In 2002 a project was initiated to evaluate and restructure the Child and Youth Mental Health (CYMH) services in three Health Service Districts: Cape York, the Torres Strait and Northern Peninsula Area and remote Cairns. The objective was to develop, establish and evaluate models of best practice for remote area CYMH services for Indigenous families living in far north Queensland. For the purposes of the project, an action research framework was adopted to guide the project design, methodology, implementation and evaluation. The first phase involved mapping of needs, the second phase focused on service restructure and outcomes were measured in the third phase. The planning/implementation/planning cycle was an ongoing part of the project and raised five significant themes: service equity, service quality, service sufficiency, Indigenous workforce, and service structure/infrastructure. The principal project outcome was the establishment of a defined model of service delivery that incorporates the identified themes and sits within a community development framework. Other significant outcomes include the implementation of regular supervision and professional development activities and improvements in service data collection. This paper is a descriptive account of the process of service restructure and discusses the key project outcomes.

**Key words:** Child and youth mental health, Models of service delivery, Service evaluation, Participatory action research, Remote area health, Indigenous health

Far north Queensland faces unique challenges in improving the mental health of children and young people. The region’s population is diverse, mobile and spread across rural and remote areas and regional centres. Demography and geography have specific implications for health service delivery, particularly in remote settings. Long distances, limited road access and seasonal variations contribute to making the provision of mental health outreach services time-consuming and costly. In the context of these difficulties and in recognition of the unmet Child and Youth Mental Health (CYMH) needs in remote far north Queensland, the University of Queensland and Queensland Health developed a partnership project “Rethinking Child and Youth Mental Health Service Delivery Models for Indigenous Children and Families Living in Far North Queensland” (Santhanam, 2005). The scope of the project encompasses three Queensland Health Service Districts which, combined, cover Cape York Peninsula and the Torres Strait. The area’s total population is approximately 25,000, the significant majority of whom are Indigenous Australians.

Commencing in 2002, the Project reviewed existing service effectiveness and explored alternate models of service delivery with a view to developing a best practice model for CYMH service delivery in remote communities of the region. Prior to the project, the Child and Youth Mental Health Service consisted of one full-time clinician to provide a service every 8 to 12 weeks to several remote areas in the Cairns and the Torres and Northern Peninsula Health Service District. The Cape York Health Service District did not receive any outreach CYMH service. Child and youth mental health services throughout the region were, thus, inconsistent, poorly supported and not well integrated with primary care activities. This paper describes the restructuring process of CYMH services to remote Indigenous communities as it occurred within the broader project framework and discusses key outcomes.

**Location and context**

To contextualise this paper it is worth considering the circumstances of one of the three health districts involved in this project. Cape York Health Service District covers 144,000 square kilometres, and is thus more than half the size of the state of Victoria, with a predominantly Indigenous population totalling some 10,000 people. It is a
region characterised by high levels of poverty and unemployment, poor health and educational outcomes and significant housing problems. While Cairns and the Torres Strait differ from Cape York in terms of geographic and demographic features, their Indigenous populations are also similarly disadvantaged. All communities have a disproportionate number of young people with the youth dependency ratio twice as high as for the wider Queensland population (Hunter, 1993). Consequently, there is a high level of need, reflecting the family and community stresses compounded by the paucity of non-clinical child services and facilities (such as child care, diversional activities and alternative vocational or educational opportunities), and high levels of morbidity and premature mortality (Harper et al., 2004). These factors reduce the availability of older generations for child and family support roles.

Clinical services for children are poorly developed. Predictably, the costs associated with supporting staff to work in such remote areas are high and there are structural inequities by discipline such as the Remote Area Nurses Incentive Package (RANIP) as compared to Allied Health salaries. Each community has a Queensland Health Primary Health Care facility. In addition there are several government and a few non-government organisations operating, by and large, through a centralised outreach model. Community infrastructure to support health improvement is poor with few recreational activities or training facilities.

Residential overcrowding is common. There are usually six to eight people sharing one house and it is not uncommon to see up to 13 residents for extended periods of time. Compounding the socioeconomic disadvantage of these populations are poor quality and high prices for basic sustenance items (Leonard, Zlotowski, & Harrison, 1997). However, most communities have access to either the coastline or the river, which allows limited dietary supplementation and recreation. While communities in the Torres Strait have a better-developed infrastructure, housing needs, health indices, quality education, employment opportunities, trade/vocational training, governance and autonomy remain significant challenges in both societies.

