RETHINKING CHILD AND YOUTH MENTAL HEALTH SERVICE DELIVERY MODELS

FOR

INDIGENOUS CHILDREN AND FAMILIES LIVING IN FAR NORTH QUEENSLAND

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INDEX

How to read this Report ................................................................................................3
Glossary of Acronyms and Key Terms ........................................................................4
Executive Summary ................................................................................................... 5-7
Lessons Learnt .......................................................................................................... 8-9
Challenges for the Future ..................................................................................... 10-11
Personal Reflections ............................................................................................. 12-13
Part One
  Introduction ...................................................................................... 14-23
Part Two
  Remote Cairns District..................................................................... 24-30
Part Three
  Cape York District ............................................................................ 31-35
Part Four
  Torres District................................................................................... 36-39
Part Five
  Overall Development across Districts ............................................ 40-43
Part Six
  Evaluation ......................................................................................... 44-54
Recommendations ................................................................................................. 55-56
Acknowledgements ............................................................................................... 57-58
Appendices ............................................................................................................ 59-89
This report deals with the planning and developments of a service evaluation activity that spanned a period of three years, 2002-2004 and covered three health service districts, namely Cairns, Cape York and Torres Straits and Northern Peninsula Area.

Parts two to four deal with discrete project activities year by year in each of the Districts. Parts one, five and six deal with general developments and key activities for the whole project across the districts.

Although the report reads in a phased way, the project was not planned in phases. It needs to be clarified at the outset that the phases emerged as part of the action research findings. The sequence evolved as a recognition of and response to needs and findings on the ground.

The report is structured on project activities by districts, Cairns, Cape York and Torres Strait and Northern Peninsula Area. However under each district, activities of the project are divided by the year ie, 2002, 2003 and 2004. Each district report also carries a brief evaluation section.

Evaluation of the whole project across districts is dealt within Part Five.

This report does not carry a literature review section. Although literature was reviewed extensively for this project, it is not included in a separate section in the report, essentially to reduce the length and increase reader friendly aspects of the report. However key references that guided the project activities have been included in the relevant sections.
GLOSSARY OF ACRONYMS AND KEY TERMS

CYMH - Child and Youth Mental Health
CYMHS - Child and Youth Mental Health Service
CYMHS Cairns - Child and Youth Mental Health Service from Cairns District
CYMHS Cape - Child and Youth Mental Health Service from Cape York District
CYMHS Torres - Child and Youth Mental Health Service from Torres Strait and Northern Peninsula District
RACYMHS - Remote Area Child and Youth Mental Health Service
CYIMHW - Child and Youth Indigenous Mental Health Worker
AMHS - Adult Mental Health Service
CESA - Client Event Service Application
EXECUTIVE SUMMARY

Aims and Objectives
In November 2001 a project was designed to establish and evaluate a model of best practice for Remote Area Child and Youth Mental Health Service Delivery for Indigenous families living in Far North Queensland. The project was a partnership between Queensland Health and University of Queensland. It was built on and has continued to be informed by a series of initiatives in Far North Queensland between 2001 and 2004. These initiatives include the Chronic Disease Strategy, Family Well Being Program, The Making Changes Meeting Challenges Report and The Australian Integrated Mental Health Initiative - Indigenous Stream, North Queensland among others.

Context
The project covered three districts, Cairns (the Remote areas of Cooktown, Hopevale, Wujal Wujal) Cape York (Kowanyama, Pormpuraaw, Lockhart River, Aurukun, Napranum, Weipa, Old Mapoon and Coen) Torres Strait (Thursday Island and Outer Islands) and the Northern Peninsula Area, NPA (Injinoo, New Mapoon, Seisia, Umagico and Bamaga).

Funding was provided by the mental health unit and the University of Queensland initially for two years and with a subsequent extension for a further year.

This report documents in detail the activities of the project, evaluation of outcomes, critical learnings and a summary of recommendations.

Method
The project used an Action Research framework and a community centred approach to review service needs and evaluate service activities in communities. The first step was to map community resources and needs through community/inter-agency consultations. Step two involved restructuring existing service delivery practices and evaluating the impact of this restructure. The next step consisted of a trial of an alternate model of service delivery. Evaluation was built into every step of the activity. Final activities for the project were documentation and developing strategic recommendations for the future.
**Findings**

The project's findings or outcomes spread across five key areas:

**Sufficiency of service (frequency and regularity)**

The frequency of the service was increased from secondary consultations once every three months in the first year to direct clinical consultations two days every month in the final year of the project.

Across the three districts the service changed, from a need-based, crisis driven service to a regular and predictable activity.

**Structure of service (roles, liaison and integration)**

The service, as a result of the project, has increased liaison activities with other government and non-government agencies in the communities. The service has increased integration with local activities in each community.

**Community partnership (involvement and participation)**

Communities acknowledge an increased 'presence' and accessibility of the service. Community has increased information about the service.

**Workforce development (supervision for Indigenous and non Indigenous practitioners)**

In the last three years the service has been restructured to have weekly supervision, weekly clinical reviews, monthly peer reflective practice sessions and a range of other professional development activities.

**Quality of service (documentation)**

Standardised data about the service was collected in a systematic way in the year 2004.

**Implication**

The significance of the project findings is based on two critical changes in service restructure that contributed to capacity building: a) Implementation of support structures (through supervision and professional development activities) for the remote area child and youth mental health staff; b) increased levels of community engagement through direct links with community members; through Indigenous workers in the team and through facilitation of community development activities. Undoubtedly, the service changes have had a 'cost benefit' equation that is yet to be analysed. To protect the improvements gained, it is essential to prove better outcomes and evaluate the costs of this process.


**Recommendations**

The principle recommendations flowing from the work are the following:

1. RACYMHS to continue to action research its service delivery models in order to build and enhance a clinically effective, socially valid and resource sustainable remote area team.

2. RACYMHS to be supported with a full time administrative position to fulfil the needs of the team and facilitate the operational management of team duties.

3. RACYMHS to work towards a model where one full time clinician position is devoted to no more than 3-4 communities. In the current structure this would entail having one more full time clinician for the Cape and one more full time clinician for the Torres.

4. RACYMHS to advocate and recruit for three more Indigenous CYMH workers, essentially, to work as a team with clinicians. Thus if there are five clinicians proposed for the team, there is a need for five Indigenous workers.

5. RACYMHS management to share the responsibility for Indigenous children and families living in remote area Far North Queensland, with the three districts with clear division of operational management, funding accountability and professional development roles.

6. In the far north region, RACYMHS to pioneer efforts in trialing and evaluating models of supervision and professional support for remote area child and youth workers.

7. RACYMHS to build the capacity of non Indigenous workers by providing training and professional development opportunities to learn and integrate multiple knowledge and context sensitive therapies.

8. RACYMHS to play an advocacy role in building the capacity of Indigenous workers and participate proactively in rethinking career structures and professional development pathways for the Indigenous workers in the team.

9. RACYMHS to work on better ways of engaging consumer and community participation to measure and evaluate the impact of the service.

10. RACYMHS to trial robust ways to quantify indices of service change, community participation and practitioner satisfaction in addition to clinical parameters.
The lessons learnt were innumerable both along the way and in hindsight. Some of these enabled better planning and informed the rectification of errors. But mostly, the lessons have become insights that helped understand the complexity of service development activity in remote settings. These are, by no means, unique to this project, as there is sufficient literature from several disciplines supporting these findings. However for this project these were crucial lessons:

- The major learning has been that when a service becomes more functional the service demands exponentially increase. In this project when the remote area service was infrequent and irregular, the demands were undoubtedly there, in the manageable range. As the service evaluation progressed and changes were made to the way service was being delivered, the expectation and needs on the ground ie in the communities grew rapidly. This phenomenon needs to be acknowledged (and even anticipated). However, there is no need for immediate quick fix reactions. The need is to recognise that although service demands increase greatly at the beginning of this process, they eventually even out as a service continues to provide and manage situations effectively in a consistent, sustained and proactive way.

- The importance of working at different levels simultaneously rather than one level at a time. The levels of change have to be facilitated in three contexts - service, community and institutional. The amount of change will inevitably be different in different areas. This project had maximum change within the service context ie, work force development, improving the support and structures for enhancing service practice; moderate change within the institutional context ie, informing on action research findings, linking learning to grass roots practice restructures and providing strategic directions for future expansion; and, low level change within the community context ie, improved community engagement but no other measurable change in policy or health outcomes for children. However, for future activities this trend could well reverse. For example as the service context gets strengthened the focus can move to ways of creating and sustaining change in the community context.
• The concepts of partnership, networking and collaborations became overlapping and overwhelming. Although it was immensely useful to network with other service and community members, the processes were time consuming and added to the existing demands of the workers. It created a web of disparate activities, sometimes with no coherent theme pulling it together. Networking meetings are also highly sensitive meetings. They open great possibilities but also present challenges of hierarchy and exclusion if it not mediated carefully and skilfully. To expect every member of the team to bring the know-how of running networking meetings was, essentially, unrealistic.

• There is a moral, complex issue related to ethics of change. Change, by nature, is seen as disempowering or in the least a destabilising process. In this project although the workers clearly saw the need for existing structures to change for outcomes to improve, becoming the change agents was not possible. When change is initiated how democratic should the process be? The gains produced by change are always relative. Some gain more, some gain less and some lose due to the changes. Exploring the possibilities of change is easier than understanding the consequences of change in its entirety. Thus, any process of empowerment through fundamental change or rigorous change can create a destabilising environment. This, in and of itself, needs to be addressed openly and judiciously.
The challenges for the next phase are multi-fold. They are intricately linked to regular and thorough review and evaluation of service activities, systems constraints and community concerns. The five major areas that require considerable development are the following:

- **Building the capacity of the Indigenous workforce** - The existing career pathway and developmental structure for Indigenous health workers and in particular mental health workers is minimal and inflexible. Having Indigenous workers in any service is a significant addition for the service. However the capacity of the service to address the needs of Indigenous workers is, at this stage, limited and limiting. There needs to be critical rethinking of professional development models with the aim of genuinely supporting and validating Indigenous workers. For example, in RACYMHS, the risk of Indigenous RACYMH workers becoming pseudo clinicians is high. If the role is seen as a community development role, where and how are supports structured for training and development?

- **Building the capacity of non-Indigenous workers** – Most clinicians or practitioners from the disciplines of psychology, social work, nursing, psychiatry and welfare are trained without population health frameworks. The clinically or medically driven model is obsolete in settings where sociopolitical factors create and contribute to distress. The experience and expression of this distress is so varied that a 'one size fits all' paradigm is useless. Remote area work needs a unique set of skills. The sensitivity and expertise needed to do community development and integrated interventions are not part of university mainstream training. Invariably, workers who are new to the field or inexperienced are the ones sent to do remote area work. Mostly, as professionals gather more experience they steadily gravitate back to tertiary academic centres. There is also a great need for lateral thinking for innovative ways of doing 'business'. For example, the high rates of youth offending in communities is usually dealt within silos by the juvenile legal system, by school authorities and mental health referrals for 'anger management'. This fragmented, non-utilitarian approach does not break the revolving door crises for these young people.
However the option of doing or accessing creative programs like restorative or transformative justice, is unavailable. This is partly due to a lack of trained experts in the area and largely due to systems’ incapacity to see the futility of existing programs.

- **Community participation** - A significant challenge that was and continues to impact on this work is community participation or consumer participation. The barriers that the project workers faced to achieve community engagement and participation were multiple. These factors are succinctly argued in Nathan's article¹. The three areas include, building the capacity of people (young people in this context) and the community to influence; building the capacity of the health system to accept their views and values and thirdly providing opportunities for the most marginalised to be heard.

- **Recording and measuring data** - Data collection is another major challenge. In its current form using the CESA the data provides quantitative clinical contact indices in the form of Provision of Service (POS). Service management activity for remote area work includes network meetings, community consultations, group work and a range of health promotion or educational activities carried out on the ground. The category of Service Management Activity or SMA is neither standardised nor easily interpreted. This area, perhaps, the most complex to conceptualise, needs careful collection of all service activities, rigorous documentation of time units and careful elucidation of frameworks to research. It would be vital to borrow the learnings from international (particularly Canadian and New Zealand) developments in this area.

- **The critical administrative support** - It is hard to conceive that administrative support would become a challenge area. However for this project, at every stage, the many failed activities were directly related to lack of administrative support. For example, the project started a newsletter which could not be sustained after two issues; the advisory reference group meetings that were due to be held three monthly were not coordinated; inter agency meetings were not adequately documented etc. An administrative unit would have strengthened the project activities for database service entries and outcomes statistics.

In November 2001 when I started grappling with issues of service delivery to remote communities, I realised, almost immediately, that these are intricately linked to issues of service equity. It is similar to peace dialogue - one cannot talk about issues of peace without addressing issues of justice.

The striking thing about remote area mental health work, whether in indigenous or non indigenous settings, is that it is not perceived as glamorous or interesting as work in metropolitan tertiary institutions. Having been exported from one such tertiary institute myself, I was astonished when a colleague remarked on the first week, "so you have come from the sublime to the ridiculous". This comment was the beginning of many assumptions and beliefs that I would encounter and unpack in the next three years. One of the critical questions I had to ask myself was, what would make remote area work appealing or how should things be restructured in order to increase the 'value' of such work and consequently the workers? Ironically, remote area workers were as marginalised as the remote areas they were serving. This parallel despair and disillusion fed both systems ie, the context and the worker. One of the practitioners in a reflective moment spoke of the 'utter fear' of what and how to do work in a remote Indigenous community. Most, if not all workers/practitioners who provided service to remote Indigenous communities were as fragile and lacking in confidence (read 'skills') as the communities they were trying to support. Disempowerment was everywhere - in the communities, in the morale of the workers and in the system ie, Queensland Health which was the backdrop (if not the backbone).

The reality, on the ground ie, in communities, is layered and complex. There is: a) cultural reality that speaks of racism, discrimination, loss, dispossession, grief and trauma; b) social reality that shows appalling health status, disastrous educational outcomes, criminal offences and ever-increasing incarceration rates; c) political reality that demonstrates friction and fragmentation in local and regional power groups; and d) a practical reality of overcrowding, lack of civic amenities, lack of employment, absence of vocational training opportunities and a perpetual stream of outreach workers.
Given the enormity of the situation, I had to remind myself, in enabling an environment "insisting only on fundamental and revolutionary social change is dooming us to programs that will take years and generations to take effect. Since it is difficult to implement such major social change, it is easy to ignore inequalities because, they say, nothing can realistically be done about them. Moral outrage about inequalities is appropriate but self-indulgent. If we really want to change the world we may have to begin in more modest and practical ways".  

This initiative is a modest beginning and the goal was to make service delivery practical and sustainable. The process of this modest activity was shaped and guided by many thinking and feeling people, Indigenous and non Indigenous, who work and/or live, in remote areas.

Finally, for me, this initiative has been driven by the sentiment expressed in Jack Davis’s poem, Eulogy for Peace by an Old Aboriginal, "why does white man always want to stand up and fight for? Why doesn't he sit down quiet and talk by fire?"

To be able to sit down by fire and quietly talk is essentially, all there is.

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2 Syme SL. Individual vs community interventions in public health practice: some thoughts about a new approach. Health Promotion Matters, 1997; 2; 2-9
PART ONE - INTRODUCTION

This chapter deals with the following sections:

1. Background and historical details for the project
2. Geographical location and infrastructure of the project activity
3. Context for the project
4. Purpose
5. Objectives and Aims
6. Methodology
7. Findings of the first stage of the project

**Background & History**

The Project entitled 'Best Practice Mental Health Service Delivery Models for Indigenous Children and Families Living in Far North Queensland' began in November 2001. The project resulted from recognition of unmet need in terms of child and youth mental health activities in remote Far North Queensland. It sought to explore alternate models of service delivery to improve and enhance community outcomes.

In Far North Queensland, health services have undergone major changes and are currently under the jurisdiction of Districts. In the last ten years these changes and modifications have significantly affected the provision of remote area mental health, both adult and child and youth services\(^3\).

**Infra Structure**

The project crossed three districts (see Map on page 16):

- Cairns (Cooktown, Hopevale, Wujul Wujul)
- Cape York (Kowanyama, Pormpuraaw, Lockhart River, Aurukun, Napranum, Weipa, Mapoon and Coen)
- Torres Strait (Thursday Island and Outer Islands) and Northern Peninsula Area, NPA (Injinoo, New Mapoon, Seisia, Umajico and Bamaga)

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\(^3\) Hunter, E. Cape York Mental Health Services Presentation, Weipa, 2001.
Between 1999 - 2001, Cairns District CYMHS had the allocated funding and sole responsibility for providing services to all three districts and the communities therein (around 20 communities). The funding provided one full time clinician to service the entire remote area. This translated, on the ground, as one trip every eight weeks to Cairns Remote communities and every twelve weeks to the Torres Strait and NPA District. Due to failed negotiations, services to the Cape District had been curtailed. Given the complexity of remote area work and in particular Indigenous health and well being, it is not surprising that the Child and Youth mental health service has had an unpredictable history with adhoc random presence in the remote communities of Cape York and Torres Strait up until 2001.

