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The frustration is that the model that the health system has is east and what the communities need is west.¹

¹ RACYMHS evaluation respondent (2006).
12. Appendices

A. Steering committee membership list
B. Evaluation committee minutes.
C. eCYMHS review documents
D. Interview consent form
E. Interview questions
F. Project newsletters
1. Acronyms and Key Terms

AMHS - Adult Mental Health Service
CESA - Consumer Event Service Application
CYMH - Child and Youth Mental Health
CYMHS - Child and Youth Mental Health Service
eCYMHS – Electronic Child and Youth Mental Health Service
IMHW – Indigenous Mental Health Worker
MSOAP - Medical Specialist Outreach Assistance Program
NGO – Non Government Organisation
PAR – Participatory Action Research
PHCC – Primary Health Care Centre
PI – Performance Indicators
RACYMHS - Remote Area Child and Youth Mental Health Service
RACYMHIW – Remote Area Child and Youth Mental Health Indigenous Worker
RAMH – Remote Area Mental Health
2. Location map

Figure 1: Major Indigenous communities in north Queensland. The outlined area shows the geographical scope of Remote Area Child and Youth Mental Health Service.
3. Executive summary

This report describes a pilot initiative to restructure remote area child and youth mental health service which begun in 2001. An extension of this project from 2005 to 2006 initiative built upon learnings from the earlier phases of the project, the aim being to enhance, develop and evaluate the remote area child and youth mental health service (RACYMHS).

The project operated across three health service districts, Cairns (the remote areas of Cooktown, Hopevale and Wujul Wujul); Cape York (Kowanyama, Pormpuraaw, Lockhart River, Aurukun, Napranum, Weipa, Old Mapoon and Coen) and Torres Strait (Thursday Island and Northern Peninsular Area which includes Injinoo, New Mapoon, Seisia, Umagico and Bamaga). Recurrent funding was provided by the Mental Health Branch, Queensland Health. The project’s service arm was located with Queensland Health, Cairns Integrated Mental Health (Remote Area Mental Health Team) and the research arm was located with North Queensland Health Equalities Promotion Unit under the School of Medicine at the University of Queensland.

The project used an action research framework and involved: adaptation of the national performance indicator template to the local service context; development of RACYMHS performance indicators; evaluation of the current service on the adapted performance indicators; data analyses from questionnaire feedback and practitioner narratives; refining RACYMH service model based on performance indicator implementation of professional development program for RACYMHS. The fundamental adaptation made to the national performance indicator template was the introduction of two concurrent, complementary yet intersecting streams of practice with the RACYMHS model: Community Engagement and
Clinical Care. Two other themes emerged as critical to the service model: 1) the role of RACYMH Indigenous worker, and; 2) ethical issues of practice.

The findings from this evaluation demonstrate the practicability of this model of service delivery and the importance of ongoing evaluation research to support sustained RACYMH service capacity, responsiveness and quality. It also suggests a process model for developing services for remote Indigenous populations in other areas of Queensland.
4. Introduction

4.1 Purpose of the report

The overall aim of the Remote Area Child and Youth Mental Health Service (RACYMHS) project, from its inception in November 2001, has been to improve and increase the capacity of RACYMHS delivery to Indigenous families living in far north Queensland. This report has been compiled to mark the end of the 2005 to 2006 RACYMHS project cycle and to provide a summary of the key achievements during this period. The key project developments during the 2005 to 2006 period were

1. The development of RACYMHS service Performance Indicators (PI)
2. A refining of the RACYMHS service model
3. Implementation and analysis of RACYMHS evaluation questionnaires and interviews
4. The implementation of the RACYMHS professional development program

Like the earlier phases, the 2005 – 2006 RACYMHS evaluation adopted an action research cycle of planning, collecting data, observing, reflecting and evaluating. The development of the RACYMHS PI was the result of a process of adaptation of the national Performance Indicator template to a remote area mental health service (Commonwealth of Australia, 2005).

4.1.1 How to read this report

Firstly, this report considers the current RACYMHS evaluation activities in the light of the previous RACYMHS project report and recommendations (Santhanam, 2005). Then the philosophical framework and policy context are outlined. Continuing from this, the RACYMHS program is described in terms of how it has functioned since remote area Child and Youth Mental Health services in far north Queensland underwent restructure during 2003.
The report outlines:

- The evaluation methodology
- The process involved in the adaptation of the national PI template to the local service context.
- Key service evaluation data sources. These included questionnaire feedback from Primary Health Care Centres, District Management, Collaborative Partners and narratives derived from semi-structured interviews with RACYMHS team members. These are presented in the form of a commentary accompanying the RACYMHS PI and definitions having been imported from the national Performance Indicator template.
- Implications of the RACYMHS evaluation results for service development. Following this, the recommendations reflect the key themes arising from the evaluation process. The recommendations also respond to the potential contribution which an action research framework could contribute to future RACYMHS service development. The overall aim is to share the lessons learnt and to strengthen service sustainability.

4.2 Background

In November 2001 a project partnership between Queensland Health and University of Queensland was initiated with the aim of establishing a remote area CYMH best practice service model for Indigenous families living in far north Queensland. The project objectives were 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 RACYMHS project adopted an action research approach. Details of this method of evaluation cycles (planning – action - reflection - feedback – planning) are outlined in the
report (Santhanam, 2005). During the project’s first year (2002) a steering committee was formed and community resources and needs were systematically mapped across a range of child services in each community. 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, political environment, infrastructure, functional access, existing local mental health resources and capacity.

The second phase, between 2002 and 2004, involved the restructure of remote area CYMHS services within the three Health Service District areas. The current RACYMHS service commenced operation in 2004, its establishment being the key outcome of the second phase of the project.

One of the recommendations from the second phase of the RACYMHS project was that RACYMHS continue to action research its service delivery model in order to build and enhance a clinically effective, socially valid and resource sustainable remote area team (Santhanam, 2005:7). Other key recommendations from the RACYMHS 2005 report included

- Enhancing service capacity; increasing the number RACYMHS workers and successful recruitment to these positions.
- Capacity building of skills and knowledge of the RACYMHS; over the last two years this has included the implementation and evaluation of professional development activities for RACYMH team.
- Engaging consumer and community participation. Evaluation and measurement of the impact of the service.
4.3. Theoretical/philosophical framework

The 2005 to 2006 RACYMHS evaluation has been influenced by Flyvberg’s approach to social inquiry (2001). Flyvberg’s central thesis is that the natural and social sciences make different, though complementary contributions to challenges facing society. Within this context Flyvbjerg explains that value-rational questions require ‘phronesis’ prudence or practical wisdom, involving “the analysis of values as a point of departure for action”. These questions are contrasted against those requiring the application of scientific and/or technical rationality, which fall within the purview and competence of Science. The implication for social research is that, in Aristotelian terms, a phronetic researcher aims for pragmatism, focuses on context, the variable or particular, as opposed to the universal and context-independent. In addition, a contemporary conception of phronesis cannot “be adequate…unless it confronts an analysis of power” [2001:88].

These theoretical insights influenced the process of evaluation in several ways. Firstly, they provided some of the philosophical basis of the RACYMHS evaluation. In terms of “value rationale questions”, the RACYMHS evaluation was asking the “where to now?” and sought to elicit information related to the situational ethics of remote area CYMH practice. They also afforded an explicit recognition of the complex position in which health practitioners (mostly non Indigenous) sit in relation to power when engaging with Indigenous Australians in remote settings. These power dynamics include those operating within local communities, the broader health care system and governmental policy directions.

Improving the health and wellbeing of Indigenous Australians is a major challenge to Australian society. Flyvberg’s distinction between Episteme (scientific knowledge), Techne (craft/art) and Phronesis (ethics and values) encouraged a conscious critique of the bio-
medical approach to service delivery and a re-contextualising of what a health service might look like where the express aim is to maintain cultural relevance to families in remote communities. This influenced the development of two complementary and intersecting streams of Community Engagement and Clinical Care within the RACYMHS Performance Indicators.

