check
Independent learning program for GPs

Unit 473 August 2011

Aboriginal and Torres Strait Islander health

The Royal Australian College of General Practitioners

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This unit of *check* explores the concept of identification and different aspects of the health of Aboriginal and Torres Strait Islander people, such as chronic disease and mental health. The prevalence of chronic disease for the Indigenous Australian population is substantially higher than the Australian average, and life expectancy at birth for Indigenous Australians is over 10 years less than for the general community.[1]

- For Indigenous Australians, health is viewed in a holistic context that includes physical, psychological, social, cultural, environmental and spiritual health. Awareness of Aboriginal and Torres Strait Islander culture, and the important factors that influence the health of Indigenous Australians, such as family, relationships, culture, identity, land, housing, employment and education, as well as experiences of trauma, loss, grief and discrimination, provides a basis on which to deliver culturally relevant and appropriate heath care, with the aim of 'closing the gap' between the disparate health outcomes of Indigenous and non-Indigenous Australians.

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The objectives of this unit are to:

- understand the reasons for implementing a system within your practice to identify Aboriginal and Torres Strait Islander patients
- recognise the factors that contribute to the poorer health outcomes of Indigenous Australians
- understand the Aboriginal and Torres Strait Islander concept of health and wellbeing, and the concept of ill health as a disruption of the inter-related domains of psychological, physical, social, spiritual and cultural factors
- understand how the Aboriginal and Torres Strait Islander concept of health affects presentation and treatment of illness, and provide culturally safe healthcare based on this understanding
- understand the role of the Closing the Gap program, Aboriginal Health Check, GP Management Plan and Team Care Arrangement, and the roles of the Aboriginal health worker and practice nurse in improving access to appropriate prevention, screening, medical and allied health treatment, and in ensuring culturally appropriate provision of healthcare.

We hope this unit of *check* will assist you to provide competent and culturally safe healthcare to Aboriginal and Torres Strait Islander patients with the aim of improving their wellbeing, health outcomes and experience of the health system.

Kind regards

Catherine Dodgshun

Medical Editor

CASE 1

YOU DISCUSS IDENTIFICATION AT YOUR PRACTICE MEETING

You are preparing your practice for accreditation and have been studying the 4th edition of the RACGP *Standards for general practices*.[2] You read that your practice needs to: 'demonstrate that we routinely record Aboriginal and Torres Strait Islander status in our active patient health records'.

You have a quick look in your waiting room and see a few patients you know to be Aboriginal, and many who you have always assumed weren't. Might they actually be Aboriginal or Torres Strait Islander?

At the practice meeting that morning, you talk to the rest of the practice team about the need to identify Aboriginal and Torres Strait Islander patients in your practice. Always practical, Vesantha, your practice manager, says, "Okay then, but it will be the receptionists who will have to do this. What do they need to do?"

QUESTION 1

What do you tell Vesantha?

FURTHER INFORMATION

At the meeting, Michael, one of the doctors in the practice, says, "I don't see why we should be doing this. We'll only cause offence by asking our patients, and we already know which of our patients are Aboriginal."

QUESTION 2

What reasons can you give Michael for identifying Aboriginal and Torres Strait Islander patients in your practice?

FURTHER INFORMATION

Following your explanation, Michael can now see that there may be reasons for identifying Aboriginal and Torres Strait Islander patients, but still looks uncomfortable with the idea. He says he thinks you will really annoy your patients by asking.

QUESTION 3

What ways are there to ask about identifying as Aboriginal or Torres Strait Islander without annoying your patients?

FURTHER INFORMATION

Michael thinks this will be possible to do but he has one final query for you, "Surely just doing this is not enough to 'close the gap'?" You agree that this isn't enough.

QUESTION 4

What other measures could your practice undertake, and what activities could it participate in, to increase your practice's awareness of, and thereby improve its care of, Aboriginal and Torres Strait Islander people?

CASE 1 ANSWERS

ANSWER 1

Receptionists need to ask each patient: 'Are you of Aboriginal or Torres Strait Islander origin?' This can be done in person or with a standard questionnaire, such as a registration sheet. The possible answers are: 'No'; 'Yes, Aboriginal'; 'Yes, Torres Strait Islander'. Patients who are of both Aboriginal and Torres Strait Islander origin can answer 'Yes' to both of the latter categories, or a fourth response category can be added: 'Yes, both Aboriginal and Torres Strait Islander'.

The answer should be recorded in the clinical notes, with a notation of the date the question was asked if possible. Further information can be found in the *Australian Institute of Health and Welfare (AIHW) guidelines*.[3]

ANSWER 2

There are many reasons for identifying your Aboriginal and Torres Strait Islander patients.

- To assess disease risk – Aboriginal and Torres Strait Islander patients are at higher risk of certain diseases, such as cardiovascular disease, diabetes and renal disease. To make appropriate treatment decisions, knowing someone's indigenous status will allow you to more accurately measure their risk
- To provide appropriate screening and treatment – there are different recommendations for screening for some conditions in Aboriginal and Torres Strait Islander patients of certain ages. For example, the National guide to a preventive health assessment in Aboriginal people[4] recommends screening for diabetes and renal disease from the age of 15–17, whereas the RACGP 'red book'[5] only recommends this from age 45–49 upwards for diabetes, and age 50 onwards for renal disease
- To offer appropriate immunisations – there are different recommendations for Indigenous Australian patients with respect to immunisations
- To enhance access to medication – there are some medications that are available on the Pharmaceutical Benefits Scheme (PBS) for Aboriginal and Torres Strait Islander patients, such as some antifungal medications and ciproflaxcin ear drops, as well as other medications that are subsidised through the PBS Closing the Gap Co-payment Measure, once the patient and doctor participate in the Closing the Gap program
- To ensure access to particular Medicare Benefits Schedule (MBS) item numbers – there are particular MBS items available only for Aboriginal or Torres Strait Islander people, such as the Aboriginal Health Check (AHC), which aims to identify risk factors for chronic disease and provide early intervention. The AHC allows access to five funded allied health consultations
- To facilitate access to Aboriginal or Torres Strait Islander outreach workers who can provide support and advice to prevent or treat chronic disease
- To access extra income for your practice if it participates in the Indigenous Practice Incentives Program (PIP)
- To provide the possibility of auditing the quality of your care for Aboriginal and Torres Strait Islander people.

It might also be worth pointing out to Michael that when the BEACH study asked GPs to routinely identify their Aboriginal and Torres Strait Islander patients, the proportion of Aboriginal and Torres Strait Islander patients went up from 1.2% to 2.4%.[6] Is he sure your practice would be so different? It has also been pointed out that some patients from other ethnic backgrounds are misclassified as Aboriginal or Torres Strait Islander when the patients are not asked.[7]

ANSWER 3

Studies show that very few patients are annoyed at being asked about their indigenous status if they are given appropriate explanations.[8] Explain to patients that everyone is being asked, and that it helps in providing the most appropriate care for that person. The question can be handled sensitively by all staff. Having posters or pamphlets in the waiting room explaining that everyone will be asked about their indigenous status, and the reasons for asking, could also be helpful.

