PHC services. The medicalisation of the health system as a result of health reforms brought biomedical understandings that were entrenched in regimes of practices based on managerialism. This brought an expanding and tightening complex web of power relations that worked across different sites and levels of government where there were a range of political actors involved. In particular, the findings show how power was exercised in a way that controlled agendas so that options and opinions of staff and clients were not considered.

This thesis also offers insights into practitioner reflections on their practice within PHC services. A lack of power and autonomy was identified by practitioners and service managers over the way they practiced that heavily restricted how they were able to respond to depression and their capacity to empower individuals and the community. The findings of this study are also consistent with Schon (1983) who point out that when staff are not provided autonomy and legitimacy in their role there is greater difficulty in empowering clients. It also supports findings by Laverack (2007) and Labonte (1994) who identify when practitioners feel relatively powerless in their organisation this can reduce their confidence to help clients. This presents a barrier to individual and community empowerment and implies the need to find ways to support staff to feel they are making a positive contribution particularly when influences of neoliberalism and individualism are evident.

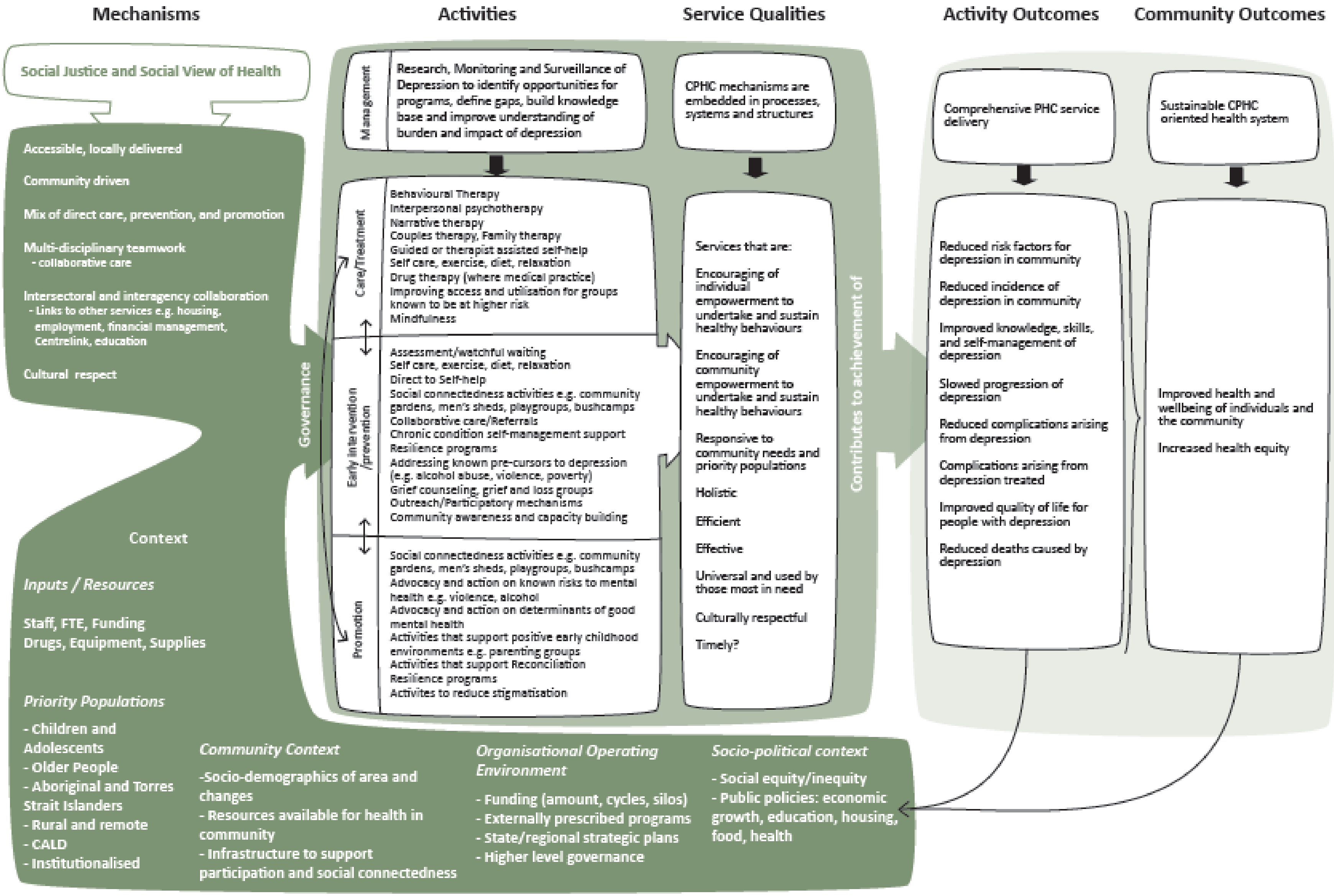
10.5 Future policy directions and suggestions for research

The results of this study lead to a number of future directions for CPHC policy and practice. The dominance of medical power has been persistent and long lasting. There is extensive evidence supporting models of service delivery that have a social model of health that expand beyond primary medical care that offer a holistic approach and promote advocacy, empowerment and increased health equity. For those who suffer from mental illness there have been repeated calls for governments to provide an adequate community-based model of care (Griffiths, et al., 2015). Governments need to take responsibility for creating conditions and structures under which community empowerment is possible (Solar & Irwin, 2010). In order to reverse neoliberal health care reforms PHC services need to be reorientated to promote health equity by focusing on the social determinants of mental health. Therefore, funding needs to be allocated to mental health prevention and the promotion of good mental health. This study revealed a number of barriers of access and highlights the need for attention to be paid to address these barriers. For example, mental health needs to be considered in conjunction with physical health and health services need to be able to respond to community needs.

Further research is needed to enhance the evidence base for the implementation of CPHC in response to mental health. In particular exploring clients’ experiences of treatment and health promotion and support groups and how it affects their management of depression. Further research on a wider scale to fully explore mental health outcomes and empowerment linked to the services received at PHC services is needed.

Depression is one of the most prevalent mental illnesses and its treatment and prevention in the community is an important issue. Ensuring the health system can respond comprehensively and in a culturally appropriate way is important for mental health and wellbeing. This thesis contributes to this goal by offering new knowledge regarding the ways in which PHC can contribute to responding to depression and the limitations of a selective rather than a comprehensive approach and the ways in which CPHC can be undermined by the broader dominance of neo-liberalism and its inherent individualism.

APPENDIX A: SOUTHGATE MODEL FOR DEPRESSION


Mechanisms
Activities
Service Qualities
Activity Outcomes
Community Outcomes
Social Justice and Social View of Health
Accessible, locally delivered
Community driven
Mix of direct care, prevention, and promotion
Multi-disciplinary teamwork
- collaborative care
Intersectoral and interagency collaboration
- Links to other services e.g. housing, employment, financial management, Centrelink, education
Cultural respect
Governance
Management
Research, Monitoring and Surveillance of Depression to identify opportunities for programs, define gaps, build knowledge base and improve understanding of burden and impact of depression
Care/Treatment
Behavioural Therapy
Interpersonal psychotherapy
Narrative therapy
Couples therapy, Family therapy
Guided or therapist assisted self-help
Self care, exercise, diet, relaxation
Drug therapy (where medical practice)
Improving access and utilisation for groups known to be at higher risk
Mindfulness
Early intervention /prevention
Assessment/watchful waiting
Self care, exercise, diet, relaxation
Direct to Self-help
Social connectedness activities e.g. community gardens, men's sheds, playgroups, bushcamps
Collaborative care/Referrals
Chronic condition self-management support
Resilience programs
Addressing known pre-cursors to depression (e.g. alcohol abuse, violence, poverty)
Grief counseling, grief and loss groups
Outreach/Participatory mechanisms
Community awareness and capacity building
Promotion
Social connectedness activities e.g. community gardens, men's sheds, playgroups, bushcamps
Advocacy and action on known risks to mental health e.g. violence, alcohol
Advocacy and action on determinants of good mental health
Activities that support positive early childhood environments e.g. parenting groups
Activities that support Reconciliation
Resilience programs
Activites to reduce stigmatisation
CPHC mechanisms are embedded in processes, systems and structures
Services that are:
Encouraging of individual empowerment to undertake and sustain healthy behaviours
Encouraging of community empowerment to undertake and sustain healthy behaviours
Responsive to community needs and priority populations
Holistic
Efficient
Effective
Universal and used by those most in need
Culturally respectful
Timely?
Contributes to achievement of
Comprehensive PHC service delivery
Reduced risk factors for depression in community
Reduced incidence of depression in community
Improved knowledge, skills, and self-management of depression
Slowed progression of depression
Reduced complications arising from depression
Complications arising from depression treated
Improved quality of life for people with depression
Reduced deaths caused by depression
Sustainable CPHC oriented health system
Improved health and wellbeing of individuals and the community
Increased health equity
Context
Inputs / Resources
Staff, FTE, Funding
Drugs, Equipment, Supplies
Priority Populations
- Children and Adolescents
- Older People
- Aboriginal and Torres Strait Islanders
- Rural and remote
- CALD
- Institutionalised
Community Context
-Socio-demographics of area and changes
- Resources available for health in community
- Infrastructure to support participation and social connectedness
Organisational Operating Environment
- Funding (amount, cycles, silos)
- Externally prescribed programs
- State/regional strategic plans
- Higher level governance
Socio-political context
- Social equity/inequity
- Public policies: economic growth, education, housing, food, health

APPENDIX B: INITIAL INTERVIEW GUIDE FOR CLIENTS WITH DEPRESSION

- *Explain the project and go through the participant information sheet. Explain participant involvement through interviews and health care diaries.*
- *Explain anticipated length of time*
- *Interviewer reassures participant of confidentiality and checks if there are any questions in relation to the project and their participation.*
- *Participant to complete consent form if willing to participate.*
- *Interviewer to check contact details for participant and explain they will ring monthly to support them to fill in the log.*
- *Interviewer to use language consistent with what the practitioner is using. The interviewer will check with practitioner prior to interview regarding what language is currently being used to refer to depression (ie. whether they refer to their condition as depression or social and emotional wellbeing)*

Questions:

1. What services, groups or activities have you used at the health service?

2. What services, groups or activities have you used in relation to your emotional wellbeing (depression)?

3. How did you come to start using the health service for depression – were you referred by a GP, other health professional, self-referral?

4. When did you start using the health service for depression services?

5. When you were first told you had depression?

6. What other services do you use to manage your emotional wellbeing (depression)? e.g. GP, psychiatrist, other health professional

7. Tell me about your experience of one-to-one services you have received at the health service for depression so far?

    - Has the services helped you to manage your depression? How?
    - Are there things you would change?

Have you accessed any of the group activities or other activities that operate through the health service?

- What has been your experience of the group activities? Has it had an impact on your health, your emotional wellbeing?
- Have you been satisfied with the group activities?
- Are there things you would change?

8. Do you feel you will be able to achieve what is important to you (goals)?

How do you think the health service could help reduce the number of people that experience depression in the community?

9. How has depression affected your life?

10. What factors in your life and background do you think contributed to your emotional wellbeing (depression)?

11. How has the health service helped you manage your emotional wellbeing? Would you have liked more help in different areas, for example physical health, mental health, family issues? Could they have helped differently?

12. Do you feel the information you've been given has been useful and appropriate?

13. How able are you to act on the information you've been given? Is it difficult to act on the information provided? What makes it difficult?

14. What was the most useful thing that the PHC service has don

APPENDIX C: SECOND INTERVIEW GUIDE FOR CLIENTS WITH DEPRESSION

Questions:

1. Tell me about what services you have used at
    a. [name of health service] [Look at log and discuss]
    b. Have you attended any appointments with other services in the last 6 months [Look at log and discuss]

2. Tell me about your experience of the services you have received for depression at .[name of health service] in the last 6 months?

3. What do you think has worked well for you in relation to the services you have received for depression at [name of health service]? Has there been anything that has not worked well or could have been done differently or better?

4. Have there been any changes in your depression since you started using the service? [Improvements, differences in how you felt] Have there been any difference in how you have managed your depression now?

5. Tell me about how you feel about having depression? What does it mean for you?

    Patient Empowerment Tool

    <u>Experience of service – </u>[holistic]

6. Do you think the services you have received for depression have considered other aspects of your life e.g. living conditions, relationships with others, employment?

    a. Have you been treated in a respectful way? Can you give examples?
    b. Do you think your cultural background has been taken into consideration?
    c. Have there been any big changes or improvements in aspects of your life since the initial interview?
    d. Have you had any help in solving problems related to your health (i.e. advocacy work which may include referrals made to other agencies - housing, Centrelink or suggestions for other things eg. Attend a group)

    e. If yes, do you think this has helped you to manage your depression? (How did this work?)

<u>Accessibility</u>

7. The next questions are about how accessible you found the services at [name of health service]?

    a. Were appointments available when needed?
    b. Did you feel that the service was safe and welcoming?
    c. Was transport provided to you when needed?
    d. Were there any other issues to do with accessibility e.g. gp there, waiting list? If yes, how?

<u>Empowerment</u>

8. Have you been given information or support that has helped you to take action on managing your depression?

    a. Have you been involved in decisions regarding the planning of treatment for your depression? Were various options discussed?
    b. Have you been involved in the identification and solution to other problems you may be experiencing? Have you received help in solving these problems?
    c. Have you gained confidence and skills in managing your depression? If yes, what action have you taken towards improving your health and wellbeing?
    d. Have there been any barriers to managing your depression?

9. [Look at log] It looks like you have/haven't been involved in a group activity at the health service? E.g. I understand they have Mindfulness groups, information sessions, cooking, exercise groups, community gardens
    a. If yes, how much say do you have in how these groups run, what activities are done each week etc?
    b. If no, the health service runs [list groups]. Did you know about these groups? Were you offered them?

10. As well as help people to manage their depression, are you aware of any work the service does to try and prevent people from becoming depressed, or to help people to stay healthy? e.g. community awareness campaigns, food co-ops, health events. Have you been involved in these activities?

11. [Look at log – how many/what services they accessed within the centre. If > 1] How well did you find they worked together?
    a. Did you have to repeat information, any doubling up?
    b. Did the services complement or support each other?

12. a. Do you have a GP? Does the service communicate or work with your GP?
    b. How about other services you access for your depression?

13. Have you ever been asked by [name of health service] to give feedback on services you have received?

14. Is there anything that the service should do differently in terms of what they offer for people experiencing depression?