Methodology

Remote child and youth mental health services in far north Queensland function within a social context in which complex cultural, economic and historical determinants influence the mental health and wellbeing of children and families. For the purposes of the project, an action research framework was adopted to underpin the project design, methodology, implementation and evaluation.

As a method of social enquiry and praxis, action research has broad theoretical underpinnings. A diversity of perspectives has developed and the literature evidences the articulation of various sub-strands (Masters, 1995; Hughes, 2004). The restructuring of remote area CYMH occurred in terms of steps passing through cycles of planning, acting, observing, reflecting and evaluating. A critical feature was the “practitioner/researcher”—the clinician/practitioner and her/his work functioning both as the researcher and the researched. This demanded particular attention to reflective practice, which was supported in this project through a steering committee, practitioner supervision groups and local reference groups. The primary practitioner/researcher in this project interfaced at both research and practice levels with the CYMH service but was employed through an independent organisation (The University of Queensland).

Green (n.d.) defines participatory research as a “systematic inquiry, with the collaboration of those affected by the issue being studied, for purposes of...effecting change”. The process of service restructure in this project was not initiated as a result of an articulated need arising from the
remote Indigenous communities involved. The process can thus be considered an institutional "systematic inquiry". Consistent with Green's definition, it sought collaboration with those affected by the issue. In this case, the issue was the need to establish appropriate child and youth mental health services in remote Indigenous communities.

Although the project was not designed in discreet or defined stages, project phases emerged out of the action research process. In retrospect, it is possible to describe the project in terms of three phases, all of which were underlined by ongoing evaluation. These three phases are briefly defined in Table 1.

### Table 1: Project phases

**Phase one: Mapping**
During the Project's first year (2002) a project steering committee was formed and community resources and needs were systematically mapped across a range of child services in each community. Information was collected in terms of responses to the following questions:

- a) Who visits the community to work with children and from which organisation; that is, health, education, families etc?
- b) How often does this person/s visit?
- c) What is the capacity of the service; that is, how many positions (full-time or part-time) and how many are currently vacant?
- d) What do the service providers do in the community; for example, see children at school, talk to parents, talk to justice groups?
- e) How do they do it; that is, what framework do they use (e.g., counselling framework, educational assessments, legal assessment etc.)?
- f) What does the community know about the service; that is, names, contact numbers, visit dates of the service?
- g) How does the community use the service; that is, referrals and report process?
- h) Does the community participate in discussions regarding the service?
- i) Is the community able to decide whether they need more or less of the service?

Data sources included:
- individual and group interviews with community members identified through opportunistic sampling;
- 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;
- focus groups;
- audits of clinical workload (such as number of referrals, consultations and demands on practitioner time related to travel, client and family contact times and time spent engaged in community liaison);
- field notes and researcher/practitioner observations.

Community feedback highlighted that there was awareness, at least by some informants in most communities, that a CYMH outreach clinician visited the community. However, there was little clarity in terms of what that service provided and the means of access. Most informants associated CYMH workers with the Queensland Government Department of Child Safety and held fears related to the possibility of child notification, removal or foster care placement. This feedback also emphasised the fact that there was very limited community engagement, participation or control over CYMH issues and services. Also, communities were disinclined to use the term "mental health" due to reasons of stigma and prejudice associated with mental illness. In terms of service activities, a variety of outreach activities relating to child health occurred in every community. However, service providers reported that there was little coordination between providers and the services offered. Existent knowledge related mainly to crisis management and emergency evacuations. By comparison, there was a deficiency of general knowledge regarding developmental aspects of psychological wellbeing in children.

**Phase two: Service restructure**
The data collected through the mapping process were used to identify pilot sites for initial service restructuring. A number of factors were considered including:

- community need
- politics and infrastructure
- functional access
- existing local mental health resources and capacity.

The process of service restructure commenced in 2002 across the three Health Service District areas. The focus hereafter was both to ensure a basic service provision and continue the cycle of resource mapping, restructuring, evaluation and follow-up. Prior to the restructure, management and responsibility for remote area CYMH services was with Cairns Health Service District, Child and Youth Mental Health Service. Within that model the CYMH clinicians responsible for the metropolitan Cairns service were also required to travel to and provide services in remote communities.