**Location and Context**

The area covered by this project across the three districts has a population of 20,000 people, predominantly Indigenous (Aboriginal and Islander) groups. Travel is difficult and usually expensive. There is limited or no road access during the wet season that usually lasts four months in a year. High levels of poverty, poor educational outcomes, unemployment and housing problems exist across the region. Even communities that are small in numbers have high number of children. All communities have a disproportionate number of children and youth with the youth dependency ratio\(^4\). This means that the child and youth needs are significantly greater than that of a similar sized population anywhere in mainstream Australia. The costs associated with supporting staff to work in such remote areas are expensive and there are structural inequities by discipline such as the Remote Area Nurses Incentive Package (RANIP) as compared to Allied Health salaries. The Primary Health care clinics are autonomous and driven by intervention models that are disparate across settings, some more medical and others more community oriented. There are few or no community based Non Government Organisations and services largely operate with a government driven outreach model. Health and community infrastructure is poor with few recreational or community activity facilities. There are usually six to eight people sharing one house and it is not uncommon to see up to thirteen members sharing a house for extended periods of time. Nearly every community has a beach, river or coastline that is easily accessible. The Islander communities have a better-developed infrastructure ie, roads, hotels, take away shops, corner stores etc but housing

needs, health indices, governance and autonomy issues are significant challenges in both societies.

**Purpose of the Project**

The original purpose of the project was to review the context, service demands and service effectiveness of the existing Child and Youth remote area mental health service in Far North Queensland.
A secondary purpose, following the review and evaluation, was to trial alternate models of service delivery to meet the mental health needs of Indigenous children and families living in Far North Queensland.

**Objectives**

The overall aim of the project was to improve and increase the capacity of RACYMHS delivery in Far North Queensland.

The feedback and response from communities and CYMH staff to the changes (or restructuring) being made at every stage determined the specific objectives for the next stage of the project.

The objective for stage one was scoping and mapping of community resources, needs and conducting community / interagency consultations.

The objective for the next stage involved restructuring existing service delivery practise. The impact, the changes/restructures had on the service was evaluated in the next phase.

This led to the next stage of a trial of an alternate model of service delivery.

This alternate model was then evaluated.

And in the final phase of this project the objective was documentation, recommendation and dissemination of findings to Queensland Health, District managements and communities. (See figure one below)

**Figure One**
The objectives at each stage of the project included the following components:

- **Phase design** - considering the context and collecting evidence; reflecting on assumptions (individual and systems), clarifying the issues being addressed, outlining strategies to address the issue, trialing one or more strategy and reviewing the issues;

- **Process evaluation** - the extent to which the design/steps are being implemented and identifying the challenges in this process;

- **Impact evaluation** - the immediate impact on the ground by stakeholders, community members and consumers on the implemented steps;

- **Outcome evaluation** - the outcome of the implemented changes, community feedback and practitioner's reflections;

- **Reporting** - an accountable line of reporting, documentation and discussion in different forums ie, stakeholders, management committee, advisory committee;

- **Follow up** - an action implementation of the whole design to form the next phase of the project.

**Methodology**

In the first six months the project infrastructure was created with a local Steering Committee to oversee and monitor the project. An interregional Advisory committee was set up to inform the project about contemporary national initiatives and direct the scientific rigour of the project (see Acknowledgments for details).

Several focus group and/or individual meetings with members in the communities, other service providers such as the Department of Families, Education, Sports and Recreation, Disability, Royal Flying Doctors Service, Paediatric Outreach Service, Tharpuntoo Legal service were conducted.

These data (community members and stakeholders feedback) were critical to inform the strategies that determined time line and pilot sites for the restructure of CYMHS for remote areas.

In the first year the project activity predominantly involved a scoping review of personnel and funding resources available for the purpose of addressing social and emotional needs of children and families in each community. An example of the lead questions is:

- Who works in the community with children and families?
• Who does this person work for? How does the community identify them eg, counsellor, guidance officer

• How often do they visit? Who can give more information about their visit?

• How many workers visit the community doing this kind of work ie, two workers or a team with one indigenous health worker etc.

• What does this person do? Do they do home visits? Do they sit in the clinic? Do they meet the family? Does the community know what work they do?

• How do they go about their work? Do they 'yarn'? Do they use drawings? Do they show videos? Are written reports available to families?

• Are community members aware of the various agencies that provide services with regards to children's issues?

• If the community member is aware, do they use these services?

• Does the community participate with the services? For example: Would a parent join the counsellor or a welfare worker for meeting with the schoolteacher? Would a justice group member act as a cultural consultant for a family mediation? Do these practices exist?

• Does the community decide what they need with regards to a particular service? For example, if they need the CYMH worker to visit the community on a Tuesday rather than a Friday, is that negotiable?

• Does the community have any sense of control over what services get offered for children?

• If not, are these predetermined by systems outside of the community? For example, if the community requires swimming coaches/ carpenters to visit the community to teach the children woodwork/advanced swimming every week how would they go about arranging it? (See figure two).
This mapping was done with community members focussing on parents and grandparents (those living in the community including service providers eg, teachers, and nurses) utilising an opportunistic sampling frame. For example, meeting with the justice group and going to their homes and speaking to the neighbour next door; interviewing outreach service providers who are in the community at the same time as this project manager. Up to ten interviews were conducted in each community with community members and ten with service providers from different organisations doing child health. Although young people were interviewed it was hard to get enough of a sample and it ranged from 1-3 in communities. There was no gender or age matching in the interview sample.

Data was analysed from five sources throughout the project activities:

- content of the interviews from community members to identify existing information of the service and the perceived need of the communities
- content from the semi structured interviews with service providers from different government and non government organisations
- in-depth reflective interviews with practitioners of the CYMH remote area service
• audits of clinical work load ie, number of referrals, cases seen and time demands
  (travel, client/family contact time, community time)

• field notes and researcher’s observation

The information thus collected formed the critical basis for understanding the context ie,
existing resources, perception and utilisation of services by the community, needs and
circumstances on the ground.

Findings

The information thus collected provided the basis for understanding resources that are
available and those that are being used by the community. For the purposes of this report
only the CYMH resources are discussed in detail.

With regards to the lead questions, most communities were aware of the child and youth
mental health clinician. They also knew that it was a visiting service. However, the
community did not have a clear idea on what these workers do or how and when to access
them. Most communities grouped the Department of Families workers and the Child and
Youth mental health workers under the same category and were wary of discussing any
child related problem issues with either service due to fear of notification and a possibility
of removal/ foster care placement. The communities felt they had no engagement,
participation or control over these services. Community members stated that they lacked
confidence to raise important issues such as cultural issues or lack of educational
outcomes with appropriate agencies. Most community members did not have a response
on how or where to begin an affirmative initiative to bring about change.

All the existing resources in a community available for children and families were also
collected and collated (see figure 3 on page 22).
Figure three above shows the resource mapping in one remote community.

The above chart needs further explanation. Although every community had a different set of services, all had several outreach visitors addressing children's well being. However there was little or no coordination between service providers and the services that they offered. At times even the clinic was unaware of how other governmental or non-governmental services operated. Knowledge or information was most clear for crisis presentations or evacuations ie, both community members and services as health clinic and the school in the community knew what was to be done if a child presented with a crisis, that is, abuse disclosure or an accident. Least knowledge or information was around emotional well being of children ie, worries and fears.

The information collated through scoping and mapping activities was used to determine the choice of pilot sites in 2002 ie, which communities to concentrate on in the first instance to introduce changes in service practice. The following factors or variables were considered in each district: community need, politics and infrastructure, access, existing mental health resources on the ground, capacity/potential, and impact of lessons learned. Although this is a fairly simple categorisation of contexts, it provided a reasonable means to match structural, political and organisational issues across districts. Below (see page 23) is an example of this exercise.
<table>
<thead>
<tr>
<th>District</th>
<th>Need</th>
<th>Infrastructure &amp; Politics</th>
<th>Access</th>
<th>Existing resources</th>
<th>Capacity/Potential</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cape York</td>
<td>Very high</td>
<td>Complex</td>
<td>Difficult to very difficult</td>
<td>Nothing substantial</td>
<td>Integration less likely</td>
<td>Start small locally Eg: Mapoon</td>
</tr>
<tr>
<td>Torres and NPA</td>
<td>High</td>
<td>Complex</td>
<td>Expensive – transport costs</td>
<td>CYMH; Family Support Team</td>
<td>Good structure but Recent</td>
<td>Is not representative of Cairns/Cape</td>
</tr>
<tr>
<td>Remote Cairns</td>
<td>High</td>
<td>Manageable</td>
<td>Relatively easy</td>
<td>CYMH; Adult MH; LPO Family Resource centre</td>
<td>Family Well Being program from Apunipuma;</td>
<td>Portability of pilot experience possible</td>
</tr>
</tbody>
</table>
This chapter is divided into the following sections for each of the years, 2002, 2003 and 2004

Description of the process

Changes to the service

Evaluation of service changes

Key activities for the year

2002

Remote Cairns was chosen as the first site for introducing changes in service delivery following the activities detailed in Part One. Remote Cairns was under the Cairns Health District and included the following communities: Hopevale, Wujul Wujul (Bloomfield) and Cooktown for on site regular service. Crisis and telephone support was to be provided to Laura, Ayton and Lakeland.

Once the pilot site was chosen, a series of workshops were conducted in Wujal-Wujal, Cooktown and Hopevale in early 2002. These included community representatives, community organisations and other service agencies. These consultations highlighted the following issues as priorities for Cairns CYMHS remote service:

- The service provided through CYMHS Cairns is and will be for the foreseeable future a secondary specialist consultation service ie, CYMHS Cairns will be a visiting service and not a service based in the community.

- This outreach service must be regular and effective (sufficient in quantity and quality).

- These activities should take into account and respond to local circumstances and priorities.

- The service should also provide for training and capacity building for Indigenous workers.

- The service should be sustainable.
InfraStructure

In 2002, the CYMH clinician position funding was with Cairns District and the responsibility for service provision remained, as in the previous years, with Cairns CYMHS. The provision was for one full time clinician at PO2/PO3 level. This was utilised by 0.5 of a service to Remote Cairns and 0.5 of a service to Torres Districts.

Thus Remote Cairns and Torres Districts were serviced using a secondary consultation model during the year 2002. Also, in 2002 Cape York District had obtained funding for a CYMH Cape York position to service the Cape region (this new initiative was to be reviewed, restructured and evaluated in 2003).

Thus the first phase of enhancing the remote area CYMHS model involved addressing each of the priorities raised by the communities. The following variables were examined carefully to restructure the service in Remote Cairns District:

- The existing allotted resource had to be translated into time spent in the community, costs and outcomes for the community and Queensland Health ie, the employer. The restructure of the CYMHS therefore involved increasing the presence by more frequent visits to the communities. In 2002 the visits were increased to once every 8 weeks from the original once every 12 weeks.
- The team was increased from one practitioner to two practitioners and the community time was increased to one week at every visit.
- Regular supervision and training for the team was provided including conjoint case work and mentoring community development work.
- Work towards a standardised and effective model of documentation, clinical and community capacity building work.

Evaluation of Activities in 2002

As mentioned on page 6 under methodology, evaluation was built into every aspect of the project ie, at the process, impact and outcome levels. Evaluation indices for the activities of the first 14 months of the project included the following:

- Process issues: Feedback to community members (see appendices A and B for examples of communication and feedback reports) in both oral and written forms were provided
- Outcome issues: At the outset, it was crucial to define 'outcomes' for every phase.
After a series of informed discussions with the community, steering committee and professionals with expertise in evaluation work (see acknowledgments on page 57), outcomes were conceptualised and defined to measure levels of change. The key concept underpinning outcomes in this project was "empowerment". This is further elaborated under Part Five, 'evaluation' section (page 44-54).

- Outcome for the community: Service changes that were made following the community consultations, for example, Wujal Wujal justice group members requested that the CYMH Cairns team visit the community on Tuesdays or Wednesdays rather than a Friday. The role and responsibility of the CYMH service was co-constructed with the community and other agencies within the community. To this effect flow charts describing the CYMHS activity were distributed and other mediums were used for disseminating information ie, community radio. The flow charts were examples of what to do when a child has a problem and who are the people in the community who can help (see appendix three and appendix four)

**Key Activities for 2002 in Remote Cairns Service**

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<tbody>
<tr>
<td>1.</td>
<td>increase in human resources (a team of two instead of one)</td>
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<tr>
<td>2.</td>
<td>increase in the frequency of community visits (from visits once every 12 weeks to once every 8 weeks)</td>
</tr>
<tr>
<td>3.</td>
<td>enhancement of skills base by regular supervision</td>
</tr>
<tr>
<td>4.</td>
<td>inter-agency and skill building forums on the ground in the communities</td>
</tr>
<tr>
<td>5.</td>
<td>improvement in data collection through better documentation.</td>
</tr>
</tbody>
</table>

Thus, in the evaluation for the first year, change was measured and documented in the following 'core' activities that modified the critical baseline of practice of CYMHS in Remote Cairns District.

In the first year, one of the priority areas identified by the community that was unaddressed by the project activity was the issue of an 'Indigenous work force'. Communities had clearly expressed the importance of having an Indigenous person in the team either as a clinician or as a health worker for RACYMHS. This complex issue and the efforts that went into accomplishing this need is elaborated under the 'Overall evaluation' section. Suffice to say that this priority was unfulfilled at this stage of the project.
2003

Review of the changes made in 2002 for Remote Cairns District

As determined by the mapping activities and consultations, in 2002 (see page 19 & 20) the service delivery and practice protocols were changed for Remote Cairns communities (Hopevale, Wujul Wujul and Cooktown). These restructures were reviewed and evaluated in 2003 to see what the impact was on the ground (for example, having a two member team increases the referral rates; does increased frequency of visits improve access to the service by community members; professional satisfaction levels etc) and whether these resulted in a demonstrable change.

The clinical audit was undertaken to ascertain workload and time management demands since the restructure occurred.

Clinical audit (Table one) revealed the following for Remote Cairns work profile 2002 January - 2002 December.

**TABLE ONE**

<table>
<thead>
<tr>
<th>Remote Cairns documented work:</th>
<th>The available resource was as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinician 1 = 10 Cases</td>
<td>Remote Cairns = 0.5 Full time Clinician (approx)</td>
</tr>
<tr>
<td>Clinician 2 = 8 Cases</td>
<td>The outreach visits were once every 8 weeks</td>
</tr>
<tr>
<td>Therefore,</td>
<td>Therefore,</td>
</tr>
<tr>
<td>18 families in 3 communities for 2002</td>
<td>Allocated resource = 26 weeks per year</td>
</tr>
<tr>
<td>9 families per clinician for the year 2002</td>
<td>Used resource = 12 weeks per year</td>
</tr>
<tr>
<td></td>
<td>Unused resource = 14 weeks per year</td>
</tr>
</tbody>
</table>

In mid 2003, in depth reflective interviews were carried out with each Cairns CYMH clinician to appreciate their personal, professional and contextual viewpoints and how these perspectives impacted on their practice ie, remote area mental health work.

This was followed by a feedback presentation and a discussion forum to redefine the service framework and service practice (professional, clinical and operational) guidelines.
Evaluation of the activity

The clinical audit (table one) revealed the under-use of allocated resource and the quantitative evidence showed a stark under servicing to communities. This meagre service to families in communities is a result of complex and varied factors between communities, CYMHS clinicians and structural issues within Queensland Health.

Process Evaluation with CYMHS clinicians: In the in depth interviews the clinicians spoke candidly about the 'catch 22' situation ("remote area outreach work is a forced activity. Given a choice I would prefer not to do this but there is no choice. I am expected to do some remote work as part of this employment"). The key sentiments expressed by the group of clinicians who were part of the CYMH Cairns remote service in 2003 are as follows:

1. Remote area work cannot be combined with mainstream CYMH work ie, clinicians cannot cope with doing a bit of remote work alongside their routine work at Cairns CYMHS. Time demands, poor infrastructure, conflicting clinical paradigms, absence of indigenous workforce, lack of cultural expertise, insufficient training in community development skills and shifting social politics contribute to ineffectual and inefficient service delivery.

2. Lack of energy to become change agents for the service. Although every single worker recognised the limitations of their work and of the service, to commit to change was seen as a hard option.