APPENDIX D: CLIENT LOG BOOK

Keeping Track of the Care Received for DEPRESSION

Client Log Book of Services Accessed for Depression

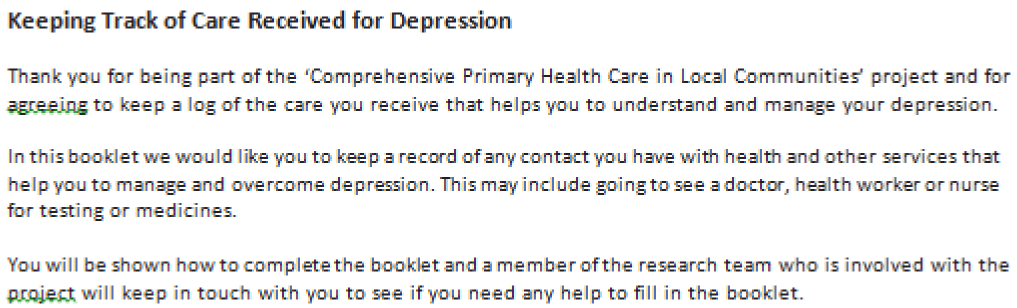
Keeping Track of Care Received for Depression

This Log book is for clients who have agreed to be involved in the case tracking of clients with depression. This forms part of the 'Exploring Comprehensive Primary Health Care in Local Communities' project. The booklet is to help clients 'keep track' of the services, programs and care they are provided and access for depression.

The aim of the 'case tracking' is to find out how health services supports people with depression and how it links with other services offered for clients that have this condition. So, we want to record the types of health care and other relevant services that people with depression access over a 6 month period. We are not evaluating the care they provide or the people who deliver them.

SACHRU
South Australian
Community Health
Research Unit

Flinders
UNIVERSITY



Keeping Track of Care Received for Depression

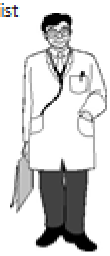
Thank you for being part of the ‘Comprehensive Primary Health Care in Local Communities’ project and for agreeing to keep a log of the care you receive that helps you to understand and manage your depression.

In this booklet we would like you to keep a record of any contact you have with health and other services that help you to manage and overcome depression. This may include going to see a doctor, health worker or nurse for testing or medicines.

You will be shown how to complete the booklet and a member of the research team who is involved with the project will keep in touch with you to see if you need any help to fill in the booklet.

Month: ____________________

☐ Medical appointment - for review and assessment by a doctor or psychiatrist



☐ Attend group therapy sessions to discuss common issues, learn coping strategies

☐ Attend a counselling session (eg. Cognitive Behaviour Therapy) with a psychologist or trained counsellor

☐ Medications for depression

☐ Hospital admission

☐ Self care activities (eg. increase physical activity, change diet, relaxation)

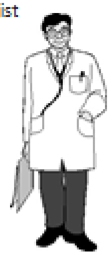
☐ Assistance from the health service for other social needs (eg. housing, income support)

☐ Attend information sessions to build life skills (eg. budgeting, time management)

Month: ____

☐

Medical appointment - for review and assessment by a doctor or psychiatrist



☐

Attend group therapy sessions to discuss common issues, learn coping strategies

☐

Attend a counselling session (eg. Cognitive Behaviour Therapy) with a psychologist or trained counsellor

☐

Medications for depression

☐

Hospital admission

☐

Self care activities (eg. increase physical activity, change diet, relaxation)

☐

Assistance from the health service for other social needs (eg. housing, income support)

☐

Attend information sessions to build life skills (eg. budgeting, time management)

APPENDIX E: PATIENT ENABLEMENT INSTRUMENT

Client Interviews – First Interview Extra Questions

As a result of your care at this service, do you feel you are ....

	MUCH BETTER	BETTER	SAME OR LESS
Able to cope with life	☐	☐	☐
Able to understand your depression	☐	☐	☐
Able to cope with your depression	☐	☐	☐
Able to keep yourself healthy	☐	☐	☐

	MUCH MORE	MORE	SAME OR LESS
Confident about your health	☐	☐	☐
Able to help yourself	☐	☐	☐

APPENDIX F: 6 MONTHLY SITE AUDIT TOOL

Comprehensive Primary Health Care in Local Communities Project

Six Monthly Site Audit **Jan – Jun 2013**

The purpose of the six monthly audit is to document any changes in the service over the project timeframe to ensure the project continues to be appropriate, timely, and accurate.

This audit is for the period: **January – June 2013** (or as close to as documentation easily allows).

Many of these questions could be answered using information from activity reports, annual reports, and other documentation. *Please do feel free to just pass on relevant documents that will answer the questions wherever possible!* We don't want services to have to duplicate effort.

Service/site organization

1. At the end of this period (June 2013) how many staff were employed in your service (both in number of people and total FTE)?

Jan-June 2013	
Response from most recent audit (July-Dec 2012)	

2. At the end of this period (Jun 2013), what disciplines (and how many / total FTE) were employed in your service?

Jan-June 2013	
Response from most recent audit (July-Dec 2012)	

3. During this period (Jan–June 2013), were there any new ongoing positions? New contract positions? Lost ongoing positions? Contract position completed?

Jan-June 2013	
Response from most recent audit (July-Dec 2012)	

4. Has the organisational structure at your service, both within the site and where the site sits in the broader regional structure, changed? Attach organisational chart if available.

Jan-June 2013	
Response from most recent audit (July-Dec 2012)	

5. Were any planning or priority setting documents produced in Jan-June 2013? Attach copy if available.

Jan-June 2013	
Response from most recent audit (July-Dec 2012)	

6. What was your budget (sources, amounts, tied or open) for this period, and how was funding disbursed?

Jan-June 2013	

Response from most recent audit (July-Dec 2012)	

7. Were there any **changes** to funding and if so what were these?

Jan-June 2013	
Response from most recent audit (July-Dec 2012)	

8. Were there any **changes** to policies or structures (e.g. around community participation) during this period? Attach policies if available.

Jan-June 2013	
Response from most recent audit (July-Dec 2012)	

9. Does the service have an orientation package, and if so, were there any significant **changes** to the orientation package during these periods?

Jan-June 2013	
Response from most recent audit (July-Dec 2012)	

10. What staff development and training did staff undertake during this period?

Jan-June 2013	
Response from most recent audit (July-Dec 2012)	

Services

11. What programs were run or auspiced during this period? From recurrent funding or grant funded? Any changes?

Jan-June 2013	
Response from most recent audit (July-Dec 2012)	

12. What proportion of time and resources do you estimate would have been devoted to a) individual work, b) group work, and c) community activity?

Jan-June 2013	
Response from most recent audit (July-Dec 2012)	

13. Any changes to the committees, networks, or regional structures the service was involved with during this period?

Jan-June 2013	
Response from most recent audit (July-Dec 2012)	

14. What other agencies/organisations did the service work with during this period (eg, GPs, schools, community centres, childcare centres)?

Jan-June 2013	
Response from most recent audit (July-Dec 2012)	

15. What was the purpose of these relationships (eg, provided and received referrals, used venue to run a group, collaboration)?

Jan-June 2013	
Response from most recent audit (July-Dec 2012)	

16. Has the service ceased working with any other agencies or organisations in these periods, and why?

Jan-June 2013	
Response from most recent audit (July-Dec 2012)	

17. Did the service undergo any accreditation during these periods (eg Equip)? If possible, please attach any resulting reports

Jan-June 2013	
Response from most recent audit (July-Dec	

2012)	

Community / Clients

18. Any changes in how information was provided to clients and the community about the service (eg, brochures on display, newsletters)?

Jan-June 2013	
Response from most recent audit (July-Dec 2012)	

19. How was feedback invited and received from clients or the community in this period (e.g. surveys, suggestion box)?

Jan-June 2013	
Response from most recent audit (July-Dec 2012)	

20. Any change to the catchment area of the service for this period?

Jan-June 2013	
Response from most recent audit (July-Dec 2012)	

21. **New**. How many clients attended your service (1:1 or groups or other) for the period Jan-Jun 2013? (This number will be used to contextualise the client survey results).

Jan-June 2013	

Regional or higher level

22. Were there any major changes at regional or higher level that had an impact on your service? (e.g. changes in personnel, policy, focus/priorities)

Jan-June 2013	
Response from most recent audit (July-Dec 2012)	

APPENDIX G: EXCERPTS FROM REFLECTIVE JOURNAL

Staff interview mental health practitioner– Blue service November 2013

- Very reserved and sad and down about the whole situation of PHC. Especially that there are no groups running anymore. She is very anxious about it, this is why she recently had to take a month’s leave.
- She was at times guarded and seemed like she didn’t want to say much.
- She has been feeling very unsupported in her role. There is a lack of supervision, she mainly talks to her colleagues.
- She is worried that she is not doing any good work anymore – she doesn’t get any feedback anymore because groups are not running.

Staff interview mental health practitioner – Green service – December 2013

- Works in the Social and Wellbeing Team for 12 months
- A barrier is that depression is not classed as a chronic disease – unsure whether they will just accept referrals from chronic disease clinics or whether they will accept self-referrals
- At the moment they are accepting self-referrals as well as those on a mental health plan. If this changes then there will be a large proportion of the population who will not have their needs met through this service.
- Since employed there have been no groups running. They hope to start up ‘Moving through Depression group next year if they can get another social worker/psychology position. Only two staff in Social work, no psychologist, this position hopefully will be filled next year.
- Since commenced work here there has been talk of future changes coming – a move to working more closely with outpatient clinics – Diabetes, Coronary, Respiratory, Cancer identified clinics at this stage. These changes are coming possibly won’t come into effect until after state election in March. Feels very frustrated that there is no group work, no advertising still.

APPENDIX H: CLIENT JOURNEY FRAMEWORK QUESTIONS

- To what extent are there external referrals/suggestions to services and internal referrals within the health service (e.g. to Dietician, psychology, health promotion groups)?
- Are clients being linked into social supports/suggestions to attend groups/courses in the community (particularly for those that are socially isolated)?
- To what extent do they offer/provide help with housing, Centrelink, employment, advocate for clients on these issues. Does this vary across professions i.e. psychology, social work?
- To what extent do the services offer /provide help in other areas: stressful events/problems that clients are experiencing – help to link a child into counselling, help with family issues, parenting issues, linking into financial counselling? (Help in other areas)
- Do the flowcharts show internal discussions between workers regarding shared clients (multi-disciplinary teamwork)?
- Are there phone calls/letters/meetings/case conferences with external agencies/services that are also working with the client (e.g. Hospital, GP, Marion Mental Health, Housing SA, Adair Clinic, private psychiatrist etc.). Also for clients that were referred by their GP – is there communication with the GP?
- Do the flowcharts show consideration/suggestions with physical health issues – asking whether they see a GP regularly, if not suggesting they see a GP?
- Do workers see clients regularly, is there any indication of barriers to access – limits on appointments for long term clients, childcare – access to crèche. Do the flowcharts indicate a waiting list for services within the health service e.g. Dieticians?
- Do the flowcharts show that workers follow-up with clients if they do not attend?
- Is transport offered or provided to clients – e.g. for those that are struggling financially e.g. can’t attend appointments because haven’t got enough money for the fare, or can’t afford anti-depressants, or for those that have difficulty using public transport?
- Is there any evidence of preventive or health promotive work (whether within 1:1 or groups)?

- Are clients referred/ suggestions made to access health promotion groups within the service or when health promotion groups stopped, do workers refer to groups running out in the community (- evidence of links to physical activity groups or walking groups in the community - community health centres, groups run by non-government agencies and local councils)?
- Are clients made aware of community events in the community or health events and encouraged to attend (e.g NAIDOC week celebrations)?
- Is there evidence that the client's culture was respected and taken into account?
- Is there any evidence of the client being asked to provide feedback as an individual (e.g. verbally or in evaluation form) or as part of a collective (eg participation forum)
- Is there any evidence of practitioners feeding individual client experiences into a macro strategy e.g. discussion of access or social or advocacy issues to management or to a network?

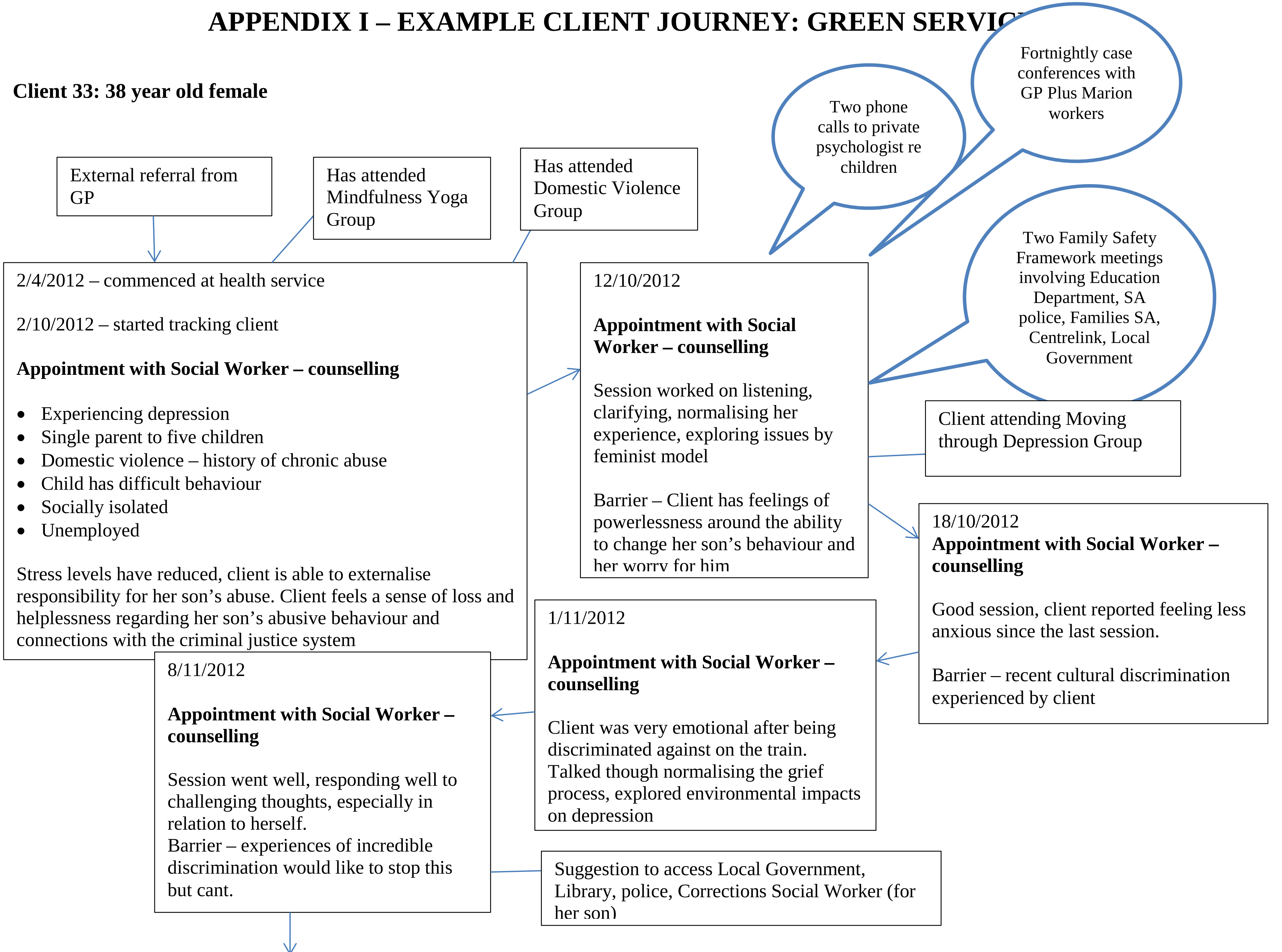
Quantification

- Where client was referred from GP, self-referral, Internal referral, health promotion group, other
- What different contributing factors were mentioned (number clients-, Unemployed, Alcohol, Childhood trauma, Criminal court proceedings, Domestic violence, Drug abuse, Employment, Family history of depression, Family issues, Grief and loss, Housing, Marriage breakup, Other mental illness, Parenting issues, Physical health, Postnatal depression, Previous abuse issues in the past, relationships, Single parent)
- Number of internal professionals seen
- Number of different groups attended
- Number of DNAs mentioned
- Number of external health referrals made
- Number of other sector referrals made (per client, health service). Number of internal referrals made
- Number of clients accessing private psychiatry (or psychology – where not available at the health service)
- Number of times that workers advocated for clients (per client/service) (Number of examples of advocacy)