It is important to note that adopting Flyvberg’s approach does not involve a discounting of the role of RACYMHS as a specialist clinical service. Indeed, RACYMHS’ capacity to provide evidence based therapeutic interventions, such as family therapy, pharmacological therapy and/or behavioural management, rests upon Episteme. However, as has been illustrated in relation to the medication management for Indigenous Australians (Emden, Kowanko, de Crespigny and Murray, 2005), contextual considerations are pivotal to effective clinical care. For example, Emden et al make the point that “social and emotional wellbeing issues deeply pervade the lives of all Aboriginal people and seriously diminish the value that individuals place upon medications and the potential of these medicines to improve their quality of life” (2005:83). This becomes even more pertinent when dealing with children and young people.

In conclusion, the assumption is not that we need either phronesis or episteme or teche – rather, in the area of healthcare all three Aristotelian ‘intellectual virtues’ (Flyvberg, 2001:57), are required, in varying degrees, in any clinical situation. Hence, the value of interdisciplinary and inter-sectorial approach to health service delivery. The RACYMHS evaluation afforded the opportunity to explore or analyse alternative ways of providing a holistic clinical service with the aim of improving understanding and responses to the lives and CYMH needs of Indigenous families in remote settings.
4.4 Policy context

Three policy documents informed the RACYMHS evaluation during 2005 to 2006. These were:


3. *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research*. (National Health Medical Research Council, 2003)

1) *Strategic Policy for Aboriginal and Torres Strait Islander Children and Young People 2005 – 2010.*

Several of the principles articulated in this strategy are of particular relevance to RACYMHS aims and objectives and to the regional practice context. These can be summarised, as follows:

1.1 Cultural respect and reconciliation

Cultural beliefs must affect how services are planned, designed and delivered.

1.2 Rights of children to health care

All Aboriginal and Torres Strait Islander children will have access to services and carers who can support their health development and wellbeing, thereby ensuring early and effective interventions that increase their life chances.

1.3 Holistic community approach

This includes health promotion for children and young people that focuses on enhancing family, community, social, economic, and physical environments in which they live and
improving individual physical, spiritual, cultural, emotional and social wellbeing, community
capacity and governance.

1.4 Population-based approach

This includes maximising the scope, accessibility and acceptability of health services to those
who find it hard to attend owing to transport, financial, cultural or other barriers.

1.5 Building the capacity of health services and communities

Health services and communities need increased capacity to respond to health needs in an
evidence based way. This includes equipping staff effectively with appropriate cultural
knowledge and clinical expertise, building the indigenous workforce, and adopting service
delivery models that foster community leadership.

1.6 Needs-based resourcing

Funding levels needed to address children and young people’s health inequalities are
determined by using measures of need (for example socio-economic disadvantage, health
status and premature and avoidable mortality and morbidity) in the context of evidence based
practices and sound knowledge of local service systems.

The RACYMHS evaluation feedback obtained from primary health care staff, district
management staff, collaborative partners, stakeholders and RACYMHS team members
reflected the above principles. RACYMHS aims to observe these principles in its engagement
with families and communities within its capacity, scope and resources.
2) **Key Performance Indicators for Australian Public Mental Health Services**² (Key Performance Indicator report)

The *Key Performance Indicator report* is based on the National Health Performance Framework and is linked to the strategic directions of the *National Mental Health Plan 2003 – 2008*. It outlines a new performance indicator framework for evaluation of public mental health services and has been adopted as the template for the *RACYMHS Draft Performance Indicators (2006)*. It is important to note that the current national template focuses on performance indicators (PI), i.e., service indicators for initial trial within public mental health services. Within each domain the *Key Performance Indicator report* also provides a summary regarding what might be considered as appropriate indicators to be established during the next, or second phase of the national PI development process.

The *Key Performance Indicator report* outlines nine domains of service performance, as shown in figure 2 on the next page.

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² (NMHWG Information Strategy Committee Performance Indicator Drafting Group: 2005)
**Figure 2: Key performance Indicators for Australian Public Mental Health Services**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Sub Domain</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective</td>
<td>Consumer outcomes</td>
<td>★</td>
</tr>
<tr>
<td></td>
<td>Care outcomes</td>
<td>★</td>
</tr>
<tr>
<td></td>
<td>Community tenure</td>
<td>38 day re-admission rate</td>
</tr>
<tr>
<td>Appropriate</td>
<td>Compliance with standards</td>
<td>National Service Standards compliance</td>
</tr>
<tr>
<td></td>
<td>Relevance to client needs</td>
<td>★</td>
</tr>
<tr>
<td>Efficient</td>
<td>Inpatient care</td>
<td>* Cost per acute inpatient episode</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Average length of acute inpatient stay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Cost per 3 months community care period</td>
</tr>
<tr>
<td></td>
<td>Community care</td>
<td>* Treatment days per 3-month community care period</td>
</tr>
<tr>
<td>Accessible</td>
<td>Access for those in need</td>
<td>* Population receiving care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* New-client index</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Comparative area resources</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Local access to inpatient care</td>
</tr>
<tr>
<td></td>
<td>Local access</td>
<td>★</td>
</tr>
<tr>
<td></td>
<td>Emergency response</td>
<td>★</td>
</tr>
<tr>
<td>Continuous</td>
<td>Continuity between providers</td>
<td>★</td>
</tr>
<tr>
<td></td>
<td>Cross-riding continuity</td>
<td>★</td>
</tr>
<tr>
<td></td>
<td>Continuity over time</td>
<td>★</td>
</tr>
<tr>
<td>Responsive</td>
<td>Client perceptions of care</td>
<td>★</td>
</tr>
<tr>
<td></td>
<td>Consumer &amp; carer participation</td>
<td>★</td>
</tr>
<tr>
<td>Capable</td>
<td>Provider knowledge &amp; skill</td>
<td>★</td>
</tr>
<tr>
<td></td>
<td>Outcomes orientation</td>
<td>Outcomes readiness</td>
</tr>
<tr>
<td>Sustainable</td>
<td>Workforce planning</td>
<td>★</td>
</tr>
<tr>
<td></td>
<td>Training investment</td>
<td>★</td>
</tr>
<tr>
<td></td>
<td>Research investment</td>
<td>★</td>
</tr>
</tbody>
</table>

Key ★ = Phase 2 Indicators for development

*Key Performance Indicators for Australian Public Mental Health Services*
These nine domains are taken from the National Health Performance Indicators Framework, which “is intended for use at all levels of the health system – that is, for assessing an individual service or at higher levels of aggregation, such as State and Territory” (2005:6). The development of the RACYMHS Draft Performance Indicators (2006) required that the national Performance Indicators be adapted to capture the essential aspects of a child and youth mental health service provision in remote, Indigenous settings.

The process of development and rationale for the RACYMHS PI is addressed in the Methodology section of this report.

3) Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research.

This document provides guidance for the integration of the values and ethical standards of Aboriginal and Torres Strait Islander cultural groups when engaging, writing, developing and documenting research. It aims to enhance ethical relationships between Aboriginal and Torres Strait Islander Peoples and researchers. Within this framework, the six core values underpinning Aboriginal and Torres Strait Islander health research are Spirit & Integrity; Reciprocity; Respect; Equality; Survival & Protection and Responsibility.