3. The 'change process' itself was perceived as disempowering and challenging their core practise issues.

4. There was no or little clarity regarding their remote area service role, responsibility and accountability.

5. There was a sense of helplessness ("I do not know what the community wants from me") that ensued in despair or cynicism most of the time.

Impact Evaluation in Remote Cairns region:

The community feedback and perception of change with regards to CYMHS in the year 2002 was also candid and insightful. The participatory feedback raised the following themes:

- Service needs are enormous in communities
- Community clearly feels the difference, having two clinicians visiting regularly to do clinical work. The interagency meetings are also useful. It provides the opportunity for workers to come together and tackle issues.

- The quality of clinical service is good.

- The quantum of people visiting communities has increased (from one to two). However the current frequency, once every eight weeks is insufficient even for Cooktown.

- The regularity of visits has been established but on the ground there is still no clear presence or expectations of these visits, particularly in Hopevale and Wujal.

- Feedback loops need to improve as they are fragmented.

- Follow up is inconsistent due to a variety of reasons, lack of availability of clients on the one-day when clinicians visit the community being most pertinent.

- Comprehensive assessment reports are difficult to access

- No indigenous worker as part of the visiting service team

- No group work or capacity building community program facilitated

**Key activities for 2003**

<table>
<thead>
<tr>
<th>1.</th>
<th>Implementing the service changes - the marginal restructures introduced to the service following 2002 community consultations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>Clinical review of work demands and outputs</td>
</tr>
<tr>
<td>3.</td>
<td>Evaluation feedback to practitioners about the service</td>
</tr>
<tr>
<td>4.</td>
<td>Practitioners' reflective feedback on how and what they perceived as being demanded of them</td>
</tr>
<tr>
<td>5.</td>
<td>Communities' perception and observation of the service changes</td>
</tr>
</tbody>
</table>

**2004**

Based on the feedback from the community and the reflections from practitioners on the service changes in 2003, the next stage of planning was carried out to meet the needs on the ground. These included increasing the frequency to a once a month service (in 2003 it was once every two months and in 2002 it was once every three months) and an Indigenous Mental Health worker was replaced to the team that serviced Hopevale and Wujul Wujul. Feedback loops and partnerships with both communities and other agencies
were strengthened. Comprehensive reports were made available to families and other service providers. Every effort was taken by the team to regularly follow up families who made contact.

**Evaluation**

In Nov 2004, evaluation was carried out to assess the outcome of the changes made for 2004 in Remote Cairns area. The participatory feedback from the community (members and service providers) highlighted the increased 'presence' of the service. The views also reflected the increased collaboration, information sharing and better accessibility of the service. Having an indigenous worker as part of the team was seen as a critical indicator for a user-friendly service. However the responses indicated that group work or some facilitation of community development programs is still lacking. Although the frequency of visits have gradually increased there was a belief both from workers and community members that the number of days spent in each community is still less than desired to do comprehensive intervention and follow up work.

**Key activities for 2004**

<table>
<thead>
<tr>
<th>No.</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Service outreach increased to once a month visit</td>
</tr>
<tr>
<td>2.</td>
<td>Indigenous worker part of the team for Indigenous communities (Hopevale and Wujal Wujal) in the region</td>
</tr>
</tbody>
</table>
This chapter is divided into the following sections for each of the years, 2002, 2003 and 2004

Description of the process

Changes to the service

Evaluation of service changes

Key activities for the year

**2002**

Cape York District, for the purposes of CYMH service delivery was divided into two regions, approximating Western and Eastern geographical areas. Western Cape covers four communities, Aurukun, Mapoon, Napranum and Weipa. Eastern Cape covers four communities Kownayama, Lockhart, Coen and Pormpuraaw. There was no regular child and youth mental health service for this region between 2000 - mid 2002. The funding available was 1.0 full time clinician to cover seven communities across Western and Eastern Cape York. Organisational changes, poor coordination, inadequate infrastructure, significant travel costs, the logistics of getting to eastern communities during the wet season all contributed to a complete collapse of Child and Youth outreach services for the Cape region.

Following the mapping of resources and service activity, an intensive one-day workshop was held in mid 2002 to draft a model of mental health service delivery for the Cape York region. This included in-depth consultation for child and youth mental health services. The participants of the workshop included council members from Cape York communities; Cape York and Cairns District Management; Queensland Health Chronic Disease Strategy Team; Northern Zone Mental Health; Director, Mental Health Unit, Brisbane; Royal Flying Doctors Service; Mental Health service providers in the Cape York and Cape York mental health team.
Evaluation

The mapping of service needs, service capacity and community understanding of the service was most fraught in the Cape York region. The communities were not aware of the infrequent service but also frequently confused the service with Department of Families service (the current Child Safety department). Most outreach services had infrequent or fragmented contact in the Cape York region and those who had regular service (for example paediatric outreach) it was a three-monthly service. Justice group members in communities were the most accessed for gathering information. Reaching other members of the community was difficult due to lack of rapport, irregular presence of the service and inconsistent follow up of existing clients.

The intensive one-day workshop resulted in a draft model of service delivery for Cape York outreach Mental Health Service (appendix Five). This document identified service priorities and service partners for child and youth mental health.

Key activities for 2002

1. Mapping of existing resource and Community needs in Cape region
2. Draft of a service delivery model for Cape York Mental Health Outreach Team that outlines service priorities and service partners for child and youth mental health service for Cape York District.

2003

In 2003 the recommendations of the 2002 draft were approved and structures put in place for implementation and funding finalised for resources.

Cape York District, by March 2003, had recruited to the vacant positions of the adult mental health team based in Weipa and this team included one CYMH full time clinician position.

Two significant milestones marked early 2003 activity, the first being the division and delegation of CYMH services between Cape York and Cairns districts. The Eastern Cape (Kowanyama, Pormpuraaw and Lockhart River) communities was to be serviced by Cairns based CYMHS and Western Cape (Aurukun, Weipa/Napranum, Mapoon and Coen) was to be serviced by Cape York Mental Health Service Unit based in Weipa with their one full time child and youth clinician position. The second milestone was the partnership agreement between Queensland Health Remote Area Mental Health Service and the
Thus in 2003, the Eastern Cape communities had a clinical service by CYMH using RFDS transport and support. The Western Cape was serviced by the Mental Health Outreach based in Weipa.

**Evaluation of the activity**

Dividing the Cape into Eastern and Western region provided a turning point in the CYMHS. It made the practitioner's workload manageable and less despairing. The clinicians who serviced Eastern and Western Cape regions worked collaboratively and were able to do modest levels of community capacity building work. (This is covered in detail under 2004 evaluation activity). The unrealistic situation in which one clinician covering seven complex Cape communities was rectified with the division of work between Western and Eastern Cape regions. The strategy of dividing Cape by East and West regions, also led other agencies ie, Department of Families (now called Child Safety) into reconfiguring and resizing their service arrangements.

With regards to the RFDS, due to their reputation as a reliable, regular and efficient service, their partnership proved to be a crucial strategic step towards networking and enhancing CYMHS in the communities. In addition, in the year 2002, RFDS had expanded their allied health section to include adult counselling services to the Cape region. This increased the critical mass of workers on the ground doing social and mental health practice in Cape communities. This formalised partnership is likely to ensure sustained long-term outcomes well beyond the scope of this project.

**Key activities for 2003**

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<tbody>
<tr>
<td>1.</td>
<td>Division of responsibility for Western and Eastern Cape region between Cairns and Cape District.</td>
</tr>
<tr>
<td>2.</td>
<td>Regular CYMH service for Western cape from Weipa.</td>
</tr>
<tr>
<td>3.</td>
<td>Regular CYMH service for Eastern Cape from Cairns.</td>
</tr>
<tr>
<td>4.</td>
<td>Partnership with the Royal Flying Doctor Service for collaboration of allied health service and regular transport.</td>
</tr>
</tbody>
</table>
2004

In 2004 Eastern Cape (Pormpuraaw, Kowanyama, Lockhart and Coen) got regular service by a team of indigenous and non-indigenous CYMH workers once a month throughout the year. The travel, as determined in 2003, was with RFDS. In Kowanyama, a group activity for young girls called 'yarning' was commenced. Here visual medium ie, educational videos made in Aboriginal and Islander settings were used to foster dialogue and discussion in the group. The range of topics included: early pregnancy, use and misuse of drugs and solvents, role models, family violence, sexual abuse and identity and culture. Similarly a young mothers group was organised in Coen by the indigenous Mental Health worker and this group met once a month where the IMHW acted as a facilitator.

Western Cape, in 2003 had one CYMH worker who serviced four communities from Weipa. The worker resigned in early February of 2004 and the position remained vacant the whole of 2004. Two attempts were made for recruitment without success and series of discussions and negotiations occurred between Cape District, Cairns District and Queensland Mental Health Team for creating and trailing an alternate model. However these did not come to practical fruition in the year 2004. Thus Western Cape communities of Aurukun, Mapoon, Weipa and Napranum received only crisis oriented secondary consultations from RACYMHS and Cairns CYMHS in 2004.

Evaluation

Although in 2003, Cape District appeared to be in a robust position to effectively service all Cape communities, this proved unachievable in 2004 as the Western Cape CYMH worker resigned. Recruitment to this position also became increasingly difficult. The issues around recruitment and retention of staff are explored more in the 'Evaluation' chapter. The evaluation feedback of the outgoing CYMH worker highlighted the following challenges in servicing Western Cape from on site (in Weipa).

a) Travel by road during the wet season is impossible and travel arrangements through chartering flights is inadequately planned.

b) Professional isolation is very high as there is no peer group of CYMH workers.

c) Having an Indigenous worker as a partner (even if they are from a different stream, e.g. Bringing Them Home counsellor, youth worker etc) is useful and effective.
d) The demands on the ground centre on crisis work and there is little time to do therapeutic work with children and families or strengthening communities capacity through carefully planned empowerment work.

For Eastern Cape region, 2004 had a steady growth of activities. All four communities (Poropuraaw, Kowanyama, Lockhart and Coen) unanimously agreed on the positive impact of CYMHS and equally raised the need for expanding the service to increase the quantity of visits, overnight stay in communities and broadening the service to include community group programs.

The young girls’ group program in Kowanyama and the young mothers’ group in Coen are activities akin to community capacity building programs. The focus was on early intervention and health promotion topics. Although the activities received a lot of positive feedback, the participation ie., group numbers waxed and waned between 6-16 girls and 6-9 mothers. In the evaluation of these activities, what became apparent was the need for an identified support person, like a teacher or youth worker, for assembling and coordinating the group. Despite the random attendance, the group activities proved to be a critical link for the CYMH worker to engage with young girls and young mothers in the respective communities.

**Key Activities in 2004**

| 1. | Regular direct clinical service for Eastern Cape. |
| 2. | Service for Western Cape ceases and recruitment to the position becomes difficult. |
| 3. | A group activity focussing on an early intervention and health promotion model commences in two communities. |
This chapter is divided into the following sections for each of the years, 2002, 2003 and 2004

Description of the process

Changes to the service

Evaluation of service changes

Key activities for the year

**2002**

Torres Strait and Northern Pennisula Area (NPA) District includes Thursday Island (TI); around 18 outer Islands; NPA that includes five communities, Seisia, New Mapoon, Bamaga, Injinoo and Umajico. Torres & NPA District Health Service controls all outreach and on-site health programs including Mental Health.

Between 2000 and 2002, Torres District received CYMH service from Cairns CYMHS once every three months (three days in TI and two days in the NPA). This outreach service was primarily a secondary consultation model ie, to provide expertise, support and supervision for complex clinical and developmental issues to practitioners and clinicians on the ground. However the model was flawed as there was no worker or practitioner on the ground to do Child and Youth work for this District.

By the end of year 2002, Torres District Mental Health program had made significant advances to establish a mental health team to service adults and children in the District. The District's Mental Health component was funded for the following positions:

- 2.0 FTE - NO3 - Clinical Nurse Consultant (one for NPA and one for TI)
- 1.0 FTE - AO2 - Administration Officer (based on TI)
- 2.0 FTE - TO2 - Indigenous Mental Health Worker (one for NPA and one for TI)
- 1.0 FTE - NO2, PO2, PO3 - Child & Youth Mental Health clinician (to be shared between TI and NPA)

As shown in Fig one on page 18, the Torres service scoping and mapping exercise occurred after Remote Cairns and Cape districts.
Evaluation of 2002 phase

Torres District Management expressed a clear need for a service presence on the ground for CYMH. The district management and community members unanimously agreed that secondary consultation service does not meet the needs on the ground.

By the time Torres District became the focus site in the project, the project had learnt significant lessons from the Remote Cairns restructure, implementation and evaluation of the changes in the service. The changes trialed in Remote Cairns District and the renegotiations with Cape District were invaluable insights to form the backdrop for rethinking CYMHS models for Torres District.

Key activity for 2002

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<tbody>
<tr>
<td>1.</td>
<td>Secondary consultation service from Cairns to Torres District</td>
</tr>
<tr>
<td>2.</td>
<td>Torres District procures funding to have a full time Child and Youth clinician position.</td>
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</tbody>
</table>

2003

A major planning workshop occurred in early 2003 (see appendix Eight) to discuss ways in which Torres Mental Health service could be supported and professionally developed to provide a service that is clinically competent, culturally appropriate and sustainable.

In 2003, for the first time the Torres District, having procured funding to base a full time Child and Youth clinician, recruits for the position. This position had operational responsibility to the District. It was envisaged that this position would receive supervision and mentoring from this project and added clinical support through the visiting secondary consultation service from Cairns.

At the end of 2003, the Child and Youth worker resigned and the position fell vacant. An in- depth evaluation interview was conducted with the Torres CYMHS worker in order to understand the service, system and professional challenges.
Evaluation of this activity

Between 2003-2004, several workshops were conducted and two reports (Davomani, 2003 & Swain, 2004 - reports available by contacting the district) were submitted to the District proposing models of mental health service delivery. These activities and processes resulted in grave uncertainty for the newly established CYMH position on the ground.

Process Evaluation

Although it was a significant milestone for Torres District to procure and ensure funding for one full time child and youth position, a structure (such as service frameworks, protocols, infrastructure, lines of communication) to build the capacity of this position was not developed in the first year. In the evaluation interview, the worker revealed the following challenges:

1. The perception that there were too many 'supervisors' for the position ie, Torres District; Cairns CYMHS and this project coordinator.
2. There was a lot of confusion and lack of clarity in communication lines and reporting formats.
3. The issue of housing and accommodation in Thursday Island
4. Regular sessions of professional supervision are useful however, these have to be from one source and approved by Torres District.
5. Visiting specialists must work towards empowering the worker on the ground.

Impact Evaluation

Irrespective of the initial hiccups the Torres CYMHS position was having, communities felt the creation of such a position to be based in Torres as a highly positive move. Other agencies, both government and NGO, affirmed this for easier networking and accessibility.

Key activities for 2003

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<tbody>
<tr>
<td>1</td>
<td>On site full time CYMH service for Torres district commences.</td>
</tr>
<tr>
<td>2</td>
<td>Supervision support from Cairns.</td>
</tr>
</tbody>
</table>
2004

In 2004, Torres District filled the CYMH vacant position and CYMHS recommenced in March 2004. The structure was two days every fortnight outreach to NPA and the rest to Thursday Island. The worker provided secondary and crisis consultations to outer islands. The position was operationally responsible to the Torres District Family Support Team and professionally responsible to RACYMHS team. The worker participated in weekly case management reviews, weekly clinical supervision and monthly peer supervision programs with RACYMHS. Once every three months there was a professional development activity in the form of attending workshops or having on site hands on clinical training with the supervisor.

Evaluation

In 2004, Torres made substantial gains in providing an “on the ground” CYMHS. Based on the feedback from 2003 (see page 38) and with the development of RACYMHS becoming autonomous, the links between Torres position and RACYMHS team was clarified and became more functional. The structures put in place to support and nurture the sole clinician's position significantly contributed to the satisfaction and motivation level of the worker. The Family Support Team was steadily expanding its critical mass of workers and there was a sense of a 'team' being developed. The evaluation feedback by the Torres worker, amongst other things, highlighted the strong sense of 'having a team' albeit a virtual one (as the RACYMH team is spread across three districts) as being a critical factor. The community feedback emphasised an increased presence of CYMH activities, interagency meetings and collaborative case sharing. The major limitations identified by the community are not having an Islander worker to work alongside the CYMH worker and for the absence of group/community programs for young people.

Key activities for 2004

1. Regular CYMH service for Torres District
2. Weekly supervision and clinical reviews with RACYMHS Cairns
This section deals with the overall project developments across districts each year, infrastructure and funding over the three years and the significance of these developments at the end of the project.