- Number of times transport is provided for clients/service
- Number of health issues addressed
- Number of social issues addressed
- Number of average client contacts per month
- Number of case conferences/discussions within the service regarding a client
- Number of case conferences/discussions with agencies outside the service regarding a client

APPENDIX I – EXAMPLE CLIENT JOURNEY: GREEN SERVIC

Client 33: 38 year old female



External referral from GP

Has attended Mindfulness Yoga Group

Has attended Domestic Violence Group

2/4/2012 – commenced at health service

2/10/2012 – started tracking client

Appointment with Social Worker – counselling

- Experiencing depression
- Single parent to five children
- Domestic violence – history of chronic abuse
- Child has difficult behaviour
- Socially isolated
- Unemployed

Stress levels have reduced, client is able to externalise responsibility for her son's abuse. Client feels a sense of loss and helplessness regarding her son's abusive behaviour and connections with the criminal justice system

Two phone calls to private psychologist re children

Fortnightly case conferences with GP Plus Marion workers

12/10/2012

Appointment with Social Worker – counselling

Session worked on listening, clarifying, normalising her experience, exploring issues by feminist model

Barrier – Client has feelings of powerlessness around the ability to change her son's behaviour and her worry for him

Two Family Safety Framework meetings involving Education Department, SA police, Families SA, Centrelink, Local Government

Client attending Moving through Depression Group

18/10/2012

Appointment with Social Worker – counselling

Good session, client reported feeling less anxious since the last session.

Barrier – recent cultural discrimination experienced by client

1/11/2012

Appointment with Social Worker – counselling

Client was very emotional after being discriminated against on the train. Talked though normalising the grief process, explored environmental impacts on depression

8/11/2012

Appointment with Social Worker – counselling

Session went well, responding well to challenging thoughts, especially in relation to herself.
Barrier – experiences of incredible discrimination would like to stop this but cant.

Suggestion to access Local Government, Library, police, Corrections Social Worker (for her son)

Client 33 Continued

Suggestion to go to Centrelink regarding her son

21/11/2012

Appointment with Social Worker – counselling

Good session, client interactive and is more animated. She is making connections in the community and seems more confident.

Client is able to verbalise/understand models of understanding/changing/causes/effects of depression

Re-referral to Family Safety Framework – she was taken off the list but have requested that she be put back on

5/12/2012, 30/1/2013, 4/2/2013, 11/2/2013, 14/2/2013, 19/2/2013, 28/2.2013, 14/3/2013, 21/3/2013 and 2/4/2013

Appointments with Social Worker – counselling

Sessions have gone incredibly well, client is very receptive to her own self exploration and change. Have talked through a lot of strategies of re-affirming her strengths and skills, her rights, giving her a voice

8/4/2013, 16/4/2013, 18/4/2013 and 20/5/2013

Appointments with Social Worker – counselling

Depression is becoming more evident with clients' husband due to come out of jail soon. Client is extremely stressed and concerned that he will seek her and the children out.
Barrier – Can't keep husband away

27/5/2013, 17/6/2013, 21/6/2013, 2/7/2013, 10/7/2013, 18/7/2013, 22/8/2013 and 26/8/2013

Appointments with Social Worker – counselling

Sessions have gone well. Client has a lot going on in her life, one crisis after the other. Have organised safety measures in her house in case ex-husband find them. Worker has been able to give client a different perspective. Worker is supporting client with parenting issues

Meeting with CAMHS psychologist

Accessing CAMHS psychologist for her daughter

10/9/2013

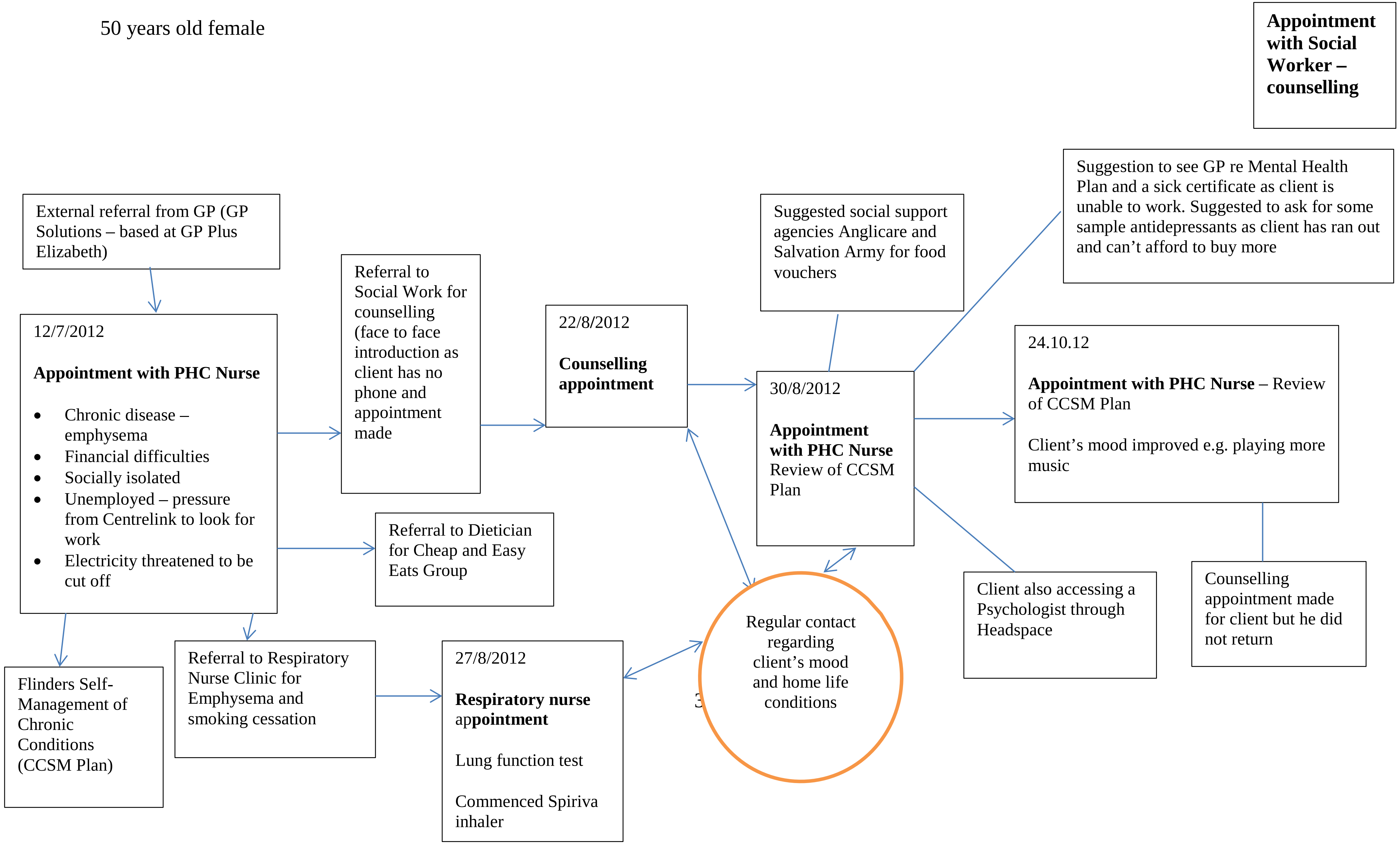
Appointment with Social Worker – counselling

Session went well; client has incredible strength and ability to change.

Barrier – This client will need long term counselling and help when ex-husband gets out of jail. Can't offer long-term counselling, restricted to 3 months, then client has to self-refer and go back on the waiting list. This is due to the model that they offer. Therefore are offering appointments to this client less often – once a month due to service changes. Other changes are that they will be working with the Clinics – Bariatric, Allergy, Chronic Disease focus – threat that for people without a chronic disease will have to refer them to Medicare Local.

APPENDIX J – EXAMPLE CLIENT JOURNEY: ORANGE SERVICE

50 years old female



Appointment with Social Worker – counselling

External referral from GP (GP Solutions – based at GP Plus Elizabeth)

12/7/2012

Appointment with PHC Nurse

- Chronic disease – emphysema
- Financial difficulties
- Socially isolated
- Unemployed – pressure from Centrelink to look for work
- Electricity threatened to be cut off

Referral to Social Work for counselling (face to face introduction as client has no phone and appointment made

Referral to Dietician for Cheap and Easy Eats Group

Flinders Self-Management of Chronic Conditions (CCSM Plan)

Referral to Respiratory Nurse Clinic for Emphysema and smoking cessation

27/8/2012

Respiratory nurse appointment

Lung function test

Commenced Spiriva inhaler

22/8/2012

Counselling appointment

Suggested social support agencies Anglicare and Salvation Army for food vouchers

30/8/2012

Appointment with PHC Nurse Review of CCSM Plan

Regular contact regarding client's mood and home life conditions

Suggestion to see GP re Mental Health Plan and a sick certificate as client is unable to work. Suggested to ask for some sample antidepressants as client has ran out and can't afford to buy more

24.10.12

Appointment with PHC Nurse – Review of CCSM Plan

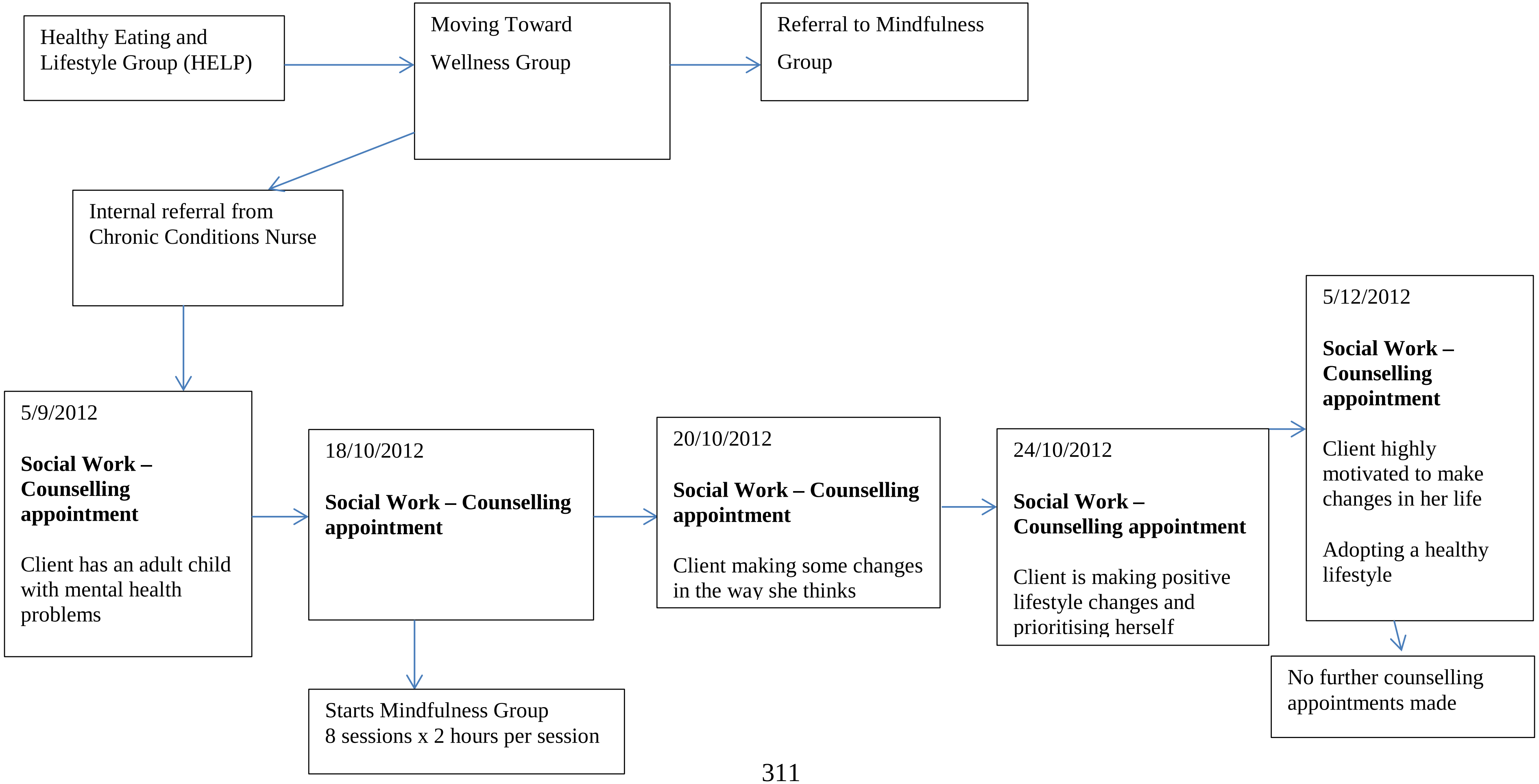
Client's mood improved e.g. playing more music

Client also accessing a Psychologist through Headspace

Counselling appointment made for client but he did not return

APPENDIX K - EXAMPLE CLIENT JOURNEY: ORANGE SERVICE

48 year old female



APPENDIX L – EXAMPLE CLIENT JOURNEY: GREEN SERVICE

42 year old female

External referral rom state-funded community mental health service on 10/4/2013

14/5/2013

Appointment with Social Worker – counselling

- Experiencing depression
- Recent marriage breakup – living apart from children
- Difficult childhood – Mother an alcoholic
- unemployed

21/5/2013

Appointment with Social Worker – counselling

- Session went well, talked about believing in herself
- Client is very depressed and bored with life
- Worker away all of June 2013 next scheduled appointment in July