These guidelines have informed the service framework both for service practice and service evaluation. It opened the space for critical reflection on how best to honour the values and ethics of community outcomes with service/clinical outcomes. Factors such as ‘reciprocity, responsibility’ have been carefully considered and integrated whereas others like ‘equality; spirit & integrity’ need richer and stronger links to health research, practice and vision.
5. RACYMHS Program Description

5.2.1 Service location and structure

RACYMHS is based in Cairns and operates as an outreach service, encompassing Cape York, the Torres Strait and Northern Peninsula Area and remote areas of the Cairns Health Service District in far north Queensland (see Figure One). The service shares office space with the Remote Area Adult Mental Health Service (both remote area C&Y and Adult MH services are a component of Cairns Integrated Mental Health Service District) and the North Queensland Health Equalities Promotion Unit, University of Queensland. This co-location allows for active networking and collaboration. The uniqueness of this environment also encourages a community of ‘inquiry’ that underpins service delivery impacts and policy implications. Additionally, it affords practitioners, across teams and disciplines, the opportunity to discuss and debate ‘big picture’, systems issues, frustrations, aspirations and to participate in joint planning activities. The morale-boosting value of ‘corridor ethical discussions’ and mutual support cannot be underestimated. The RACYMHS/RAMH team structure is shown in figure 3.
The RACYMHS service model

The aims and objectives of RACYMHS are to:

- Provide specialist Child and Youth Mental Health Services in designated remote Indigenous communities in far north Queensland.
- Promote the social and emotional wellbeing of children and young people.
- Participate and provide leadership in CYMH health promotion and prevention activities.
- Actively contribute to service evaluation activities.
- Adopt an advocacy role for the target population based on available evidence of community and consumer needs.
- Conduct CYMHS related professional development activities for Queensland Health staff and other relevant service providers, stakeholders and community groups.
• Establish and maintain a best practice CYMH service model for remote and Indigenous communities in far north Queensland.
• Foster a collaborative practice model as defined in the Primary Clinical Care Manual³.
• Advocate for and support the development of the indigenous CYMH workforce.
• Establish a model that may be of value or replicated in other MH services in rural and remote northern Queensland

RACYMHS has also articulated the following practice themes:
• To improve political and social understanding of clinical issues in remote Indigenous settings.
• To promote opportunities for culturally appropriate care for the consumers, families and communities.
• To have families and communities interests at the forefront of clinical practice.
• To build relationships with parents and community members.
• To understand the relationship between people and the environment they live in.
• To strengthen collaborative partnerships and mutual knowledge transfer between Indigenous and non-Indigenous workers.
• To acknowledge the cultural and spiritual dimensions of health and health practice.

³ The collaborative practice relationship incorporates the dual notions of collaboration and delegation. The defining characteristics of the collaborative practice relationship are:
• mutual respect and acknowledgment of each profession’s role, scope of practice and unique contribution to health outcomes
• clearly stated protocols and guidelines for clinical decision-making which comply with relevant legislation and are supported by the health facility and the health organisation
• clearly defined levels of accountability with an acceptance that joint clinical decision-making is an integral component of collaborative practice
• a belief that the best health outcomes are achieved when well prepared health professionals work in collaboration and partnership in both the practice and educational setting. Queensland Health and the Royal Flying Doctor Service (Queensland Section). (4th Edition, 2005) pg vii.
• To take the responsibility for integrating ethical standards and values of ATSI communities while participating in research.

RACYMHS practice is underpinned by the nexus between health status and human rights. As Rees et al (2004) notes “an inadequate realisation of human rights with respect to Indigenous Australians is illustrated by deficient health status, high unemployment rates, lower than average living standards, lower educational status and inadequate participation in political decision making”.

Child and Youth Mental Health Services in the Northern Area were subject to review during 2005 (Rogan: 2005). Rogan noted that CYMH services “operate within an environment where there are few alternative health services with less participation by the NGO sector compared to Brisbane and fewer local General Practitioners, or great distances to access services” (2005:pg). These issues are accentuated in remote areas where factors such as long distances, limited road access and seasonal variations contribute to making the provision of mental health outreach services time consuming and costly. In addition, 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 (Santhanam, Hunter, Wilkinson, Whiteford and McEwan, 2006).

Rogan (2005) states that the lack of relevant support services and service alternatives in the Northern Area means that “CYMHS practitioners often operate in isolation or in small groups and may not be delivering appropriate services (responding to crises rather than a promotion/prevention model)”. This observation is consistent with feedback obtained during the RACYMHS project mapping stage in 2002. Extensive community consultation identified the
need for an appropriate and comprehensive remote area CYMH service model to include early intervention, group work and community development activities, in addition to quality clinical interventions.

In light of this feedback and through a series of service restructuring process, RACYMH service increased capacity from a single worker to a team of eight. RACYMHS currently features teams of two workers: one Indigenous Health Worker and one Clinician, dedicated to three to four communities across the three districts: remote Cairns; Cape York and the Torres area. Team One provides service to Hopevale, Wujul Wujal Cooktown and Pormpuraaw; Team Two services Weipa, Napranum, Coen and Aurukun and the third team (operationally responsible to Torres district and located on Thursday Island) services Thursday Island and Northern Peninsula Area. The RACYMHS team is led by a full-time clinical and practice supervisor who is also the project coordinator and a clinical practitioner. This position is responsible for the provision of clinical services to Kowanyama and Lockhart River. A permanent full time team leader position funded in 2004 was to operationally manage Remote Area Mental Health service, including the adult and child & youth teams.

Each RACYMH team visits its designated communities once a month, for between one and four days. The length of time spent in each community is dependent on the size of the community and current need. Team duties during community visits include consumer assessment, follow-up, community education, community liaison, facilitation of community group work, local staff education and support. The RACYMH Indigenous worker is responsible for the cultural aspects of consumer and family assessments and mediates across the community, families and RACYMHS workers. Clinical and community engagement activities are shared within each team. However, at this stage, the clinician undertakes the
majority of clinical work and the Indigenous worker focuses on community engagement activities. There is substantial overlap between these facets of service activity. As a consequence, the clinician and Indigenous health worker work side-by-side. Between visits RACYMHS maintains contact with communities via phone and email on the basis of need. An example of a monthly schedule for a RACYMHS team member is shown in table 1.

Table 1: Typical Monthly RACYMHS schedule

<table>
<thead>
<tr>
<th>Week One</th>
<th>Monday – Weipa</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tuesday – Napranum</td>
</tr>
<tr>
<td></td>
<td>Wednesday – Coen</td>
</tr>
<tr>
<td></td>
<td>Thursday – Napranum</td>
</tr>
<tr>
<td>Week Two</td>
<td>Monday – Friday: Cairns</td>
</tr>
<tr>
<td>Week Three</td>
<td>Monday – Thursday</td>
</tr>
<tr>
<td></td>
<td>Aurukun</td>
</tr>
<tr>
<td>Week Four</td>
<td>Monday – Friday: Cairns</td>
</tr>
</tbody>
</table>

A wide range of professional development activities have been implemented following the establishment of RACYMHS and development of critical mass. These include:

- regular weekly clinical supervision,
- monthly peer group supervision,
- cultural mentoring for RACYMH Indigenous workers,
- regular needs based training and skills building workshops
- regional and national conferences.
RACYMHS regularly receives requests from government and non-government agencies for training and guidance on remote area mental health. RACYMHS team members provide peer supervision and educational sessions for remote practitioners, including school guidance, life promotion officers, health workers, clinic staff, police and members of justice groups. Formalised agreements have been negotiated for the RACYMHS clinical supervisor to provide regular monthly supervision for the Community Development Centre Cooktown (CDCC); Senior Guidance Officers, Education Queensland and for the Kowanyama Healing Centre counsellors.

In keeping with the intent of the initial project methodology (see earlier report, Santhanam, 2005), the service utilises action research to guide service development. The increased resource capacity and professional development programs have strengthened RACYMHS’ ability to develop effective relationships with communities. It is through these relationships that the service assesses community needs and engages in prevention and health promotion work.

**RACYMHS service model commentary and service snapshot**

The RACYMHS service model illustrated in figure 4 was developed as part of 2005 - 2006 RACYMHS evaluation. The diagram represents the service dynamics, which are framed by participatory action research (PAR). The PAR framework allows for the identification and integration of emerging evidence as to community need and service outcomes. The service model also recognises the role of supervision in professional and service development.
Within the RACYMHS model the child (consumer) is at the heart of the service. All dimensions of activity and interaction occur with the aim of supporting and enhancing the child’s social and emotional wellbeing. The following vignettes and comments made by RACYMHS team members provide a snapshot of the breadth and tenor of current RACYMHS activities in remote communities. They point to some of the challenges inherent in RACYMH work and capture the essential aspects of the service model in terms of practitioner experience.