**Project Developments across Districts**

Each year the aim was to

- ensure basic service delivery to each district
- map the available resources and community needs
- introduce service changes to meet the needs
- evaluate these service changes with regards to outcomes and sustainability for the community, the practitioners and the system ie, Queensland Health
- resume the cycle of ensuring basic service delivery and resource mapping

It needs to be recognised at every stage of the project, the activities of the earlier phase continued to happen along with added activities of the current stage. Thus in 2003, the review, restructure, implementation and evaluation activities of 2002 continued to occur in addition to activities that were planned for 2003.

**Infrastructure and Funding**

In 2002 and 2003, the responsibility and accountability for CYMH remote area position (one full time position utilised as 0.5 across Torres and Remote Cairns) remained with CYMHS Cairns District for operational and clinical responsibility. Cape District had, by 2003, secured funding and recruited a full time child and youth clinician to cover their region. Torres district had also secured, by 2003, funding to recruit a full time position to cover Torres District. The respective districts were responsible for these positions and it was agreed that these positions would receive professional development activity and clinical supervision through Cairns CYMHS and this project coordinator.

In 2004, three core activities occurred a) establishment of structures to make remote work completely autonomous from Cairns based service and this service was called RACYMHS; b) pioneering Indigenous child and youth mental health workers as part of RACYMHS; and, c) developing the workforce capacity to manage the demands and challenges of the service in their autonomous roles.
By 2004, RACYMHS had expanded to include three full time Child and Youth clinician positions (one for Torres District; one for Cape District to cover half of the Eastern Cape and one for Remote Cairns that serviced parts of Cape and Remote Cairns region). In addition RACYMHS was given one full time Indigenous Mental Health Worker position to support their work in communities. These positions were supported and supervised by the coordinator of this project.

**Significance of these developments**

This development of RACYMHS as an independent, autonomous service was a result of the last two years participatory evaluation review of the service. As articulated clearly by clinicians (see page 28) combining remote area work with mainstream Cairns work was not efficient, effective or sustainable. Self-governance was seen an imperative for a service such as RACYMHS in order to develop, reflect and learn. What this meant in terms of practical arrangements was that the RACYMH workers were no longer required to do Cairns based work (conversely, CYMHS Cairns workers did not have to be pressured to do remote area work). RACYMHS had a separate physical location, infrastructure (separate cost centre, planning days, budgets etc) and data collection arrangement. The service was directly accountable and responsible to the Manager and Clinical Director of Mental Health, Cairns District.

**Remote Area Indigenous Child and Youth Mental Health Workers**

For the first time in 2004 RACYMHS had an Indigenous child and youth mental health worker who serviced five remote communities as part of a two member team.

**Workforce Capacity Building**

Workforce development focussed on supervision (see appendix Nine for a brief review document). Although the concentrated effort aimed to build the workforce capacity of RACYMHS, the target group included any practitioner who deals with social and emotional issues of children in a remote area. Three different supervision forums occurring between 2002-2004 informed this process (see appendix nine, under current scenario section). It was only in 2004 that a stable critical entity was formed as part of the project activity. The 'peer group forum' as a group met once a month for reflective discussions on service practice principles that impact on personal and professional identities. These supervision forums set the stage for future direction to evaluate and review models of supervision, an activity that has grown throughout the length of this project, for remote area workers
(Professional development workshops were facilitated in areas of 'narrative practice' and 'cultural and clinical aspects of knowledge'.

In 2004 the MSOAP (Medical Specialists Outreach Activity Program) was facilitated in three sites, Cooktown, Weipa and Thursday Island. The aim of this activity was to invite child psychiatrists to a remote area to inform, share and contribute expertise to the child and youth mental health clinical work in remote communities.

Data collection through CESA database was being monitored from 2003 and Outcomes data was added in 2004.

**Impact and Process evaluation of the above activities**

Achieving autonomy was a significant step for RACYMHS towards becoming a mature, key partner within and across Districts. Prior to this RACYMHS accompanied Cairns CYMHS making it difficult for both systems to cope and expand. The practitioners who serviced the remote area felt they could concentrate completely on remote communities' work, rearrange their time management and increase the 'quantity' of their service to communities. This enabled the workers to reflect on the 'quality' of their work without having to merge or clash the philosophies of mainstream work with remote area work.

With regards to having an Indigenous worker in the team the communities response was firmly positive. For the staff in the service this position proved to be an invaluable addition. There is considerable ambiguity about the education, certification, roles and responsibilities of IMHW in Queensland. CYIMHW pose even greater uncertainties. Remote area child and youth mental health work, the structure ie, roles and responsibilities of this position is evolving and being shaped by the lessons from the ground. One of the dilemmas that any practitioner faces in this position is: How much of the Indigenous worker's role is to do with clinical support and how much is to do with community development. How much of this is a practitioner decision and how much is it a policy decision? These issues are discussed in more detail in Part Six.

With regards to the peer group support forum, a document theorising supervision frameworks based on an information survey, literature and experiential reflections was put together to provide a comprehensive understanding and future direction for this complex area (Appendix Nine). From the feedback interviews with group members what is clear is that supervision and peer group support underpin the effectiveness and sustainability of remote area work for the CYMH team. What is less clear is ' what models of supervision work and why'.
Evaluation of MSOAP activity occurred in all three sites (see appendix Ten). The consensual feedback by the visiting child psychiatrists was that this activity was beneficial for networking and building the expertise of local workers through secondary consultations. The activity was not seen as conducive for direct clinical consultations and the sustainability of this funding and program was also a concern raised by the RACYMHS and the visiting child psychiatrists.

As for the databases, although these are time consuming activities, the rationale for collecting the data was to inform and provide evidence in relation to the quantitative aspects of remote area work. It is also a means by which RACYMHS would be able to observe, explore and recommend a different system of data or outcome collection if the current systems proved inadequate in capturing the 'multifaceted nature' of remote area work.

In 2004, the RACYMHS was able to collect CESA data (see evaluation chapter for more details). However outcomes data was not collected due to time demands and perceived relevance of this data in indigenous contexts. It is important though to be cognisant of the fact that unless outcome data is collected in its existing form, it would be impossible to provide evidence to contend for a different, more relevant and contextually appropriate tool.
Evaluation was an ongoing activity from the beginning of this action research project. As evidenced in the service development sections each phase was evaluated hand in hand with implementation. This chapter summarises the evaluation activity under the following headings: objectives, methodology, frameworks of evaluation and multiple outcomes.

**Objectives**

The overall aim of the project was to improve and increase the capacity of RACYMHS delivery in Far North Queensland.

The feedback and response from communities and CYMH staff to the changes (or restructuring) being made at every stage determined the specific objectives for the next stage of the project.

The objective for stage one was scoping and mapping of community resources, needs and conducting community / interagency consultations.

The objective for the next stage involved restructuring existing service delivery practise. The impact, the changes/restructures had on the service was evaluated in the next phase.

This led to the next stage of a trial of an alternate model of service delivery.

This alternate model was then evaluated.

And in the final phase of this project the objective was documentation, recommendation and dissemination of findings to Queensland Health, District managements and communities.

The objectives at each stage of the project included the following components:

- **Phase design** - considering the context and collecting evidence; reflecting on assumptions (individual and systems), clarifying the issues being addressed, outlining strategies to address the issue, trialing one or more strategy and reviewing the issues;

- **Process evaluation** - the extent to which the design/steps are being implemented and identifying the challenges in this process;
• Impact evaluation - the immediate impact on the ground by stakeholders, community members and consumers on the implemented steps;

• Outcome evaluation - the outcome of the implemented changes, community feedback and practitioner's reflections;

• Reporting - an accountable line of reporting, documentation and discussion in different forums ie, stakeholders, management committee, advisory committee;

• Follow up - an action implementation of the whole design to form the next phase of the project.

**Methodology**

In the first six months the project infrastructure was created with a local Steering Committee to oversee and monitor the project. An interregional Advisory committee was set up to inform the project about contemporary national initiatives and direct the scientific rigour of the project (see Acknowledgments on page 57 for details).

Several focus group and/or individual meetings with other service providers such as the Department of Families, Education, Sports and Rec, Disability, Royal Flying Doctors Service, Paediatric Outreach Service, Tharpuntoo Legal service were conducted wherever feasible.

These data (community consultations and stakeholders feedback) were critical to inform the strategies that determined time line and pilot sites for the restructure of CYMHS for remote areas. (See Figure One on page 17)

Data was analysed from five sources throughout the project activities:

• content of the interviews from community members to identify existing information of the service and the perceived need of the communities

• content from the semi structured interviews with service providers from different government and non government organisations

• in-depth reflective interviews with practitioners of the CYMH remote area service

• audits of clinical work load ie, number of referrals, cases seen and time demands (travel, client/family contact time, community time)

• field notes and researcher's observation
Frameworks of Evaluation

Because of the limitations inherent in a project like this that works in and with a context, outcomes were ascertained through process measures or indices of change as a result of the project activities.

Three significant works informed the framework of evaluation in this project:


b) Flyvberg's critical inquiry in social research (Flyvberg B. Making Social Science Matter: why social inquiry fails and how it can succeed again. 2001. Cambridge University Press, Cambridge); and


In his book 'Our right to take responsibility' Pearson urges service providers to question their practice in Indigenous communities with regards to service programs. He cautions them not to proceed down the 'category fallacy' method of inquiry. To quote, "we see that Aboriginal people have needs or problems - therefore they need a program; we see that other citizens in the wider community have these services and programs - therefore Aboriginal people need the same services and programs in the name of equity and citizenship".

Flyvberg talks about three methods of critical inquiry that ought to guide any social research. Scientific inquiry that is based on universal, context independent variables, technical inquiry which has pragmatic and context dependent variables and ethics inquiry that is based on values and ethics of an activity. These three inquiries form the empowerment process for individuals, systems and societies.

Pawson and Tilley outline a 'realistic' evaluation framework. Simply put, it is Context + Mechanism = Outcome. The context, for this project is remote Indigenous settings in Far North Queensland. The mechanism(s) include project's service restructures. The Outcome is the impact of these mechanisms on the context.
Multiple outcomes for the project

Defining outcomes in this project has been both exciting and exhausting. The outcomes have been multiple and the mechanisms of attaining these goals have been dimensional and on a continuum.

One outcome of the project has been to **identify critical themes** for RACMHS in Far North Queensland. As the themes emerged, in the first phase of the project following the mapping exercise, the themes, in themselves determined the priority and focus for the project. The critical themes are:

a) Equity of service - The conventional method of matching funding based on population numbers for example one CYMH position for x number of children is seriously fraught for remote area work, especially in child and youth mental health work. Mooney and Henry⁵ argue for a more viable and sophisticated model for Aboriginal Health. They argue for equity based on three departures: a) the use of "capacity to benefit" as the basis of need as opposed to the more conventional 'sickness based' need 2) the weighting of capacity to benefit to reflect relative disadvantage and 3) the incorporation of the concept of MESH - Management Economic Social and Human, infrastructure to recognise that not all communities are equally well placed to use funds to allow them to realise their capacity to benefit. Such careful analyses have not been carried out in the three districts for mental health service. To address the very real inequities that currently exist, it is vital to follow the recommendations that are outlined at the policy level.

b) Sufficiency of service - For a service to become sufficient it has to function beyond the minimal service without basic standards. The service has to be regular (not adhoc), well resourced (not under resourced) and sustainable (not short term). Such sufficiency would enable a service to work towards achieving benchmarks in practice. A service that is unpredictable, random and struggling for resources commands little motivation or appeal (and meets no standard).

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c) Indigenous workforce - Developing and fostering Indigenous workforce is a fundamental issue, particularly in this context. The validation of their knowledge, training, development and transfer of needed skills, and creating culturally meaningful practices is as indispensable for current service as it is for the future sustainability of any service. Furthermore, a sensible career structure and developmental pathways for Indigenous workers needs to be affirmatively advocated and worked upon.

d) Structure and infrastructure of a service - Roles and responsibilities for a remote area CYMHS and the importance of liaison and collaborative partnerships with other service providers in enhancing holistic models of care needs to be articulated clearly. Clinical accountability, operational management and professional responsibility need to be formalised and agreed upon between the employees and the employer and between districts.

e) Quality of Service - Service quality is determined by appropriateness, comprehensiveness and relevance of service activities be it assessment, diagnosis, intervention or documentation. Feedback, inter agency communication, supervision formats and professional development plans also provide indications of a well functioning service. A remote area CYMHS is more than a clinical service. There is an imperative based on needs to expand service models, paradigms and philosophies. The service has to be able to initiate, lead, facilitate and develop capacity building programs in communities. Community development activities, a highly relevant and useful aspect of RACMHS, require sets of skills and expertise that extend beyond clinical professional skills.

Quantitative outcomes of the project measured the service delivery component in greater detail. The overall objective of the project was to improve and increase the capacity of RACYMHS delivery in Far North Queensland. This included increasing the capacity of the service, increasing the level of access in the communities to the service, and improving the appropriateness of the service.

Service Capacity Outcomes

Progress to service development was tabulated to give a clearer sense of the change created in the last three years. (See table two, page 50). As shown in the tabulated profile, between 2002 -2004 the following critical steps to service development were made:

1. The service grew from one worker to a team of 5 workers. One full time clinician for Cape York District to Western Cape region; one full time clinician for the Torres
District; one full time clinician for Remote Cairns and parts of Eastern Cape region; one full time practice supervisor who coordinated this project and also provided clinical service to Eastern Cape communities; one full time Indigenous mental health worker covered five communities;

2. The service models were expanded to include early intervention, group work and community development activities;

3. Autonomy of the RACYMHS and increased self governance; and

4. Ongoing research evaluating and reviewing models of practice.
<table>
<thead>
<tr>
<th>District/Year</th>
<th>Cape</th>
<th>Torres</th>
<th>Remote Cairns</th>
<th>Cairns CYMHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>Nil</td>
<td>• 3 Monthly • 0.5 FTE • Secondary Consultation</td>
<td>• 3 Monthly • 0.5 FTE • Secondary Consultation</td>
<td>Sole responsibility for remote area service</td>
</tr>
<tr>
<td>2002</td>
<td>• 1 full time clinician • Beginning of a service</td>
<td>• 3 Monthly • Secondary Consultation</td>
<td>• Two monthly visits • No: of clinician increased from one to two • Community networking</td>
<td>• Sole responsibility for remote area service • Supervisory support on the ground • Monthly supervision (optional)</td>
</tr>
<tr>
<td>2003</td>
<td>• Division of Cape York regions • Service from Weipa • Service from Cairns</td>
<td>• Primary consultation • One full time clinician to service TI and NPA • 3 Monthly supervisors • Not coordinated between districts</td>
<td>• Service evaluation of 2002 • Restructuring • Six Weekly visits</td>
<td>• Sole responsibility for remote area service • Monthly supervision (optional)</td>
</tr>
<tr>
<td>2004</td>
<td>• Service ceases for Western Cape • 1.0 FTE position vacant • Eastern Cape service regular (From Cairns)</td>
<td>• Full time worker • Coordination improving • Supervision and professional development support from Cairns</td>
<td>• Visits once a month • Indigenous health worker joins the team • Community participation increase</td>
<td>• Responsibility and funding devolved to remote area team • Weekly supervision (compulsory) • Weekly case reviews. • Monthly peer reflection forum</td>
</tr>
</tbody>
</table>
Service outcomes

A quantitative measure of 'provision of service' was also collected as part of the service database. Provision of service (POS) indicates face to face or telephone contact with a client or a family. POS does not reflect community development activities or inter agency discussions or supervision forums. POS for 2001, 2002 and 2003 have been difficult to collate and transcribe meaningfully. This is largely because CYMH remote area service was not functioning as an autonomous body and statistics were fragmented across districts and outreach workers. It was partly due to also lack of true representation of the work that CYMH outreach workers were doing in building the credibility of a service. The service, as described in the bulk of this report, became an independent entity in March 2004. Thus for the purposes of this report, POS for 2004 is highlighted below in table 3.

TABLE THREE  
March - December 2004

<table>
<thead>
<tr>
<th>District</th>
<th>Community</th>
<th>Provision of Service POS</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cape</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kowanyama</td>
<td>34</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lockhart</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pormpuraaw</td>
<td>46</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Coen</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Aurukun</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mapoon</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Weipa</td>
<td>2</td>
<td>144</td>
</tr>
<tr>
<td>Torres</td>
<td>Thursday Island</td>
<td>71</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Badu Island</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bamaga</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Seisia</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Injinoo</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Remote Cairns</td>
<td>New Mapoon</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
<td>------------</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Umajico</td>
<td>3</td>
<td>113</td>
</tr>
<tr>
<td></td>
<td>Cooktown</td>
<td>47</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hopevale</td>
<td>44</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wujul Wujul</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Laura</td>
<td>7</td>
<td>130</td>
</tr>
<tr>
<td></td>
<td>Grand Total</td>
<td>387</td>
<td></td>
</tr>
</tbody>
</table>

The following factor needs to be recognised when reading the above table:

- In the absence of relevant statistics for 2001, 2002 and 2003 it is hard to determine POS trends over time. However this data is extremely significant to enable comparisons for the coming years and to acknowledge the fact that systems are in place to collect this information routinely.

