The Aboriginal Mental Health Worker Program: The challenge of supporting Aboriginal involvement in mental health care in the remote community context

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Abstract

This paper draws on our experience as evaluators of the Aboriginal Mental Health Worker Program that has been operating in eight remote communities across the Top End of the Northern Territory, Australia, for over four years. The program aimed to fund the placement of Aboriginal Mental Health Workers (AMHWs) in remote community health centres, to work under the clinical leadership of General Practitioners and to contribute to development of a culturally appropriate community based mental health care service for Indigenous people. In this paper, we examine the key features of the AMHW program and the originating partnership, the degree of integration of AMHWs in health centre processes and the provision of support for the development of the AMHW role in community mental health work. While there are many examples in this program of AMHWs providing highly valued services within their communities, the evaluation showed that the program did not achieve clear commitments to develop mental health practice around the AMHWs' role. In addition there was variability in levels of local managerial support for the AMHWs, vulnerability to staff turnover and other discontinuities, as well as tensions in views about what the role of the AMHWs should be. Should it be culturally informed, clinically-related mental health work or community 'wellbeing work', and how should each role be supported? Together these factors undermined the sustainability of positive achievements within the program.

Keywords

Aboriginal Mental Health Worker, primary mental health care, remote, remote community health centre, program support, role development, sustainability

Introduction

Although Aboriginal communities in remote regions of northern Australia struggle with a significant burden of mental health and psychosocial problems, most lack any community-based mental health care services and visits from any mental health practitioner are, at best, infrequent (O'Kane & Tsey, 1999).

The Australian Burden of Disease Study reports that some 30% of the non-fatal disease burden in Australia is attributable to mental health disorders (Mathers, Vos & Stevenson, 1999). This is higher in rural and remote communities where the majority of Indigenous Territorians reside (Aoun & Johnson, 2002; Wainer & Chesters, 2000) and among Aboriginal and Torres Strait Islander populations compared to non-Indigenous populations in general (Roxbee & Wallace, 2003). Nguyen (cited in Roxbee & Wallace, 2003) reports that admission rates for all mental health disorders have been found to be four times higher for Aboriginal and Torres Strait Islander people than non-Indigenous

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Australians. Indigenous people also experience particularly high rates of comorbidity between mental and other illnesses.

Investigation of the failure of the health care system to respond to clear need is central to strategies for achieving better outcomes (Armstrong & Van Der Weyden, 2005; Australian Medical Association, 2004; Cunningham, 2002; Coorey & Walsh, 2005; Kowal & Paradies, 2005). In the face of overwhelming service shortfalls the potential contribution of AMHWs to provision of community-based and culturally appropriate service has received increasing recognition (Malcolm, 2000; Parker, 2003; Royal Australian and New Zealand College of Psychiatrists, 2002; Vicary & Andrews, 2001).

The first steps toward defining a coordinated national response to the mental health or social and emotional wellbeing needs of Aboriginal and Torres Strait Islander people were taken in 1995 with the *Ways Forward* report (Swan & Raphael, 1995). This move to inform policy development through a comprehensive study and review of mental health needs and services triggered several important initiatives in the late 1990s including the *Emotional and Social Wellbeing Action Plan* (Social Health Working Group, 1996), the *Bringing Them Home* report (Human Rights and Equal Opportunity Commission, 1997) and the *Evaluation of the Action Plan* (Urbis Keys Young, 2001; cf. Roxbee & Wallace, 2003).

More recently, the Australian Government's *National Mental Health Plan 2003-2008* outlines an extensive list of 'key directions' for mental health care in Australia (Australian Health Ministers, 2003). These include the need for stronger linkages between services in order to ensure greater continuity of care and the need to strengthen the capacity of professionals and services at the community level according to appropriate workforce standards and service delivery benchmarks. The Plan emphasises the need to increase the proportion of Aboriginal and Torres Strait Islander mental health workers in the mental health workforce, along with appropriate support and career structures (Australian Health Ministers, 2003, p.27). This received support from the *Northern Territory (NT) Aboriginal Emotional and Social Wellbeing Strategic Plan* released in July 2003 (Northern Territory Aboriginal Health Forum, 2003) and from the Australian Medical Association (2004).