1/7/2013

Appointment with Social Worker – counselling

- Client had her children visit but they didn’t want to be around her. Client thinking of walking away, talked this through, challenged her on this

17/7/2013

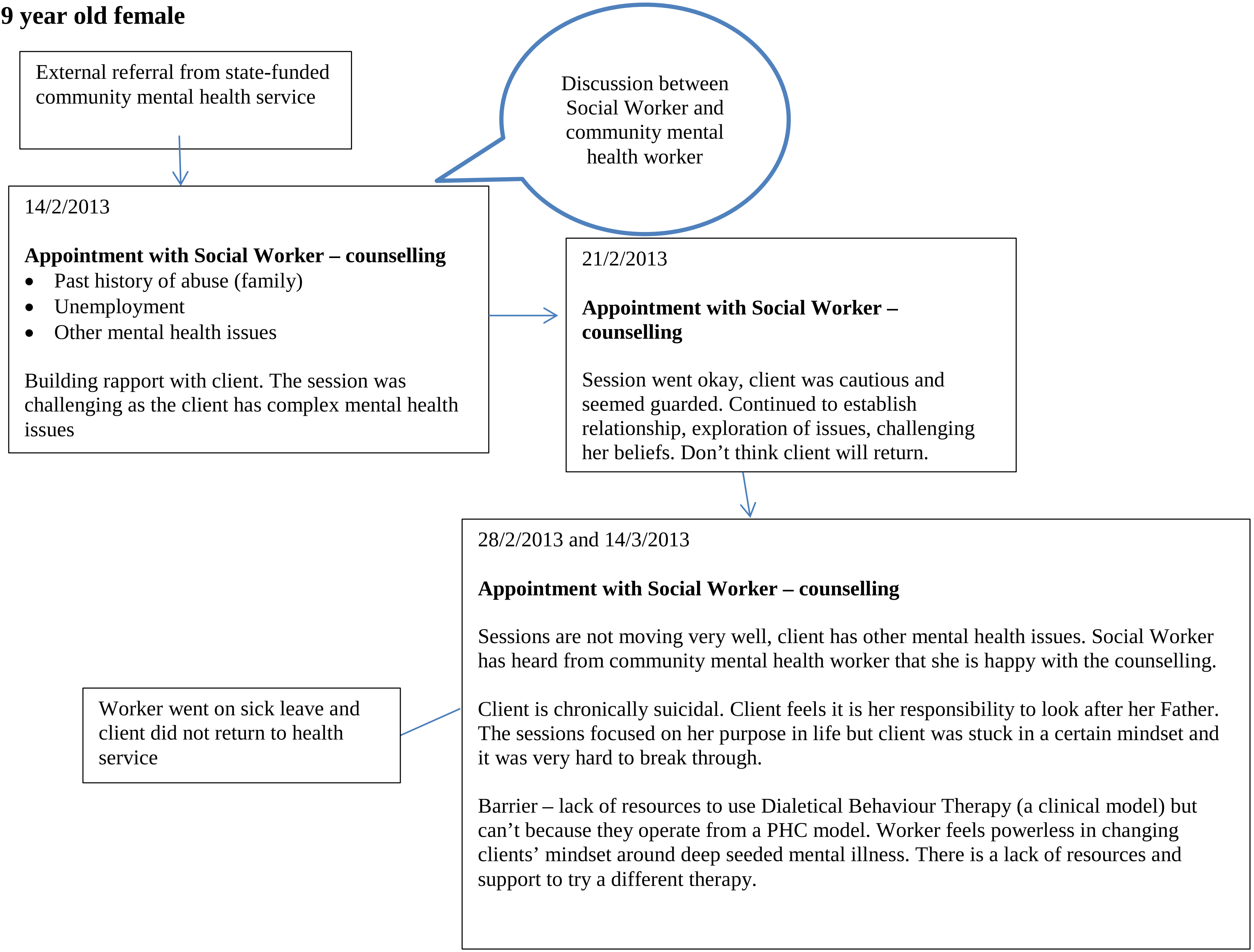
Appointment with Social Worker – counselling

- Client starting to believe more in herself – explored with her the effects in her children
- Client was able to move on and work through her feelings
- Client has a different world view – worker acknowledges, accepts and respects this – not sure where children fit into clients life

No further appointments set, client found a job and moved out of the area

APPENDIX M – EXAMPLE CLIENT JOURNEY: GREEN SERVICE

39 year old female



External referral from state-funded community mental health service

Discussion between Social Worker and community mental health worker

14/2/2013

Appointment with Social Worker – counselling

- Past history of abuse (family)
- Unemployment
- Other mental health issues

Building rapport with client. The session was challenging as the client has complex mental health issues

21/2/2013

Appointment with Social Worker – counselling

Session went okay, client was cautious and seemed guarded. Continued to establish relationship, exploration of issues, challenging her beliefs. Don’t think client will return.

28/2/2013 and 14/3/2013

Appointment with Social Worker – counselling

Sessions are not moving very well, client has other mental health issues. Social Worker has heard from community mental health worker that she is happy with the counselling.

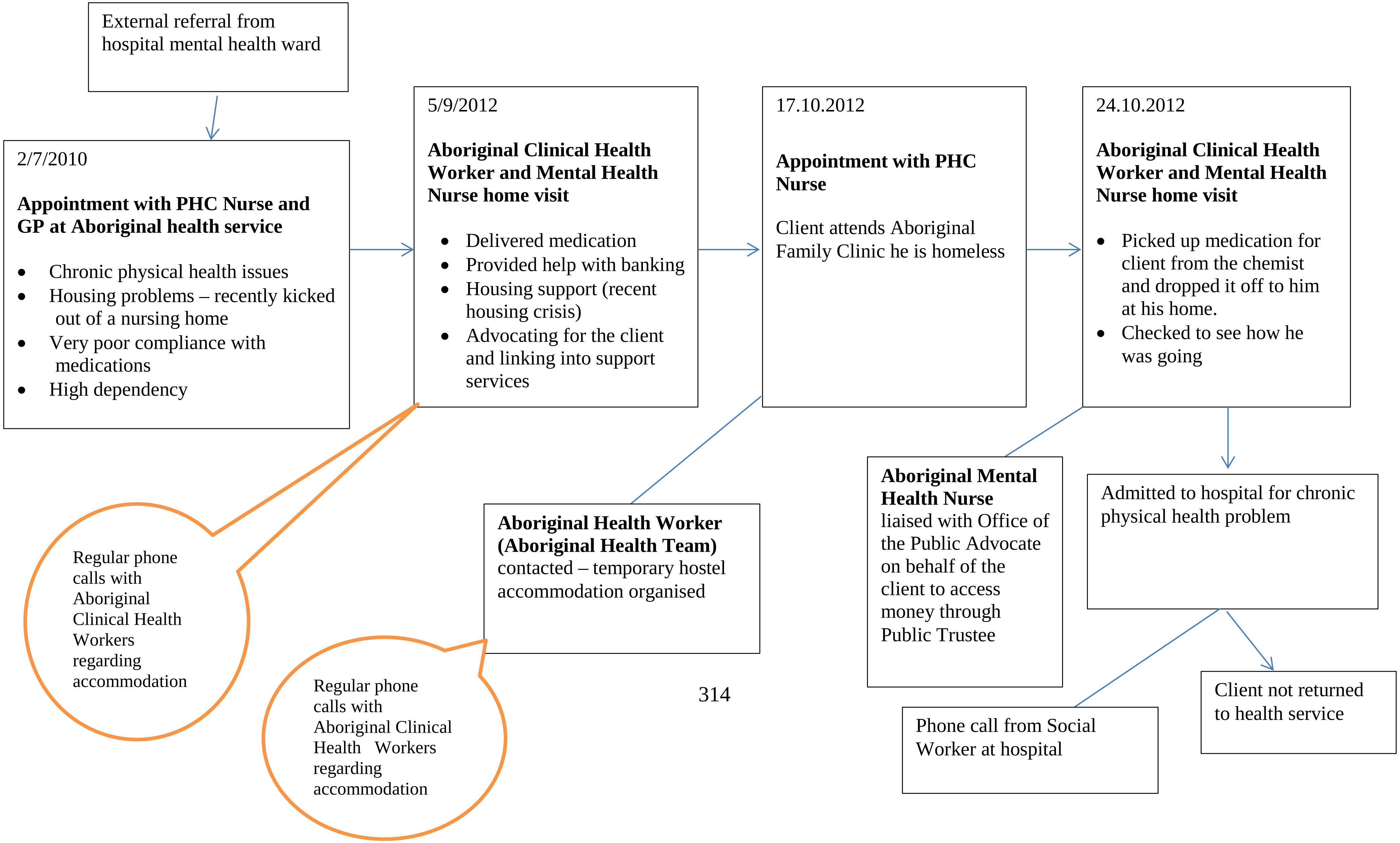
Client is chronically suicidal. Client feels it is her responsibility to look after her Father. The sessions focused on her purpose in life but client was stuck in a certain mindset and it was very hard to break through.

Barrier – lack of resources to use Dialetical Behaviour Therapy (a clinical model) but can’t because they operate from a PHC model. Worker feels powerless in changing clients’ mindset around deep seeded mental illness. There is a lack of resources and support to try a different therapy.

Worker went on sick leave and client did not return to health service

APPENDIX N – EXAMPLE CLIENT JOURNEY: ABORIGINAL HEALTH SERVICE

40 year old male



External referral from hospital mental health ward

2/7/2010

Appointment with PHC Nurse and GP at Aboriginal health service

- Chronic physical health issues
- Housing problems – recently kicked out of a nursing home
- Very poor compliance with medications
- High dependency

Regular phone calls with Aboriginal Clinical Health Workers regarding accommodation

5/9/2012

Aboriginal Clinical Health Worker and Mental Health Nurse home visit

- Delivered medication
- Provided help with banking
- Housing support (recent housing crisis)
- Advocating for the client and linking into support services

Regular phone calls with Aboriginal Clinical Health Workers regarding accommodation

17.10.2012

Appointment with PHC Nurse

Client attends Aboriginal Family Clinic he is homeless

Aboriginal Health Worker (Aboriginal Health Team) contacted – temporary hostel accommodation organised

24.10.2012

Aboriginal Clinical Health Worker and Mental Health Nurse home visit

- Picked up medication for client from the chemist and dropped it off to him at his home.
- Checked to see how he was going

Aboriginal Mental Health Nurse liaised with Office of the Public Advocate on behalf of the client to access money through Public Trustee

Admitted to hospital for chronic physical health problem

Phone call from Social Worker at hospital

Client not returned to health service

REFERENCES

Abusabha, R., & Woelfel, M. (2003). Qualitiaive vs quantitative methods:Two opposites make a perfect match. *Journal of the American Dietetic Association, 103*(5), 566-569.

Alam, R., Speed, S., & Beaver, K. (2012). A scoping review on the experiences and preferences in accessing diabetes-related healthcare information and services by British Bangladeshis. *Health & social care in the community, 20*(2), 155-171.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5®)*: American Psychiatric Pub.

Anderson, I. (2007). Policy processes. In B. Carson, T. Dunbar, R. D. Chenhall & R. Bailie, (Eds) (Eds.), *In Social Determinants of Indigenous Health* (pp. 231-269). Crows Nest, NSW: Allen & Unwin.

Anderson, J. (1996). Empowering patients: issues and strategies. *Social Science & Medicine, 43*(5), 697-705.

Andrews, B., Simmons, P., Long, I., & Wilson, R. (2002). Identifying and overcoming the barriers to Aboriginal access to general practitioner services in rural New South Wales. *Australian Journal of Rural Health, 10*(4), 196-201.

Andrews, G. (2001). Should depression be managed as a chronic disease? *BMJ, 322*, 419-421.

Andrews, G. (2008). Reducing the Burden of Depression. *The Canadian Journal of Psychiatry, 53*(7), 420-427.

Armstrong, D. (1994). Bodies of knowledge/knowledge of bodies. In C. Jones & R. Porter (Eds.), *Reassessing Foucault: Power, Medicine and the Body*. London: Routledge.

Australian Bureau of Statistics. (2009). Australian demographic statistics, March 2009 (ABS Catalogue no 3101.0). Canberra: Australian Bureau of Statistics.

Australian Bureau of Statistics. (2011). Socio-Economic Indexes for Areas (SEIFA) March 2013 (Catalogue no. 2033.0.55.001). Canberra: Australian Bureau of Statistics.

Australian Bureau of Statistics. (2016). Changing patterns of mortality reflect ageing population. Canberra: Australian Bureau of Statistics.

Australian Community Health Association. (1986). Review of the Community Health Program. Sydney: Australian Community Health Association.

Australian Community Health Association. (1992). The Corporate Context for Community Health. Sydney: Australian Community Health Association.

Australian Government Department of Health. (2014). National Mental Health Strategy Retrieved April 2016, 2016, from http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-strat

Australian Government Department of Health. (2015). Australian Government Response to Contributing Lives, Thriving Communities - Review of Mental Health Programs and Services. Canberra.

Australian Government Department of Health & Ageing. (2005). *General Practice in Australia: 2004* (First ed.). Canberra, ACT: Commonwealth of Australia.

Australian Government Department of Health and Ageing. (2010). Building a 21st century primary health care system: Australia's first national primary health care strategy. Canberra, ACT: Commonwealth of Australia.

Australian Health Ministers. (2003). Evaluation of the Second National Mental Health Plan March 2003. Canberra: Australian Government.

Australian Institute of Health and Welfare. (2008). Australia's Health 2008. Cat. no. AUS 99. Canberra, ACT: Australian Institute of Health and Welfare.

Australian Institute of Health and Welfare. (2011). The health and welfare of Australia's

Aboriginal and Torres Strait Islander people, an overview 2011. Canberra.

Australian Institute of Health and Welfare. (2014). Mental health services-in brief 2014. Canberra: AIHW.

Azétsop, J., & Rennie, S. (2010). Principlism, medical individualism, and health promotion in resource-poor countries: can autonomy-based bioethics promote social justice and population health? *Philosophy, Ethics, and Humanities in Medicine*, *5*(1), 1.

Baker, P., & Stevenson, C. (2000). *The Construction of Power and Authority in Psychiatry*. Oxford: Butterford Heinemann.

Ballie, R., Matthews, V., Brands, J., & Schierhout, G. (2013). A systems-based partnership learning model for strengthening primary healthcare. *Implementation Science, 8*(143).

Banfield, M., Gardner, K., Yen, L., McRae, I., Gillespie, J., & Wells, R. (2012). Coordination of care in Australian mental health policy. *Australian Health Review, 36*(2), 153-157.

Barnes, M., & Bowl, R. (2001). *Taking ove the Asylum. Empowerment and mental health*: Baskinstoke, Palgrave.