**One: looking at the entire fabric**
“When we get a referral for someone to assist, you know, someone might think they have a mental illness but I’m looking at the entire fabric of the context that person lives in, the community, some family connections”

**Two: crisis intervention**
“A lot of your interventions are about dealing with crisis rather than genuinely impacting on a person’s life choice and direction, particularly with the serious mental illnesses where you’re intervening and trying to keep people out of hospital …your best intentions can sometimes fall over”

**Three: supporting cultural expressions of grief and loss**
“Following a death in the community and its effect on a particular child our intervention was to talk to key players at the local healing centre. As a cultural expression of grief, there were signs used to show the areas which could not be entered following the death of this person. The signs used were yellow tapes. However, the child was distressed seeing this everyday as the signs had been in place for 5 months. We were wondering if there was a way to change this to something less obvious, such as branches, twigs, leaves placed around the areas. One of us spoke to the child’s grandfather and the other to his aunts regarding this”

**Five: doing good works for the community**
“The other thing is mainly doing community building – trying to do good works for the community, trying to involve others in the community, getting involved in activities, whatever is culturally friendly for them, whether they want to do some things on domestic violence or…child protection…or mental health – just networking”

**Six: you gotta go and build a relationship with the sisters**
“You gotta go and build a relationship with the sisters……they’re the ones that look at you and sus you out and say…where is she from, they do background tracing on you before they even engage with you…that can take a long time. They usually do that to make sure that they’re safe…you can trust her”
6. Methodology

6.1. Project reporting mechanisms

The project was reported via regular steering and through the distribution of RACYMHS project newsletters (see appendix A and F). The RACYMHS Steering committee was reconvened for the third stage of the RACYMHS project in March 2005. Between March 2005 and December 2006 the committee meet at six monthly intervals. The objectives of the Steering Committee were to “guide the project at a general level, oversight of everyday activities and to provide a place to bring problems, successes and to seek guidance”. Between January 2005 and December 2006 there were several changes to organisational and departmental representation. For example, the position of chairperson changed, with Mr Kevin Freele, Executive Director, Cairns Integrated Mental Health Services, agreeing to adopt this role in January 2006. At times, changes in representation required that some services be contacted prior to the meeting to identify an appropriate person to attend. The project officer would then provide the relevant background information to the identified representative. The RACYMHS evaluation committee provided another avenue for reporting and reflecting on the project (appendix B).

The RACYMHS project team consisted of Radhika Santhanam, RACYMHS/ University of Queensland and Alexandra McEwan, Senior Research Officer, University of Queensland (Oct 2005 – Jan 2007). The Senior Research Officer position provided coordination and implementation of research based activities. Additional duties included administrative support for the evaluation and steering committee meetings and project newsletters. The newsletters were distributed to steering committee members (including Torres Strait district) and Cape York community contact via Apunipima Cape York Health Council at six monthly intervals.
6.2 Evaluation committee

During 2005 to 2006, the role of the evaluation committee provided support and advice on methodological issues. Members of the RACYMHS evaluation advisory committee consisted of: Melissa Haswell-Elkins, Chair of Mental Health, North Queensland Health Equalities Promotion Unit (NQHEPU), School of Medicine, University of Queensland, Cairns and Komla Tsey, Associate Professor, School of Australian Indigenous Studies/School of Public Health and Tropical Medicine, James Cook University, Cairns.

Advice was also sought from Dr Darryl Doessel, Associate Professor, Health Economics, Policy and Economics Group QCMHR, University of Queensland, and Dr Ernest Hunter, Regional Psychiatrist, Queensland Health.

Evaluation Committee agenda items included

- identifying an evaluation framework
- formulating categories of service measurement
- defining the service measurement categories
- development of draft RACYMHS Performance Indicators
- review of questionnaires and interview questions
- transcript and feedback analysis
- data interpretation
- review of the draft RACYMH model of service
- final evaluation report


Since the submission of the first RACYMHS report in January 2005, the key project achievements have been:
1. Development of RACYMHS Performance Indicators (PI).

2. The development, implementation of evaluation tools and data analysis: questionnaires and RACYMHS team interviews.

3. Refining of the RACYMH service model and PI based on data analysis.

4. Implementation of RACYMHS Professional Development program.

5. Evaluation of RACYMHS Professional Development program.

Evaluation questionnaires were distributed to Primary Health Care Centres, District Contacts and Collaborative Partners. A set of evaluation interview questions were used to obtain feedback from RACYMHS team members. The development of the RACYMHS PI can be considered both a key project outcome and a form of service evaluation.

6.4. The action research approach

Consistent with the January 2005 report recommendations, the evaluation during 2005 and 2006 was conducted as action research. Generally, action research takes the form of iterative cycles of planning, acting, observing, reflecting and evaluating.

A critical feature of the RACYMHS evaluation has been the “practitioner-researcher”, in this case, the clinician/practitioner and her work functioned both as the researcher and the researched. This demanded particular attention to reflective practice, which was supported through the RACYMHS steering committee, practitioner supervision groups and local reference groups. In this case Radhika Santhanam, worked within the Queensland Health system as a primary practitioner/researcher operating at both research and practice levels with RACYMHS and was employed through an independent organization, The University of Queensland.
6.5. Development of RACYMHS Performance Indicators

6.5.1 Choosing the national template

A significant part of the 2005 to 2006 evaluation was devoted to the development of service specific Performance Indicators (PI). The RACYMHS PI was developed in consultation with the RACYMHS evaluation committee and in conjunction with the findings from the earlier phases of the project (2001 – 2004). RACYMHS PI has been adapted from the *Key Performance Indicators for Australian Public Mental Health Services (Key Performance Indicator report)* (Commonwealth of Australia, 2005).

The RACYMHS evaluation committee recommended that the *Key Performance Indictor report* be adopted as the evaluation framework. The *Key Performance Indictor report*, in turn, provided pragmatic rationale for adapting the national Performance Indicators to the local service context:

“The use of performance indicators and the movement towards benchmarking is becoming routine in the Australian health care system. The challenge for the mental health sector is to develop a set of meaningful performance measures and to develop the culture and processes so that benchmarking becomes the norm” (Eagar, Burgess and Buckingham, 2003 in NMHW 2005: viii)

The decision to develop PI for RACYMHS was consolidated as a result of an evaluation committee workshop. Associate Professor Darrel Doessel, University of Queensland, assisted the committee in developing of a set of evaluation equations and several service element definitions. These elements and equations served as analytical tools and influenced the structure of the RACYMHS Performance Indicators. For example, in considering how to define ‘Clinical Care’ it was necessary to identify, for the purpose of service measurement,
what aspects of service provision would be included in and excluded from this category (see appendix B)

6.5.2 Adaptation of the National Performance Indicator template to the local service context

The development of the RACYMHS PI involved three inter-connected processes. Firstly, a clear and thorough reading and understanding of the national document *Key Performance Indicator report*. This document offers a sufficiently comprehensive model for monitoring the performance of mental health services. It identifies nine domains. Each of the nine domains represent a broad area of concern relevant to health service performance such that, within any domain it is necessary to specify further levels of detail as a first step towards indicator development. For example, the domain Responsiveness covers the concept of respect for consumer dignity and choice, promptness etc. Each of these may be the subject of one or more indicators. For the majority of domains, the national document identifies key sub domains relevant to the delivery of mental health services. Each sub domain can be regarded as describing a topic of concern, or the most salient aspects of organisation performance.

The second step was a process of reflective discussion, collation of earlier findings, and the formulation of draft PIs within the evaluation committee. Following this, the feedback obtained from questionnaires and interviews was utilised to assess RACYMHS performance in line with some of the draft indicators and finally to refine the RACYMHS Performance Indicators.