The Top End Division's AMHW program

The Aboriginal Mental Health Worker (AMHW) Program was established by the Top End Division of General Practice with the aim of funding the placement of one to two AMHWs in eight remote community health centres across the Top End of the NT, Australia, from late 2002 to 2005. Initial funding was secured from the Australian Government's More Allied Health Services (MAHS) program. Further funding was received from *beyondblue: the national depression initiative*, contingent on the commissioning of an external evaluation. At the time of writing, while continuing to operate across several communities, the structure of the program and funding strategies into the future were under discussion between program partners.

The AMHWs are almost all employed by local community councils rather than the local health service although they are in most cases based at the community health centre. By mid 2004 ten AMHWs were employed under the program. At the time, this more than doubled the number of community-based AMHWs working in the Top End and provided the basis for the development of a dedicated mental health service in communities in which none at all had previously existed.

Throughout Australia, most mental health problems are dealt with by General Practitioners (GPs). However, attracting adequate numbers of GPs to rural and remote regions has proven to be an ongoing and seemingly intractable problem. Aboriginal mental health issues have become a significant and difficult part of the remote practitioner workload and are a source of considerable strain in health centre practice (Edwards & Madden, 2001; Freeman & Rotem, 1999; Robinson & Harris, 2004; TEDGP, 2001). A recent study of Top End Remote Service Providers in the NT indicates that 68% of GPs surveyed report low levels of confidence in undertaking mental health assessments (Nagel, 2004, p.3). The pressing need for rural and remote mental health training throughout

Australia has been well documented (Aoun & Johnson, 2002, p.39; Australian Health Ministers, 1998), with few remote communities in the NT having any health care staff with mental health training or any previous experience of mental health care. By mid 2004, of the eight communities in the AMHW program only two had registered nurses with psychiatric training, and these individuals had only joined the health centre in the previous six months. This situation is exacerbated by the absence of appropriate cross-cultural assessment, diagnostic and care planning tools that could aid isolated practitioners (cf. Westerman & Kowal, 2002). This persists in a context where funds and infrastructure for health care generally in remote and regional NT are severely under-resourced.

The shift of mental health care from a traditional institutional setting to community based services with a push to greater integration between all levels of service is a global trend (Potter & Russell, 2002; Sweeney & Kisely, 2003; World Health Organization, 2001). As Hickie and Groom (2002, p.377) note, in the Australian context the policies and initiatives of the Commonwealth Government since the early 1990s have addressed 'the need for the development of collaborative and integrated ways of delivering mental health care, and an increasing emphasis on the central role of primary health care'.

A key driver behind the AMHW Program was therefore the low level of both vertical and horizontal integration between existing mental health and related services. An intention of the Program was to counter the thinness and general lack of cultural competence of services through development of a role for AMHWs as cultural interlocutors between clients and service providers. The AMHW Program sought to forge stronger links between the Indigenous community and the various predominantly non-Indigenous providers, coordinating the efforts of other stakeholders toward the program goal of achieving shared primary mental health care. The program was based on the view that local knowledge ought to underpin the management of mental health problems, and aimed to establish collaborative partnerships and processes of inquiry between local people, health professionals and other service providers in an environment of 'two-way learning'. The AMHWs were envisaged broadly as key stakeholders in the delivery of culturally appropriate services. They were to become integral members of remote primary health care teams in participating communities, to partners GPs and link with visiting mental health teams and other relevant services.

Approach

A Partnership Agreement (PA) was formed over a year after commencement of the program with *beyondblue's* support for the program's expansion (TEDGP, 2002). The PA was signed by the Top End Division of General Practice (TEDGP) as manager of the program; Batchelor Institute for Indigenous Tertiary Education, the provider of certificate level training for the AMHWs; Top End Mental Health Services (TEMHS), the NT Government agency responsible for provision of visiting services to communities; and Charles Darwin University (CDU), who would undertake an independent evaluation of the program. The analysis presented here draws on that evaluation. The Final Evaluation Report was completed in December 2004 (Robinson & Harris, 2004). Ethics approval for the final phase of the evaluation was granted by the NTU (CDU) Human Research Ethics Committee (approval no. HO2027) and the Top End Human Research Ethics Committee (approval no. 3/47) in 2003.