ANSWER 4

Your practice could undertake numerous other measures and participate in several activities to increase your practice's awareness of, and thereby improve its care of, Indigenous Australian people, such as:

- arranging for as many staff of the practice as possible to undertake local 'cultural safety' training. The concept of cultural safety is discussed in *Case 4, Answer 4*
- placing Aboriginal and Torres Strait Islander literature, information and artwork in the waiting room. The practice could also consider displaying Aboriginal and Torres Strait Islander flags, and provide an Acknowledgement of Country, where the practice puts up a sign acknowledging the traditional owners of the land they work on
- participating in the celebration of local and national Aboriginal and Torres Strait Islander festivals, such as National Aborigines and Islanders Day Observance Committee (NAIDOC) Week and National Sorry Day
- engaging with the local Aboriginal and Torres Strait Islander community, perhaps through local Elders, the Land Council or local Aboriginal Community Controlled Health Service (ACCHS). Some divisions of general practice have Aboriginal or Torres Strait Islander project officers or outreach workers with whom your practice could engage
- being aware of local barriers to care. Some practices may need to bulk bill or advocate that local specialists or allied health professionals bulk bill their patients where possible
- developing strategies that allow Aboriginal and Torres Strait Islander people to develop personal therapeutic relationships with staff, which is often more important than policy or other barriers to care.

Your practice might like to look at the RACGP's publication: *Identification of Aboriginal and Torres Strait Islander patients in Australian general practice*.[9]

CASE 2

YOU ARE CONCERNED ABOUT ALISON'S SITUATION AT HOME

Alison is 26 years of age, and a mother of two young children. You have been treating her for depression but she does not seem to be improving with antidepressants and she has not wanted to be referred to another health professional. Her physical health has been good, and recent blood tests, including thyroid function, are normal.

She brings her two children to see you quite frequently and when you examine them there is not much to be found. You wonder what this means.

She lives with her partner Trevor in a two bedroom flat and she has extended family in the area. Alison and Trevor both identify as Aboriginal.

She has come to see you on her own today and seems very depressed and sad.

QUESTION 1

What might be happening to Alison behind this presentation of depression?

QUESTION 2

You wonder how you might ask Alison about the possibility of family violence. What questions would you ask?

FURTHER INFORMATION

You ask Alison if she is ever afraid of her partner. She says he shouts at her, threatens to hit her and wants to know exactly how she has spent the money he gives her.

QUESTION 3

Is this a form of abuse? What is a common emotional response to this sort of behaviour?

QUESTION 4

When Alison starts to tell you about what it is like at home, what is the most important thing you should do? What would you say to Alison?

QUESTION 5

If Alison didn't perceive Trevor's behaviour as abusive, what would be her 'stage of behavioural change'?

QUESTION 6

You begin to understand that there may be a link between Alison's depression and her situation at home. What important issue about her situation at home do you need to address?

QUESTION 7

Does it make a difference to the situation that Alison identifies as Aboriginal?

QUESTION 8

Summarise the role of the GP in dealing with a person who discloses their experience of family violence.

QUESTION 9

What services are available in your area for women and children who have been involved in family violence? List the names of these services, the scope of each service and their contact details.

FURTHER INFORMATION

Some time later Alison presents with the two children. She has remained in the relationship, and last night Trevor came home very angry and started hitting her and the children. He accused her of having an affair, which she says is completely untrue. Alison is very frightened and does not know what to do.

QUESTION 10

How would you manage this situation?

CASE 2 ANSWERS

ANSWER 1

Family violence needs to be considered. Family violence is a broad term that encompasses intimate partner violence/abuse (also called domestic violence), child and elder abuse. Intimate partner abuse is common; one in five currently depressed women attending a general practice in Victoria experienced physical, emotional or sexual abuse by a partner or expartner in the past 12 months.[10,11]

ANSWER 2

Questions you could ask to find out about possible family violence are listed in *Table 1*. These include: 'has your partner ever physically threatened or hurt you?' 'Is there a lot of tension in your relationship?', 'Have you ever been afraid of your partner?'

Table 1. Questions to ask and statements to make if you suspect domestic violence[10]

- Has your partner ever physically threatened or hurt you?
- Is there a lot of tension in your relationship?
- How do you resolve arguments?
- Sometimes partners react strongly in arguments and use physical force; is this happening to you?
- Are you afraid of your partner?
- Have you ever been afraid of your partner?
- Violence is very common in the home. I ask a lot of my patients about abuse because no one should have to live in fear of their partners.

ANSWER 3

Yes, this is a form of abuse. Alison is intimidated and her partner is controlling her with threats of violence and by demanding to know how she spends the money he gives her. A common emotional response to family violence is low self esteem and guilt, thinking that the abusing partner's anger and control may be the fault of the person suffering the violence.[10]

ANSWER 4

Listen to her and believe her story. When a woman experiencing family violence first discloses her story, the most important thing is that she is believed. If a health professional disbelieves or dismisses her story, the opportunity is lost and the evidence suggests that it may be a long time before she will disclose her experience to anyone else.[10] Confidentiality is also important (within the limits of danger to the children, others or to the woman).

You should reassure Alison that she is not to blame and that everyone deserves to feel safe at home. This will help to validate her.

ANSWER 5

Alison's 'stage of behavioural change' would be that of 'precontemplation', where there is no intention of acting on the abusive behaviour.

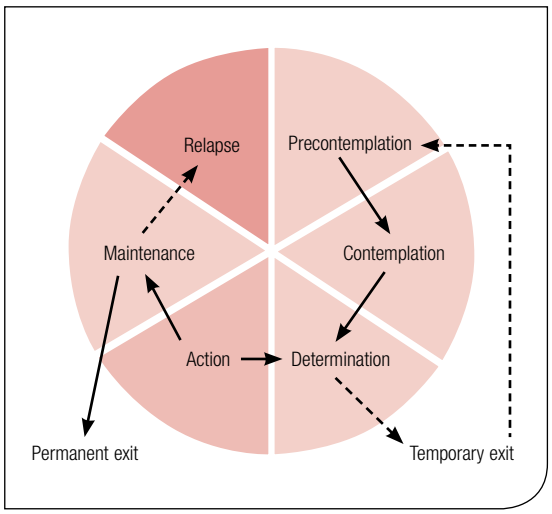

Figure 1. Stages of behavioural change[10]

ANSWER 6

You need to address the issue of safety for Alison and her children. You need to ask her whether he abuses the children and how she can keep herself and the children safe.[10]

ANSWER 7

It may make a difference that Alison identifies as Aboriginal. It may mean that Alison is less likely to call the police for protection. She may be very fearful that her children will be taken from her. She may be unable to leave because family is often considered the most important thing to maintain. She may have experienced abuse in her family of origin and the members of her family of origin may not be supportive or she may be unable to trust them.