- In 2004, Western Cape service ceased and the numbers shown are crisis consults. Mapoon has an inflated number of 18 POS because of one family consult (with seven children) who had a psychosocial intervention planned, coordinated and implemented in Cairns.

**Community outcomes**

The service development, restructure and changes were followed by stakeholders and practitioners’ feedback at every stage. These feedback details were collated to provide indices of change. The client/families outcomes as given by community members are the following:

- An increased number and proportion of community members know and recognise the RACYMH workers;

- Increased number of effective referrals are made by community members and by other agencies such as Education or Child Safety.
• Increased number of children and families receive therapeutic interventions and are followed up in a long-term way.

**Outcomes for RACYMHS providers**

For the practitioners, the changes were the following:

• The increase in autonomy helps manage time and workload of remote area service.
• Expansion of services to include group work and community development makes the service more appropriate.
• Collaborative working relationship established across key services in communities has helped enhance RACYMHS.
• Regular supervision and professional development activities provides RACYMHS with a greater capacity and confidence to meet with the needs of remote area work.

In improving and increasing the capacity of RACYMHS the project also aimed at empowering individuals, systems and communities. **Empowerment** as a concept is hard to measure and quantify. However the project attempted to draw on some of the modest empowerment methods that were part of the change processes.

Personal empowerment was defined as those processes aimed at facilitating and aiding a reflective stance to one’s life practices (work included) and beliefs and the way in which one makes sense of one’s values within the larger socio-political context. The professional peer supervision activities created a space for the RACYMH practitioners to discuss these issues and validate their triumphs and trials. Regular participation in inter agency meetings and being part of decision making process, as where possible, contributed to an increased sense of control.

Systems empowerment was defined as the process of people coming together to tackle issues, having a set of values and standards to which groups aspire. The steering committee of the project that negotiated and advocated for a common goal, the interagency liaison meetings, the local indigenous group network, critical discussions/presentations to Districts and managements created a body of shared knowledge and information that informed policies.
Community engagement was defined as the community's participation in service development and delivery. The affirmative engagement with justice groups, reaching out to community mentors, dialoguing with extended families, broadening the frameworks of practice to include community development activities, listening to community members' expectations of the service and rearranging priorities and increased communication with community members through the indigenous worker were factors that strengthened the communities' participation.

A formalised outcome was the quarterly report of the project documenting developments for the funding agency in the format prescribed (see appendix eight). Four progress reports were submitted to the Mental Health Branch, the funding body of this project.

**Changing titles**

The changing titles of this project reveal and reflect the complexities in measuring, delivering and evaluating structures and peoples capacity at the grassroots level for reliable and sustainable outcomes.

In 2002, the first year of the project the name was 'Best Practice Models for Mental Health Service Delivery for Indigenous Children and Families in Far North Queensland'. In 2003, the project was renamed to 'Better Practice Models' and in 2004 it got its current name 'Rethinking Service Delivery Models'. 
The following are the principle recommendations for RACYMHS

1. RACYMHS to continue to action research its service delivery models in order to build and enhance a clinically effective, socially valid and resource sustainable remote area team.

2. RACYMHS to be supported with a full time administrative position to fulfil the needs of the team and facilitate the operational management of team duties.

3. RACYMHS to work towards a model where one full time clinician position is devoted to no more than 3-4 communities. In the current structure this would entail having one more full time clinician for the Cape and one more full time clinician for the Torres.

4. RACYMHS to advocate and recruit for three more Indigenous CYMH workers, essentially, to work as a team with the clinician. Thus if there are five clinicians proposed for the team, there is a need for 5 Indigenous workers.

5. RACYMHS management to share the responsibility for Indigenous children and families living in remote area Far North Queensland, with the three districts with clear division of operational management, funding accountability and professional development.

6. In the far north region, RACYMHS to pioneer efforts in trialing and evaluating models of supervision and professional support for remote area child and youth workers.

7. RACYMHS to build the capacity of non Indigenous workers by providing training and professional development opportunities to learn and integrate multiple knowledge and context sensitive therapies.

8. RACYMHS to play an advocacy role in building the capacity of Indigenous workers and participate proactively in rethinking career structures and professional development pathways for the Indigenous workers in the team.

9. RACYMHS to work on better ways of engaging consumer and community participation to measure and evaluate the impact of the service.
10. RACYMHS to trial robust ways of measurements to quantify indices of service change, community participation and practitioner satisfaction in addition to clinical parameters.
ACKNOWLEDGMENTS

This project would not have been possible without the guidance and support of the following members:

Ernest Hunter Regional Psychiatrist, Queensland Health
Yvonne Wilkinson, Team Leader, Mental Health, Northern Zone
Komla Tsey, Associate Professor of Public Health, University of Queensland

Remote area Child and Youth Mental Health Team:
  Carly McKinnins, Psychologist
  Denise Sebasio, Indigenous Mental Health Worker
  Anita Rudd, Social Worker
  Judy McKeown, Social Worker

Steering Committee members:
  Guiliana Mogorovich, Team Leader, Cairns CYMHS
  Patsy Bjeeraguard, Director, Child Development Unit, Cairns
  Graham Sanderson, Manager, Integrated Mental Health, Cairns
  Mercy Baird, Coordinator, Indigenous Mental Health

CYMHS Cairns Remote Area Staff:
  Kathy Stapley, Social worker
  Megan Colahan, Psychologist
  Richard McClounan, Clinical Nurse

Health Equalities Promotion Unit, University of Queensland:
  Melissa Haswell, Associate Professor, Public Health (Mental Health)
  Mary Whiteside, Research Manager
  Larissa Wilkinson, Research support
  Trish Taylor, Finance Planning

Brod Osborne, Psychologist, Royal Flying Doctors, North Queensland

Cape District Management

Cairns District Management
Torres District Management

Community Justice groups

Department of Education staff in remote areas

Department of Child Safety staff in remote areas

Department of Disability Staff in remote areas

Advisory Group

  Graham Martin, Professor of Child Psychiatry, University of Queensland
  Matt Sanders, Professor of Psychology, University of Queensland
  Steve Zubrick, Professor of Psychology, Institute of Child Health, Perth
  Sue Vlack, Senior Lecturer and Paediatrician, Indigenous Health Studies
  Paul Colidtz, Professor of Paediatrics, University of Queensland
  Cindy Shannon, Professor, Indigenous Studies, University of Queensland
Appendix One

Minutes of the Meeting sent to Community members/agencies who participated

Meeting Details

- Date: Tuesday 5 March 2002
- Time: 2.30 - 4.45
- Venue: Hopevale School

Attendance

Present

Chris Anderson, School Guidance Officer; Greg Cruise, Cooktown Police; Stuart Wright, Queensland Transport; Derrick Oliver, Queensland Transport; Anthony Gibson, Police Liaison Officer; Pearl Deemal, Teacher; Maureen Liddy, Principal; Robert Bowen, Youth Interest; Shane Gibson, Hopevale Police; Dora Gibson, Deputy Principal; Kate Abberton, Teacher; Estelle Bowen, Life Promotion Officer; Shirley Costello, Teacher; Aaron Aguis, Teacher; Cathy Singh, Teacher; Jill Bertwistle, Teacher’s aide; Maude Olbar, Teacher’s aide; Madge Bowen, Teacher aide; Alice Walker, Teacher; Lillian Bowen, Teacher; Alison Worrell, DON Health Center; Joan McLean, Hopevale School; Daryl Hitchcock, Hopevale school; Lois Sanders, Hopevale School; Justin Singh, Hopevale School; Tom Jantke, Pastor Lutheran Church; Glenda Woibo, Family Resource Center; Deborah Gibson, Hopevale Health Center; Priscilla Gibson, Hopevale Health Center; Megan Colahan, Child and Youth Team; Richard McClounan Child and Youth Team; Komla Tsey University of Queensland; Radhika Santhanam Queensland Health; Lorain Hayes, Apunipuma.

Apologies

Glenis and the Justice Group.

Issues raised with regard to child mental health service delivery

- What are the entry and exit points for children who present with problems
- What is the identity of different workers and what are their roles?
- Communication between service providers is poor
- Feedback between agencies is minimal
- Support for staff on the ground is minimal
- Lack of coordination between workers and between agencies
- Services are adhoc
- There is no triage system spelt out
- No support for parents
- School absenteeism increasing
- Accountability of agencies not been looked into
- Need for more community based programs
- How to support on the ground initiatives in a better way for example, proactive programs like that of Robert Bowen’s be supported by the community and agencies like School?
- How can community members support each other in nurturing parents or others who are in dire need? How can community members encourage Council for larger community initiatives such as having a gym, a swimming pool, recreational routines etc., as these would direct impact on health and well being of the community.
- Monitoring people skills and further training not happening.
- Crisis management VS maintenance management, there is a huge gap
- No help for high-risk families. Engaging parents is difficult and the issue is not being addressed
- Lack of trained staff on the ground
• One-day visit does not provide for a ‘visible presence’ of workers. To spend more time in the community, on the ground.

**Suggested Changes**

• The existing system has one Child and Youth mental health specialist worker visiting. From April 2002 there would be 2 child and youth specialist workers visiting Hopevale
• These clinicians would take referrals for children (see flow chart for referral), parents and families. In the usual circumstances these clinicians would see the child/family with the local support worker for example, with Willie Gordon or the school guidance officer, Chris Anderson
• For the referred families (parents and children) the clinicians would formulate a case management plan that includes treatment strategies, liaison with other agency workers including school teachers, feedback to primary referral agency/person, follow up between visits through telephone with the local support worker as per need
• To work towards increasing clinicians ‘presence’ in the community.

**5. Outcomes**

• Better structure for referrals of children and management protocols- see flow chart
• Improved follow up and feedback
• In-service training on a range of topics such as risk assessment, management of child’s grief, understanding self harm behaviour and other relevant topics as raised by staff who look after children
• Implementation of secondary consultation and teleconferencing across agencies/workers
• Supporting and transferring skills training to workers in the community

**5. To work towards**

• Community proactive programs for youth and parents
• Multiagency involvement in running community group programs
Appendix Two
Letter to the community

Re: Mental Health Service Delivery for Children and Families Living in Hopevale

Dear Participant

Thank you for participating in the community consultation process on the 5 March 2.30pm to 4.45pm. The consultation was carried out to understand the existing available resources for integrated mental health needs of children and families in Hopevale. This process hoped to aid structural changes on the ground to improve the child and youth mental health service delivery in the first instance. It is also hoped that the community needs as reflected in the meeting would enable larger health and community issues to be addressed in a sustainable way by a range of service providers and agencies including health. Herewith attached are minutes of the meeting, flow chart of mental health referrals and changes as of April 2002.

For feedback and comments you can reach Radhika or Ernest on 07- 40503670.

We thank you for your time and contribution and look forward to ongoing dialogue in coming months.

Dr. Radhika Santhanam
Senior Lecturer
School of Population Health
10/01/2002

Professor Ernest Hunter
Chair of Public Health (Mental Health)
School of Population Health

CC: Giuliana Mogorovich, Team Leader Child and Youth Mental Health Team
Graham Sanderson, Manager Child and Youth Mental Health Team
Marlane Byrne, District Manager, Remote Cairns
Yvonne Wilkinson, Coordinator Northern Zone Mental Health
Appendix Three: Flow Chart

**Child in Crisis**

- Parent/Grandparent/Elder
- Teacher
- Police

**Family Services**
- Mental Health Nurse
- Health Clinic
- Life Promotion Officer
- Family Resources

Feedback arrows:
- from Parent/Grandparent/Elder to Family Services
- from Teacher to Family Services
- from Police to Family Services
- from Family Services to Psychiatrist
- from Family Services to Doctor
- from Family Services to Child & Youth Consultant
Appendix Four: Flow Chart

School Child with Problems
(non crisis)

Parent/Grandparent/Elder

Teacher

Pastor

Principal
Deputy Principal

School Guidance Officer

Life Promotion Officers

Mental Health Nurse

Health Clinic

Social Worker

Child and Youth Team Consultants

feedback

feedback

feedback

feedback

feedback

feedback
Appendix Five
Draft of Cape Region Model of Mental Health Service

Cape York Mental Health Outreach Team
Model of Service Delivery

Philosophy / Vision
Provide equity of access to a range of mental health services across a developmental spectrum that is acceptable and appropriate to communities.

Principles
1. Services are provided locally to the person receiving the service.
2. Consumers, carers, communities and service partners participate in the planning and evaluation of the Cape York District Mental Health Service.
3. Practices are informed by the best available evidence.
4. Access to service is equitable to all communities in the District.
5. The Mental Health Service Model is congruent with the Enhanced Model of Primary Health Care.
6. A multidisciplinary team provides mental health services.
7. Service provision is guided by the directions set in the 1st and 2nd National Mental Health Plans promoting the concepts of
   ▲ Developing partnerships,
   ▲ quality and effectiveness,
   ▲ mental health promotion and illness prevention,
   ▲ mainstreaming services,
   ▲ research and evidence based practice,
   ▲ outcome measurement and
   ▲ consumer participation.
8. Opportunities to develop working relationships and partnerships with other agencies will be pursued.
9. Cape York MHOT is an equal partner in all Queensland Health service partnerships and will participate in planning, management and evaluation of the services provided by the service partners.
10. When collaborating with service partners, the needs of Cape York HSD communities will influence all discussions.

Definitions
Service Partner:
Another agency that provides clinical services to areas of the HSD that cannot be serviced by the MHOT. The agency can be another HSD, a Non-Government Organisation or another government agency.

Principal Service Centre:
The Mental Health Service within the network (in this case Cairns IMHP) that has a critical mass of staff and other resources. This service is obligated to provide support to the satellite service (Cape York MHOT) in relation to non clinical services such as service development, professional development, CESA, Mental Health Act administration. Clinical services provided by the principal service centre will be accepted using a service partner model.
Service Outcomes
1. All people who experience a serious mental illness have regular contact, including assessment, treatment and ongoing management from a mental health clinician.
2. Distress caused by the mental illness is reduced and optimal level of functioning is achieved for each consumer.
3. All clinical information is collected, interpreted and used to inform clinical decisions.
4. Intersectoral, intra-district and inter-district links ensure continuity of care for consumers.

Consumer Characteristics
Consumers accessing this service will be
1. A person who experiences a serious mental illness and requires acute or long term interventions from the mental health team.
2. A person and/or their families who are at a high risk of developing a mental illness and where early intervention strategies are judged to be required.
The community is also considered to be a potential consumer of this service primarily in terms of mental health awareness and other selected illness prevention education

Team Characteristics
The MHOT consists of the following staff:
Team Leader (who has at least a 70% clinical load and is part of the Mental Health Specialist Staff)
Mental Health Specialist Staff
1 x Mental Health Clinician for adults
1 x Mental Health Clinician for children
2 x Indigenous Mental Health Workers
Non Mental Health Specialist Staff
2 x Stolen Generation Counsellors
1 x Administration Officer
The MHOT is a component of the Primary Health Care team and as such reports through the Director of Primary Health Care.

Scope of Service
♦ The Mental Health Outreach Team (MHOT) is based in Weipa. This service is a component of the Cairns Network Authorised Mental Health Service (for the purposes of the Mental Health Act 2000)
♦ Clinical services are offered to all areas of the Health Service District using either the MHOT or one of their service partners.
♦ The MHOT will travel using the most cost effective and efficient form of transport. In most instances this will be by land using a 4WD vehicle.
♦ The staff members will utilise CYHSD accommodation in each of the communities in most instances.
♦ Types of services offered include
  ♦ Clinical services such as assessment, diagnosis, treatment, ongoing case management, rehabilitation services
  ♦ Early intervention
  ♦ Community MH education and awareness
  ♦ Education, training and skill development targeting all PHC staff
♦ Hours of operation are from 8.30am until 5pm on weekdays.

Adult services:
♦ Minimum level of service:
  ♦ Weipa and Napranum will receive services from the MHOT as required.
  ♦ Mapoon will receive a visit from the MHOT every 2 weeks
  ♦ Kowanyama, Lockhardt River, Coen, Aurukun and Pormpuraaw will receive a visit from MHOT 6 times per year.