While the PA set out areas for collaboration between partner organisations, it avoided prescription of roles and responsibilities. It allowed for a flexible response to a diversity of community contexts while providing at least some indicative parameters for guiding program establishment and development. Yet this also meant that the PA lacked clear objectives and timelines for key developments. This lack of specification of objectives and intended outcomes in turn influenced the development of an evaluation framework. There was an underlying ambiguity in formulation of the AMHWs' role by key participants. On the one hand, there was a general assumption that 'two-way learning' based on the cultural knowledge of the AMHWs would lead to improved mental health outcomes for clients. On the other hand, there was no consensus about how AMHWs would work in the clinical setting, whether they

would have any role at all in direct support of clinical mental health care, as opposed to a more diffuse role in mental health promotion, or what one GP called, 'wellbeing work'. Along with this lack of unanimity of objectives, there was also an indifferent commitment to the development of specific supportive mechanisms for the integration of AMHWs in mental health practice.

The evaluation of the AMHW Program presented significant challenges. The evaluators judged that there would be little point in seeking to assess mental health outcomes for clients in participating communities. The lack of specification of the core intervention meant that development and administration of baseline and post-intervention measures, much less the establishment of statistical controls, would be of little value, and would in any case be beyond available resources. Existing institutional mental health records, including consultations, diagnoses and hospitalisations remain patchy and incomplete and thus could not provide measures of program outcomes. The program was already underway at commencement of the evaluation and there was resistance among some influential practitioners to even the idea of an evaluation.

In this context, the evaluation team adopted what can retrospectively be termed an 'as if' evaluation strategy. It would proceed *as if* the program partners had adopted the objectives of inclusion of AMHWs in decision making about assessment of client health status and formulation and review of care plans as members of the primary health care team and *as if* they had committed themselves to implementation of measures to achieve this. For this purpose the evaluation would focus on the presence or absence of records of AMHW involvement in processes of client care such as could be ascertained by an audit of a limited sample of client records (N=30) across five health centres. The template for the audit protocol was based on elements of a '3 Step Mental Health Process' of assessment, mental health care planning and review which was promoted by the Australian Divisions of General Practice (ADGP) under the *Better Outcomes in Mental Health Care Initiative* (ADGP, 2001). This model of mental health care planning had been recommended by TEDGP, but not formally adopted as an objective of the AMHW Program. This component of the evaluation was in effect an intervention by the evaluators which aimed at promoting the adoption of objectives for improvement of mental health practice by the program partners. In addition to the audits, the evaluators engaged in participant observation in each health centre and conducted semi-structured interviews with personnel in order to assess the actual processes of engagement of AMHWs in work in the health centres and in the wider community. A small number of interviews with consenting mental health clients enabled the compilation of case study material on the actual work of AMHWs and the pattern of mental health care in response to the needs of community members.

Semi-structured interviews (N=52) were undertaken with community-level practitioners and clients in participating program communities, in conjunction with brief periods of participant observation in each community during 2003 and 2004. Interviewees included all employed AMHWs, up to six mental health clients in each community, remote community GPs, registered nurses, mental health nurses, clinic managers and other community based support service providers such as women's centres, schools, aged care support and men's groups, and council and health board members. Interview questions focused on the experiences and views of those participating in or associated with the program and were designed to address the issues outlined above. We also interviewed staff from the TEDGP, psychiatrists and mental health nurses who periodically visit remote communities, regional health service coordinators and policy-makers in remote communities and in regional centres, with the intention of ensuring representation of perspectives of all stakeholders. Written consents for interviews were obtained from all interviewees, with those from clients obtained in the company of AMHWs. Sample size of interviewees was limited by cultural and ethical considerations in Aboriginal communities, the time constraints of staff in under-resourced remote health centres and the modest size of the program.

The following section focuses on health centre processes and supports for the development of the role of the AMHWs and reports the results of

interviews and observations in health centres and in other contexts. It only briefly summarises some findings of the audit of client records (cf. Robinson & Harris, 2004).