FEEDBACK

Women who have suffered child abuse are twice as likely to be involved in a relationship involving abuse as women who have not suffered child abuse.[12] There is a wide range of types of abuse and violence, from physical, emotional, sexual and economic abuse, to social isolation. There are also many different ways in which women will perceive the violence, and many different ways they will use to deal with it or remove themselves from it.

Some women, due to their experience of living in an abusive family of origin, fail to see that they are being abused in their current relationship, some women think they deserve the abusive treatment, and some women excuse the behaviour of the perpetrator and find it very difficult to leave. Some perpetrators threaten the woman with death, suicide of the

perpetrator, keeping the children, and use other manipulative tactics to threaten the woman with if she dares to leave. It is important to work with the woman to help her find solutions for herself and her children.

Research has shown that children living in a family where there is family violence are affected by the abuse and violence whether or not they are directly abused.[13] Although only 50% of men who perpetrate family violence have been drinking alcohol, alcohol may lead to greater physical violence due to its effects in relaxing inhibition. Some women suffer horrific physical injuries that cause ongoing disability and can be fatal. It is important to remember that in situations of family violence, the abuse and violence tends to escalate over time.

ANSWER 8

The role of the GP is to listen to, believe and support the affected person, assess the person's safety and the safety of the children, and refer to an appropriate agency or health worker when the person is ready and it is appropriate.[11,12] (See *Resources* for advice on how to manage patients suffering family violence.)

FEEDBACK

Table 2 outlines what abused women say they want from clinicians.[10] It would be ideal to ask a female patient experiencing family violence whether they would prefer to see a female doctor.

ANSWER 9

You may need to research this if you do not currently have these resources in your practice contact list. Some resources are available on page 17 of the RACGP white book.[10]

ANSWER 10

The safety of Alison and the children is the most pressing issue. Women are at most risk of injury or death at the time of separation.[10]

Alison may want to go and stay with family or friends. However, this option may not be safe if her partner knows where she is or can track her down.

Alison may at this stage be willing to go to a shelter for women and children. If she lives in a country town, this may need to be in another town where the location is not known by her partner. You may need to ring a domestic violence service or hotline in your state to find a shelter. This search for a shelter may take time but it may also be life saving as this is a crisis situation.[14]

Alison's children are at risk. They have been abused physically (last night) and exposed to ongoing family violence. If Alison is unwilling to leave the home, you have a mandatory responsibility to report. You need to explain this to Alison. If you feel she is caring for her children, then you also say that you are supporting her care of her children and trying to keep them all safe. The law about mandatory reporting is different in each state; see page 31 of the RACGP white book for information about each state.

You could also discuss with Alison whether she would like to report the assault by her partner to the police. Your medical notes and photographs of any injuries may be very important in any future case. The GPs willingness to believe and support her at this time is very important.

Table 2. What abused women say they want from clinicians[10]

Before disclosure or questioning
• Understand the issue, including knowing about community services/appropriate referrals
• Ensure that the clinical environment is supportive, welcoming, and nonthreatening
• Place brochures/posters in the clinical setting
• Try to ensure continuity of care
• Be alert to the signs of abuse and raise the issue
• Use verbal and nonverbal communication skills to develop trust
• Assure abused women about privacy, safety and confidentiality issues
• Be compassionate, supportive and respectful toward abused women
When the issue of intimate partner abuse is raised
• Be nonjudgmental, compassionate and caring when questioning about abuse
• Be confident and comfortable asking about intimate partner abuse
• Do not pressure women to disclose, as simply raising the issue can help them
• Consider asking about abuse at later consultations because patients may disclose at another time
• Ensure that the environment is private and confidential, and provide time
Immediate response to disclosure
• Respond in a nonjudgmental way, with compassion, support and belief of experiences
• Address safety concerns
• Acknowledge the complexity of the issue, respect the patient's unique concerns and decisions
• Put patient identified needs first, making sure social/psychological needs are addressed
• Take time to listen, provide information and where appropriate offer referral for more specialised help
• Validate experiences, challenge assumptions and provide encouragement
• Assist patients to make their own decisions
Response in later interactions
• Be patient and supportive, allow the patient to progress at their own pace
• Understand the chronicity of the problem and provide follow up and continued support
• Respect the patient's wishes and do not pressure them into making any decisions
• Be nonjudgmental if patients do not take up referrals immediately

CASE 3

RITA HAS DIABETES AND PRESENTS FOR A CHECK UP

Rita is 48 years of age, and is an Aboriginal woman who you haven't seen for 1 year. Your records show she has diabetes complicated by microalbuminuria, and she also has hypertension and hyperlipidaemia. When you last saw her you referred her to a cardiologist for investigation of atypical chest pain, but she did not attend.

Rita has been getting 'boils' lately for which she has been seeing different doctors. Over the past year she has been back and forth between her sister's place in the country and her own home. Rita tells you she wants to start looking after herself more and plans to see you more regularly. She stopped taking all her medications several months ago when she ran out of them as she thought that she was on too many.

Rita smokes 25 cigarettes per day, does not drink alcohol and has a family history of ischaemic heart disease and 'kidney problems'. She has not had any immunisations for some time.

QUESTION 1

To what extent does chronic disease contribute to the higher mortality of Aboriginal and Torres Strait Islander people?

FURTHER INFORMATION

Rita has multiple medical issues that will take some time to help her sort out. As she has decided to attend your practice regularly now, you enrol her in the Closing the Gap program.

QUESTION 2

What is the Closing The Gap program and how do you access it?

FURTHER INFORMATION

You explain to Rita that you can assist with some of the cost burden of her medications through the Closing The Gap program.

QUESTION 3

How do you write the prescriptions to enable Rita to receive subsidised medication? Are these prescriptions valid at all pharmacies?

QUESTION 4

What other strategies may assist Rita in taking the medications you prescribe for her?

QUESTION 5

What immunisations would you recommend for Rita?

FURTHER INFORMATION

You decide that one of the most useful things you can do for Rita is to arrange for her to return for a care plan to help her set some achievable health goals.

QUESTION 6

What are the key steps in preparation of a GP Management Plan (GPMP)? Does the GPMP result in any difference in Medicare access to allied health and dental services?

CASE 3 ANSWERS

ANSWER 1

Chronic diseases are the largest contributors to the unacceptable life expectancy gap between Aboriginal and Torres Strait Islander people and non-Indigenous Australians; diabetes, ischaemic heart disease, cerebrovascular disease and chronic kidney disease are major health issues.[15–17] Chronic kidney disease is commonly multifactorial in origin and can be related to low birth weight, lifestyle factors, diabetes, hypertension and infection.