Phase two involved the implementation of three core strategies. Firstly, the burden of doing both metropolitan and remote area work was removed and the existing remote area CYMH services were re-configured as an autonomous unit—the Remote Area Child and Youth Mental Health Service (RACYMHS). This enabled those responsible for remote area CYMH services to engage more meaningfully with remote area communities. Additionally, an Indigenous CYMH health worker position was allocated to the RACYMHS team to improve cultural appropriateness and enhance client access. The third strategy involved the implementation of workforce development activities focusing on individual and team supervision.

**Phase three: Evaluation and reframing**
The principle evaluation framework for the project was drawn from Pawson and Tilley's (1997) concept of "realistic evaluation", illustrated by the following equation:

\[ \text{Outcome} = \text{Context + Mechanism} \]

The context for the project was twofold:

1. The social, economic and cultural circumstances (importantly involving significant disadvantage) characterising remote Indigenous settings in far north Queensland.
2. The characteristics of health services (specifically mental health) operating in the region.

While the longer-term strategy is to improve social and emotional wellbeing, at this stage, the objective was to develop service capacity through ensuring service access, developing provider competencies and building Indigenous workforce. The mechanism, which resulted in restructure of the service, was an action research cycle engaging consumers, carers, community members, service providers, administrators and researchers in a dynamic process of incremental change.
Results

Five significant themes emerged from the planning/implementation/planning cycle. These themes are outlined below, accompanied by one or two examples describing how each theme informed “real” changes in practice.

Service equity

Resources do not ensure equity but are a critical precondition. In terms of resource allocation, conventional population-based models are clearly inadequate to address remote area child and youth mental health work. As an alternative approach, Mooney and Henry (2004) argue that equity will be better achieved if (a) “capacity to benefit” is used as the basis of need as opposed to the “sickness based” approach (b) the weighting of capacity to benefit reflects relative disadvantage, and (c) the concept of Management Economic Social and Human (MESH) infrastructure is considered in order to give effect to the recognition that not all communities are equally well placed to use funds to allow them to realise their capacity to benefit. Restructure of RACYMHS sought to move toward substantive equity by increasing outreach clinical visits. As a result of the restructure clinical visits to the remote Indigenous communities increased from once every three months to monthly, two-day visits. In addition to these improvements, the service sought to strengthen the community’s “capacity to benefit” by balancing clinical and community development work in response to existent community infrastructure. For example, in one community, RACYMHS tailored its activities to approximately 70% community capacity building and 30% clinical service provision. In some other communities this ratio was the reverse.

Service quality

In addition to benchmarks of clinical service quality, other critical elements include ensuring that services are relevant (to cultural and social circumstances), comprehensive (across the range of mental health needs from prevention and promotion to clinical care) and flexible (in order to accommodate the changing needs of children and families in these settings). Supporting service quality demands particular attention to communication across and within agencies, supervision formats, professional development, and innovation in conceptualising and operationalising performance indicators both for the service and for the workforce. As a result of the project implementation, the remote area CYMH services have steadily moved towards increasing community engagement and participation. The service framework is now broader, strengths-focused and community-centred. By comparison, the previous service model was clinically-based, symptom-driven and deficiency-focused.

The process of reflection and evaluation also led to conceptual shifts in terms of the outcomes that could be achieved within the given timeframe and available resources. This is reflected in the evolution of the name of the project. In 2002, the focus was on the establishment of a “best practice model”. By 2003 it became clear that adopting a “one size fits all” model across communities and districts would not be effective in addressing the differing needs of each community. The notion of a singular “best” was revised to “better” and the project was re-named “better practice models”. In order to more closely represent the active nature of maintaining and improving the current RACYMHS service, the project title was again revised in 2004 to “Rethinking CYMH delivery models for Indigenous Children and Families living in far north Queensland”.

Service sufficiency

Effectiveness demands not only services of high quality but that they are also sufficient in terms of staffing, frequency, predictability and sustainability. Defining levels of service sufficiency is an ongoing process that must take into consideration changing community infrastructure and existing community capacity building programs (including non-health-related programs). As a result of the restructure, all of the communities involved now have increased frequency and duration of visits. Further, the introduction of Indigenous health workers goes towards enhancing “cultural” sufficiency for Indigenous communities.