The initial evaluation meeting occurred in November 2005 and involved a discussion regarding the relevance of the *Key Performance Indicator report* and identification of the RACYMHS evaluation equations. It appeared that the National Performance Indicator sub-
domains and indicators focused on inpatient care and that the service measurement dimensions assumed a bio-medical approach to health care provision. The focus on specialised public clinical mental health is recognised in the *Key Performance Indicator report* (2005:19). Therefore, the challenge for RACYMHS was to develop indicators that would capture the broader type of service provision required in remote, indigenous settings with a comparable level of rigour and reliability. In this respect the *Key Performance Indicator report* was helpful in providing a commentary of intended interpretation of each domain, sub-domain and service indicator. As an example, Table 2 outlines some of the main points regarding the interpretation of the ‘Effective’ domain.⁴

**Table 2: Summary of Effective domain (summary)⁵**

<table>
<thead>
<tr>
<th>Level of specificity</th>
<th>Meaning</th>
<th>Interpretative comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain</td>
<td>Effectiveness:</td>
<td>Widely recognised as presenting the most complex area for indicator development.</td>
</tr>
<tr>
<td></td>
<td>“care, intervention or action achieves desired outcome in an appropriate timeframe”</td>
<td>Multiple levels of measurement e.g. whole populations, service systems or level of consumer.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Multiple outcome sub-domains: the concept of outcome has multiple dimensions.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Multiple perspectives on outcomes – ask the question ‘according to whom?’ Consider different perspectives e.g. consumer and clinicians.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Multiple timeframes: an outcome may be initial, intermediate or long-term.</td>
</tr>
</tbody>
</table>

⁴ This table is not intended to completely reproduce the original document content on this point. It is illustrative only and the reader is referred to the original document for further information.
Sub-domain

1. Consumer outcomes: measures the impact of health care on the consumer’s clinical status and functioning.
2. Community tenure: extent to which MH services are effective at maintaining consumers in the community.

| Performance Indicator | Community tenure | 28 day readmission rates, i.e. unplanned early returns from hospitals following discharge |

6.5.2.1 RACYMHS PI - Articulation of the Community Engagement and Clinical Care streams

The fundamental adaptations made to the national PI template was, the establishment of two concurrent, complementary and intersecting streams of practice within the RACYMHS model: Community Development and Clinical Care.

The Community Engagement and Clinical Care streams sit between the nine national ‘Domain’ and ‘Sub-domain’ levels of performance measurement. Table 3 outlines the details and provides a comparative analysis with the national template. There are several reasons for the incorporation of these two streams into the RACYMHS PI. Firstly, the current RACYMHS model of care was established in response to a process of broad community consultation, which occurred during 2002 and 2003. Community feedback indicated a need for a culturally appropriate and contextually sensitive yet comprehensive service model to include early intervention, group work and community development activities, in addition to quality care interventions. In order to respond to this the RACYMHS model of care integrates non-clinical activities aimed at facilitating community participation in service development and responses to community needs as they arise. One example is working closely with justice group elders or community members in times of crisis, such as the trauma the community experiences following a suicide or a riot. Adding these two streams also served to visually...
represent the differences between what ‘service performance’ might mean within a secondary or tertiary health care setting and the nature of remote health care service provision. The difference between these contexts is the manner in which the notion of holism is integrated into health care practice. Although hospital based care and indicators may generate meaningful measurements though focusing upon the individual, this can be conceptually problematic in relation to the delivery of health care services in remote Indigenous communities.

In the current Social and Emotional Well Being Framework (Cth of Australia: 2004) the concept of ‘connectedness’ and ‘community’ are fundamental to Indigenous concepts of individual health and healing. Wellness of an individual is related to ‘wholeness’ i.e., totality of the person’s experience and the environment that holds the person. This has particular resonance when considering children and young people in whom health, illness, growth and development are most tangibly determined by connectedness with significant others. These two steams also link to the principle of a ‘holistic community approach’ expressed in the Strategic Policy for Aboriginal and Torres Strait Islander Children and Young People 2005 – 2010.
<table>
<thead>
<tr>
<th>National domain</th>
<th>RACYMHS streams</th>
<th>RACYMHS sub-domain</th>
<th>National sub-domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective</td>
<td>Community Engagement</td>
<td>Consumer related</td>
<td>Consumer outcomes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Service related</td>
<td>Carer outcomes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Community Tenure</td>
</tr>
<tr>
<td>Appropriate</td>
<td>Community Engagement</td>
<td>Compliance with standards for community engagement and cultural safety</td>
<td>Compliance with standards</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Care is relevant to consumer needs</td>
<td>Relevance to consumer needs</td>
</tr>
<tr>
<td>Efficient</td>
<td>Community Engagement</td>
<td>Cost of service provision</td>
<td>Inpatient care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cost effectiveness of service programs</td>
<td>Community Care</td>
</tr>
<tr>
<td>Accessible</td>
<td>Community Engagement</td>
<td>Access for those in need/local access</td>
<td>Access for those in need</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Emergency response</td>
<td>Local access</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Emergency response</td>
</tr>
<tr>
<td>Continuous</td>
<td>Community Engagement</td>
<td>Continuity between providers</td>
<td>Continuity between providers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Continuity over time</td>
<td>Cross-setting continuity</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Continuity over time</td>
</tr>
<tr>
<td>Responsive</td>
<td>Community Engagement</td>
<td>Consumer and family perceptions of service</td>
<td>Consumer perceptions of care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Perception of service by relevant workers and stakeholders</td>
<td>Consumer and carer participation</td>
</tr>
<tr>
<td>Capable</td>
<td>Community Engagement</td>
<td>Provider knowledge and skill</td>
<td>Provider knowledge and skill</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Service capacity and core competencies</td>
<td>Outcomes orientation</td>
</tr>
<tr>
<td>Safe</td>
<td>Community Engagement</td>
<td>Consumer related</td>
<td>Nil noted</td>
</tr>
<tr>
<td></td>
<td>Clinical Care</td>
<td>Service provider related</td>
<td></td>
</tr>
<tr>
<td>Sustainable</td>
<td>Individual service related</td>
<td>Workforce Planning and development</td>
<td>Workforce planning</td>
</tr>
<tr>
<td></td>
<td>Systems related (area, regional, national)</td>
<td>Research Investment</td>
<td>Training investment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Research investment</td>
</tr>
</tbody>
</table>
6.5.2.2 Indicators

Having identified the sub-domains for each domain, the next task was to decide upon the RACYMHS Performance Indicators. The following factors were considered in order to establish parameters around the type of indicators that would be feasible. These considerations were:

- RACYMHS is at an early stage of service development. Consequently, the context in which the indicators were developed was within a broad establishment phase and as a result the evaluation focused on service measurement rather than consumer outcomes.
- Consumer Event Service Application (CESA) and Provision of Service (POS) data are the systems currently available to determine the usability for service assessment. Ongoing challenges related to data collection and measurement also influenced the decision to focus on service measurements (Santhanam, 2005).
- Linking the information obtained through the questionnaires and interviews to the RACYMHS Performance Indicators.
- Incorporating the concept of ‘holism’ into the RACYMHS Performance Indicators. This lead to inclusion of indicators relating to the involvement of parents, aunties etc in consumer care.
- Reflecting a commitment to service collaboration and partnerships in communities, across government and non government agencies, and research institutes.
- Identifying items that were too complex to measure at this stage. For example, the concept of “Efficiency” and the question as to what mixture of activities in what proportions are required to maximise outcomes. Efficiency is a comparative concept and relate to what actions provide the best outcomes for the specific cost. One of the major challenges in remote work is the cost associated with providing services. As a new service RACYMHS has no framework for measurement efficiency. In order to measure this domain...
RACYMHS would need to develop baseline data. The RACYMHS PI under Efficiency therefore includes indicators which aim to create baseline measurements for the service.

- As RACYMHS evaluation evolved it became evident that the limited timeframe, resources and, in some instances, the lack of, or limited access to necessary data, meant that many of the specific RACYMHS indicators were ‘aspirational’- in the sense that although they could not be measured within the current evaluation cycle, they were considered important service indicators for the future.

### 6.6 Questionnaires

RACYMHS Evaluation questionnaires were sent to three groups:

1. Stakeholders including collaborative partners,
2. District management and
3. Primary Health Care Centres (PHCC).

The Primary Health Care Centre and District Contact questionnaires requested feedback on RACYMHS’ performance under four of the nine National Mental Health Performance Indicator domains. The four domains included were Effective, Sustainable, Accessible and Appropriate.\(^6\) This was in addition to general issues of service delivery. The stakeholders’ questionnaire focused on the collaborative processes and did not include questions explicitly related to the domains. Nonetheless, many of the responses did fall within these domains.