Barr, V. J., Robinson, S., Marin-Link, B., Underhill, L., Dotts, A., Ravensdale, D., & Salivaras, S. (2003). The expanded Chronic Care Model: an integration of concepts and strategies from population health promotion and the Chronic Care Model. *Healthcare Quarterly, 7*(1).

Barry, M. (2007). Building capacity for effective implementation of mental health promotion. *Australian e-Journal for the Advancement of Mental Health, 6*(2), 1-9.

Bartlett, B., & Boffa, J. (2005). The impact of Aboriginal community controlled health service advocacy on Aboriginal health policy. *Australian Journal of Primary Health, 11*, 53-61. doi: 10.1071/PY05022

Battersby, M., Von Korff, M., Schaefer, J., Davis, C., Ludman, E., Greene, S., . . . Wagner, E. (2010). Twelve Evidence-Based Principals for Implementing Self-Management Support in Primary Care. *The Joint Commission Journal on Quality and Patient Safety, 36*(12), 561-570.

Baum, F. (2008). The Commission on the Social Determinants of Health: reinventing health promotion for the twenty-first century? *Critical Public Health, 18*(4), 457-466.

Baum, F. (2014). Comprehensive primary health care amd social determinants of as top priorities. *Medical Journal of Australia, 200*(2), 86-87.

Baum, F. (2016). *The New Public Health* (5th ed.). Melbourne: Oxford University Press.

Baum, F., Begin, M., Houweling, T. A. J., & Taylor, S. (2009). Changes not for the fainthearted: Reorienting health care systems toward health equity through action on the social determinants of health. *American Journal of Public Health, 99*, 1967-1974. doi: 10.2105/AJPH.2008.154856

Baum, F., Cooke, R., & Murray, C. (1998). Community-based health promotion: evaluation and development. South Australia: South Australian Community Health Research Unit, Flinders University.

Baum, F., & Fisher, M. (2014). Why behavioural health promotion endures despite its failure to reduce health inequities. *Sociology of Health & Illness, 36*(2), 213-225.

Baum, F., Freeman, T., Sanders, D., Labonte, R., Lawless, A., & Javanparast, S. (2016). Comprehensive primary health care under neo-liberaliam in Australia. *Social Science & Medicine, 168,* 43-53.

Baum, F., Fry, D., & Lennie, I. (Eds.). (1992). *Community Health: Policy and Practice in Australia*: Pluto Press Australian.

Baum, F., Jolley, G., Hicks, R., Saint, K., & Parker, S. (2006). What makes for sustainable Healthy Cities initiatives? - a review of the evidence from Noarlunga, Australia after 18 years. *Health Promotion International, 21*(4), 259-265.

Baum, F., Kalucy, L., Lawless, A., Barton, S., & Steven, I. (1996). Medical Practice in Women's and Community Health Centres in South Australia. Adelaide: Flinders Press.

Baxter, E., & Diehl, S. (1998). Emotional stages: consumers and family members recovering from the trauma of mental illness. *Psychiatric Rehabilitation Journal*, *21*, 349-355.

Beck, U., & Beck-Gernsheim, E. (2002). *Individualization: Institutionalized individualization and its social and political consequences*. London: Sage.

Bennett, C. (2013). Are we there yet? A journey of health reform in Australia. *The Medical Journal of Australia, 199*(4), 251-255.

Beyondblue. Keeping Strong - a flyer for Aboriginal and Torres Strait Islander people Retrieved 13 February 2017, 2017, from http://resources.beyondblue.org.au/prism/file?token=BL/0821

Biggs, A. (2013). *Health in Australia: a quick guide*. Canberra: Commonwealth of Australia Retrieved from http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp1314/QG/HealthAust

Birks, M., Mills, J., Francis, K., Coyle, M., Davis, J., & Jones, J. (2010). Models of health service delivery in remote or isolated areas of Queensland: a multiple case study. *Australian Journal of Advanced Nursing, 28*(1), 25-34.

Bower, A. J., Gilbody, S., Lovell, K., Richards, D., Gask, L., Dickens, C., & Coventry, P. (2012). Collaborative care for depression and anxiety problems (review).

Braveman, P., & Gruskin, S. (2003). Poverty, equity, human rights and health. *Bulletin of the World Health Organization, 81*(7), 539-545.

Bravo, P., Edwards, A., Barr, P. J., Scholl, I., Elwyn, G., McAllister, M., & Cochrane Healthcare Quality Research Group, C. U. (2015). Conceptualising patient empowerment: a mixed methods study. *BMC health services research, 15*, 252-266.

Brijnath, B., & Antoniades, J. (2016). "I'm running my depression:" Self-management of depression in neoliberal Australia. *Social Science & Medicine, 152*, 1-8.

Brophy, L., Hodges, C., Halloran, K., Grigg, M., & Swift, M. (2014). Impact of care coordination on Australia's mental health service delivery system. *Australian Health Review, 38*, 396-400.

Browne, A. J., Varcoe, C. M., Wong, S. T., Smye, V. L., Lavoie, J., Littlejohn, D., . . . Lennox, S. (2012). Closing the health equity gap: evidence-based strategies for primary health care organizations. *International Journal for Equity in Health, 11*(59).

Burr, V. (2003). *Social Constructionism* (Second edition ed.). London; New York:: Routledge.

Butler, D. C., Petterson, S., Bazemore, A., & Douglas, K. A. (2010). Use of measures of socioeconomic deprivation in planning primary health care workforce and defining health care need in Australia. *Australian Journal of Rural Health, 18*, 199-204.

Campbell, S., Watson, B., Gibson, A., Husband, G., & Bremner, K. (2004). Comprehensive service and practice development: City Hospitals Sunderland's experience of patient journeys. *Practice Development in Health Care, 3*(1), 15-26.

Carling, P. (1995). *Return to community:Building support systems for people with psychiatric disabilities*. New York: Guilford Press.

Cassano, P., & Fava, M. (2002). Depression and public health: an overview. *Journal of psychosomatic research, 53*(4), 849-857.

Cheng, I., Wahidi, S., Vasi, S., & Samuel, S. (2015). Importance of community enagagement in primary health care: the case of Afghan refugees. *Australian Journal of Primary Health, 21*, 262-267.

Chung, B., Jones, L., Jones, A., Corbett, C. E., Booker, T., Wells, K. B., & Collins, B. (2009). Using community arts events to enhance collective efficacy and community engagement to address depression in an African American community. *American Journal of Public*

Health, 99(2), 237-244.

Clarke, D. (2011). beyondblue guide to the management of depression in primary care: A guide for health professionals. Melbourne: beyondblue.

Cleworth, S., Smith, W., & Sealey, R. (2006). Grief and courage in a river town: A pilot project in the Aboriginal community of Kempsey, New South Wales. *Australasian Psychiatry, 14*(4), 390-394.

Cole, D., Ibrahim, S., Shannon, H., Scott, F., & Eyles, J. (2002). Work and life stressors and psychological distress in the Canadian working population: a structural equation modelling approach to analysis of the 1994 National Population Health Survey. *Chronic Diseases and Injuries in Canada, 23*(3), 91.

Collinson, S., & Copolov, D. (2004). Challenges and opportunities for mental health research in Australia. *Journal of Mental Health, 13*, 29-36.

Commission on Social Determinants of Health. (2008). Closing the gap in a generation: Health equity through action on the social determinants of health. Geneva: World Health Organization.

Commonwealth Department of Health & Aged Care. (2000). National Action Plan for Promotion, Prevention & Early Intervention for Mental Health. (C. Commonwealth Department of Health & Aged Care, Trans.). Canberra: Mental Health & Special Programs Branch.

Commonwealth of Australia. (2013). *A national framework for recovery-orientated mental health services: Guide for practitioners and providers*. Canberra: Department of Health and Ageing.

Copeman, R., Sangster, A., & Lennie, I. (1990). Factors enhancing and inhibiting the development pf primary medical care in community hwalth centres. *Community Health Studies, 14*(2), 108-117.

Corrigan, P. W. (2002). Empowerment and serious mental illness: Treatment partnerships and community opportunities. *Psychiatric Quarterly, 73*(3), 217-228.

Coulter, A., & Elwyn, G. (2002). What do patients want from high quality general practice and how do we involve them in improvement? *British Journal of General Practice, 52*, 22-26.

Council of Australian Governments. (2007). Council of Australian Governments' Meeting 20 December 2007 Communique. Melbourne, Vic: COAG.

Council of Australian Governments. (2012). The Roadmap fopr National Mental Health Reform 2012-2022. Canberra: Council of Australian Governments.

Creswell, J. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches* (3rd ed. ed.): Sage.

Creswell, J. W. (2013). *Qualitative inquiry and research design* (3rd Ed ed.). Thousand Oaks, California: Sage Publications, Inc.

Crotty, M. (1998). *The Foundations of Social Research: Meaning and perspective in the research process* ((1st ed) ed.). Sydney: Allen & Unwin.

Crowe, T. P., Deane, F. P., Oades, L. G., Caputi, P., & Morland, K. G. (2006). Effectiveness of a collaborative recovery training program in Australia in promoting positive views about recovery. *Psychiatric Services, 57*(10), 1-5.

Dailey, D., Humphreys, J., Rankin, S., & Lee, K. (2011). An exploration of lifetime trauma exposure in pregnant low-income African American women. *Maternal and child health journal, 15*(3), 410-418.

Davidson, L., Chinman, M., Kloos, B., Weingarten, R., Stayner, D., & Tebes, J. (1999). Peer support among individuals with severe mental illness: A review of the evidence. *Clinical Psychology: Science and Practice, 6*, 165-187.

Davidson, L., & Roe, D. (2007). Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery. *Journal of Mental Health, 16*(4), 459-

470.

Davies, G. P., Perkins, D., McDonald, J., & Williams, A. (2009). Integrated primary health care in Australia. *International Journal of Integrated Care, 9*, e95.

De Vos, P., De Ceukelaire, W., Malaise, G., Perez, D., Lefevre, P., & Van der Stuyft, P. (2009). Health through people's empowerment: a rights-based approach to participation. *Health & Human Rights, 11*(1), 23-35.

Deacon, B. J. (2013). The biomedical model of mental disorder: A critical analysis of its validity, utility, and effects on psychotherapy research. *Clinical Psychology Review, 33*(7), 846-861.

Denzin, N., & Lincoln, Y. (2011). *The Sage Handbook of Qualitiative Research* (4th Edition ed.): SAGE Publications.

Department of Health and Ageing. (2009). Fourth National Mental Health Plan - An agenda for collaborative government action in mental health 2009-2014. Canberra: Commonwealth of Australia.

DeVoe, J. E., Bazemore, A. W., Cottrell, E. K., Likumabuwa-Ackman, S., Grandmont, J., Spach, N., & Gold, R. (2016). Perspectives in Primary Care: A conceptual framework and path for integrating social determinants of health into primary care practice. *Annals of Family Medicine, 14*(2), 104-108.

Doherty, D., Benbow, S., Craig, J., & Smith, C. (2009). Patients' and carers' journeys through older people's mental health services: Powerful tools for learning. *Dementia, 8*, 501-513.

Douglas, K. A., Rayner, F. K., Yen, L. E., Wells, R. W., Glasgow, N. J., & Humphreys, J. S. (2009). Australia's primary health care workforce - research informing policy. *Medical Journal of Australia, 191*(2), 81-84.

Doyal, L. (1979). *The Political Economy of Health*. London: Pluto Press.

Draine, J., Salzer, M., Culhane, D., & Hadley, T. (2002). Role of social disadvantage in crime, joblessness, and homelessness among persons with serious mental illness. *Psychiatric Services*.

Duckett, S. (2014). Priorities for a new government: keeping the Medicare promise, thinking beyond services and getting governance right. *Medical Journal of Australia, 200*(3), 138-139.

Duckett, S., & Willcox, S. (2015). *The Australian Health Care System* (5th ed. ed.). South Melbourne: Oxford University Press.

Dumesnil, H., & Verger, P. (2009). Public awareness campaigns about depression and suicide: a review. *Psychiatric Services, 60*, 1203-2013.

Durey, A. (2010). Reducing racism in Aboriginal health care in Australia: where does cultural education fit? *Australian and New Zealand journal of public health, 34*(s1), S87-S92.

Dwyer, J. (2004). Australian health system restructuring - what problem is being solved? *Australia and New Zealand Health Policy, 1*(6). doi: 10.1186/1743-8462-1-6

Dwyer, J., Boulton, A., Lavoie, J. G., Tenbensel, T., & Cumming, J. (2014). Indigenous Peoples' Health Care: New Approaches to contracting and accountability at the public administration frontier. *Public Management Review, 16*(8), 1091-1112.

Earle, S. (2007). Promoting public health in a global context. In Lloyd CE, Handsley S, Douglas J, Earle S & Spurr S (Eds.), *Policy and practice in promoting public health*. London: Sage Publications.

Elliot, L., & Masters, H. (2009). Mental health inequalities and mental health nursing. *Journal of Psychiatric and Mental Health Nursing, 16*, 762-771.

Elliott, A. (2009). *Contemporary Social Theory: An introduction*. Abingdon, Oxon: Routledge: Taylor & Francis.

Ellis, P., & Smith, D. (2002). Treating depression: the beyondblue guidelines for treating depression in primary care." Not so much what you do but that you keep doing it". *The Medical Journal of Australia, 176*, S77-83.

Emden, C., Kowanko, I., de Crespigny, C., & Murray, G. (2005). Better Medication management for Indigenous Australians: findings from the field. *Australian Journal of Primary Health, 11*, 80-90.

Eng, E., Salmom, M., & Mullan, F. (1992). Community Empowerment: The critical base for primary health care. *Family and Community Health, 15*, 1-12.

Fairlamb, J., & Muir-Cochrane, E. (2007). A team approach to providing mental health services in a regional centre using a comprehensive primary health care framework. *Australian e-Journal for the Advancement of Mental Health, 6*(1), 1-10.

Fallowfield, L. J. (1988). Counselling for patients with cancer. *British Medical Journal, 297*, 727-728.

Feinsilver, J. (2010). Cuba's Health Politics: At Home and Abroad Retrieved 7th March 2017, 2017, from http://www.coha.org/cuba%E2%80%99s-health-politics-at-home-and-abroad/

Finfgeld, D. (2004). Empowerment of individuals with enduring mental health problems. Results from concept analyses and qualitative investigations. *Advances in Nursing Science, 27*(1), 44-52.

Fletcher, J., Bassilios, B., Kohn, F., Naccarella, L., Blashki, G., Burgess, P., & Pirkis, J. (2008). Meeting demand for psychological services for people with depression and anxiety: recent developments in primary mental health care. *MJA, 188*(12), S107-S109.

Fletcher, J., Pirkis, J., Bassilios, B., Kohn, F., Blashki, G., & Burgess, P. (2009). Australian primary mental health care: Improving access and outcomes. *Australian Journal of Primary Health, 15*, 244-253.