Findings and discussion

A goal of the program was to 'provide ongoing support, training and mentoring to AMHWs in remote communities' (TEDGP, 2002). Those responsible for providing this support were the TEDGP through its program manager, the community based health care providers who hosted the AMHWs, TEMHS as provider of visiting mental health services, and Batchelor Institute, the provider of AMHW training. In seeking to understand the determinants of effectiveness of the framework of support for the AMHWs' role, it is necessary to consider two general dimensions of the program: the program model and its 'logic' or structural features, and the tensions in objectives shaping the work of the AMHWs in the practical setting of the community health centre.

Program model and features

As indicated, TEDGP's role was to provide funding equivalent to one full time AMHW position in participating communities. The TEDGP's program manager negotiated an agreement with community government councils or health centres to employ the AMHWs in each community. Additional supervisory support and limited training was provided in the form of visits by two experienced AMHWs who were located in remote centres, who provided local training to the community-based AMHWs and helped them to access special events and training at Batchelor Institute.

From the standpoint of the ability to implement specific objectives for AMHW work, these arrangements were relatively weak, in that once funding was granted, the process of integration of the AMHWs and determination of their role and workload was largely determined by the pre-existing preferences and resources of the local health centres. In return for a relatively small amount of funds, TEDGP was not in a position to demand adoption of a particular approach or set of practice objectives, such as the ADGP '3 Step Mental Health Process' which had been advocated at commencement. It could only provide limited support for practice development through its two visiting AMHWs.

In fact, the strongest determinant of integration of the AMHWs in the community health care team was the availability of strong support from the local nurse practice manager or health centre manager, or, in two communities, the availability of a nurse with mental health training. However, even in these cases, the capacity to formulate specific objectives for the development of the AMHW's role was limited, and could not be generalised to other participating communities.

The other key feature of the model consisted of the intention that the AMHWs would work in partnership with the GP as leader of the remote primary health care team. The GP would mentor the trainee AMHWs and the AMHWs would in turn provide the first point of call for mental health clients, assist the GP to understand cultural and social issues and so on. While GPs occasionally reported that the AMHWs were indeed very helpful as assistants in some mental health consultations, two years into the program it became clear that the model of 'GP as mentor' was not fully realised in any of the participating communities. In general terms, this dimension of the program model is undermined by the high rate of turnover of GPs in remote communities which results in long periods of temporary appointments or even periods without a GP at all. In two communities, GPs who had very strong personal and work relationships with the AMHWs based on many years' practice left the communities, leaving the entire situation of the AMHWs to be renegotiated.

However, other GPs resisted responsibility for a proactive role in mentoring the AMHWs at all, citing two main factors: the pressures of the GP workload and limits on time to work with the AMHWs; and the view that the AMHW role is primarily cultural, focused on 'wellbeing work', and not therefore to be overshadowed by the medical paradigm represented by the GP. There were variations of the latter position. For example, one GP considered that the AMHWs should be working with Aboriginal-controlled community organisations and processes and only marginally engaged in clinical service delivery. In another community, the AMHWs worked mainly with a mental health nurse, assisting with a caseload consisting of mental health clients of

the health centre and cases of threatened self harm or domestic violence and other issues which had the potential to present at the health centre. However, the mental health nurse's view was that the work of the AMHWs was not primarily clinical, that the culturally informed skills and strategies of the AMHWs were their strength, and that there was no point in involving them in formal clinical consultations, formal assessments and record-keeping.

These features of the program model point to a second dimension of the program and its outcomes: tensions and ambiguities in the practical working out of the AMHWs' role.

Wellbeing or mental health work?

The mix of duties and activities for AMHWs varied considerably from community to community. In some, they are frequently involved in crisis situations, responding to attempted suicides, acute episodes involving threatened violence or other manifestations of distress. In some cases they are engaged in advocacy on behalf of the client, undertaking measures to assist with client welfare, including liaison with courts, prison, community services, providing assistance with food and clothing, or with accommodation and travel following hospitalisation in Darwin. AMHWs also carry out counselling of clients with a range of difficulties relating to substance misuse, marital violence and relationship difficulties, and have variously participated in community health promotion and education activities in the areas of general wellbeing, men's and women's health, youth issues, alcohol abuse, and domestic violence, sometimes working with personnel responsible for prevention of domestic violence or alcohol abuse.