Statistically, Aboriginal and Torres Strait Islander people experience marked socioeconomic disadvantage and increased life stressors compared to the rest of the Australian polulation, this contributes to their higher burden of chronic disease and risk of early death.[16,18,19]

Rita is likely to die prematurely if there is no aggressive management of her medical problems.

ANSWER 2

The Australian Government's Closing The Gap program aims to improve the health of Aboriginal and Torres Strait Islander people who have a chronic disease, or are at risk of chronic disease, through reducing lifestyle risk factors and improving chronic disease management. The program involves multiple strategies, including employing healthy lifestyle and tobacco action workers within Aboriginal and Torres Strait Islander communities and establishing chronic care outreach positions in ACCHS and divisions of general practice. At the GP level there are two important components of the program, which are support payments to practices to promote systematic chronic care through the PIP system and PBS medication subsidy for eligible patients.[20]

To be eligible to take part in the Closing the Gap program, two staff members from the practice, at least one of whom is a GP, must undertake cultural awareness training within 12 months of signing on to the incentive. Practices can then access annual PIP payments for registered Aboriginal and Torres Strait Islander patients age 15 years or older with existing chronic disease. Chronic disease is defined for this purpose as a disease that has been, or is likely to be, present for at least 6 months, including but not limited to asthma, cancer, cardiovascular illness, diabetes, musculoskeletal conditions and stroke. General practitioners are required to offer AHCs, which can be performed annually under the specific Medicare item number 715 and regular GPMPs, which can be performed annually under specific Medicare item number 721, and review to patients within this program. Patients must re-enrol annually at the practice of their choice.[21]

ANSWER 3

In view of Rita's comorbidities, you are likely to be recommending her to start back on five or more medications. The price of medications is a major barrier to Aboriginal and Torres Strait Islander patients filling their prescriptions. Government spending on PBS

medication is lower per head for the Indigenous Australian population despite their much higher morbidity, and this contributes to their poorer health outcomes.[22–24]

Aboriginal and Torres Strait Islander people of all ages who have chronic disease or are at risk of chronic disease, which realistically applies to most if not all of this population, are eligible for subsidised medications under the 'co-payment' component of the Closing the Gap program. The GP registers patients for the Closing the Gap Co-payment Measure using the same process as that of the Closing the Gap PIP program but registration for the co-payment is only required once. After registration, Aboriginal and Torres Strait Islander people are able to access this medication support from any Closing the Gap-registered GP and the specialists to whom that GP refers the patient. The script is valid at all pharmacies after a handwritten or computerised Closing the Gap notation is made on the script.[21]

ANSWER 4

Patient centred approaches such as simplifying drug regimes, using dose administration aids such as Webster packs, and offering effective patient education may promote medication adherence.[24]

A home medicines review by a community pharmacist may be useful for Rita. The acceptability of home medicines reviews for Aboriginal and Torres Strait Islander patients may be increased by being flexible in conducting the review, for instance, the pharmacist may conduct the review with an Aboriginal health worker or in an ACCHS (MBS still applies) rather than in the patient's home.

The Good Medicines Better Health program has patient education resources that GPs, Aboriginal health workers and nurses may find useful when discussing medications with their Aboriginal or Torres Strait Islander patients who have chronic disease.[25]

ANSWER 5

Vaccines for which there are different recommendations for Aboriginal and Torres Strait Islander adults compared with non-Indigenous Australian adults include influenza and pneumococcal vaccines. Rita should be offered immunisation with influenza vaccine, and if she has not yet had her pneumococcal vaccine, this should also be offered.

Annual influenza immunisation is recommended for all Aboriginal and Torres Strait Islander people 15 years of age or older, in view of the substantially increased risk of hospitalisation and death from influenza and pneumonia.[26] Immunisation with the 23-valent pneumococcal polysaccharide vaccine (23vPPV) is funded for all Aboriginal and Torres Strait Islander people 50 years of age or above, and for those 15–49 years of age who have high risk underlying conditions, due to their high risk of invasive pneumococcal disease.[26,27]

ANSWER 6

The GPMP must include personal attendance by the GP with the patient, as part of Medicare item number 721. The GP may be assisted by their practice nurse or Aboriginal health worker, in the GP's medical practice or health service.

The key steps in preparation of a GPMP are:

- identifying the healthcare needs and conditions of the patient
- agreeing with the patient on management goals for the changes to be achieved by the treatment and services identified in the plan
- identifying actions to be taken by the patient
- identifying treatments and services that the patient is likely to need and making arrangements for the provision of these services
- documenting the patient needs, goals, actions, as well as treatment services and a review date
- providing a copy of the plan to the patient.

The GPMP can be accompanied by a Team Care Arrangement (TCA), which involves the patient's usual GP and at least two other healthcare providers, under Medicare item number 723. The key steps in coordinating a TCA are:

- discussing with the patient which treatment/service providers should participate
- obtaining patient consent to share their health information with the proposed providers
- contacting the other care providers and obtaining their consent to participate
- collaborating with participating providers to discuss treatment/services they will provide to achieve the management goals for the patient
- documenting the following: goals; collaborating providers; treatment services the providers have agreed to provide; actions to be taken by the patient; a review date
- providing relevant parts of the TCA to the collaborating providers.

Rita can access five Medicare rebatable allied health and dental services annually through the usual Enhanced Primary Care system after having her GPMP and TCA completed. The main difference is that she is also eligible for five additional allied health services annually if she also has an AHC. In addition, follow up visits after care planning can also be claimed under Medicare when performed by registered Aboriginal health workers. In Rita's case, consultations with an Aboriginal health worker or registered nurse may be particularly useful to reinforce the self management aspects of the care plan the GP has put in place. Support and case management of Aboriginal or Torres Strait Islander patients with chronic disease, such as assistance with making and attending appointments, can also be given by the Closing the Gap outreach workers attached to the ACCHS or to the divisions of general practice.

Finally, Rita would benefit from being recalled for review of her GPMP and TCA in 6 months. The need for recall systems to ensure patients are flagged for routine and other planned follow up episodes of healthcare is particularly important among Aboriginal and Torres Strait Islander people. In spite of the challenges in implementation, recall and reminder systems have been associated with improvements in the delivery of preventive services in Aboriginal communities.[28,29]

CASE 4

MICHELLE IS HAVING DIFFICULTY SLEEPING

Michelle is a 44 year old Aboriginal woman who has been living in a housing commission unit with her three children. Although born and raised in a rural Aboriginal community, she has spent the last few years in an urban setting. She is currently on a single parent's pension and has been estranged from her last partner for several months.