♦ Service Partners:
  ♦ RFDS – Fly in/Fly out psychology service into Aurukun, Pormpuraaw, Mapoon, Lockhart River, and Coen one day per month, with 2 visits per month into Kowanyama.
  ♦ CIMHP – Remote area psychiatrist visits each community three times per year, with one visit accompanied by MH team leader.
  ♦ PHC – primary health care staff (both health professionals and health workers) will provide ongoing support between MHOT and service partner visits.
Child and youth services:

- **Minimum level of service:**
  - Weipa and Napranum will receive services as required.
  - Aurukun and Mapoon will receive services once per month.
- **Service Partners:**
  - Cairns CYMHS – Outreach clinical service to Lockhardt River, Coen, Kowanyama and Pormpuraaw one visit per month.
  - PHC – primary health care staff (both health professionals and health workers) will provide ongoing support between MHOT and service partner visits.
  - Communication with other agencies / sectors is vital for consumers to receive a seamless service. Strategies to foster this type of clinical environment include
  - Fortnightly case reviews involving the MHOT and the remote area psychiatrist and registrar (when position filled).
  - Commitment to increase the use of videoconferencing for case conferencing and clinical assessments where possible.
  - Weekly discharge meetings (video or tele conference) with the Cairns IMHP inpatient service.
  - Monthly meetings with the Northern Zone Forensic Community Mental Health Service (Townsville) to discuss forensic mental health issues.
  - Meetings as required with the Secure Mental Health Unit (Townsville), Kirwan Rehabilitation Unit, Charters Towers Rehabilitation Unit and Pandanus Psychogeriatric Unit to update progress of any Cape York consumers within their clinical programs.
  - Clinical management will be provided in business hours (as stated above) with some room for flexibility to meet the needs of the consumers and to accommodate the demands of travelling.
  - After hours service will be offered by telephone through Crisis and Assessment Team in Cairns or through the RFDS on call system.
  - The MHOT will offer secondary consultation in relation to providing care for people with a mental illness during business hours as requested by Primary Health Care staff.

Information Management

- Service information will be managed through CESA. All specialist MH staff will enter information into this database within the existing guidelines for CESA. The administrative officer will open and close service episodes.
- Outcomes will be measured using the MHI, HoNOS and LSP (being the tools used nationally).
- The MHOT and their service partners will ensure that treatment plans and other clinically significant information is entered into the files of local primary health centre. Copies of this information will be held by the MHOT for case conferencing and clinical review purposes.

Professional Development

- All staff of the MHOT are encouraged to pursue professional development opportunities particularly those to be offered by the Mental Health Professional Development Program being rolled out across the state.

Clinical Supervision

- All MH Specialist staff have access to the Mental Health supervision project.
- Cairns Remote Area Psychiatry Service will provide clinical leadership and supervision to the MHOT.

Quality Processes

- The MHOT will participate in the District wide accreditation system (that is currently EquiP through ACHS).
- The MHOT will undergo an indepth review against the NSMHS before June 30 2003 as a Commonwealth Requirement and agreed to by Queensland Health.
- A report on the implementation of the NSMHS will be provided to MHU (Corporate Office) every 6 months, (which is a requirement).

Rationale/Justification of Model

* discuss the two options first considered and add in advantages and disadvantages.
STATEMENT OF INTENT

between the

ROYAL FLYING DOCTOR SERVICE OF AUSTRALIA (QUEENSLAND SECTION)

and

CAIRNS INTEGRATED MENTAL HEALTH SERVICE

for the transportation of

Child and Youth Mental Health Personnel
1.0 Abbreviations

Royal Flying Doctor Service of Australia (Queensland Section) (RFDS)
Cairns Integrated Mental Health Service (CIMHS)

2.0 Child and Youth Mental Health Service to Cape York Health District

The need for a consistent clinical mental health service for children and young people living in Cape York communities was acknowledged at a meeting held in July 2002 in Weipa. A service structure was agreed to linking Child and Youth Mental Health Service (through CIMHS and the Queensland Mental Health Branch), the Northern Zone Management Unit, the Cape York Health District, and the Royal Flying Doctor Service (Queensland Section).

The model is to be implemented from January 2003 and proposes regular clinical service delivery through three geographical areas. One of these, comprised of Weipa, Napranum, Mapoon and Aurukun, will receive child clinical services through the Cape York Health District based in Weipa. The other two areas (Pormpuraaw and Kowanyama constituting one area, and Coen and Lockhart River the other) will be provided for from Cairns. The interim proposal is for the latter two areas to be serviced by an arrangement between CIMHS and the RFDS. The Statement of Intent focuses on the arrangement between these two parties.

Community consultations to date have emphasised the critical need for a regular and predictable clinical service. The proposed model will be informed by further discussions with community members, justice groups, families, childcare groups, council and primary health care staff, and modified accordingly.

3.0 CIMHS role

The CIMHS has agreed to provide child and youth mental health services to selected Cape York Health Service District communities, namely Kowanyama, Pormpuraaw, Lockhart River and Coen. Kowanyama and Pormpuraaw will receive three visits each in an eight week period, Lockhart River and Coen will receive one visit each in a four week period.

The CIMHS will meet all accommodation and meal costs for the child and youth mental health workers and ensure professional indemnity insurance is arranged.

4.0 RFDS role – Statement of Intent

The RFDS will endeavour to facilitate transportation of the child and youth workers to selected communities in the Cape York Health District at the frequency outlined in the previous section. Two child and youth mental health workers will usually accompany the clinic run which visits the communities of Kowanyama or Pormpuraaw visiting each community three times in an eight week period. Two mental health workers will visit Lockhart River and Coen once each in a four week period. Details of arrangements are to be found in the attached Protocols and Procedures document.

This arrangement is subject to internal and external priorities which may require rescheduling, for example poor weather or aircraft incapacity. The RFDS reserves the right to set priorities regarding transporting both internal and external staff. However, based on the history of use of the agreed clinic runs, it is anticipated that the level of demand for transportation will normally be able to be met.

The RFDS does not accept responsibility for professional indemnity insurance for the accompanying child and youth mental health workers.

The above will be trialed for an initial period of three months to determine whether the arrangements are working effectively. If successful the trial will continue for a further nine months.

In addition to transportation it is anticipated that the child and youth mental health workers will attend a Cairns RFDS base operations meeting lasting approximately two hours and meet with the RFDS Senior Allied Health Officer and RFDS Cairns base psychologist for one hour, both on a monthly basis.
5.0 Protocols

The attached Protocols and Procedures document has been completed after consultation with the RFDS, UQ and Cairns Integrated Mental Health Service. This document includes guidelines for child and youth workers visiting the Cape District communities with the RFDS, together with roles and responsibilities. A copy of the Protocols and Procedures document is attached to this Statement of Intent.

6.0 Review

It is agreed to review the Statement of Intent after a period of three months from the initial transportation of child and youth mental health workers (January 2003). If the arrangements are successful the trial will be extended to 12 months.

The Statement of Intent relates to the transportation of child and youth mental health workers to communities in the Cape York Health District. If other communities are to be considered for the transportation of child and youth mental health workers modification of the Statement of Intent is required.

7.0 Signatories

--------------------------------------------------  --------------------------------------------------
Graham Sanderson                             Dr Geoff King
Manager                                    Medical Superintendent
CIMHS                                      RFDS (Queensland section)
Date: / /2003                               Date: / /2003
Appendix Seven
Service Agreement with Cape District

Draft
Summary Agreement for Child and Youth Mental Health Clinical Service in Cape District

The service structure agreement arising from the July 2002 meeting in Weipa links CYMHS (through Integrated Mental Health and the Mental Health Branch), the Northern Zone Management Unit, the Cape District, and the Royal Flying Doctor Service (Queensland Branch). The absence of a consistent clinical service from either the Cape District or Cairns District for children living in Cape communities was acknowledged.

The model is to be implemented (and subsequently evaluated) from January 2003 (for details see the document from Yvonne Wilkinson prepared following that meeting). The model proposes regular clinical service delivery through three service areas. One of these, comprised of Weipa, Napranum, Mapoon and Aurukun, will receive child clinical services through the Cape District based in Weipa. The other two service areas (Pormpuraaw and Kowanyama constituting one area, and Coen and Lockhart River the other) will be provided for from Cairns. The interim proposal is for the latter two areas to be serviced by a partnership between Integrated Mental Health (Cairns) and the RFDS.

Community consultations to date have emphasised the critical need for a regular and predictable clinical service. The proposed model will be informed by further discussions with community members, justice group, families, childcare groups, council and primary health staff, and modified accordingly. In addition to supervision and professional development provided through Cape District, service standards for the child mental health activities in Weipa, Mapoon, Napranum and Aurukun communities will be supplemented clinical supervision from Cairns.

The details of this arrangement will be put in the form of a Memorandum of Understanding between Cape District and Northern Zone Management Unit (Mental Health Coordinator).
Appendix Eight
Planning workshop Torres District

Child mental health meeting
Bamaga March 18, 2003

DAY 1

Present
Ernest Hunter   Queensland Health
Judith Piccone   Zonal Management Unit
Giuliana Mogorovich  CYMHS
Kathy Stapley   CYMHS
Rosalie Matysek   NPA FRC
Stephen Christian Torres District: NPA
Michael Fletcher Torres District: NPA
Kim Veiwasehavanna Community health
Patti Nona Torres District: NPA
Annette Wilson Police
Lexi Thorpe Torres District
Radhika Santhanam IMH
Sue Cameron Primary Health Care
Ray Kettle Community Police
Yvonne Wilkinson Northern Zone
Sandra Mussu Justice group
Charmaine Torres District: NPA
Tracy O’Driscoll FRC
Dame Patti Nona Torres District: NPA
Vicky Kennedy Torres District: NPA

MORNING SESSION

The meeting was opened with a prayer from Stephen Christian

Patti Nona
NPA health strategy goal to develop comprehensive mental health plan. My intention was to have local mental health service in Bamaga but also with other organisations playing a part in the mental health service provision. Need to have integration to provide comprehensive service provision.
Have recently done an audit of service availability – one of the areas noted was mental health. Today we need to look at strategic directions to meet the mental health plan.

Yvonne
Reform agenda commenced in 1993 – national priorities.
Objectives as per slide – treatment and reducing impact through a series of priorities in the first NMHP – 11 priorities which basically reflect need to improve service delivery, needs of consumers, linking services with other sectors, service mix... and, importantly, placing mental health services within a primary health care context. Standards and monitoring also critical. Legislation etc.

1996: Qld decided to articulate with these developments through reform of existing institutional structures. 10 year plan in 1996 which resulted in increasing bed numbers (and capacity) in regional settings.
Decentralisation associated with nett increase in beds and workforce. Also developed funding models and service integration. Thus – the development of Integrated Mental Health Services with formalisation of consumer participation.

At the same time Qld developed Indigenous mental health policy
Culturally appropriate service provision
Participation and partnerships
Needs based criteria
Information monitoring
Workforce planning  
Community education and support  
Across government approach

This has been poorly done, particularly workforce planning and support – this is continuing to be developed

1997 – Second NMHP – keep going with the first plan but give some focus on promotion and prevention, service reform and partnerships. There is now another plan due in 2003.

What is the vision for the future from a national perspective  
Seamless system with individual pathways and continuity of care  
Responsive to promotion and prevention  
Accessible to all  
Consumers and carers participating throughout

Judith Piccone  
Child issues need to be seen in the wider context but formal attention to child and youth now emerging. Now important addition is that in 1996 Future Directions for child and youth developed. Very broad but a start. Historically mental health focused through child guidance clinics at the needs of younger children. Did not address needs of older, serious and complex cases who were not being seen. However, policy also emphasised need to maintain emphasis on promotion and prevention. Thus, realign but continue basic preventative work. It has taken since then for existing services to get their heads around that.

Currently workforce planning based on population. This is clearly not appropriate outside of a metropolitan context. The nature of work is far broader than basic clinical care. With the second MHP there was attempt to reframe this for C&Y – this has not been published but work is in progress – I have responsibility – issues include definition of caseness, culturally appropriate services, organisational structures …

A number of principal service centres identified across the state which provide support more distantly (satellite services). Need to develop flexible individualised service plans. Also now need to address outcome measures. Multidisciplinary teams – how is this interpreted in settings which have only one worker. Need to link more with wider services and develop partnership. This includes developing partnership with adult teams.

Need to develop comprehensive range of services – referral and intake, assessment and treatment, emergency response, acute inpatient, extended treatment, alternatives to acute admission. These are all more difficult in remote settings and small teams.

Developing a skilled workforce is critical. There has been focus on development of professional development program. Another project looking at allied health and nursing supervision. Rural and remote issues and recruitment & retention are still on the agenda and not yet adequately addressed. There is a mid-term review of the 10 year Qld mental health strategy. This will consider these issues.

Future issues include research and development, particularly around outcome measures. Also need for flexible service delivery models and resources such as e-mental health. One of the other issues is that there are no inpatient beds outside of Brisbane.

Ernest Hunter  
Review of historical issues leading to development of principles at present.  
Up to 1991 working with hospital boards – driven from Brisbane  
1991-1995 – regionalisation was an important development – led to 13 regions in Qld, in Brisbane may have caused confusion, but up here shifted resources to remote areas like the Cape & Torres. Started to develop infrastructure and services  
1995/96 – moved to 39 Districts, led to problems with small areas taking on lots of responsibilities  
1999 – Zonal structure assisted somewhat in coordination for small areas.

1992 – hardly any MH services – no consistency  
1992 onwards – Ernest’s position as Regional Psychiatrist commenced  
1994 – ATSI MH Educators continued to 1999 when they were relocated to Cairns  
1994/95 – three nursing (2 for Torres & 1 NPA) and 6 mental health positions (2 for Torres & 1 NPA) funded + Regional Child Psychologist (to 1996) – then Cairns CYMHS commenced Outreach

Outside Qld Health
Location of Social Workers, setting up of Family Resource Centre, psychologist

200-300 that have been assessed by Ernest in the area
80 active clients currently

1993/94 Torres Health Strategy – shift away from Cairns focus
1999 NPA Health Strategy

2002 – Radihika & Ernest – review and restructure of MHS

Principles – to build on Torres Strait & NPA Health Strategies
• Quality Care
• Local Skill Development & Capacity Building, Skill Transfer
• Indigenous Workforce Development
• Sufficient and Adequate Service Delivery – appropriate to local needs and there enough

Giuliana Mogorovich
1994 - child service – remote area child and youth psychologist. To cover Cape, Torres and remote Cairns.
1996 – position reviewed – incorporated in CYMHS.
1998 – CYMHS outreach service to Torres/NPA. Trish Toohey initially 4 visits per year. Last visit September/October 1999 (due to practitioner illness). 2001 (August) visits commenced – two workers from CYMHS. Initially intent was to combine an Indigenous worker from Cairns with clinician.

Michael Fletcher
CNC mental health structure. Team leader position vacant. These constituting the NPA mental health service. Line management through SC and SC on to Patti Nona and Phillip Mills. Visiting adult and child teams q3 months. At present there is also the beginnings of the child and youth services for NPA which is based on TI.

Other lines of responsibility through IMH in Cairns. TI/Torres team function in parallel under Poi and Siri. Close relationship and need for liaison on particular projects and needs for staffing. The Child mental health team is a shared position.

YW – when I first came to my position the Torres was on paper meant to be one team – for example for reporting purposes.
SC – there are issues relating to earlier personality issues locally which caused division with the Torres section of the team.

Additional resources include Family Support Centre where Lexie works. Team leader is a mental health worker position. Gabriel is, in fact, a coordinator across three teams. Also coordinates ATODS and social work.

Specific issues activities include solvent abuse taskforce including ambulance, police, community police, council, justice groups, schools and sport & rec. Solvent abuse is one of the major issues at the present. Vacant team leader hampers addressing mental health promotion and prevention.

Lexie Thorpe
Family Support team on TI – Gabriel – Admin assistant (Mona Williams – new position); CNC (currently technically vacant but now with locum for 3 months), Child clinician (LT, the only position across TI and NPA), Indigenous mental health worker (vacant); Social Worker for FST (vacant). Also consideration for incorporating School Nurse (currently Shannon but she is leaving). Dalton Bon also provides pastoral care at the hospital. Mental health team itself is CHC, CYMH and IMHW. CNC position and SW position have been vacant for months. At present LT is covering the bases. Other components of the team CYMH and Regional Psychiatrist from Cairns (+RS).

LT has been in the position since November – as it is a new position there is not a lot of structure. Torres needs to consider how the larger picture incorporates this role. Issues for child and youth include depression and self-harmful behaviour. At present there has been little contact with the children and families from NPA. Violence at school is also identified as a key issue. Previously had been working as a Social Worker with Port Kennedy Association. Role there was with children and youth – similar issues with a backdrop of lack of family support. Need to move from being reactive to proactive. Take up the challenge of addressing the needs of outer island communities.
Regional Psychiatrist Role (EH)
Come up by land for more flexibility
Critical to link in with community services
Developing care plan with local services
Role – inservice work not just with Health Workers (eg. MH Act)
NH&MRC Project (5 year project based in the Cape) – Better models of care for those with serious MH
Need to think about Outcome Measures – work is occurring to develop Indigenous appropriate versions, but
what to do in the meantime.