As indicated in Figure 1, the AMHWs' role reflected a tension between 1) working on ancillary tasks relating to clinical care, especially medications and assisting with follow-up by clinicians, providing background cultural advice which clinicians generally reported as valuable to them, and 2) a more independent role in which they developed their own styles of intervention and response to community and client issues, often linking up with practitioners engaged in community health promotion or alcohol and domestic violence initiatives, if these were available. However, neither facet of the role was clearly and explicitly supported, and both developed largely through informal arrangements with available and interested personnel.

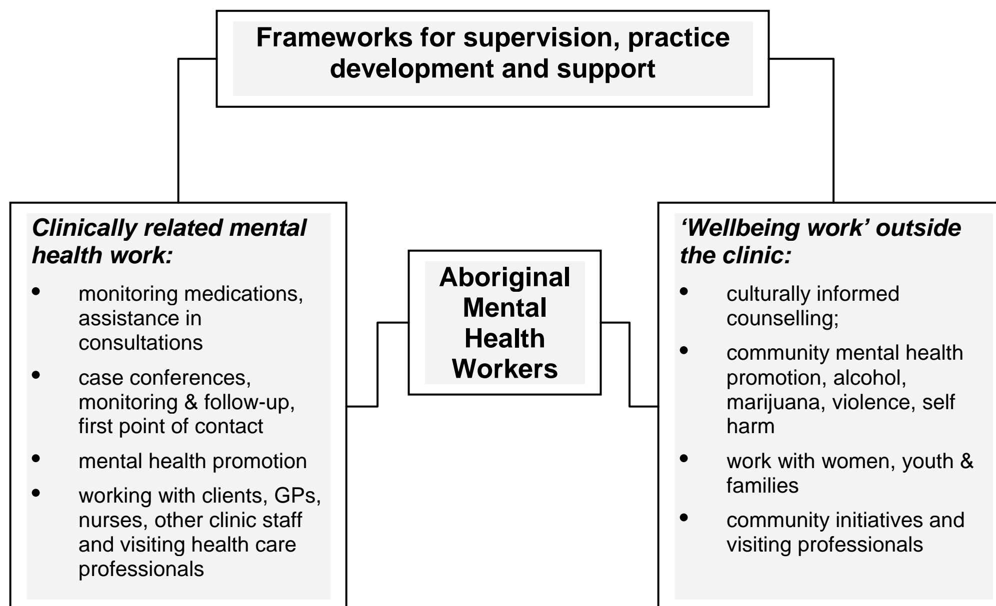

Figure 1. Dimensions of the Aboriginal Mental Health Workers' role

The audit of client records provided some insight into the AMHWs' clinically related work. It showed that there were only infrequent references to key elements of mental health assessment, care planning and review in consultations recorded by any practitioner (Robinson & Harris, 2004, p.90 ff). There were almost no records of case conferences or other mechanisms of consultation between providers which could include AMHWs. Thus with the exception of one health centre, there was only minimal reference to involvement of AMHWs in records of consultations at all. These observations were an indication of (a) the lack of commitment to any formal model of mental health practice at health centres within the program, (b) the lack of formal training in mental health practice among practitioners, and (c) the lack of a specific framework to integrate and support the development of clinically related mental health work by AMHWs.

Against this, many GPs and nurses asserted that there were high levels of *informal* engagement between clinicians and AMHWs over client care. There were again two variants: in one health centre, the AMHWs recorded *all* of their activity in client records, including many consultations conducted without direct supervision or assistance by GP or nurses, and covering issues such as domestic violence and marriage counselling, or family issues associated with a client's personal difficulty. In another health centre, already referred to, there were *no entries at all* made by AMHWs in client records and only scant records of care planning, counselling and other non-pharmacological interventions by GPs and nurses – even though the activity of AMHWs in informal support of clinicians seemed to be fairly extensive and was well regarded by them. In *both* cases there was a tension between the ancillary role of AMHWs in clinically related work, and their independent contribution through culturally informed practices, for which there was little or no systematic support.