Foucault, M. (1973). *The Birth of the Clinic*. New York: Tavistock Publications.

Foucault, M. (1977). *Discipline and punish: The birth of the prison*: Harmondsworth: Penguin.

Foucault, M. (2003). *Society must be defended: Lectures at the Collège de France, 1975–76, trans*. David Macey New York: Picador.

Freeman, T., Baum, F., Labonte, R., Javanparast, S., & Lawless, A. (2017). Primary health care reform, dilemmatic space, and risk of burnout among health workers. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine, Online First*. doi: DOI: 10.1177/1363459317693404.

Freeman, T., Baum, F., Lawless, A., Jolley, G., Labonte, R., Bentley, M., & Boffa, J. (2011). Reaching those with the greatest need: how Australian primary health care service managers, practitioners and funders understand and respond to health inequity. *Australian journal of primary health, 17*(4), 355-361.

Freeman, T., Baum, F., Lawless, A., Labonte, R., Sanders, D., Boffa, J., . . . Javanparast, S. (2016). Case study of an Aboriginal Community-Controlled Health Service in Australia: Universal, Rights-Based, Publicly funded Comprehensive Primary Health Care in action. *Health and Human Rights Journal, 18*(2), 93-108.

Freire, P. (1971). *Pedagogy of the oppressed*. New York: Seabury Press.

Fullagar, S., & Gattuso, S. (2002). Rethinking gender, risk and depression in Australian mental health policy. *ustralian e-Journal for the Advancement of Mental Health, 1*(3).

Fuller, J. D., Perkins, D., Parker, S., Holdsworth, L., Kelly, B., Roberts, R., . . . Fragar, L. (2011). Building effective service linkages in primary mental health care: a narrative review part 2. *BMC health services research, 11*(1), 66.

Fumagalli, L. P., Radaelli, G., Lettieri, E., Bertele, P., & Masella, C. (2015). Patient Empowerment and its neighbours: Clarifying the boundaries and their mutual relationships. *Health Policy, 119*, 384-394.

Gardner, H., & Barraclough, S. (Eds.). (2002). *Health Policy in Australia* (Second Edition ed.).

Melbourne: Oxford University Press.

Germov, J. (2005). Managerialism in the Australian public health sector:towards the hyper-rationalisation of professional bureaucracies. *Sociology of Health & Illness, 27*(6), 738-758.

Germov, J. (2009). *Second Opinion: an introduction to health sociology* (Fourth edition ed.). South Melbourne, Victoria: Oxford University Press.

Ghaye, T. (2000). Empowerment through reflection: Is this a case of the emporor's new clothes? In D. G. T.Ghaye, & S. Lillyman (Ed.), *Empowerment through reflection: the narratives of healthcare professionals* (pp. 65-92): Wiltshire: Quay Books.

Gibson, C. (1991). A concept analysis of empowerment. *Journal of Advanced Nursing, 16*, 354-361.

Gilbody, S., Bower, P., Fletcher, J., Richards, D., & Sutton, A. J. (2006). Collaborative Care for Depression. A Cumulative Meta-analysis and Review of Longer-term Outcomes. *Archives of Internal Medicine, 166*, 2314-2321.

Goldney, R. D., Eckert, K. A., Hawthorne, G., & Taylor, A. W. (2010). Changes in the prevalence of major depression in an Australian community sample between 1998 and 2008. *Australian and New Zealand Journal of Psychiatry, 44*(10), 901-910.

Government of South Australia. (2003a). Better choices better health: Final report of the South Australian generational health review. Adelaide: Government of South Australia.

Government of South Australia. (2003b). Primary health care policy statement 2003-2007. Adelaide: Government of South Australia.

Government of South Australia. (2007). GP Plus health care strategy. Adelaide: South Australia Department of Health, Government of South Australia, http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+services/gp+plus+health+care+services+and+centres.

Government of South Australia. (2009). South Australia's Health Care Plan. Adelaide, SA: Department of Health, Government of South Australia.

Government of South Australia. (2010). South Australia's Mental Health & Wellbeing Policy 2010-2015. Adelaide, SA Health.

Government of South Australia. (2013). SA Health's Response to the Review of Non-Hospital Based Services: South Australian Department of Health, Government of South Australia.

Griffiths, K. M., Mendoza, J., & Carron-Arthur, B. (2015). Whereto mental health reform in Australia: is anyone listening to our independent auditors? *The Medical Journal of Australia, 202*(4), 172-174.

Groom, G., Hickie, I., & Davenport, T. (2003). 'Out of hospital, out of mind!'. A report detailing mental health services in Australia and community priorities for national mental health policy for 2003-2008. Canberra: Mental Health Council of Australia, 2003.

Guba, E., & Lincoln, Y. (1989). *Fourth generation evaluation*: Sage.

Gunn, J., Ayton, D., Densley, K., Pallant, J., Chrondros, P., Herrman, H., & Dowrick, C. (2010). The association between chronic illness, multimorbidity and depressive symptoms in an Australian primary care cohort. *Social Psychiatry & Psychiatric Epidemiology*, DOI 10.1007/s00127-00010-00330-z. doi: DOI 10.1007/s00127-010-0330-z

Gurung, G., Derrett, S., Hill, P. C., & Gauld, R. (2016). Governance challenges in the Nepalese primary health care system: time to focus on greater community engagement? *The International Journal of Health Planning and Management, 31*, 167-174.

Halperin, S., Nathan, P., Drummond, P., & Castle, D. (2000). A cognitive-behavioural, group-based Intervention for Social Anxiety in Schizophrenia. *Australian & New Zealand Journal of Psychiatry, 34*, 809-813.

Hardy, C. (1994). Power and politics in organizations. In C. Hardy (Ed.), *Managing strategic* *action: Mobilizing change*. London: Sage.

Hardy, C., & Leiba-O'Sullivan, S. (1998). The power behind empowerment: implications for research and practice. *Human Relations, 51*, 451.

Harrington, A. (2005). *Modern social theory*: Oxford: Oxford University Press.

Harris, M., Chan, B. C., Laws, R. A., Williams, A. M., Powell Davies, G., Jayasinghe, U. W., . . . Milat, A. (2013). The impact of a brief lifestyle intervention delivered by generalist community nrses (CN SNAP trial). *BMC Public Health, 13*(375-378).

Harris, M. F., Jayasinghe, U. W., Taggart, J. R., Christl, B., Proudfoot, J. G., Crookes, P. A., . . . Davies, G. P. (2011). Multidisciplinary Team Care Arrangements in the management of patients with chronic disease in Australian general practice. *Med J Aust, 194*(5), 236-239.

Harvey, D. (2005). *A brief history of neoliberalism*: OUP Oxford.

Haughney, J., Cotton, P., Rosen, J., Morrison, K., & Price, D. (2007). The use of a modification of the Patient Enablement Instrument in asthma. *Primary Care Respiratory Journal, 16*(2), 89-92.

Hayes, S. C., Pistorello, J., & Levin, M. E. (2012). Acceptance and Committment Therapy as a Unified Model of Behavioural Change. *The Counselling Psychologist, 40*(7), 976-1002.

Healy, B., & Renouf, N. (2005). Contextualised Social Policy: An Australian Perspective. In S. Ramon & J. E. Williams (Eds.), *Mental Health at the Crossroads: The Promise of the Psychological Approach* (pp. 39-50). Aldershot, Hants, England & Burlington, VT: Ashgate Publishing.

Herrman, H., Shekhar, S., & Moodie, R. (2005). Promoting mental health: concepts, emerging evidence, practice : report of the World Health Organization: Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne, WHO, Geneva, Switzerland.

Hickie, I., & McGorry, P. (2007). Increased access to evidence-based primary mental health care: will the implementation match the rhetoric? *The Medical Journal of Australia, 187*(2), 100-103.

Holland, C. (2016). *Close the Gap* Canberra: The Close the Gap Campaign Steering Committee.

Hospitals and Health Services Commission. (1973). *A community health program for Australia : report from the National Hospitals and Health Services Commission, Interim Committee, June 1973*. Canberra: Govt. Pr.

Howie, J., Heaney, D., Maxwell, M., & Walker, J. (1998). A comparison of a Patient Enablement Instrument (PEI) against two satisfaction scales as an outcome measure of primary care consultations. *Family Practice, 15*(2), 165-171.

Hugo, M. (2001). Mental health professionals’ attitudes towards people who have experienced a mental health disorder. *Journal of psychiatric and mental health nursing, 8*(5), 419-425.

Hung, D. Y., Rundall, T. G., Tallia, A. F., Cohen, D. J., Halpin, H. A., & Crabtree, B. F. (2007). Rethinking prevention in primary care: applying the chronic care model to address health risk behaviors. *Milbank Quarterly, 85*(1), 69-91.

Hunter, E. (2002). "Best intentions" lives on: untoward health outcomes of some contemporary initiatives in Indigenous affairs. *Australian and New Zealand Journal of Psychiatry, 36*, 575-584.

Hunter Institute of Mental Health. (2015). Prevention First: A Prevention and Promotion Framework for Mental Health. Newcastle, Australia.

Hurley, C., & Baum, F. (2007). *Narrative synthesis of the literature on CPHC for the Australasian region.* Paper presented at the Revitalising health for all: Learning from comprehensive primary health care (CPHC) experiences. First international meeting, Johannesburg, South Africa.

Hurley, C., Baum, F., Johns, J., & Labonte, R. (2010). Comprehensive Primary Health Care in

Australia: Findings from a narrative review of the literature. *Australasian Medical Journal, 1*, 147-152. doi: 10.4066/AMJ.2010.201

Illich, I. (1975). The Medicalisation of life. *Journal of Medical Ethics, 1*, 73-77.

Israel, B. A., Checkoway, B., Schulz, A., & Zimmerman, M. (1994). Health education and community empowerment: conceptualizing and measuring perceptions of individual, organizational, and community control. *Health Education & Behavior, 21*(2), 149-170.

Jackson, K., Oelke, N. D., Besner, J., & Harrison, A. (2012). Patient Journey: Implications for Improving and Integrating Care for Older Adults with Chronic Obstructive Pulmonary Disease. *Canadian Journal of Aging, 31*(2), 223-233.

Jané-Llopis, E., & Gabilondo, A. (Eds) (2008). Mental Health in Older People. Consensus Paper. . Luxembourg: European Communities.

.

Jane-Llopis, E., Barry, M., Hosman, C., & Patel, V. (2005). Mental health promotion works: a review. *Promotion & Education, 12*(Suppl 2), 9-25.

Jensen, L. W., & Wadkins, T. A. (2007). Mental health success stories: finding paths to recovery. *Issues in Mental Health Nursing, 28*, 325-340.

Jolley, G., Freeman, T., Baum, F., Hurley, C., Lawless, A., Bentley, M., . . . Sanders, D. (2014). Health policy in South Australia 2003-10: primary health care workforce perceptions of the impact of policy change on health promotion. *Health Promotion Journal of Australia, 25*, 116-124.

Jones, C., Parker, M., & Ten Bos, R. (2005). *For business ethics*: Routledge.

Jones, G., & Delany, T. (2014). What Does Collaborative Practice Mean Within Mental Health Care? A Qualitative Study Exploring Understandings and Proposing a Definition. *Journal of Research in Interprofessional Practice and Education, 3*(3).

Jorm, A. F. (2012). Mental health literacy: empowering the community to take action for better mental health. *American Psychologist, 67*(3), 231.

Jorm, A. F., Christensen, H., & Griffiths, K. M. (2006). The public's ability to recognize mental disorders and their beliefs about treatment: changes in Australia over 8 years. *Australian and New Zealand Journal of Psychiatry, 40*(1), 36-41.

Jorm, A. F., Korten, A. E., Jacomb, P. A., Christensen, H., & Henderson, S. (1999). Attitudes towards people with a mental disorder: a survey of the Australian public and health professionals. *Australian and New Zealand Journal of Psychiatry, 33*(1), 77-83.

Keleher, H. (2001). Why primary health care offers a more comprehensive approach for tackling health inequities than primary care. *Australian Journal of Primary Health, 7*, 57-61.

Keleher, H. (2007). The drivers for health lie outside the health sector. In Keleher H, MacDougall C & Murphy B (Eds.), *Understanding health promotion* (pp. 47-60). Melbourne: Oxford University Press.

Kennedy, S., Hardiker, N., & Staniland, K. (2015). Empowerment an essential ingredient in the clinical environment: A review of the literature. *Nurse Education Today, 35*(487-492).

Kermode, M., Herrman, H., Arole, R., White, J., Premkumar, R., & Patel, V. (2007). Empowerment of women and mental health promotion: a qualitative study in rural Maharashtra, India. *BMC Public Health, 7*(1), 1.

Kidd, S., Kenny, A., & McKinstry, C. (2014). From experience to action in recovery-oriented mental health practice: A first person inquiry. *Action Research, 12*(4), 357-373.

Kincheloe, J., & McLaren, P. (2000). Rethinking critical theory and qualitative research. In N. Denzin & Y. Lincoln (Eds.), *Handbook of Qualitative Research* (pp. pp. 279-314): Sage, Thousand Oaks.

King, M., Smith, A., & Gracey, M. (2009). Indigenous health part 2: the underlying causes of the health gap. *The Lancet, 374*(9683), 76-85.

Kowanko, I., de Crespigny, C., Murray, H., & Groenkjaer, M. (2003). Better medication management for Aboriginal people with mental health disorders and their carers - Survey of Service Providers. South Australia: Flinders University.

Kuipers, P., Harvey, D., Lindeman, M., & Stothers, K. (2014). Aboriginal and Torres Strait Islander health practitioners in rural areas: credentialing, context and capacity building. *Rural and remote health, 14*(2897).

Laatikainen, T., Dunbar, J. A., Chapman, A., Kilkkinen, A., Vartiainen, E., Heistaro, S., . . . O'Neil, A. (2007). Prevention of type 2 diabetes by lifestyle intervention in an Australian primary health care setting: Greater Green Triangle (GGT) Diabetes Prevention Project. *BMC public health, 7*(1), 249.

Labonte, R. (1990). Empowerment: Notes on Professional and Community Dimensions. *Canadian Review of Social Policy, 26*, 64-75.

Labonte, R. (1992). Heart health inequalities in Canada: Models, theory and planning. *Health Promotion International 7*(2), 119-127. doi: 10.1093/heapro/7.2.119

Labonte, R. (1994). Health promotion and empowerment: reflections on professional practice. *Health Education Quarterly, 21*(2), 253-268.

Labonte, R., Sanders, D., Baum, F., Schaay, N., Packer, C., Laplante, D., . . . Pooyak, S. (2008). Implementation, effectiveness and political context of comprehensive primary health care: preliminary findings of a global literature review. *Australian Journal of Primary Health, 14*(3), 58-67. doi: 10.1071/PY08037

Lamb, J., Dowrick, C., Burroughs, H., Beatty, S., Edwards, S., Bristow, K., . . . Gask, L. (2014). Community engagement in a complex intervention to improve access to primary mental health care for hard-to-reach groups. *Health Expectations, 18*, 2865-2879.