**Developing the questionnaires**

Draft questionnaires were developed by the project team for the Stakeholders/Collaborative Partners, District Contacts and Primary Health Care Centres. Professor Harvey Whiteford (personal communication: 13 March, 2006) provided advice informing the project team that

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the national Performance Indicator domains were not intended to be hierarchical. However, there were some that seemed more relevant than others when completing an initial service evaluation and more likely to elicit feedback than others. These chosen domains seemed to capture the fundamental requirements of a newly established service and which, when considered from the perspective of a remote area worker, had immediate relevance and meaning. These were reviewed by the evaluation committee. From this process came the recommendation that the questions be triangulated with the national Performance Indicator domains and were evaluated to determine which domains were addressed within the existing questions. Respondents were then asked to consider RACYMHS’ performance within the context of formal definitions of the domains as well (for more clarification see appendix E for the different questionnaires).

A total of 30 questionnaires were distributed in hard copy, accompanied by a covering letter and an addressed return-envelope. To optimise the number returned, an email reminder was sent approximately one month after questionnaire distribution. After a further fortnight a phone call reminder was made. A second phone reminder for those still outstanding was made in November 2006. The numbers of questionnaires received are current at 14th December 2006.
<table>
<thead>
<tr>
<th>Questionnaire distribution</th>
<th>Number received</th>
</tr>
</thead>
<tbody>
<tr>
<td>District Contacts (n = 7)</td>
<td>2</td>
</tr>
<tr>
<td>Torres and NPA HSD (2)</td>
<td></td>
</tr>
<tr>
<td>Cairns HSD (3)</td>
<td></td>
</tr>
<tr>
<td>Cape York HSD (2)</td>
<td></td>
</tr>
<tr>
<td><strong>Primary Health Care Centres (PHCCC) (n = 10)</strong></td>
<td>8</td>
</tr>
<tr>
<td>Aurukun PHCC (1)</td>
<td></td>
</tr>
<tr>
<td>Coen PHCC (1)</td>
<td></td>
</tr>
<tr>
<td>Cooktown Multipurpose Health Centre (1)</td>
<td></td>
</tr>
<tr>
<td>Hopevale PHCC (1)</td>
<td></td>
</tr>
<tr>
<td>Lockhart River PHCC (1)</td>
<td></td>
</tr>
<tr>
<td>Kowanyama PHCC (1)</td>
<td></td>
</tr>
<tr>
<td>Napranum PHCC (1)</td>
<td></td>
</tr>
<tr>
<td>Pormpuraaw PHCC (1)</td>
<td></td>
</tr>
<tr>
<td>Weipa Hospital (1)</td>
<td></td>
</tr>
<tr>
<td>Wujal Wujal PHC (1)</td>
<td></td>
</tr>
<tr>
<td><strong>Collaborative partners (n = 14)</strong></td>
<td>8</td>
</tr>
<tr>
<td>Apunipima Cape York Health Council Aboriginal Corporation (1)</td>
<td></td>
</tr>
<tr>
<td>Cairns Base Hospital Mental Health Unit (1)</td>
<td></td>
</tr>
<tr>
<td>Cape York Family Violence Prevention Legal Unit (1)</td>
<td></td>
</tr>
<tr>
<td>Department of Child Safety (2)</td>
<td></td>
</tr>
<tr>
<td>Disability Services Qld (1)</td>
<td></td>
</tr>
<tr>
<td>Education Queensland School Guidance Officers (3)</td>
<td></td>
</tr>
<tr>
<td>Queensland Health Indigenous Mental Health Co-ordinator, Northern Zone (1)</td>
<td></td>
</tr>
<tr>
<td>Remote Area Mental Health (1)</td>
<td></td>
</tr>
<tr>
<td>Royal Flying Doctor Service (2)</td>
<td></td>
</tr>
<tr>
<td>Wu Chopperen Health Service (1)</td>
<td></td>
</tr>
</tbody>
</table>
**Questionnaire analysis**

On receipt of each completed questionnaire, the responses were sorted into themes which identified four targeted domains (Effective, Sustainable, Accessible and Appropriate). Additional themes that emerged which did not yield themselves to be grouped under any existing domain were also recorded. Questionnaire respondents were asked to indicate what they believed to be the essential competencies for CYMH workers in remote areas. Hence, one of the questionnaire themes was “essential competencies”. Feedback on this topic was entered into this theme box whether or not the response was given to this. After the theme summary document was completed the data was then linked to the RACYMHS performance indicators. This data was also used to review and refine the RACYMHS PI.

The preliminary findings arising from the questionnaire analysis were presented to the evaluation committee for review. Feedback from this meeting assisted in categorising the data and identifying the framework in which to report the results.

### 6.7 Interviews

In addition to feedback obtained via questionnaire, all RACYMHS team members and one past team member were interviewed. The interviews were semi-structured and sought to elicit information related to the current model of service, ethical dimensions of remote area practice, professional development needs and service development (see appendix E – Interview questions for Practitioners).

In preparation, the role of the interviews within the RACYMHS evaluation was discussed with team members. After an interview appointment was made, the interview questions were emailed to the interviewee. All those approached agreed to be interviewed and provided
written consent. The RACYMHS evaluation interview questions are attached in appendix (E) along with the consent form (appendix D). The interview recordings were audio-taped and transcribed. A total of seven practitioners were interviewed. In view of the small sample size, confidentiality could not be ensured and thus the interview analysis is not attached to this report.

**Interview analysis**

Interviews with RACYMHS team members resulted in the collection of detailed narratives related to remote area child and youth mental health practice. Each interview was analysed in terms of the RACYMHS performance indicators. During the process of analysis it became apparent that some of the information provided in the interviews articulated key aspects of service activity which had not been included in the draft RACYMHS PI. For example, the interviews highlighted the crucial role of the RACYMH Indigenous worker and the need for collaborative practice. Consequently RACYMHS PI needed to reflect this component in a robust way. Thus, for example, this led to the inclusion of a performance indicator under the domain, Appropriate, within the Clinical Care stream “RACYMH Indigenous worker is regularly involved in consumer/family assessment, management and care” explicitly.

Although the interviews provide feedback on some of the RACYMHS PI, the key value of the interview data was its contribution to clarifying and refining the current service model. It also ensured that directions for service development were developed as part of a collective, participatory process. The main themes arising from the interviews were:

- The role of the Indigenous health worker
- Professional development needs
- The ethical challenges faced by remote area CYMH workers
• Mentorship and team cohesion
• Community engagement
• Worker motivation and longevity
• Succession planning

6.8. RACYMHS Professional development program

6.8.1. Supervision

During the first and second phase of the RACYMHS project, there was an identified need in relation to clinical and professional supervision (Santhanam, 2005:81–84). Subsequent to this finding a supervision framework was developed and introduced into the RACYMHS service model. The current approach to supervision is based on social constructionist theory (Fook, 2003; Bobele et al, 1995). This involves reflective practice, in which the practitioner’s daily practice and decisions are examined and explored in order to identify assumptions which may be limiting skills development and to draw upon qualities such as creativity and intuition in practice. The approach also acknowledges, following Flyvberg’s approach (2001), that ethical practice must take into consideration issues of social, cultural and political power and recognise the health practitioner’s role within such dynamics. There is evidence that a strong supervision structure is necessary to support the development of a reflective and proficient mental health workforce (Queensland Health, 2004).

The RACYMHS supervision structure has three facets. The first is weekly team supervision, during which there is an emphasis on integrating clinical (includes diagnostic formulation) issues within the social and cultural context and to synthesise the various forms of knowledge each practitioner brings as it relates to the child, family, environment and the issues at hand. These sessions generally are in the form of discussion and debate around the complexities of a clinical case.
The second facet of the RACYMHS supervision program occurs as a monthly peer group reflection. The group consists of remote area practitioners from different agencies, such as Royal Flying Doctor Service, Allied health team; Cape York Family Violence Legal Prevention Unit; Senior Guidance officers from Department of Education and the RACYMH team, usually involving 10 to 12 people. The discussions take a broader scope, connecting practice with the “big picture”, systems complexities with worker’s values, ethics and practice outcomes. This group is effectively a community of inquiry and the aim is to articulate and to develop a collective advocacy voice in addition to having the opportunity to knowledge pool.

The third facet of RACYMHS supervision is ‘cultural mentoring’. This program commenced in response to a need, identified by RACYMHS Indigenous workers, for a regular opportunity to reflect upon their role, responsibilities and aspirations under the guidance of an Indigenous elder. A cultural elder was chosen by the Indigenous RACYMHS team members. Following this, an agreement was negotiated in relation to funding, consultancy fees, frequency of sessions and feedback methods. The program commenced, on a monthly basis, in August 2006.