Michelle complains of insomnia on a regular basis for at least 1 month. She has difficulty falling asleep, and will watch television until midnight to tire herself out. She then has 5 or 6 hours of broken sleep. She feels tired during the day, lacks motivation and finds it difficult to cope with housework. Her appetite is low and she has become socially withdrawn, isolating herself from her friends and family. She describes an anxious mood with feelings of low self esteem. Her only enjoyment in life is her children, although she reports that lately they have become a source of irritation for her. A symptom review reveals no specific physical symptoms.

Michelle has a history of diabetes that you diagnosed 1 year ago, which is being treated with diet and exercise. She is on no medications.

On examination, Michelle is an overweight lady who makes little eye contact and speaks in a soft, hesitant voice. Her mood is low and anxious and her affect is restricted. She does not demonstrate any thought disorder, nor does she report any perceptual abnormalities or delusional beliefs. She reports passive wishes of wanting to die, stating that she would like to go to sleep and not wake up. She has partial insight in as much as she refers to herself as 'stressed out' and she requests sleeping tablets to help her sleep.

You test her finger prick blood glucose level; it is 10 mmol/L.

QUESTION 1

What is the likely diagnosis?

QUESTION 2

What are the differential diagnoses?

QUESTION 3

How may Indigenous Australian and 'Western' or mainstream concepts of mental illness differ?

QUESTION 4

What is meant by the term 'culturally safe practice'?

QUESTION 5

What psychopathological mechanisms may contribute to the development of depressive disorders in Aboriginal and Torres Strait Islander people?

QUESTION 6

What are some issues to be aware of in the interpretation of mental state examination findings in Aboriginal and Torres Strait Islander people?

QUESTION 7

What interpersonal approaches can you use to address these issues?

QUESTION 8

What is the relationship between diabetes and depression?

QUESTION 9

What would be your management plan for Michelle?

CASE 4 ANSWERS

ANSWER 1

Michelle meets the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) criteria for major depressive disorder with anhedonia and changes in sleep, energy, appetite and concentration, and passive suicidal ideation.[30]

ANSWER 2

Two differential diagnoses apart from major depressive disorder are substance induced mood disorder and a mood disorder due to a general medical condition. Substance induced mood disorder can be diagnosed if depressive symptoms are due to the direct physiological effects of a drug of abuse. Surveys have shown consistently that Indigenous Australian people are less likely to drink alcohol than non-Indigenous Australians, but those who do drink are more likely to consume at hazardous levels, this applies to both genders.[31] Mood disorder due to a general medical condition can be considered if depressive symptoms are due to the direct physiological effects of a general medical condition such as hypothyroidism. An underlying medical condition is important to consider because Indigenous Australians remain the least healthy subpopulation in Australia.[31]

ANSWER 3

For Aboriginal and Torres Strait Islander people, health is viewed in a holistic context that encompasses mental and physical as well as cultural and spiritual health. Ill health is often understood as a disruption of these interrelated domains. The term 'social and emotional wellbeing' may be preferred by Indigenous Australians, because of its holistic and more positive connotations. Indigenous Australians have a holistic view of mental health, inextricably woven into the fabric of their communities with an emphasis on social, emotional and spiritual wellbeing. Hence, psychiatric assessment of Aboriginal and Torres Strait Islander people is a socially and culturally mediated practice, and recognises that there is a continuum between mental health (or social and emotional wellbeing) and mental illness, defined as 'a clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional and social abilities'.[32]

ANSWER 4

'Culturally safe practice' is simply defined as, 'effective clinical practice for a person from another culture',[33] 'unsafe cultural practice' is defined as, 'any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual'. Culturally safe practice is particularly important for Aboriginal people from remote Australia where Morgan[34] notes that, 'serious and unrecognised miscommunication is pervasive in non-Aboriginal doctor/Aboriginal patient interactions'. An atmosphere of cultural safety should be a component of any assessment or intervention.

Aboriginal and Torres Strait Islander people may have strongly held traditional cultural beliefs relating to the influence of evil spirits on health and wellbeing. They may be reluctant to discuss these with a mainstream medical practitioner, or see it as simply not relevant to discuss with them. It is possible that discussion and recommendations that do not reference an Aboriginal or Torres Strait Islander world view will be met with misunderstanding or indifference.

ANSWER 5

Experiences of trauma and loss, present since European invasion, are considered to be a direct outcome of the disruption to cultural wellbeing with intergenerational transfer of trauma leading to mental health disorders.[35] Social and emotional wellbeing problems can result from grief, loss, trauma, abuse, violence, substance misuse, physical health problems, child development problems, gender identity issues, child removals, incarceration, family breakdown, cultural dislocation, racism and social disadvantage.[36]

ANSWER 6

An Indigenous Australian person is more likely to say that they are generally unwell rather than communicate specific illness symptoms.[35] Shyness is common in the Indigenous Australian population, and can be distinguished from guardedness by extreme avoidance of eye contact and the absence of hostility. Delayed answers and minimal speech should not necessarily be considered as psychomotor retardation or poverty of speech.[37]

Traditional Indigenous Australian people may be reserved and apparently indifferent with mainstream doctors. Patients with a blank or unreactive expression in a one-to-one interview may come alive when their family joins in the interview.[37]

What may be culturally appropriate beliefs such as conversing with the spirits of animals or people, needs to be distinguished from true perceptual abnormalities or delusional beliefs. A health worker from the patient's cultural background, or a family member, may assist with this discernment.

ANSWER 7

Nonverbal skills are very important and include the appropriate use of eye contact, posture and gesture.

It is important not to conduct the assessment as a battery of questions. A conversational or 'yarning' approach is more appropriate. One of the most important aspects of assessment is to let the person tell you their story in their own way; don't get caught up in asking direct questions in order to obtain information for your assessment because this tends to lead to inaccuracies. And remember that information exchange may occur in forms that are not verbal.

A nod from the Aboriginal or Torres Strait Islander person may not constitute their answer to the question you have asked, but rather indicate an acknowledgment of what you have asked. The clinician or practitioner needs to check if the person has understood what has been said.