Indigenous workforce

Development and support of the Indigenous workforce is fundamental to providing appropriate, effective and sustainable remote area CYMH services. These workers have not only an invaluable role in the validation of cultural knowledge and continuation of culturally meaningful practices for a holistic health service, but they are also the
only “real voice” to advocate on behalf of their communities, to educate and challenge the systems’ policies and procedures. The current service model involves teams consisting of two workers—one Indigenous and one non-Indigenous. The role of the Indigenous worker focuses on prevention, health promotion and early intervention group, and community work. The Indigenous mental health workers within the team also act as powerful cultural mediators both for the community and for the service.

**Structure and infrastructure**

Mental health work in remote and Indigenous settings involves working across disciplines, organisations and sectors. Consequently there are significant issues relating to coordination and the development of effective working partnerships. Furthermore, despite the relatively small size of these remote Indigenous communities, there are significant hierarchical factors reflecting discipline, tenure and insider versus outsider status. Developing activities that are capable of addressing needs across the mental health spectrum of interventions thus demands structures that support communication and cooperation within and between institutional hierarchies (for instance between Indigenous health workers and service administrators). This is not only a matter of developing explicit service agreements (themselves important), but also of providing enabling mechanisms and resources including transport, accommodation, communication, supervision and so on. While such infrastructure may be taken for granted in metropolitan services, the nature of remote practice presents major logistical and financial challenges. One of the achievements of the project has been the establishment of clear lines of communication, full-time administrative support, and protocols to guide clinical documentation.

**Outcomes**

As part of a longer-term strategy to improve the social and emotional wellbeing of children living in remote Indigenous communities, this project sought to develop the capacity of remote area CYMH service delivery in far north Queensland. This included increasing workforce capacity, improving access and making the service more appropriate to the remote communities. In terms of service provision, the principal outcome has been the establishment of a defined service model for remote area Child and Youth Mental Health in remote Cairns, Cape York and the Torres Strait region. The next phase of the project will aim to compare the established service against national performance indicators.

Community feedback obtained during the mapping stage of the project identified the need for an appropriate and comprehensive service model to include early intervention, group work and community development activities, in addition to quality clinical interventions. In response, during 2002-2004, the number of remote area child and youth mental health workers increased from a solo worker to a team of five, including a full-time Indigenous health worker. The RACYMHS team is now led by a full-time practice supervisor who is also the project coordinator and a clinical practitioner.

As well as an increase in the number of CYMH workers, the implementation of regular supervision and professional development has provided a multi-dimensional approach to workforce capacity development, the aim being to ensure effectiveness and sustainability of the RACYMHS. Preliminary feedback from RACYMHS practitioners indicates that increased service autonomy has assisted in developing effective time management practices and that a community development framework and increased collaboration renders the service more appropriate to its client base. Regular supervision and professional development activities have led to greater practitioner confidence in meeting the demands of remote area work. The focus of professional peer supervision has been to engender a reflective stance in both the individual’s and team’s practice. It has also facilitated the development of shared understandings regarding the manner in which individual and service values sit within the institutional and broader sociopolitical context.

Another major service outcome has been a significant improvement in quantitative data collection. RACYMHS commenced operation as an autonomous unit in March 2004 and since that point has collected standardised Client Event Services Application (CESA) data for the service. Service data had been collected prior to 2004; however, the amalgamated nature of the previous
service model marred data interpretation. The Provision of Service (POS) data from CESA collected during 2004 has established a baseline for subsequent service monitoring. In addition, RACYMHS is developing its capacity to gather relevant qualitative indices such as community development activities and culturally appropriate outcome measures.

**Conclusion**

The paper describes the planning and implementation of an action research approach to restructure a health service. Remote area CYMH services operate in complex, politically sensitive settings and in areas characterised by high levels of poverty and unemployment, poor educational outcomes and housing problems. Application of action research methodology has proven a successful and practical approach to service restructure within a culturally diverse remote setting. Implementation of this approach requires the coordination of concurrent, multidimensional evaluation activities. The method does not conform to conventional, linear models of change or progress and thus provides theoretical and logistic challenges for the researcher.

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**References**