6.8.2 Professional Development Workshops

The RACYMHS Professional Development program is guided by the two principles: a team approach and applicability of development activities to practice on the ground. On this basis and through regular feedback mechanisms, four workshops were conducted in Cairns during the 2005 to 2006 period:
1. Supporting foster carers in therapy using childhood attachment models. This was a two day workshop conducted July 2005 by Megan Chambers, Child Psychiatrist, Redbank House, New South Wales.

2. Respectful and Ethical Practice: An invitational approach for intervention with men and young men who have engaged in violence and abusive behaviour. This was a two day workshop conducted in November 2005 by Allan Jenkins and Rod Hall, NADA Counselling services, South Australia.

3. BITSS – Protective behaviours, one day workshop in April 2006 by Megan Bayliss, Director Imaginif Pty Ltd.

4. Gender and Culture Accountability – Learnings from Just Therapy team, a two day workshop in Oct 2006 by Charles Waldegrave and Taimalie Tamasese, Just Therapy Centre, New Zealand.

6.8.3 Other Training and Conferences

In September 2006, RACYMHS staff attended the ‘Creating Futures: Influencing social determinants of mental health and wellbeing in rural, Indigenous and Island Peoples’. This was an international conference held in Cairns, under the auspices of the Royal Australian and New Zealand College of Psychiatrists, Social and Cultural Psychiatry Section. At this conference, a few papers were presented by the RACYHMS team.

In addition to national or international conferences that individual practitioners may choose to attend, RACYMHS attempts to provide at least one professional development activity per year which the team can attend as a group. For example in March 2006 the whole team attended a professional development seminar entitled ‘Working with Children and Autistic Spectrum Disorders’ (organised by PsychoOz publications and presented by Diane Yapko, Speech-language pathologist, California) in Brisbane.
6.8.4 Specialist Support; Medical Specialist Outreach Assistance Program (MSOAP) and Electronic Child and Youth Mental Health Service (eCYMHS)

RACYMHS has had regular access to RAMH psychiatrists who service the three districts. And this has proved particular valuable during crisis times, where cases have compounding complex issues and for urgent onsite consultations. In addition, in 2005 the child and youth psychiatrist from CYMHS, Cairns provided consultation as and when requested by RACYMHS. The Townsville forensic child and youth psychiatrist has been utilised by RACYMHS to provide forensic and crisis support. RACYMHS participates extensively on co-managing / sharing / supporting remote area consumers when they are engaged with Cairns service providers, this includes consumers admitted to Cairns Base Hospital and other community interventions. This same consumer management strategy applies to Townsville service providers, but to a lesser extent.

During the first and second phase of the RACYMHS project MSOAP funding was utilised to provide RACYMHS increased access to Child Psychiatry services (Santhanam, 2005: appendix 10). During 2006, MSOAP funding was devolved to eCYMHS. During this period eCYMHS trial focused on the Cape York district and provided clinical support for RACYMHS workers who serviced communities in Western Cape York. The services provided were monthly video conferences and on-site visits by a child psychiatrist three times a year and each trip lasting for a week. The eCYMHS program was reviewed in October 2006. The review occurred via consultation with Cape York District Health Service, key stakeholders from Northern Area, RACYMHS practitioners and RAMH team. (see appendix C)
7. Results

The results of the RACYMHS evaluation drew upon a variety of data sources. These included the feedback obtained via the questionnaires, interviews and discussions related to the development of the RACYMHS Draft Performance Indicators and other tools, such as the evaluation questionnaires. The latter form of feedback arose within the context of the steering committee, the evaluation committee and RACYMHS team meetings. The data was expanded as a result of reviewing/consulting relevant literature.

7.1 Results summary

The significant results arising from the RACYMHS evaluation were:

1. The establishment the RACYMHS PI.

2. Assessment of current RACYMHS performance against the draft RACYMHS PI.

The results of the data analysis can be summarised under the domain headings as follows:

Effective

Generally responses indicated that RACYMHS was perceived as an effective service within its current capacity. There were no comments made suggesting that the service was not performing effectively. Areas for development include decreasing client waiting times. The lack of stable medical staff was cited as a barrier to effective referral and collaboration for client follow up in remote areas.

Appropriate

Respondents made general comments that RACYMHS operated in an appropriate manner. The need to deliver care within the context of the family and to involve the Indigenous health worker in culturally valid family and client assessments emerged as important themes.

Efficient

Performance Indicators were developed though not measured within this evaluation phase.
Accessible
General comments on accessibility indicated that the RACYMHS “staff are approachable and amicable”, service visits are more regular and that flexible service provision occurs “and is appreciated”. Feedback indicated that a consistent presence over a substantial period of time is required to ensure PHC awareness and familiarity with RACYMHS outreach workers. Relationship between RACYMHS Indigenous health workers and Primary Health Care Centres needs to be strengthened.

Continuous
One of the factors mentioned several times was mismanagement of flights and travel arrangements.
There was substantial comment recognising increases in the frequency and regularity of community visits. Overall, the feedback indicated a general awareness regarding RACYMHS’ regular community visits and presence within the communities, especially among Primary Health Care Centre staff in remote areas. One respondent identified a need for a person to be identified as a “back up contact for urgent advice”. Following this, areas for future attention include liaising with the travel department to improve reliability and ensuring all PHC workers and other relevant agencies are aware of RACYMHS emergency contact numbers.

Responsive
In general, the feedback indicated that RACYMHS is well regarded and trusted by other service providers and remote area peers. There was one comment that RACYMHS needs to “increase its response to community needs”.

Capable
Within the 2005 – 2006 evaluation, the feedback focused on provider knowledge and skills in relation to three areas: clinical, community engagement and community development. Activities related to Community Development (CD) were seen as competency for CYMH workers in remote areas. Those undertaking studies or training in this area require local mentoring. Community Development activities must be balanced with clinical responsibilities. Professional development activities including regular supervision have resulted in improvements in RACYMHS worker confidence and problem solving skills. It was suggested that similar programs are required for workers located in remote areas.

Safe

Performance Indicators were developed though not measured within this evaluation phase. The development of PI within this domain emphasised the concept of cultural safety and professional development in the area of reducing risk both for workers and consumers.

Sustainable

There was large amount of feedback related to service sustainability. Generally, comments in relation to sustainability linked service sustainability with service capacity. Combined, the feedback provides a clarion call for further increases in skilled RACYMH human service capacity in far north Queensland. A need for a remote area Child and Youth Psychiatrist for far north Queensland was also identified.

3. Refinement of the RACYMH service model

The action research process of data collection, reflection and review led to conceptual shifts and clarification of RACYMHS’s role and what was achievable within the current resources. The refinement is the explicit articulation of Community Engagement as a core activity for RACYMH service model.

4. Evaluation of professional development activities
The evaluation of the RACYMHS supervision has been integrated into the broader professional development activities evaluation. This is specifically referred to under the Capable domain, Community Engagement stream (b).

The following results from the questionnaire and interview feedback are presented in the form of a commentary that accompanies RACYMHS Performance Indicators. The Primary Health Care and District Contact questionnaires specifically requested feedback on four of these domains: Effective, Appropriate, Accessible and Sustainable. However, the feedback presented is not confined to the responses to these questions and incorporates feedback on these domains given in response to other questions and during RACYMHS team interviews.
7.2 RACYMHS Performance Indicators and
summary of the themes arising from RACYMHS evaluation
questionnaires and interviews
MHS Performance Indicators

Effective: ‘care, intervention or action achieves desired outcome in an appropriate timeframe’

Community Engagement (CE)

Clinical Care (CC)

Consumer related

Service related

a) Evidence of interagency networking
b) Evidence of inter-sectorial collaboration
c) Participation in community group work
d) Connecting consumers to community mentors
e) Facilitating involvement of young people in community activities

a) Appropriate referral mechanisms in place
b) Increase in POS
c) Duration of POS
d) Timely access to service
e) Decreased emergency evacuations
f) Documented care plan in place for each consumer
g) Regular feedback sought from collaborative partners in consumer care
h) Family assessments and therapeutic interventions consider relevant social determinants
Effective

Care, intervention or action achieves desired outcome in an appropriate timeframe

General responses indicated that RACYMHS was perceived as an effective service. One respondent stated RACYMHS “overall operates effectively within its capacity”.