Avoid using technical language as this can lead to misinterpretation, and make use of visual aids such as pictures. Reports of a 'weak spirit' may be a dependable indicator of depressed mood. You can make use of this terminology to elicit more specific information: 'do you have weak

spirit all day/every day?', 'What time of the day does your spirit feel the most weak?' You can employ communicating strategies such as substituting the word 'cranky' for irritability, and 'worry' for anxiety – this may end up being more reliable and useful than using standard psychiatric terminology.[37,38]

ANSWER 8

The association between depression and diabetes is bi-directional with diabetes increasing the risk of incident depression, and depression increasing the risk of diabetes. Therapeutic efforts targeted at both depression and diabetes are required, and collaborative approaches appear to be necessary.[39]

ANSWER 9

Your management plan for Michelle could include:

- performing a preliminary physical examination to check blood pressure (and, at a later date, performing a physical examination to assess for diabetes complications)
- requesting blood tests to exclude precipitating or perpetuating factors of her depressive symptoms, and to assess her physical health (full blood examination to check for anaemia, renal function, iron studies, and consideration of thyroid function tests) and the glycaemic control of her diabetes (HbA1C) and to help assess her cardiovascular risk (fasting serum lipids)
- providing psychoeducation about depression and social, psychological, cultural and biological factors that may drive depression
- providing support and reassurance that depression can be treated effectively
- discussing treatment for depression from a nonmedical perspective (eg. the beneficial effect of improved diet, exercise, sleep hygiene, maintaining social contacts and scheduling pleasant events)
- discussing the role of medication in treating depression if nonmedication alternatives are inappropriate or fail
- suggesting that sleep disturbance is likely to improve as the underlying depression is treated, and offering antidepressant medication rather than sleeping tablets in response to Michelle's request will treat the underlying cause rather than the symptom
- referring to a culturally appropriate counselling service if unresolved psychosocial issues such as trauma, bereavement or family violence are identified during assessment
- preparing a Mental Health Care Plan if appropriate
- discussing lifestyle treatment for diabetes (diet, exercise and weight loss)
- discussing the role of medication in treating diabetes if nonmedication alternatives fail
- involving an Aboriginal liaison officer
- involving the family and/or community (within the limits of confidentiality). This may be appropriate for Michelle if cultural issues, such as cultural dislocation, are a strong factor in her presentation, or may assist with her recovery
- ensuring safety, wellbeing and care of any children involved
- offering support and advocacy with practical matters such as finance, housing and legal issues
- remaining interested and empathic, and making an appointment to review Michelle's mental state and risk issues in the short term
- considering preparation of a GPMP and TCA (discussed in *Case 3*, *Answer 6*) and considering an AHC (discussed in *Case 5*) to address issues raised by your examination, and address Michelle's diabetes.

CASE 5

DAVID'S HEALTH CHECK

David, who is 34 years of age, comes to your practice with an upper respiratory tract infection and requests a medical certificate. He and his wife, Carla, have three young children and are Aboriginal. You have met David before when he brought in his children to see you but he has not attended as a patient himself.

David hasn't seen a GP for several years. He has a chronic cough and was diagnosed with asthma as a child. He buys a salbutamol inhaler over-the-counter every few months and uses it a few times per week. David smokes 15 cigarettes per day and has done so for 20 years.

David is on no other regular medication, has no known allergies and has had no recent immunisations. Apart from having grommets inserted when he was preschool age he has had no surgery. David's mother has type 2 diabetes mellitus and his father, who is 56 years of age, had coronary artery bypass surgery last year.

On examination, David has an obese body habitus. His blood pressure is 130/80 mmHg, his pulse rate is 76 and in sinus rhythm and he is afebrile. Otoscopic examination reveals bilateral middle ear effusions and a mildly red throat. Examination of his chest reveals a good air entry, an occasional wheeze, a normal respiratory rate and no use of his accessory muscles of breathing.

You discuss David's upper respiratory tract infection and discuss his symptoms that suggest asthma and their link with smoking, and provide him with a medical certificate as requested. You confirm that David plans to make this his usual medical practice, and suggest to him that he should have a health check.

David is happy to return for a health check. He has been thinking for a while that he should have a check because he has been getting out of breath training his 7 year old son's rugby team. You organise a follow up time to perform a health check.

QUESTION 1

What are the aims of an AHC – Aboriginal health check?

QUESTION 2

Who is eligible for an AHC?

QUESTION 3

Could an AHC be provided at this consultation if all the criteria are met?

QUESTION 4

What is involved in an AHC?

QUESTION 5

Who can be involved in carrying out an AHC?

FURTHER INFORMATION

David returns the following week for an appointment to see the practice nurse and then you.

The practice nurse finds out that David helps train his son's under 8 rugby team once per week but does little other exercise outside of this. David says his diet contains plenty of fruit but does admit that he buys his lunch at fast food outlets every day at work. He says he has been thinking about quitting smoking for a while. He drinks 2–4 cans of beer on Friday and Saturday nights when his brother visits the family. David has no issues with his sexual health. He reveals that he has been quite anxious about his health recently as he gets quite short of breath. He is worried he might also have heart disease like his father.

The nurse rechecks David's blood pressure, which is 125/85 mmHg and takes a finger prick blood glucose level which is 6.2 mmol/L. David's weight is 95 kg, height 173 cm, his body mass index (BMI) is 31.7kg/m^2 and waist circumference is 110 cm.

David then sees you again. You review the information collected by the practice nurse. You discuss David's concerns about his risk of heart disease and tell him you need to do further investigations such as fasting lipids to fully assess his risk. You also note that he is due for immunisation. You review your examination notes from the previous week and document all of the above by entering it in your practice software proforma. You ask David to come back when the results of his tests are back, and you offer him a copy of his health check.

QUESTION 6

Can you claim for the Medicare item number 715 at this stage?

QUESTION 7

What are some of the issues that need further follow up after David's AHC?

QUESTION 8

You would like David to see a dietician. Is David entitled to have this consultation billed under Medicare?

QUESTION 9

As David has expressed interest in quitting smoking you organise for him to have smoking cessation counselling by the Aboriginal health worker. Is there a Medicare item number applicable for David's consultation with the Aboriginal health worker?

FURTHER INFORMATION

David returns in response to a recall you sent out 3 months after the health check. He has quit smoking, has seen the dietician and has also had an asthma check with you since then. He says he is now trying to walk most mornings and has lost 5 kg. His blood pressure is now 120/75 mmHg and he hasn't used his salbutamol inhaler since he last had a cold. He says he is more positive about his health and thanks you for organising the health check.

QUESTION 10

When is David due for another AHC?

CASE 5 ANSWERS

ANSWER 1

Aboriginal and Torres Strait Islander people have worse health outcomes than the general Australian population. They have higher rates of diabetes, cardiovascular and kidney disease.[17,40] Aboriginal Health Checks are an initiative to detect and manage chronic conditions earlier to reduce long term morbidity and mortality.