CYMH Role (GM)
CYMH outreach to Torres.
Main issues August 2001. Need for consistency. Need for ongoing contact with local stakeholders. Need for
program development – promotion and prevention. Need for primary and secondary consultation. Information
and resource provision.

Agreement that two clinicians across TI and NPA for one week three monthly. Since October 2001 this has
been GM and CS. In late 2002 a local worker appointed. Difficulty until that time in keeping abreast of the
local issues. RS program from 2001 – developing new models of care. Future issues – outcome measures,
forensic mental health policy (position will be based in CYMHS Cairns – an Indigenous worker will have
wider zonal responsibility).

YW – last year three adult positions given to Northern Zone (Townsville, Cairns, Mackay). However, at
present they have no travel budget. Also one Indigenous health worker position based at Lotus Glen.
In relation to outcomes, Cairns is the last area to come on line and that the deadline for this is December.
This will also have a separate information system (in addition to Ferrett, CESA, MHA).

Yvonne Wilkinson
Issues for definition:
Mental illness vs mental health problems …
Principles for service provision
Support for local workers
Integration of components of service provision
Continuity of care, documentation etc.

Clinical issues:
Outcome measures
Comorbidity
Cross QH sector relationships
Cross sectoral relationships

Community interagency perspectives of service delivery (Rosalie)
CYMH
Tracy O’Driscoll and self as SWs, Mika as ATODS worker. We find that we come across children needing
greater expertise and liaise with CYMHS. Assessment done but continuum of service problematic. So – we
need more regular contact with CY mental health staff. With adult system we have referral system to
Michael. However, there are some issues relating to gender issues and youth (this is not common). The adult
side is being managed but C&Y needy. Consultation with women in the community – need some general
mental health awareness in each of the five communities. Many women not aware that CYMH present.

General discussion
RS – concepts of what constitutes mental health issues will change across the developmental spectrum,
becoming more ‘obvious’ with age.

YW – Strategy now indicating that clinicians need to have some skills across the spectrum.

RS – On the ground, demands are such that crises take priority – however this simply means that there is a
need to be opportunistic.

Kim – ultimately it is anticipated that the MHW will take on more of the promotion and prevention role and the
MHN will be focused on clinical care issues.

Rosalie – there is a range of key people in the community who are better placed to respond to community
based issues.
Kim – ambiguities related to HW roles – both functioning as managers and addressing access issues.

SC – health workers do not have formal qualifications. Thus team leader position to be more access issues. However, there is important role in clinical support although ultimately clinical responsibility devolves to those with formal qualifications.

JM – two Indigenous C&Y positions based in Cairns.

MF – Mental Health Team Leader (Health Worker) – will this position have to enter into the mandated data bases.

YW – this will ultimately be necessary but training will be necessary.

Police

RK - Currently with good rapport with the hospital and the community. Need to develop memorandum of understanding regarding protocols.

AW – Within police training of mental health issues are addressed but unless applied daily one loses touch. Working in a remote or regional centre is different to working in a metropolitan centre where there is a greater range of supports available. Always hard for us to make the call whether an individual is ‘mad or bad’.

Better practice models for remote child mental health services (RS)

Experiencing restructuring in Cape York. In the Cape prior to RS starting this project there was a deadlock between systems and services for kids had ground to a halt. We sought to find out how best to deliver child and youth services to remote communities.

This proceeded initially with a mapping and scoping exercise to identify who is going to communities, the nature, frequency etc of their work. Then we tried to identify exactly what happened. In addition we tried to identify the range of community understandings of services, how do they participate in the activities and what are perceptions of ownership etc. Initially there was no match between what services were stating were delivered and the experience and understandings of the community members themselves.

It was found that there were many de facto players with mental health responsibility – responsible adults, elders, workers in other sectors and organisations. Certain groups emerged as being key – Justice Groups. Other players include Education, Family Services (including RAATSIC workers). Many of the roles and responsibilities overlap.

Issues emerging were:
1 Community Partnership – involvement, participation, decision making, ownership. The focus was how do we engage with communities so they are meaningfully involved and able to take ownership.
2 Equity of services – need to address equity across districts vs Cairns, how does it match with national standards and other benchmarks.
3 Sufficiency of services – benchmarks vs basic standards of care; sustainability vs ad hoc services; capacity in terms of resources vs needs; participation & collaboration. Ultimately the key to sustainability is building capacity on the ground.
4 Indigenous workforce – this involves validation, training, transfer of skills and ensuring that services are culturally meaningful.
5 Structure of the service – issues include roles, responsibility, liaison and integration.
6 Infrastructure of service – community networks, interagency liaison, PHC backup, technical support…
7 Quality of services – evaluation and documentation, community outcomes, cultural appropriateness, support and training …

Critical baseline for service delivery
1 human resources – indigenous and non-indigenous
2 frequency of presence
3 skills (clinical training, community)
4 sustainability (training, supervision)
5 common information base (clinical, administration)

Experience in the Cape

Communities – Eastern and Western. One FT child and youth worker and one BTH counsellor.

Now we have team from Weipa visiting each community across Weipa Napranum and Mapoon regularly – Aurukun fortnightly, Napranum weekly, Mapoon monthly.

Pormpuraaw and Kowanyama – now are able to give fortnightly visits with two clinicians.
Lockhart and Coen – visits are monthly – this will have to increase. This will include an Indigenous practitioner in the near future.

These options reflected the comments of community members and others on the ground for more consistent and frequent visits. Working in very close relationship with RFDS who are providing mental health services across the remote communities. Thus there are three clinicians at each of these visits. Value adding through building these relationships – recent developments include cooperation with Family Services around locating a worker with supervision and support through ourselves + RFDS in the community. On each visit to the community we meet with the Justice Group, school teacher, sports and rec officer, community members who will become community mentors. The difficulty was finding such models – we have arrived at a particular resolution with this by linking with family services and local players.

AFTERNOON SESSION

Defining mental health
NAHS definition noted.
Also: National Mental Health Statement of Rights and Responsibilities defines mental health as: “The capacity of individuals and groups to interact with one another and the environment in ways that promote subjective well-being, optimal development, and the use of cognitive affective and relational abilities (the ways we think, feel and relate to one another) and the achievement of collective goals consistent with justice” (Mental Health Consumer Outcomes Task Force, 1991: vii)

<table>
<thead>
<tr>
<th>From the group</th>
<th>Examples</th>
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<tbody>
<tr>
<td>Mental illness</td>
<td>MH problems</td>
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<tr>
<td>Self harm / suicide</td>
<td>Substance use</td>
</tr>
<tr>
<td>Disordered behaviour</td>
<td>Poor self care</td>
</tr>
<tr>
<td>Disordered behaviour</td>
<td>Behaviour problems</td>
</tr>
<tr>
<td>Parenting problems</td>
<td>Poor physical health</td>
</tr>
</tbody>
</table>

Local providers
Mental health services, child health service, justice councils, FRC, Women’s shelter, Community women’s groups, men’s health support groups, health council, Health management executive committee, after activities centres, community councils, police, schools, hospital, community health, DSQ, HACC.

Primary responsibility
MHS primary responsibilities – first port of call – largely those issue conceptualised as mental illness. However, there is a much broader range of secondary responsibilities. This is consistent with the messages emerging through the ongoing review of the Second Mental Health Plan.

Roles:
• Primary
• Supportive
• Facilitative

Priorities for NPA
NPA Health Service – outcome based service plan for 2003 tabled.

NPA priorities:

Others present
Charmaine

Need to develop capacity to have children with particular needs seen and for information emanating from that to be fed back through the system. This has been the case for the three years that I have been working here in relation to children. Children usually referred through school. Parental perceptions of what CYMHS represents is unclear - ? don’t have experiential base from which to extrapolate.
RS – one way that I have operated in the past is to ensure that the visiting specialist service sees the children in collaboration with one of the local providers. We have also found interactive information sessions useful in other communities.

YW - development of collaboration with FRS to address mental health literacy issues.

Rosalie – FRS keeps only hard copy notes that are locked away. There is a memorandum of understanding between (?) and health regarding sharing of information. Mika does not have line responsibility to anyone in QH – works essentially on his own.

Danny Moresu
Working for DATSIP – will be working through MCMC with justice councils to set up community action plans for alcohol looking at issues in relation to licensing etc. First issues are setting up community justice plans and developing the alcohol action plans. COAG and whole of government processes also ongoing at the present time – there is a real focus on developing outcomes in the Cape. Cape York Strategic Unit based in Cairns – Negotiation Tables – forum for negotiating with communities. My job is to meet with councils in NPA to define the process and guidelines for the project and to examine how they will undertake business at a community level. The regional director for DATSIP needs to sign off on that before it goes to the Minister. The community justice group will have a whole range of powers relating to the management of alcohol in communities. This may involve the development of local guidelines. Justice Groups need to take into account traditional owners, people with historical investments and other key players. There will be particular issues with those communities who have canteens (Umagico and Bamaga). When the community justice members are identified there is a range of requirements including background checks and the “blue cards” necessary through Family Services now for working with children. Members of council are not able to sit on the board. Now at the very beginning stages. Need also then to develop partnerships across other organisations. Based at TI.

YW coordinated discussion
Scope of an appropriate NPA mental health service (this includes Lexi)
- Ongoing management of people with an existing mental illness.
- Assessment, referral and/or management/co-management of people who may have mental illness or serious mental health problems, or other problems causing concern or risk.
- Mental health skills transfer
- Service development/enhancement – planning, evaluation, etc to ensure sustainability. Systems empowerment.
- Rehabilitation, disability support.
- Staff support.
- Facilitating consumer participation.
- Community education
- Appropriate integration of outreach services

Service partners
CYMHS
Remote area outreach service
Community Health
Family Resource Centre

Principles
1. Culturally appropriate and sensitive services
2. Equity
3. Sustainability
4. Continuity of care across time and services
5. Community partnerships and ownership – enhancing capacity
6. Sufficiency
7. Workforce (Indigenous and non-Indigenous)
   Training/support/supervision/continuing education
8. Infrastructure
9. Quality
   Process – evaluation, documentation, feedback, review
   Evidence base, National standards, Validating local expertise
10. Consumer focus
DAY 2

Present

Ernest Hunter   Queensland Health
Giuliana Mogorovich  CYMHS
Cathy Stapley   CYMHS
Stephen Cristian  Torres District:NPA
Michael Fletcher  Torres District: NPA
Kim Veiwasehavanna  Community health
Mica Veiwasehavanna  FRS
Patti Nona  Torres District: NPA
Lexi Thorpe  Torres District
Radhika Santhanam  IMH
Sue Cameron  Primary Health Care
Ray Kettle  Community Police
Val  Relief MHN (TI)

Patti Nona
Need to clearly define roles and responsibilities.

KV
Need to be able to clarify NPA mental health nurse’s role and the requirements for with clear delineation of what is expected in terms of outcomes and Zone requirements. Issues of priorities and reporting raised.

EH
Need to ensure a local and simple system in relation to reporting. First priority is a paper and pencil register. At present there are four databases on the horizon: CESA, mental health outcomes database; FERRET and Mental Health Act.

Having all or some of these operation will take time – in the meantime we can start figuring out what is going to work for NPA. The mental health act burden for NPA will be low. FERRET will not directly impact the MHN in the short term, the outcomes register may be deferred while we attempt to see what works. That leaves CESA to deal with now. Mona, administrative support at TI enters CESA data for TI. She enters the monthly POS but new cases Michael will register on CESA directly – we need to consider whether Mona can help out with NPA data.

KV
What is the core business for Mental Health in NPA?

EH
Schizophrenia/Manic Psychoses – a small percentage
Alcohol and substance use with psychosis – substantial numbers
Self harm, ruminations, trauma – large number

For NPA an average of 25 -30 Active cases of some significance at any point in time who need to be monitored to some degree. Priorities could be considered:
- Primary: clinical care
- Secondary : supportive of interventions from other services (e.g. schools, FRS)
- Facilitatory: service enhancement, community capacity, and broader issues

Working off the NPA mental health service plan:
32A – will go ahead when Team leader position is recruited. Michael and EH to look at the burden of care with other providers like Mica for Adult MH a
32A – severe behaviour problems, self harm, solvent abuse. The mental health literacy has to address these areas identified.

GM/KS
In relation to children – overall for last year some 20/25 active in some way in NPA/TI.

EH
32B,C,D. KV  requested information regarding load and needs. EH suggested that we can, NOW provide for adults a measure of what we would anticipate in terms of the population base (not taking into account the additional burden due to local circumstances) and the existing case load. This should be part of the maintenance of a register. MF identified as ‘custodian’ of a register which would include:
- Psychiatric patients by activity status (EH’s patients)
• CYMHS patients by activity status
• Patients who have been through the system without referral on for psychiatric assessment (patients seen and dealt with by MF – a means for case reviewing these needs to be developed)
EH to provide MF with ‘index of burden’ and a register.
GM/KS also to provide for Child and Youth data derived from CESA to both Michael and Sue Cameron. This information printed out from the CESA database should be supplemented by a written notation of disposition. Cases should discussed with workers on the ground.
Ongoing plans for mental health care for adults to be handed over to MF and for Child and Youth for LT. This will give a total client burden for Mental Health.

GM
Documentation – comprehensive assessment, summary, formulation, follow up plan, care plan goes to hospital files. Single integrated system is what NPA endorses. All other child notes will be in primary health care file, custodian is MF.

KV
Communication policy document – for workers imperative.

EH
Discussion from NPA plan of issues of sufficiency. In relation to C&Y proposal was tabled re alteration of existing models of service delivery to increase time on the ground without, at present, increasing funding. Suggestion based on having a C&Y position based in Torres who will have primary responsibility for ongoing C&Y care. New model is to continue three monthly visits, but to have one worker go to each of NPA and TI, staying there for one week and working with the Torres District C&Y worker. This would have the following benefits:
• Consistency of clinician over time
• Direct involvement of local worker
• Longer period of time on the ground facilitating both clinical followup but also ability to liaise with local organisations
• Presence of a clinician in the Torres every 6 weeks (instead of 12 weeks) – thus providing for more frequent on-site review and ability to respond to crises throughout the Torres
• Will provide for more streamlined review, supervision, monitoring, linking.

PN
Frequent visits are better than three months. Six weekly is better. Once every 6 weeks is optimal but in the interim to make the best use of existing clinical resources.

LT
All referrals should come to me. It is district need – based. And there need to be flexibility. This was agreed. The system will thus change from a Cairns focused referral system to a Torres focused system/

General discussion
CESA – to be continued – for the time being
Outcome measures – to be reviewed and monitored by EH
Regular activity report – produced by adult (Michael) and child (Lexi) will go to Steven/Suzie.

Teleconference hookup with Gabe and Seri
Discussion of previous two days summarised by EH.
Gabe – Suggestions in relation to changing C&Y service delivery: this looks productive and will maximise services, regularity, frequency and consistency.
Supervision:
Continue supervision with remote area workers once a month with RS – C&Y
Clinical support and back up review - with Kathy fortnightly/monthly- C&Y

MF
Issues in relation to conflicts over roles: Professional vs line responsibilities. In particular difficulty with issues relating to requirements from the Zone and IMH relating to expectations of standards and activities that reflect State and Commonwealth requirements that are sent directly to MF who then has to negotiate up to his line managers in the District. Also issues of supervision. In addition to the visiting psychiatrist there needs to be intra-disciplinary supervision. Supervision for Nursing Mental Health issues – Andrew Brownlie (to be worked out).
Operational Management Planning – SC
Service Planning – KV
Professional development – Anthony Weller
The Zonal people (CESA, Diaana Bisset; FERRET; Mental Health Outcome; Keith Muir) need to communicate through proper line managers and not directly to MF.

EH noted that these issues of responsibility relate also to the MHNs in Cooktown, TI, Mornington and Weipa. EH suggested that MF take responsibility for commencing an email discussion across this group to begin identifying what could be a common approach to this issue across the four districts. It will NOT help to have for separate systems of dealing with these issues. We should also look to having these issues prioritised in the next MHN meeting in Cairns.

SM
For NPA
Operational accountability for Lexi – Gabe
Clinical review – Cairns CYMHS (GM +Gabe)

The meeting closed with thanks from Patti Nona followed by a prayer at 12.30.
Appendix Nine

Supervision frameworks for Practitioners in remote areas – where to begin?

Introduction

Supervision is one aspect of professional development that has been poorly theorised and insufficiently researched. This is particularly fraught in remote and rural areas where availability and quality of supervisory frameworks is ill defined. Supervision, individual, peer group or group represents one aspect of professional development. Other forms include consultation, peer review, conference attendance and presentations, workshops, and guided reading. Very little is known about which particular features of supervision are most effective at producing positive outcomes for the supervisees, the clients and the supervisor.