Frameworks to support Aboriginal mental health work

These observations draw attention to some important questions about models or frameworks to support the development of the work of AMHWs in the NT's remote communities. It is clear that there is a need to develop practice models for mental health assessment and care planning, in particular emphasising the non-pharmacological elements of comprehensive mental health care. These involve interventions relating to Aboriginal families, cultural practices relating to care and support of the mentally ill or distressed, and narrative models for talking about wellbeing and distress. For this purpose, there needs to be development of tools and methods for incorporating culturally informed counselling and other brief interventions which AMHWs are well placed to administer.

To achieve the development of these methods, there needs to be a way of addressing the tendency of clinical supervisors to submit to reactive styles of practice, acute care, community emergency, and to correspondingly have little time for development of systems of practice which include AMHWs. For example, in two communities, nurses with psychiatric training have undertaken to support the AMHWs on their own initiative, training the AMHWs when time allows:

Some of my time has been spent in training the AMHWs, but not a great deal of time because the clinic is so busy and because of the funerals so many staff have been away. Most of [the training] centres on some patients refusing their medication... A little while back we talked about drug induced psychosis, about ganja and the cumulative effects and how you can become psychotic and then get better again after that if you can reduce the intake.

In another community, geographical isolation, limited mentoring, lack of other support and difficulty accessing training all contributed to the resignation of the AMHW. This community has been unable to recruit another AMHW and has ceased participation in the program. According to the GP at the time:

[The AMHW] wanted to get [training in mental health care] because he didn't want to feel that he is useless in the clinic. He came in but he didn't know what to do. I gave him directions. He came to sit in with me a few times, but sometimes you get busy and... I knew I couldn't give him one hundred per cent because I had all these other issues that I had to attend to.

So as soon as we got a nurse that was interested in mental health - he was actually a psychiatric nurse - I gave him the responsibility to deal with his education, mentoring and paperwork, and encouraging him in every day tasks as much as he could.

He was new so I had to mentor him to mentor. Unfortunately he... left the community within two months, so then [the AMHW] was left by himself again. So he just felt like everyone was deserting him I guess.

Despite these challenges, in some communities GP and AMHWs have enjoyed a good working relationship. In the words of one GP:

[the AMHW program] has made a very positive impact on the quality and quantity of service delivery to mentally ill patients at [community]... Patients now see the health centre as a place they can go when they are mentally ill, as the community now recognises that the health centre can alleviate the suffering caused by mental illness... All the staff work together, sharing knowledge in areas of expertise and thus providing an excellent service... to the community.

By mid-2004 the original eight participating communities in the AMHW program had become six. In one of these the sole AMHW was working only part-time while management arrangements were undergoing revision and in another recruitment of a replacement AMHW was underway. In another, the AMHW had no current clients and was without a local support person or referral source with the departure of the private GP. In another a new AMHW had just commenced after the departure of the previous two AMHWs.

Where managerial support for the AMHW positions cannot be established within the community, the prospects for effective and more systematic development of their role in and outside of the clinic are diminished. However, the comments of nurses and GPs clearly indicate that a more systematic development of improved practices can not be achieved at the level of the individual health centre. It must be supported at a supra-local level by departmental strategies and resources and by a firmer set of partnership commitments to develop on-site management support and work practices than the TEDGP Program has been able to generate.

'Two-way learning' and 'wellbeing work'

The comments from all communities suggest that many substantial mental health problems are less matters for clinical treatment than matters for interventions and strategies to promote psycho-social wellbeing. Fuller, Edwards, Martinez et al. (2004, p.78) report that many of the problems encountered in remote communities in South Australia are 'general life problems' rather than diagnosed psychiatric illnesses; they fall in the 'grey areas' for mental health problems for which there are large gaps in services. Thus some communities in the NT's AMHW program experience very high levels of suicide and self harm (Measey, Li & Parker, 2005), as well as domestic violence and substance misuse, including escalating use of *cannabis sativa* by children, youth and adults. Indeed, a not insignificant component of the rationale for the AMHW program was to respond to the tendency of these issues to contribute to increasing demands for clinical treatment, leading to high levels of stress in the clinics and to a perceived 'revolving door' of committal to the secure psychiatric ward of Royal Darwin Hospital and release back to communities. In other words, there was a need to respond to this increasing burden more effectively with preventive strategies in the communities.