In practice, AHCs have been found to be an effective tool to evaluate the health status of patients. They are useful in identifying chronic disease risk factors and for implementing culturally targeted preventive health care.[41] They have also been shown to provide better treatment of existing disease and thereby reduce morbidity.[42]

ANSWER 2

All Aboriginal and Torres Strait Islander people are eligible for the AHC, irrespective of their age. Obviously the needs of the different age groups will mean that the health check will have different areas of focus depending on the patient. Medicare Australia groups patients into age ranges: 0–14 years, 15–54 years and 55 years and over and proformas for each age group are available on the Medicare Australia website.[43]

ANSWER 3

Yes. The AHC may be completed and claimed at this consultation if time permits. A separate Medicare item number such as item 23 or 36 may also be claimed if the patient has a condition that requires immediate treatment (this would need to be notated as such when processing the MBS claim). An AHC can also be completed over more than one consultation if required.[43]

ANSWER 4

Consent must be obtained from the patient to complete the health check. This may be verbal consent but it must be documented. A health check is also called a health assessment and in order to achieve its aims of assessment of risk factors and early detection of disease, and fulfil the Medicare requirements, it must include:

- information collection – patient history and undertaking examinations and investigations as required
- overall assessment of the patient
- recommending appropriate interventions
- providing advice and information to the patient
- recording the health assessment, and
- offering the patient/carer a written report with recommendations about matters covered by the health assessment.[44]

General history should cover assessment of:

- smoking
- alcohol
- diet
- exercise/activity
- mood
- sexual history.

Physical examination could include:

- blood pressure
- height, weight, abdominal circumference and BMI
- finger prick blood glucose level.

Further examination and subsequent investigations will be guided by the patient's history and commonly includes ear, nose and throat, skin, respiratory and cardiovascular checks.

ANSWER 5

The practice nurse and/or Aboriginal health worker can be involved in collecting information, which could include taking the history, taking blood pressure, recording height, weight, abdominal circumference and BMI, and checking finger prick blood glucose level.

The GP must review the history. The GP must perform relevant examinations and request further investigations as appropriate. The overall assessment of the patient's health must be made and the health assessment documented.

An Aboriginal health worker or practice nurse may be involved in providing further information and/or advice (working under the supervision of the GP).

The health check item number (item 715) can only be claimed by the patient's usual GP.[42]

ANSWER 6

Yes. The Medicare item number may be claimed at this stage as you have fulfilled all the criteria including organising further investigations and arranging follow up with David.[43]

ANSWER 7

Several issues have arisen from David's health check, including that:

- he is ready to quit smoking. You could engage motivational interviewing to assist him in quitting smoking
- he is at increased risk of ischaemic heart disease and type 2 diabetes, which you should inform him about and monitor him for
- his blood pressure and cholesterol level need monitoring given he is at risk of cardiovascular disease
- he needs to make dietary and exercise changes to reduce his cardiovascular and diabetes risk and lose weight
- he needs asthma education and management, and formal assessment of respiratory function with spirometry
- he requires immunisation with influenza vaccine and pneumococcal vaccine
- discussion about safe drinking levels would be appropriate.

ANSWER 8

Yes. David is entitled to five allied health services per year following his AHC. The allied health professionals use Medicare item numbers 81300 to 81360. Allied health professionals include Aboriginal health worker, diabetes educator, audiologist, exercise physiologist, dietician, psychologist, occupational therapist, physiotherapist, podiatrist, chiropractor, osteopath, speech pathologist or mental health services. The referral form for these five allied health consults is different to the form referring patients for allied health services after a GPMP and TCA, and is available on the Medicare website.

ANSWER 9

Yes. On completion of an AHC, patients are entitled to a maximum of 10 services for follow up by a practice nurse or registered Aboriginal health worker under Medicare item number 10987 including:

- taking a medical history
- examinations/interventions as indicated by the health assessment
- education regarding medication compliance and associated monitoring
- education, monitoring and counselling activities and lifestyle advice
- checks on clinical progress and service access
- prevention advice for chronic conditions, and associated follow up.[43]

ANSWER 10

An AHC Item 715 can be performed annually (not more than once during a 9 month period).[44,45]

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RESOURCES FOR DOCTORS

General

- Royal Australian College of General Practitioners National Faculty of Aboriginal and Torres Strait Islander Health. Identification of Aboriginal and Torres Strait Islander Patients in Australian general practice 2011. Available at www.racgp.org.au/aboriginalhealth/identificationpositionpaper.pdf
- The Australian Indigenous Health Information Net provides information on statistics, common health conditions, and other factors that impact on health, as well as health promotion resources, publications and policies. Available at www.healthinfonet.ecu.edu.au
- National Aboriginal and Torres Strait Islander social and health surveys that provide statistical information on a range of medical and social issues are available at www.abs.gov.au
- The Aboriginal Health and Medical Research Council of New South Wales provides general information on Aboriginal Health as well as a list of organisations working in Aboriginal health. Available at www.ahmrc.org.au/aboriginalhealthinformation.htm
- The Little Red Yellow and Black Book provides an introduction to Indigenous Australian culture and history. Available at http://lryb.aiatsis.gov.au
- The Remote Area Health Core Online Training is designed for health professionals to access before undertaking locums in remote Indigenous Australian communities. All units are developed by local experts with full input from local Indigenous Australian communities. Available at www.rahc.com.au/training

Family violence

- Victorian Government Department of Justice. Management of the whole family when intimate partner violence is present: guidelines for primary care physicians. Melbourne: The Department, 2006. Available at www.racgp.org.au/guidelines/intimatepartnerabuse
- Royal Australian College of General Practitioners. Abuse and violence: working with our patients in general practice (white book). 3rd edn. South Melbourne: RACGP, 2008
- Genevieve Grieves. Lani's story – the story of an Aboriginal woman's domestic violence experience (DVD). Sydney: Blackfellas Films, 2010.

Medicare item numbers relevant to Aboriginal and Torres Strait Islander health

- Medicare Australia. MBS Primary Care Items, Medicare Health Assessments Resource Kit. Available at www.health.gov.au/internet/main/publishing.nsf/Content/mha_resource_kit.

RESOURCES FOR PATIENTS

- The Australian Indigenous Health Information Net provides an on-line yarning site where Indigenous people can interact, and also provides information on common health conditions. Available at www.healthinfonet.ecu.edu.au
- The Australian Human Rights Commission provides information for Indigenous Australians on Human Rights and the Social Justice Report 2005 in response to which the Closing the Gap program was developed. Available at www.hreoc.gov.au/social_justice/health/index.html.

Aboriginal and Torres Strait Islander health

In order to qualify for 6 Category 2 points for the QI&CPD activity associated with this unit:

- read and complete the unit of *check* in hardcopy or online at the *gplearning* website at www.gplearning.com.au, and
- log onto the *gplearning* website at www.gplearning.com.au and answer the following 10 multiple choice questions (MCQs) online
- complete the online evaluation.

If you are not an RACGP member, please contact the *gplearning* helpdesk on 1800 284 789 to register in the first instance. You will be provided with a username and password that will allow you access to the test.

The expected time to complete this activity is 3 hours.