Review of supervision literature

The following review is based on 3 reports collated by Queensland Government looking at supervision practices in the Allied Mental Health areas (1,2,3).

Supervision is by and large regarded as a beneficial activity by professionals and by the systems that employ them. Supervision is usually described as a form of presentation of work examples by the supervisee (e.g. a case study presentation or video/audio taped clinical session), followed by review, discussion, clarification, and feedback of the supervisor in the areas of occupational therapy, clinical psychology, social work and speech pathology.

The supervision models can be classified into clinical/client centred, organisational /administrative and personal domains.

The clinical/client supervision relies on the active transmission of knowledge, skills and attitudes for enhancing the quality of clinical service to the client. It aims to enhance the ability to conceptualise clinical material and to select and apply best practice interventions.

Organization/administrative or agency-centred supervision focuses on transmission of knowledge relating to the goals, expectations, systems, policies, operations, philosophies, dynamics and culture of the organization. Like client-centred supervision, it aims to enhance the skills and facilitate best-practice methods – but it also involves assigning of tasks, budgeting and coordination with respect to the supervisee. The personal support supervision focuses on optimising motivation, morale and commitment. This includes planning of a career, development of conflict resolution skills and handling problematic emotions relating to clients and peers.

Heron (1990) proposes six primary styles of supervision, categorised into Authoritative and Facilitative approaches. Authoritative styles include prescription, information and confrontation. Conversely, facilitative styles include cathartic, catalytic, and supportive.

Research indicates that there are qualities of good supervision, as perceived by the supervisees and that these features are similar across allied mental health professions. These qualities usually include:

- A climate that is nurturing, supportive, respectful and empathic
- Supervisors and supervisees being available and accessible for supervision and advice
- A demonstration of interest and value in supervision
- Supervisors identifying the core skills, knowledge and attitude and competences required for professional practice for a supervisee
- Providing constructive, non-judgemental feedback (verbal and written) in a clear and concise manner
- Using a range of methods – including information giving, providing guidance for reading, modelling, audio-visual demonstration, observation of supervisee practice
- Encouraging supervisees to take increasing responsibility for their professional practice
- Being flexible

On the other hand, there are supervisory behaviours that lead to unsatisfactory outcomes from supervision. These are listed as:

- Allowing administrative issues to dominate sessions
• Telling – rather than suggesting or exploring
• Providing guidance and feedback in a vague manner
• Avoiding contentious or challenging issues
• Becoming competitive
• Setting unrealistic or unclear goals
• Being overly critical and failing to point out strengths, achievements and improvements
• Being too busy, or unavailable, etc.
• Being arrogant, self-centred, egocentric and defensive
• Being vague, distracted, inattentive, preoccupied
• Having inadequate professional knowledge/skills
• Unethical behaviour – breach of confidentiality, sexual harassment, formation of dual-relationships
• Become the therapist in relation to personal issues

There is reported evidence that the receipt of professional supervision by allied mental health professionals will result in better outcomes for clients. It is regarded by staff as an important activity, seen as a mechanism for ensuring ethical practice and practice of acceptable standard and quality. Regularity and structure of supervision process have been identified as critical ingredients for supervision. Identified significant barriers include lack of organisational policy, structure, direction and lack of workplace/corporal structure, time and budget constraints, lack of training supervision and geographical accessibility issues. Job satisfaction was not related to how much supervision was received but associated with positive relationships with supervisors.

Empirical research into supervision practices as lagged a long way behind the theoretical research due to limitations of small sample sizes, inadequate statistical power and high error rates, lack of non-intervention or non-specific comparison groups, and lack of random assignment of supervisors and supervisees to experimental conditions. Research has shown that supervisors do not change their style depending upon the supervisee needs. There is also an indication that the supervisors’ perception of their own behaviour is inaccurate, and subsequently, the validity of reports made by supervisors need to be questioned.

Survey report indicates that the areas that need rigorous rethinking are around policies on the structure of supervision – with clear definitions, line management and grievance procedures. Secondly, the supervision process itself, structures, contracts and evaluation procedures and lastly, flexibility of supervision models.

Current Scenario

There is no existing forum for face to face regular clinical or professional supervision or indeed any forum to address larger systems issues for workers in remote area child and youth mental health in Far North Queensland. As part of a larger project evaluating the service delivery models for remote child and youth mental health, three different supervision formats were piloted. The first medium was direct individual face to face clinical supervision. The second was facilitation of a group forum for Indigenous Mental Health workers and the third was a peer reflective group to discuss practice issues on the ground. Below is a summation of my experience on creating the supervision space and on being the supervisor in all of the above.

Reflections

1 The face to face clinical supervision was offered fortnightly for an hour and a half for those professionals who felt the need and working in remote area child and youth. Three members out of a team of four opted to have supervision between mid 2002- end of 2003. These sessions were fairly structured and focussed on clinical case discussions for the large part. Significant issues relating to organisational systems ie, dynamic interplay of policy or procedure with individual/group sense of power, control and perception of validation etc. were also addressed as and when relevant. These sessions terminated when the workers ceased doing remote area work. A new team of remote area child and youth workers have begun clinical and systems supervision since Oct 2003.

2 The supervisory facilitation of the group forum for Indigenous Mental Health was an initiative that began in early 2002. The impetus for this activity arose from the articulated needs of Indigenous mental health workers in Cairns who felt the need for a common forum to address professional and systems issues. In these sessions the focus was sharing and storying themes related to one’s identity in both professional and personal context. In early 2003 the facilitation was handed to an Indigenous body and the group since then has steadily withered away.

3 A peer reflective group forum began early March 2004 as a result of increasing need to bring together workers across agencies grappling with similar contextual and institutional issues. In this forum the focus is on cultural, political and personal issues that impact on everyday clinical and
community practice. The group meets once a month for two to three hours and has clearly articulated educational and professional development goals.

Rethinking models for Supervision in Cape York

Collating contextual body of information, the literature from state allied health reviews and reflective evaluations of supervision initiatives in Far North Queensland, the following framework is recommended for planning workforce development in this area.

The framework of Social Constructionism

The proposed model draws on three traditions and emphasises a social constructionist perspective (4,5).

Reflective Practice
A non-traditional 'bottom up' understanding of the relationship between theory and practice - theory as embedded in practice and a valuing of practice not traditionally valued eg, creativity, intuition, culture.

Reflexivity in Practice
A recognition of the importance of self in research and knowledge creation; a recognition of the social nature of knowledge

Postmodern/deconstructive Practice
Validating multiple and marginal positions in practice and critically reflecting on issues of power.

Key Ideas

**Supervision as a co-constructed activity**
The framework, structure, agenda of a supervision activity is usually constructed or imposed by the supervisor or the institution that offers supervision. However the process of supervision is likely to be more empowering if it is co-constructed with the group or the supervisee with regards to framework, structure and agendas.

**Supervision as mutual generation of ideas**
The value of adopting a 'not knowing' approach in order to draw multiple knowledge and create 'new knowledge'. Expertise lies in the manner in which the conversation is conducted, not in the ability to convey a venerated body of information.

**Supervision as collected and collective knowledge**
Supervision process to be able to honour collective knowledge i.e, community, cultural and historical) in a non linear non hegemonic manner. Supervision to be seen as a pedagogy of hope (6) where different models are merged to inform the principles of practice.

**Supervision as a group process**
Supervision to be construed as a group process where workers and members of a community or a group meet to discuss and reflect on how their practice is impacted by personal, cultural and systemic factors. Implicit in this group process, is an assumption that sharing such predicaments would lead to alternate solutions or multiple perspectives of knowledge and understanding.

**Supervision to open the space for multiple and contradictory ideas**
All ideas are potentially useful even if they contradict one another. Striving for consistency may hinder the progress of useful alternatives. Supervision is a space where "the dilemma of multiple truths" (5) ought to be grappled with.

**Mentoring and Supervision to coexist**
Literature usually makes a distinction between mentoring and supervision. However for workers in the remote areas it would be useful to envisage a practice model where mentoring and supervision can co exist. Mentoring, in this context refers to a relationship in which an individual who has a lot of experience, cultural or clinical takes an active role in facilitating the development of another individual. Thus there could be, within a team, mentors who are not supervisors, supervisors who are not mentors and individuals who are both mentors and supervisors. Traditionally accountability has been a requirement for supervision and not clearly defined for mentoring. This is an area that needs more critical thinking to ensure the quality of mentoring practices and areas of qualitative or narrative measurements that can capture the richness of such engagements.

**Supervision to be multimodal**
The use of several mediums such as films, fiction and not limiting supervision to ‘verbal methods’ is likely to be more effective and realistic. Conferences, summer school participations, teaching workshops are different aspects of supervisory frameworks.

**Supervision as cross professional activity**
Although cross professional supervision is a contentious issue in mainstream settings, for the remote and rural context, it is useful to consider this model. It helps resource pooling, flexibility, provides space for multiple knowledge to be validated and most crucially help sustain the activity.

**Supervision as storying professional identity**
Supervision process to open the possibility of storying the professionals’ identities by acknowledging the politics of power, class, gender and race (7).

**Supervision and Evaluation**
Evaluations are constructed and have local meaning rather than universal meaning. Thus the recognition that frameworks of evaluation are defined by those who undertake the activity of supervision. Documenting the process or mechanisms that are satisfactory and helpful for professional ecology (5).

**References**

Appendix Ten: MSOAP Evaluation

Medical Specialist Outreach Assistance Program - Trial of a Child Psychiatrist Visit to Weipa and Napranum

Feedback Meeting Details

Date: 2 July 2004
Time: 9.00 –11.00 am
Venue: Cape York District Manager’s Office

Attendance

Present: Norma Brown, Janet Struber, John Varghese, Ellen McAllon, Dorothy Stewart, Sandy Robertson, Alanah O'brien, Sarah Smith, Mercy Baird, Radhika Santhanam, Rex Burke
Apologies: Verna Singleton

General Reflection of the Process and Content of the Trial

- Needs are very high on the ground - both for workers and for families
- There is no reason to believe that incidence of childhood psychiatric morbidity to be any different to the mainstream communities.
- There is a need for realistic and sophisticated way of working with Indigenous communities.
- Clinic based service alone is not useful
- Building capacity for workers on the ground, both Indigenous and non Indigenous
- Group most at risk are least accessed ie, young men. High priority for to service this group.
- Research to be used as a useful tool
- Sustainability of initiatives " Do not start something if you cannot continue it"
- Interactive training can be useful
- Very little training resource available for workers around child and youth mental health issues
- Videoconference very useful but underutilised

Strengths of the Process and Content

- In-service is beneficial
- If it can be sustained, even short-term programs are valuable.
- Practitioners on the ground coming together is a valuable exercise
- Good will of workers and communities
- Promotes mental health and literacy

Limitations of the Process and Content

- Communities to be consulted in a more detailed manner
- Planning to be done in a non rushed way
- Health Workers participation to be structured
- Focus on diagnosis and medication intervention unlikely to provide holistic care
- To integrate culturally appropriate issues and aboriginal history

Proposed Framework

- Two trips a year (six monthly) lasting for a week
• Four video link ups (two monthly) lasting for 4 hours

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<tr>
<th>Medical Specialist Outreach Assistance Program - Trial of a Child Psychiatrist Visit to NPA and Thursday Island</th>
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**Feedback Meeting Details**

Date: 23 July 2004  
Time: 9.00 –11.00 am  
Venue: Family Support Team Thursday Island

**Attendance**

Present: Ray Cash, Jason Thackery, Anita Rudd, Adrian Bon, Rob Travillion, Tony Swain, Radhika Santhanam  
Apologies: Gabriel Bani

**General Reflection of the Process and Content of the Trial**

- A beneficial exercise both for workers and for the community. Significantly improves the ‘presence’ of Family Support Team and the networking  
- Useful to include NPA as needs are similar to TI  
- Interactive workshops/seminars a positive professional development activity  
- Whole day activities give ample time to discuss and debate group topics and provides the opportunity for the group to network  
- Time frame of a week is sufficient  
- Videoconferencing underutilised

**Strengths of the Process and Content**

- Integrating local knowledge with outreach specialist expertise  
- Balance between clinical approached and culturally sensitive practices  
- Improves the profile and credibility of the Family Support Team's work  
- A morale boosting exercise for workers  
- Provides space for reflective peer group sessions  
- Helped the Family Support Team to make some structural changes on the ground for best practice model  
- A network building exercise

**Limitations of the Process and Content**

- Meaningful direct clinical follow up is limited  
- GP’s to be included in the educational forums  
- To move towards consultation practice ie, seeing families with the practitioner on the ground for example day clinic  
- To workshop on clinical topics such as "treatment of anxiety disorders" or "treatment of Adolescent depression"  
- To consider involving parents in an educational workshop

**Proposed Framework**
• Two trips a year (six monthly) lasting for a week
• Telephone contact as and when required
• Monthly or fortnightly link ups to be discussed further by Family Support Team staff with regards to feasibility and efficacy of arrangement before funding can be argued for the activity

Cooktown Evaluation

Overall strengths and limitations of this strategy?

• Objectives of visit unclear - people on the ground did not know – by Stephen and others
• Did not see any individuals/family
• Could have done some assessments if required – but none came up
• People do not like fly-in/fly-out

• Can only work if there is clarity about modules, etc.
There are people to do the follow up
• Needs a lot of work to make it work – needs to be more formalised

MODEL: Multi Tiered model?
• Must have someone on ground – no one designated to coordinate assessment, Follow up and ongoing treatment
• Fly in/fly out clinician
  Psychiatrist – case conferencing, multi disciplinary

• QH needs to review the standards of service delivery
  Resources – GPS, EQ, FRC etc.

Types of Disorders typically present
Anxiety
Depression
PTSD – sex abuse
  – dv
Couples PTSD
Suicide
Risk assessment/suicide
D + A issues
Oppositional behaviour/conduct disorder
  (Gr 4-5)
ADHD
Psychosis
Prodromal Schizophrenia
Speech/language/learning
OCD

Will this type of visiting service help?
  Too soon to say
  Early stages of assessment
  Infrequent visits so far unable to determine

Need to examine what is the role of the team?

Strengths
- Good to do 1thing properly
- Can do supervision of practices
  Is an effective activity?
  Reduces burn out
  Takes a lot of time
- Could come from elsewhere?
- Staff in need are from EQ + NGOs plus other areas

• More planning before the team sets out. A stronger framework
• Team environment exists even though not part of team

  Child psychiatrist: Needs a new model – not a CYMHS model (ie. Severe MI, CBT + meds)

  20-30% directs clinical
  Resilience building FRIENDS,
  Form Partnerships with schools, and other agencies
  Support loosely by working together – NOT supervision

Need to have someone ID on the ground
- Mindful of Men’s business V’s Women’s business
  Broadly identify key people who are stable.

Child psychiatry heading to EI rather than specifically clinical
Need URGENT planning day
- keep minds open to different ways of doing things
- developing on the ground HP to make more appropriate decisions

Possible effective model
4 X year for 2-3 days

  Submission for VC into Hopevale planning visit
More structure
- some clinics that will dovetail with VC

Communication between IPU (CBH)+the clinic for follow up
CDMA – need satellite phone for outreach based at Cooktown?
Appendix Eight
Template for Mental Health Branch Report

PERFORMANCE INDICATORS
The outcomes to be achieved by the University Of Queensland under this funding agreement are as follows:

**Goal:** Continue to develop best practice models for Indigenous Mental Health Services in the Northern Zone using an action research model

<table>
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<tr>
<th>Outcomes Description</th>
<th>Indicators/Measures</th>
<th>Minimum Attainment Level</th>
<th>Reporting Arrangement</th>
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<tbody>
<tr>
<td>A Model of Best Practice to provide an integrated health and mental health service for Indigenous children and young people living in Far North Queensland</td>
<td>Phase • Implementation Progress reports • Final report to Zonal Manager and Manager SNgHS outlining best practice models for Indigenous mental health service delivery</td>
<td>• Continue the implementation of community consultation strategy for secondary sites by December 2003 • Data collection for evaluation activities throughout implementation of the model</td>
<td>Quarterly report due 30 April 2004, 31 July 2004, 31 October 2004, 31 December 2004 # of Project Management Committee meetings</td>
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<td>• Continue Pilot Implementation to secondary sites by December 2003 • Data collection through implementation of the model with amendments to model as appropriate to the action research model • Data analysis and interpretation by October 2004 • A report is prepared for the Zonal Manager and Manager SNgHS by December 2004</td>
<td>Quarterly report due 30 April 2004, 31 July 2004, 31 October 2004, 31 December 2004 # of Project Management Committee meetings</td>
</tr>
</tbody>
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