However, if our evaluation suggested that support for clinically related work of AMHWs was poorly developed, this is even more the case for culturally informed preventive strategies, including counselling, mediation and other interventions conducted by AMHWs beyond the walls of the clinic. There is an assumption that AMHWs are already culturally skilled, and that there is no way of formally assisting in their development through reflection on practice, on the effectiveness of particular strategies and the determinants of difficulties to which AMHWs are seeking to respond. This attitude merely reinforces their essentially ancillary status within the medical system.

It is precisely in the field of community mental health work that the role ambiguity and unclear cultural legitimacy of AMHW practice becomes a source of strain for AMHWs. It can expose them to criticism both by clinicians and by community members, with the result that they often succumb to 'burnout' or otherwise withdraw from active engagement in response to community-derived pressures. The patchwork of resources in mental health promotion and the diverse local cultural initiatives established by Aboriginal communities themselves potentially provide a rich field of engagement between

Aboriginal practitioners, seeking firmer and clearer rationales for their approach to serious problems, and non-Aboriginal practice disciplines which have a lot to learn about the determinants of effective community mental health work.

Conclusion

Role confusion and ambiguity is not uncommon among mental health service providers worldwide, even where services are comparatively adequate (Bower, Jerrim & Gask, 2004, p.343; Fuller et al., 2004; Parker, 2003). The diversity of environments encountered in remote communities may negate a one-size-fits-all approach to the AMHWs' role in community mental health care. However, the cost of the flexible approach taken in the AMHW Program of TEDGP and its partners has been substantial. A number of program participants have expressed confusion over the role of the AMHW and highlighted the need for clarification. Unresolved tensions between clinical and non-clinical roles have risen in several communities, with clinic managers, GPs and AMHWs holding conflicting views. Often these relate to the limited capacity of health centres to support more community work, or the perception of clinicians that non-clinical or 'wellbeing work' is not really within the purview of health centres. AMHWs are *informally* included in clinically-related work at the cost of systematic development of their effectiveness and autonomous contribution to mental health care. Despite the specificity of local cultures and systems of value in the Aboriginal domain, there is clearly scope and need to develop generalisable systems, tools and methods for mental health practice, particularly relating to culturally informed non-pharmacological elements of care. These can and should form the basis for more systematic inclusion of AMHWs as exponents of culturally informed practice in mental health care.

There are many clear examples in this program of AMHWs providing highly valued and, as far as it is possible to ascertain, effective services within their communities. We argue that the program may offer a potentially significant element of mental health service delivery in a context of unevenly developed resources and infrastructure available to primary health care in the NT. However, there needs to be a significant leap in the readiness to develop systems and approaches which can move significantly beyond the current dependence on the presence of motivated individuals in health centres, the vulnerability to staff turnover and the reactive processes of care which dominate current practices in remote health centres generally. The experience of this evaluation, with its constraints and limitations, suggests that there may be scope for a much stronger partnership between higher value research and processes of service development in remote areas. Well constructed research has the potential to simultaneously test new tools, methods and interventions, while significantly contributing to the development of service capacity in participating locations.

The capacity of local agencies to manage or absorb new structures, systems and ideas is often not adequately addressed when setting up new programs, and over-optimistic assumptions can be made. Getting this 'right' requires an attention to identifying local capacity to provide support and infrastructure during the assessment and start-up phase for participating institutions (Commonwealth of Australia, 2000), as well as providing adequate funding and management time for program support. Too frequently health programs are introduced into communities that lack the capacity to absorb or incorporate them into their day-to-day operations. Needs analyses are often under-funded and inadequate and investing in strengthening the capacity of local institutions as integral parts of programming are often not a priority of some funding bodies interested in visible short-term outcomes. Similarly, program expansion may take precedence over the provision of less visible but necessary support measures for existing participants. As a result, introduced programs can fail to gain sustained integration into existing structures and services and sit uneasily in parallel to them (Greenhalg, Robert, MacFarlane et al., 2004). Objectives may not be fully realised and the prospects for benefits flowing beyond the lifetime of the program are poor. This is particularly relevant to programs introduced into resource poor rural and remote communities where the most marginalised groups with the greatest needs often live (Commonwealth of Australia, 2000).

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