Please note:

- from January 2011, there will no longer be a Category 1 activity (ALM) associated with *check* units. This decision was made due to a lack of interest in this activity. The RACGP apologises for any inconvenience caused by this change
- do not send answers to the MCQs into the *check* office. This activity can only be completed online at www.gplearning.com.au.

If you have any queries or technical issues accessing the test online, please contact the *gplearning* helpdesk on 1800 284 789.

QUESTION 1

Belinda is a 36 year old woman who is a new patient to your practice. She has hypertension, renal disease and obesity. As you complete her history on the electronic medical record, you consider asking whether she identifies as an Aboriginal or Torres Strait Islander person. Which of the following is true regarding identifying Aboriginal and Torres Strait Islander patients within your practice?

A. Identification allows treatment to be targeted and culturally appropriate

B. Most patients are annoyed at being asked about their indigenous status despite explanation of the reasons for asking

C. Identification is routinely carried out by most general practices in Australia

D. Studies show that routine identification of indigenous status in general practices promotes discrimination

E. There is no point in identifying indigenous patients in your practice because it makes no difference to patient care.

QUESTION 2

You are aware of the differences in health outcomes between the indigenous and non-indigenous populations of Australia, and understand that many Indigenous Australian people experience problems with accessing medical care. Which of the following is likely to be most effective in improving the access of Indigenous Australian patients to medical care?

A. Arranging for the doctors of your practice to undertake 'cultural safety' training

B. Displaying Indigenous Australian artwork in your practice

C. Displaying Aboriginal and Torres Strait Islander flags in your practice

D. Participating in National Sorry Day

E. Enabling Indigenous Australian people to develop personal therapeutic relationships with staff.

QUESTION 3

Sally is 23 years of age and is a Torres Strait Islander who has been in a relationship with Matt for 2 years, and recently found out that she is pregnant. She says that her partner humiliates her in public and threatens her if she goes out with her friends. Which of the following would be your next step in management?

A. Reassure her that her partner's behaviour is likely to improve given that she is pregnant

B. Explore what aspects of her behaviour Sally can change in an attempt to prevent her partner's threats

C. Advise her to confront her partner

D. Advise her to leave her partner

E. Ask Sally to tell you more of her concerns.

QUESTION 4

Simone is 35 years of age, she is an Indigenous Australian woman who presents to you with a respiratory tract infection and in the course of examining her chest, you notice bruises of differing ages. When questioned, she says that she fell down the stairs last week. You suspect that her injuries are not accidental and may have resulted from family violence. Which of the following is true regarding family violence?

A. If the woman in a partnership does not perceive the behaviour of her partner to be abusive, then abuse is unlikely to have occurred

B. People experiencing abuse at home often feel distrustful of many people, not just the perpetrator

C. Feelings of low self esteem are unique to the individual being abused and are generally not experienced by the perpetrator

D. Alcohol is rarely involved in cases of domestic violence

E. Women who have suffered child abuse are ten times as likely to be involved in a relationship involving family violence as women who have not suffered child abuse.

QUESTION 5

Mark is 49 years of age, and is an Aboriginal man who has diabetes, hypertension, ischaemic heart disease and kidney disease. You consider involving him in the Closing the Gap program and consider the benefits. Benefits of the Closing the Gap program include all of the following **except**:

A. Access to subsidised medications

B. Access to healthy lifestyle and tobacco action workers

C. Access to chronic care outreach workers

D. Access to bulk billed specialty physicians in every case

E. Access to Practice Incentives Program payments.

QUESTION 6

You decide to register Mark in the Closing the Gap program and consider what you have to do in order to fulfil the Medicare requirements. Requirements of the Closing the Gap program include all of the following **except**:

A. the patient must be at risk of, or have, a chronic disease

B. an Aboriginal health worker must be involved

C. the patient and a GP at their usual practice must both register to participate

D. two practice staff members, one of whom is a GP, must participate in cultural awareness training within 12 months of enrolling

E. the GP must offer Aboriginal Health Checks (AHCs) and regular GP Management Plans.

QUESTION 7

Brad is 32 years of age, and he asks what he can do to improve his health as his older brother recently died of a heart attack. You consider arranging an AHC under Medicare item number 715. Regarding the AHC funded by Medicare, which of the following is true?

A. AHCs are available to all Indigenous Australians, except children

B. An Aboriginal health worker or practice nurse can complete the history taking, examination and management phases of the consultation

C. The GP is prevented from charging Medicare a separate item number at the same time

D. In the year following an AHC, the patient is entitled to access five allied health consultations

E. The AHC can be performed every 6 months.

QUESTION 8

Carol is 25 years of age and is an Aboriginal woman who comes in with her partner, to whom you administered a tetanus injection last week. Carol had her diphtheria/pertussis/tetanus injection following the birth of her first child. She asks whether she should have any other immunisations. Which of the following reflects the immunisation recommendations for Aboriginal and Torres Strait Islanders?

A. Immunisation with influenza vaccine is recommended to all Aboriginal and Torres Strait Islander people who are 50 years of age and older

B. Immunisation with influenza vaccine is recommended to all Aboriginal and Torres Strait Islander people who are 5 years of age and older

C. Immunisation with pneumococcal vaccine is funded for all Aboriginal and Torres Strait Islander people who are 50 years of age and older

D. Immunisation with pneumococcal vaccine is funded for all Aboriginal and Torres Strait Islander people who are 15 years of age and older

E. Immunisation with influenza and pneumococcal vaccines for Aboriginal and Torres Strait Islander people parallels that of the non-Indigenous Australian population.

QUESTION 9

Christie is 46 years of age; she is an Aboriginal woman from a remote community who is brought in to you by her two sisters who say that she has been very cranky lately and doesn't want to leave her home. You assess her and consider that she may have an anxiety disorder. Which of the following demonstrates a 'culturally safe' approach to dealing with Christie?

A. Ask Christie's sisters to leave the room at the beginning of the consult

B. Ask Christie a series of questions about symptoms of mental ill health

C. Assess Christie's understanding of her symptoms

D. Explain to Christie that she could have a mental illness

E. Advise Christie that cognitive behavioural therapy is the mainstay of treatment.

QUESTION 10

Murray is 62 years of age, and is an Indigenous Australian man who lives in a remote community. You are asked to go to visit him by the Aboriginal outreach worker who has told you that Murray's 'spirit is weak'. You listen to Murray's story and then think about performing a mental state examination. Which of the following is true regarding the interpretation of mental state examination findings in traditional Indigenous Australians?

A. Traditional Indigenous Australians are more likely to communicate specific illness symptoms than say that they are generally unwell

B. Extreme avoidance of eye contact and the absence of hostility is more consistent with guardedness than shyness

C. Delayed answers and minimal speech usually indicate psychomotor retardation

D. An unreactive expression is usually consistent with depression

E. A nod of the head can often mean an acknowledgment of what has been asked rather than a response in the affirmative.