Langharhne, J., Glennen, M., & Austin, J. (2002). The 'Maga Barndi' mental health service for Aboriginal people in Western Australia. *Australas Psychiatry, 10*, 13-17.

Lapsley, P., & Groves, T. (2004). The patient's journey: travelling through life with a chronic illness. *BMJ, 329*, 583-584.

Laris, P. (1995). Boards of directors of community health services. In F. Baum (Ed.), *Health for all: The South Australian experience*. Kent Town, SA: Wakefield Press.

Laverack, G. (2004). *Health promotion practice: Power and empowerment*. London: Sage Publications.

Laverack, G. (2007). *Health Promotion Practice: Building Empowered Communities*. London: Open University Press.

Laverack, G. (2009). *Public health: Power, empowerment & professional practice* (2nd ed.). London: Palgrave Macmillan.

Lavoie, J., & Dwyer, J. (2016). Implementing Indigenous community control in health care:lessions from Canada. *Australian Health Review, 40*, 453-458.

Lawless, A., & Baum, F. (2014). HCSCC Discussion paper: Primary Health Care in South Australia. Adelaide: Flinders University.

Lawless, A., Freeman, T., Bentley, M., Baum, F., & Jolley, G. (2014). Developing a good practice model to evaluate the effectiveness of comprehensive primary health care in local communities. *BMC Family Practice, 15*, 99. doi: 10.1186/1471-2296-15-99

Lawn, S., Delany, T., Sweet, L., Battersby, M., & Skinner, T. C. (2013). Control in chronic condition self-care management: how it occurs in the health worker-client relationship and implications for client empowerment. *Journal of Advanced Nursing, 70*(2), 383-394.

Leeder, S. (2007). *An ideal patient journey in a reformed health service*. Paper presented at the Australian Healthcare Reform Alliance Conference, Sydney, NSW.

Legge, D., Wilson, G., Butler, P., Wright, M., McBride, T., & Attewell, R. (1996). Best practice in primary health care. *Australian Journal of Primary Health - Interchange, 2*(1), 22-26.

Levesque, J. F., Haggerty, J., Beninguissé, G., Burge, F., Gass, D., Beaulieu, M., . . . Beaulieu, C. (2012). Mapping the coverage of attributes in validated instruments that evaluate primary healthcare from the patient perspective. *BMC Family Practice, 13*(1), 1.

Liddy, C., Singh, J., Hogg, W., Dahrouge, S., & Taljaard, M. (2011). Comparison of primary care models in the prevention of cardiovascular disease-a cross sectional study. *BMC Family Practice, 12*(1), 1.

Linhorst, D. (2006). *Empowering people with severe mental illness: a practical guide*. New York: Oxford University Press.

Linhorst, D., Eckert, A., Hamilton, G., & Young, E. (2001). The involvement of a consumer council in organisational decision making in a public psychiatric hospital. *Journal of Behavioral Health Services and Research, 28*, 427-438.

Linhorst, D., Hamilton, G., Young, E., & Eckert, A. (2002). Opportunities and barriers to empowering people with severe mental illness through participation in treatment planning. *Social Work, 47*(4), 425-434.

Loftland, J. (1971). *Analysing social settings: A guide to qualitative observation and analysis*. Belmont, CA: Wadsworth.

Loh, A., Leonhart, R., Wills, C., Simon, D., & Harter, M. (2007). The impact of patient participation on adherence and clinical outcome in primary care of depression. *Patient Education & Counselling, 65*(1), 69-78.

Lomas, J. (2001). Health services research: A domain where disciplinesand decision makers meet. In W. Sibbald & J. Bion (Eds.), *Evaluating Critical Care: Using health services research to improve quality*

(pp. 6-19). Amsterdam: Springer-Verlag.

Lord, J., & Hutchinson, P. (1993). The process of empowerment: implications for theory and practice. *Canadian Journal of Community Mental Health, 12*(1), 5-22.

Lukes, S. (2005). *Power: a radical view* (2nd Edition ed.): Palgrave: Macmillan.

Manandhar, D. S., Osrin, D., Shrestha, B. P., Mesko, N., Morrison, J., Tumbahangphe, K. M., . . . Thapa, B. (2004). Effect of a participatory intervention with women's groups on birth outcomes in Nepal: cluster-randomised controlled trial. *The Lancet, 364*(9438), 970-979.

Masterson, S., & Owen, S. (2006). Mental health service user's social and individual empowerment: Using theories of power to elucidate far-reaching strategies. *Journal of Mental Health, 15*(1), 19-34.

McCann, W. (2012). Review of Non-hospital Based Services. Adelaide.

McDonald, J., Powell Davies, G., Cumming, J., & Fort Harris, M. (2007). What can the experiences of Primary Care organisations in England, Scotland, and New Zealand suggest about the potential role of Divisions of General Practice and Primary Care networks/partnerships in addressing Australian challenges? *Australian Journal of Primary Health, 13*(2), 46-55.

McGorry, P. D., & Hamilton, M. P. (2016). Stepwise expansion of evidence-based care is needed for mental health reform. *Medical Journal of Australia, 204*(9), 351-353.

McKnight, J. L. (1985). Health and empowerment. *Canadian Journal of Public Health, 76*, 37-38.

McLaughlin, K., Costello, E., Leblanc, W., Sampson, N., & Kessler, R. (2012). Socioeconomic status and adolescent mental disorders. *American journal of public health, 102*(9), 1742-1750.

Meyer, S., Ward, P., Coveney, J., & Rogers, W. (2008). Trust in the health system: An analysis and extension of the social theories of Giddens and Luhmann. *Health Sociology Review, 17*(2), 177-186.

Miles, M. B., Huberman, A. M., & Saldana, J. (2014). *Qualitative data analysis: A methods sourcebook* (3rd Ed ed.). Thousand Oaks, California: SAGE Publications, Inc.

Minichiello, V., Aroni, R., & Hays, T. (Eds.). (2008). *In-depth interviewing* (3rd Edition ed.). Sydney: Pearson Education Australia.

Miret, M., Ayuso-Mateos, J., Sanchez-Moreno, J., & Vieta, E. (2013). Depressive disorders and suicide: epidemiology, risk factors, and burden. *Neuroscience & Biobehavioral Reviews, 37*(10), 2372-2374.

Morgan, C., Burns, T., Fitzpatrick, R., Pinfold, V., & Priebe, S. (2007). Social exclusion and mental health. *The British Journal of Psychiatry, 191*(6), 477-483.

Morgan, D. L. (1998). Practical strategies for combining Qualitative and Quantitative Methods: Applications to Health Research. *Qualitative Health Research, 8*(3), 362-376.

Moussavi, S., Chatterji, S., Verdes, E., Tandon, A., Patel, V., & Ustun, B. (2007). Depression, chronic diseases, and decrements in health: results from the World Health Surveys. *The Lancet, 370*(9590), 851-858.

Mrazek, P. J., & Haggerty, R. J. (Eds.). (1994). *Reducing Risks for Mental Disorders*. Washington, D.C: National Academy Press.

Muir-Cochrane, E. (2001). The care management practices of community mental health nurses: 'Doing the best we can'. *Austalian and New Zealand Journal of Mental Health Nursing, 10*(4), 210-220.

National Mental Health Commission. (2014). The National Review of Mental Health Programs and Services. Sydney: NMHC.

Navarro, L., & Shi, L. (2001). The political context of social inequities and health. *Social Science & Medicine, 52,* 481-491.

Nelson, G., Lord, J., & Ochocka, J. (2001). Empowerment and Mental Health in Community: Narratives of Psychiatric Consumer/Survivors. *Journal of Community & Applied Social Psychology, 11*, 125-142.

Noble, M. L., & Douglas, B. C. (2004). What users and relatives want from mental health services. *Current Opinion in Psychiatry, 17*(4), 289-296.

Nutbeam, D. (2000). Health literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century. *Health Promotion International, 15*(3), 259-267.

Oakley, P., & Kahssay, H. (1999). 'Community involvement in health development: an overview',. In eds Kahssay H & Oakley P (Eds.), *Community involvement in health development: a review of the concept and practice*. Geneva: WHO.

Onken, S., Dumont, J., Ridgway, P., Dornan, D., & Ralph, R. (2002). Mental Health Recovery: What Helps and What Hinders. Alexandria, VA: Center for State Mental Health Planning.

Osborne, T. (1994). On anti-medicine and clinical reason. In C. Jones & R. Porter (Eds.), *Reassessing Foucault: Power, Medicine and the Body*. London: Routledge.

Palmer, G., & Short, S. (2010). *Health Care and Public Policy - an Australian Analysis*: Palgrave Macmillan.

Parham, J. (2005). Promotion and prevention 'report card': Is Australia getting it right? *Australian e-Journal for the Advancement of Mental Health, 4*(2), 1-7.

Parikh, S. V., Segal, Z. V., Grigoriadis, S., Ravindran, A. V., Kennedy, S. H., Lam, R. W., & Patten, S. B. (2009). Canadian Network for Mood and Anxiety Treatments (CANMAT) clinical guidelines for the management of major depressive disorder in adults. II. Psychotherapy alone or in combination with antidepressant medication. *Journal of Affective Disorders, 117,* S15-S25.

Patel, V., Belkin, G., Chockalingam, A., Cooper, J., Saxena, S., & Unutzer, J. (2013). Grand challenges: Integrating mental health services into priority health care platforms. *PLOS*

Medicine, 10(5), e1001448.

Patton, M. (1990). *Qualitative evaluation and research methods* (2nd ed.). Thousand Oaks, CA: Sage.

Pearson, A. (2002). *There's no health without Mental Health*. Paper presented at the The MHS Conference, Sydney, NSW.

Perestelo-Perez, L., Gonzalez-Lorenzo, M., Perez-Ramos, J., Rivero-Santana, A., & Serrano-Aguilar, P. (2011). Patient involvement and shared decision-making. *Current clinical pharmacology, 6*(2), 83-90.

Perkins, R., & Slade, M. (2012). Recovery in England: Transforming statutory services? *International Review of Psychiatry, 24*(1), 29-39.

Petersen, I., Baillie, K., & Bhana, A. (2012). Understanding the benefits and challenges of community engagement in the development of community mental health services for common mental disorders: Lessons from a case study in a rural South African subdistrict site. *Transcultural psychiatry, 49*(3-4), 418-437.

Pirkis, J., Bassilios, B., Fletcher, J., Sanderson, K., Spittal, M., King, K., . . . Blashki, G. (2010). Evaluating the Access to Allied Psychological Services (ATAPS) component of the Better Outcomes in Mental Health Care (BOiMHC) program. Sixteenth Interim Evaluation Report. Melbourne, Vic: Centre for Health Policy, Programs and Economics, The University of Melbourne.

Poland, B., Frohlich, K., & Cargo, M. (2008). Context as a fundamental dimension of health promotion program evaluation *Health promotion evaluation practices in the Americas* (pp. 299-317): Springer.

Powell Davies, G., Williams, A. M., Larsen, K., Perkins, D., Roland, M., & Harris, M. F. (2008). Coordinating primary health care: an analysis of the outcomes of a systematic review. *Medical Journal of Australia, 8*, S65-S68.

Priest, N., Paradies, Y., Gunthorpe, W., Cairney, S., & Sayers, S. (2011). Racism as a determinant of social and emotional wellbeing for Aboriginal Australian youth. *Medical Journal of Australia, 194*(10), 546-550.

Public Health Association of Australia, & Australian Healthcare and Hospitals Association. (2014). Primary Health Networks - opportunities , challenges and recommendations: Communique. Australia.

Pusey, M. (1991). *Economic rationalism in Canberra: A nation-building state changes its mind*: Cambridge University Press.

Pusey, M., Manne, R., & McKnight, D. (2010). 25 years of neo-liberalism in Australia. *Goodbye to all that*, 125-146.

Raftery, J. (1995). The social and historical context. In F. Baum (Ed.), *Health for All: The South Australian Experience*. Adelaide, South Australia: Wakefield Press.

Ramon, S., Healy, B., & Renouf, N. (2007). Recovery from mental illness as an emergent concept and practice in Australia and the UK. *International Journal of Social Psychiatry, 53*(2), 108-122.

Raphael, D., Curry-Stevens, A., & Bryant, T. (2008). Barriers to addressing the social determinants of health: Insights from the Canadian experience. *Health Policy, 88*(2), 222-235.

Reifels, L., Bassilios, B., King, K., Fletcher, J., Blashki, G., & Pirkis, J. (2013). Innovations in primary mental healthcare. *Australian Health Review, 37*, 312-317.

Rhodes, T., Holland, J., & Hartnoll, R. (1991). Hard to Reach or Outr of Reach? An Evaluation of an Innovative Model of HIV Outreach Health Education. London: Tufnell Press.

Ritchie, J., & Spencer, L. (1994). Qualitative data analysis for applied policy research. In Bryman A & Burgess RG (eds) (Eds.), *Analyzing qualitative data*. London: Routledge.

Ritsatakis, A., Ostergren, P., & Webster, P. (2015). Tackling the social determinants inequities in health during Phase V of the Healthy Cities Project in Europe. *Health Promotion International, 30*(Supplement 1).

Rosato, M., Laverack, G., Grabman, L., Tripathy, P., Nair, N., Mwansambo, C., . . . Perry, H. (2008). Community participation: lessons for maternal, newborn, and child health. *The Lancet, 372*(9642), 962-971.

Rose, N. (1998). Governing Risky Individuals: the role of psychiatry in new regimes of control. *Psychiatry, Psychology & Law, 5*(2), 177-195.

Rose, N. (1999). *Powers of freedom: Reframing political thought*: Cambridge university press.

Rosenberg, S., Hickie, I., & Mendoza, J. (2009). National mental health reform: less talk, more action. *Medical Journal of Australia, 190*(4), 193-195.

Rosenberg, S. P., Hickie, I. B., McGorry, P. D., Salvador-Carulla, L., Burns, J., Christensen, H., . . . Sinclair, S. (2015). Using accountability for mental health to drive reform. *Medical Journal of Australia, 203*(8), 328-330.

Rost, K., Nutting, P., Smith, J. L., Elliott, C. E., & Dickinson, M. (2002). Managing depression as a chronic disease: a randomised trial of ongoing treatment in primary care. *BMJ, 325*, 934-939.

Roulston, K., & Shelton, S. (2015). Reconceptualizing bias in teaching qualitative research methods. *Qualitative Inquiry, 21*(4), 332-342.

Roxbee, L., & Wallace, C. (2003). Emotional and social wellbeing: national policy context. *Australas Psychiatry, 11*, 45-50.

Rule, J., Ngo, D., Oanh, T., Asante, A., Doyle, J., Roberts, G., & Taylor, R. (2014). Strengthening primary health care in low-and middle-income countries generating evidence through evaluation. *Asia-Pacific Journal of Public Health, 26*(4), 339-348.

Rumball-Smith, J., Wodchis, W. P., Kone, A., Kenealy, T., Barnsley, J., & Ashton, T. (2014). Under the same roof:co-location of practitioners within primary care is associated with specialized chronic care management. *BMC Family Practice, 15*, 149-156.

Sanders, D., Baum, F., Benos, A., & Legge, D. (2011). Revitalising primary healthcare requires an equitable global economic system-now more than ever. *Journal of epidemiology and community health, 65*(8), 661-665.

Sanders, D., Stern, R., Struthers, P., Ngulube, T., & Onya, H. (2008). What is needed for health promotion in Africa: band-aid, live aid or real change? *Critical Public Health, 18*(4), 509-519.

Sawyer, A. (2008). Risk and new exclusions in community mental health practice. *Australian Social Work, 61*(4), 327-341.

Schmittdiel, J. A., Shortell, S. M., Rundall, T. G., Bodenheimer, T., & Selby, J. V. (2006). Effect of Primary Health Care Orientation on Chronic Care Management. *Annals of Family Medicine, 4*(2), 117-123.

Schon, D. (1983). *The Reflective Practitioner*. New York: Basic Books.

Schrecker, T., Chapman, A. R., Labonté, R., & De Vogli, R. (2010). Advancing health equity in the global marketplace: how human rights can help. *Social Science & Medicine, 71*(8), 1520-1526.

Schreiner, A., Morimoto, T., Arai, Y., & Zarit, S. (2006). Assessing family caregiver's mental health using a statistically derived cut-off score for the Zarit Burden Interview. *Aging and Mental Health, 10*(2), 107-111.

Schulrerg, H. (2001). Treating Depression in Primary Care Practice. *The Journal of Family Practice, 50*(6), 535-537.

Schulz, P. J., & Nakamoto, K. (2013). Health literacy and patient empowerment in health communication: The importance of separating cojoined twins. *Patient Education and*

Counseling, 90, 4-11.

Segal, L. (1998). The importance of patient empowerment in health system reform. *Health Policy, 44*, 31-44.

Senate Select Committee on Mental Health. (2006). A national approach to mental health - from crisis to community. First report. Canberra: Parliment of Australia.

Sicotte, C., D'Amour, D., & Moreault, M. (2002). Interdisciplinary collaboration within Quebec community health care centres. *Social Science & Medicine, 55*(6), 991-1003.

Simon, G. E., Chisholm, D., Treglia, M., Bushnell, D., & Group, L. S. (2002). Course of depression, health services costs, and work productivity in an international primary care study. *General hospital psychiatry, 24*(5), 328-335.

Slade, M. (2010). Mental illness and well-being: the central importance of positive psychology and recovery approaches. *BMC health services research, 10*(26).

Slopen, N., Williams, D., Fitzmaurice, G., & Gilman, S. (2011). Sex, stressful life events, and adult onset depression and alcohol dependence: Are men and women equally vulnerable? *Social Science & Medicine, 73*(4), 615-622.

Smith, J., & Sibthorpe, B. (2007). Divisions of general practice in Australia: how do they measure up in the international context? *Australia and New Zealand Health Policy, 4*(15).

Solar, O., & Irwin, A. (2010). A conceptual framework for action on the social determinants of health. Social Determinants of health Discussion Paper 2 (Policy and Practice). Geneva, Switzerland.

Stake, R. E. (2005). Qualitative Case Studies. In N. K. L. Denzin, Y.S. (Ed.), *The Sage Handbook of Qualitative Research*. Thousand Oaks, California: Sage.

Starfield, B. (2011). Is Patient-centered care the same as person-focused care? *The Permanente Journal, 15*(2), 63-69.

Starfield, B., & Shi, L. (2002). Policy relevant determinants of health: An international perspective. *Health Policy, 60*, 201-218. doi: 10.1016/S0168-8510(01)00208-1

Starfield, B., Shi, L., & Macinko, J. (2005). Contribution of primary care to health systems and health. *The Milbank Quarterly, 83*(3), 457-502.

Strine, T. W., Chapman, D. P., Kobau, R., Balluz, L., & Mokdad, A. (2004). Depression, anxiety, and physical impairments and quality of life in the US noninstitutionalized population. *Psychiatric Services, 55*, 1408-1413.

Swerissen, H., Macmillan, J., Biuso, C., & Tilgner, L. (2001). Community Health and General Practice: The Impact of Different Cultures on the Integration of Primary Care. *Australian Journal of Primary Health, 7*(1), 65-70.

Tambuyzer, E., & Van Audenove, C. (2013). Is perceived patient involvement in mental health care associated with satisfactionand empowerment? *Health Expectations, 18*, 516-526.

Taylor, R., Page, A., & Morrell, S. (2004). Socio-economic differentials in mental disorders and suicide attempts in Australia. *The British Journal of Psychiatry, 185*, 486-493.

Teghtsoonian, K. (2009). Depression and mental health in neoliberal times: A critical analysis of policy and discourse. *Social Science & Medicine, 69*, 28-35.

Tew, J. (2005). Core Themes of Social Perspectives. In J. Tew (Ed.), *Social Perspectives in Mental Health: Developing Social Models to Understand and Work with Mental Distress*. London and Philadelphia: Jessica Kingsley Publishers.

Thomas, P., & Morris, D. (2016). Integrating primary mental health care and mental health promotion. [,]. *British Journal of General Practice*. doi: DOI: 10.3399/bjgp16X683533

Thomas, W., & Bellefeuille, G. (2006). An evidence-based formative evaluation of a cross cultural Aboriginal mental health program in Canada. *Australian e-Journal for the Advancement of Mental Health, 5*(3), 202-215.

Thornicroft, G. (2011). Physical health disparities and mental illness: the scandal of premature mortality. *The British Journal of Psychiatry, 199*(6), 441-442.

Tomison, A., & Goddard, C. R. (1999). *Blending qualitative and quantitative approaches: case tracking studies in child protection systems.* Paper presented at the Issues of rigour in qualitative research.

Toumbourou, J. W., Hemphill, S. A., Tresiadder, J., Humphreys, C., Edwards, J., & Murray, D. (2007). Mental health promotion and socio-economic disadvantage: lessons from substance abuse, violence and crime prevention and child health. *Health Promotion Journal of Australia, 18,* 184-190.

Tsey, K., Whiteside, M., Haswell-Elkins, M., Bainbridge, R., Cadet-James, Y., & Wilson, A. (2010). Empowerment and Indigenous Australian health: a synthesis of findings from Family Wellbeing formative research. *Health and Social Care in the Community, 18*(2), 169-179.

Turner, F. J. (2011). *Interlocking Theoretical Approaches* (5th ed.). New York: Oxford University Press.

Tylee, A., & Walters, P. (2007). We need a chronic disease management model for depression in primary care. *Br J Gen Pract, 57*(538), 348-350.

United States Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health & Addictive Disorders.Board on Health Care Services. (2006). Improving the quality of health care for mental and substance-use conditions. Washington, D.C.

Veale, B. (Ed.). (1996). *Continuity of care and general practice utilisation in Australia*: Australian National University. Australia.

Verhaeghe, M., Bracke, P., & Bruynooghe, K. (2008). Stigmatization and self-esteem of persons in recovery from mental illness: the role of peer support. *International Journal of Social Psychiatry, 54*(3), 206-218.

Vicary, D., & Bishop, B. (2005). Western psychotherapeutic practice: Engaging Aboriginal people in culturally appropriate and respectful ways. *Australian Psychologist, 40*(1), 8-19.

Vicary, D., & Westerman, T. (2004). 'That's just the way he is': Some implications of Aboriginal mental health beliefs. *Australian e-Journal for the Advancement of Mental Health, 3*(3), 1-10.

Vink, D., Aartsen, M., & Schoevers, R. (2008). Risk factors for anxiety and depression in the elderly: a review. *Journal of Affective Disorders, 106*(1), 29-44.

Vos, T., Barker, B., Stanley, L., & Lopez, A. (2007). The Burden of Disease and Injury in Aboriginal and Torres Strait Islander Peoples 2003. Brisbane, Queensland: School of Population Health, The University of Queensland.

Wahlbeck, K. (2015). Public mental health: the time is ripe for translation of evidence into practice. *World Psychiatry, 14,* 36-42.

Wallerstein, N. (2006). What is the evidence on effectiveness of empowerment to improve health? Copenhagen: WHO Regional Office for Europe (Health Evidence Network Report.

Walsh, J., & Warren, K. (1979). Selective Primary Health Care: An Interim Strategy for Disease Control in Developing Countries. *New England Journal of Medicine, 301*(18), 967-974.

Ward, P., & Coates, A. (2006). ‘We shed tears, but there is no one there to wipe them up for us’: narratives of (mis) trust in a materially deprived community. *Health:, 10*(3), 283-301.

Warin, M., Baum, F., Kalucy, E., Murray, C., & Veale, B. (2000). The power of place: space and time in women's and community health centres in South Australia. *Social Science & Medicine, 50,* 1863-1875.

Wass, A. (2000). *Promoting Health: The Primary Health Care Approach* (2ns Ed ed.). 2nd ed. Sydney: Harcourt.

Whiteford, H. (2008). Depression in primary care: Expanding the evidence base for diagnosis and treatment. *Medical Journal of Australia, 188 (Suppl),* S101-S102.

Whiteford, H., & Buckingham, W. (2005). Ten years of mental health service reform in Australia: are we getting it right? *Medical Journal of Australia, 182*(8), 396-400.

Whiteford, H., & Groves, A. (2009a). Policy implications of the 2007 Australian National Survey of Mental Health and Wellbeing. *Australian and New Zealand Journal of Psychiatry, 43*(7), 644-651.

Whiteford, H., & Groves, A. (2009b). Policy implications of the 2007 Australian National Survey of Mental Health and Wellbeing. *Australian and New Zealand Journal of Psychiatry, 43,* 644-651.

Whitley, R., & Campbell, R. D. (2014). Stigma, agency and recovery amongst people with severe mental illness. *Social Science & Medicine, 107,* 1-8.

Whitty, P., & Gilbody, S. (2005). NICE, but will they help people with depression? The new National Institute for Clinical Excellence depression guidelines. *The British Journal of Psychiatry, 186*(3), 177-178.

Wiese, M., Jolley, G., Freeman, T., Baum, F., & Kidd, M. (2010). Evaluating the effectiveness of comprehensive primary health care in local communities: How do general practitioners work with and perceive primary health care services directly funded by government? Adelaide: SA Community Health Research Unit, Flinders University. http://www.flinders.edu.au/medicine/fms/sites/SACHRU/documents/publications/SACHRU%20GP%20and%20PHC%20report.pdf.

Wilkinson, R., & Marmot, M. (2003). *The Social Determinants of Health: The Solid Facts 2nd edn.* Copenhagen: World Health Organisation.

Wilkinson, R., & Pickett, K. (2006). Income inequity and population health: a review and explanation of the evidence. *Social Science & Medicine, 62,* 1768-1784.

Wilkinson, R., & Pickett, K. (2007). The problems of relative deprivation: why soem societies do better than others. *Social Science & Medicine, 6*, 1965-1978.

Williams, D., & Mohammed, S. (2009). Discrimination and racial disparities in health: evidence and needed research. *Journal of behavioral medicine, 32*(1), 20-47.

Willis, E., Reynolds, L., & Keleher, H. (Eds.). (2012). *Understanding the Australian Health Care System* (2nd ed. ed.). NSW: Elsevier Australia.

Wilson, N. W. (2012). Chaos in Western Medicine: How Issues of Social-Professional Status are Undermining Our Health. *Global Journal of Health Science, 4*(6).

Woltmann, E., Grogan-Kaylor, A., Perron, B., Georges, H., Kilbourne, A. M., & Bauer, M. S. (2012). Cpmparative effectiveness of collaborative care models for mental health conditions across primary, specialty and behavioural health care settings: systematic review and meta-analysis. *American Journal of Psychiatry, 169*, 790-804.

Wong, S. T., Browne, A. J., Varcoe, C., Lavoie, J., Smye, V., Godwin, O., . . . Tu, D. (2011). Enhancing measurement of primary health care indicators using an equity lens: An ethnographic study. *International Journal for Equity in Health, 10*(1), 1.

World Health Organisation. (1978). Declaration of Alma-Ata, International Conference on Primary Health Care, USSR, 6-12 September. Alma Ata: World Health Organization.

World Health Organisation. (1986). Ottawa Charter for Health Promotion. *Health Promotion, 1*(4), i-v.

World Health Organisation. (1998). Health Promotion Glossary. Geneva, Switzerland.

World Health Organisation. (1999). Health 21 - Health For All in the 21st Century. Copenhagen, Denmark.

World Health Organisation. (2002). Innovative care for chronic conditions: Building blocks for actions: Global report. Geneva: Non-communicable Diseases and Mental Health Cluster, World Health Organization.

World Health Organisation. (2004) Promoting mental health: Concepts, emerging evidence, practice: Summary report. Department of Mental Health & Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne, Geneva.

World Health Organisation. (2007). Everybody's business--strengthening health systems to improve health outcomes: WHO's framework for action.

World Health Organisation. (2008). The world health report: Primary health care now more than ever. Geneva, Switzerland: WHO.

World Health Organisation. (2010). User Empowerment in mental health - a statement by the WHO Regional Office for Europe. Geneva, Switzerland: WHO.

World Health Organization. (2004a). *Changing history*. Geneva: World Health Organization.

World Health Organization. (2004b). Promoting Mental Health. Geneva.

Xiang, H. (2010). A holistic approach to preventing and treating depression. *International Journal of BioSciences, Alternative and Holistic Medicine, 1*(4), 42-47.

Yin, R. K. (2009). *Case study research: design and methods* (Fourth Edition ed.). London: Sage Publications.

Young, S., & Ensing, D. (1999). Exploring recovery from the perspective of people with psychiatric disabilities. *Psychiatric Rehabilitation Journal, 22*, 219-231.

Ypinazar, V., Margolis, S., Haswell-Elkins, M., & Tsey, K. (2007). Indigenous Australians' understandings regarding mental health and disorders. *Australian and New Zealand Journal of Psychiatry, 41*, 467-478.

Zechmeister, I., Kilian, R., McDaid, D., & MHEEN group. (2008). Is it worth investing in mental health promotion and prevention of mental illness? A systematic review of the evidence from economic evaluations. *BMC Public Health, 8,* 20-30.

Zuroff, D., & Blatt, S. (2006). The therapeutic relationship in the brief treatment of depression: contributions to clinical improvement and enhanced adaptive capacities. *Journal of Consulting and Clinical Psychology, 74*(1), 130.