Community Engagement stream (CE)

CE a) evidence of inter-agency networking

There was substantial comment indicating that the service was effective in terms of inter-sectorial collaboration. Other feedback focused upon the need to understand how groups exercising statutory powers interacted with one another in the field and that at times there was a sense of working at cross purposes.

School Guidance Officers were mentioned as a source of referrals.

Lack of stability of medical staff in remote locations such as Weipa Hospital was mentioned as a barrier to effective referral and collaboration for client follow-up.

CE b) Participation in community group work

It was noted that RACYMHS was having success working with young women in one community. Feedback from the RACYMHS team reflected efforts to involve others in the community and to actively seek involvement in community activities. Within these community groups concerns have been raised regarding the burden that many female elders carry in relation to the provision of support and care to generations of children.

Clinical Care stream (CC)

CC a) appropriate referral mechanisms in place

There was substantial comment indicating the existence of appropriate referral mechanisms.

These referral mechanisms included initial client assessments, development of management plans and clinical case review. Referrals from schools, mothers or grandmothers were mentioned.
CC d) timely access to service

The feedback varied regarding timely access to service. There was recognition that RACYMHS was “helpful in an emergency”, was “there when needed” and had “increased the frequency of its visits to certain locations”. However, there was also comment that “clients want immediate access” and of “long waiting periods in the communities”.
MHS Performance Indicators

**Appropriate:** ‘care intervention or action provided is relevant to the client’s needs and based on established standards’

- Community Engagement (CE)
- Clinical Care (CC)

**Compliance with standards for community engagement and cultural safety**

- Staff demonstrate competency re cultural protocol for community engagement
- Staff understand concept of Cultural Safety
- Outcomes of community engagement activities are documented

**Care is relevance to client’s needs**

- Culturally appropriate information and resources used in interactions with consumers and carers
- Service assesses need for interpreter/elder
- Clinical assessments and interventions comply with established protocol
- RACYMHIW is regularly involved in client assessment/care
- Regular clinical audits CESA and Outcomes
- Care is delivered within the family context
Appropriate

Care, intervention or action provided is relevant to the client’s needs and based on established standards

Respondents made general comments that RACYMHS operated in an appropriate manner. One of the response was “as a resource and via direct clinical care – improved appropriateness”.

Clinical Care stream (CC)

CC d) RACYMHIW is regularly involved in client assessment and care

This PI emerged directly from RACYMHS evaluation feedback and expressly integrates the Indigenous health worker into cultural assessments and client management and was included in response to feedback regarding the central role of the Indigenous health worker within the RACYMH service model.

It is notable that, on review of the national PI discussion on appropriateness, this PI is consistent with the suggestion that future indicators could be designed to monitor “the extent to which services for Indigenous consumers are facilitated by Indigenous mental health workers” (Commonwealth of Australia, 2005). This alignment between the locally developed PI and those suggested by the national Performance Indicator Drafting Group (Commonwealth of Australia, 2005) goes some way toward affirming the effectiveness and appropriateness of the action research method in the development of local service PIs.

On respondent stated “I think the family should be first seen by the Indigenous health worker” to engage the family and understand the family history, cultural things prior to a formal clinical assessment. The Indigenous health worker would then be in a position to co-facilitate clinical meetings with families and clinicians. The aim is for “carers to feel comfortable when they are working with a non-Indigenous clinician”.

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This PI could be measured within the next evaluation cycle via clinical audits and team reporting mechanisms.

**CC f) care is delivered within the family context**

This emerged as an important theme, with several respondents noting RACYMHS’ role in providing support to family members and collaborative work with other agencies in follow-up of family members of child clients. The feedback from RACYMHS team members reflected this, in comments such as “my main role is to engage families”, “ask, what is needed for the family in this situation” and “always try and bring the parents/carers in”.
Efficient: ‘achieving desired results with the most cost effective use of resources’

- **Community Engagement (CE)**
  - Cost of service provision
    - a) Cost assessment of clinical vs CE activities for RACYMHS workers
    - b) Estimated funding ratio for clinicians vs community development practitioners?

- **Clinical Care (CC)**
  - Cost effectiveness of service programs
    - a) Cost of individual community visits
    - b) Cost effectiveness of alternative technologies e.g. eCYMHS
    - c) Cost per client care episode estimated
    - d) Compare cost of onsite worker with outreach model
Efficient:

Achieving desired results with the most cost effective use of resources

RACYMHS Performance indicators within the domain of Efficiency were not assessed within the 2005 – 2006 evaluation cycle. This domain was the topic of discussion within the RACYMHS evaluation committee. One of the major challenges in remote area health care is the cost involved in the provision of services and the cost effectiveness of resources allocated to programs from outside (eg, eCYMHS) to support RACYMHS. The lack of appropriate framework in which to measure RACYMHS performance in relation to the cost effectiveness of establishing and sustaining an expanding service is one of the issues that RACYMHS currently faces as a result of being in an establishment phase. In the first phase of the project there was one full time clinical position funded for three districts. Since then the service has steadily grown to include two full time clinical positions and two full time Indigenous health worker positions, a team leader and a full time clinical & research supervisor position. It is also relevant to note that within the national framework, no phase 1 indicators have been developed for non-acute or residential services (2005:30) for cost analysis.

Although feedback from respondents did not assist in assessing RACYMHS Efficiency PI it did assist in refining the development of the RACMYHS PI indicators and which dimensions of service delivery would be appropriate for measurement in the future. For example, it would be useful to develop a base line estimate of the costs related to community engagement/development activities versus clinician interventions within each RACYMHS position, and to compare the cost of onsite RACYMHS work (as in Thursday Island) with those involved in an outreach model (as in Cooktown).
**MHS Performance Indicators**

**Accessible:** ‘ability of people to obtain health care at the right place and right time irrespective of income, physical location and cultural background’

- **Community Engagement**
  - Access for those in need/ local access
  
  a) RACYMHS has provided training to PHC staff on early intervention, signs of possible MH issues and appropriate referral
  b) comm. organisations in remote settings eg, justice groups, women’s shelter, aware of RACYMHS (e.g. contact details, travel schedule)
  c) Referral pathways/communication between RACYMHS and other child health agencies.
  d) PHCC staff awareness of RACYMHS
  e) Participation by parents, peers and carers in client management

- **Clinical Care**

  a) Time-line of RACYMHS response to mental health crisis
  b). Risk assessment protocols, flow charts, triage etc for CYMH crisis response.
  c). Documentation, feedback, case management and follow up procedures clearly outlined.

- **Emergency response**
Accessible

Ability of people to obtain health care at the right place and right time irrespective of income, physical location and cultural background

General comments on accessibility indicated that the RACYMHS “staff are approachable and amicable”, service visits are more regular and that flexible service provision occurs “and is appreciated”. There was also mention of long waiting periods to be seen by RACYMHS in some communities.

Community Engagement stream (CE)

CE (b) community organisations in remote settings aware of RACYMHS

From the RACYMHS team perspective “its been hard trying to get the message…what we do and what we’re there for…not only for people in the community but for other services as well”.

Community organisation awareness of RACYMHS was reflected in comments such as “I know that RACYMHS communicates with the Life Promotion officers” and that there has been an “increase in referrals from external sources e.g. justice groups”.

CE (c) referral pathways/communication between RACYMHS and other child health agencies

Existent referral pathways include referral of youth issues to RACYMHS; creation of management plan, the provision of a “great” service to “our troubled students” and RACYMHS’ participation in a Child Development working group. It was suggested that RACYMHS could assist the Department of Sport and Recreation Department with school age camps and other programs planned for 2007.

CE (d) PHCC staff awareness of RACYMHS

Feedback indicated that a consistent presence over a substantial period of time is required to ensure PHC awareness and familiarity with RACYMHS outreach workers.
Feedback indicated that for Indigenous mental health workers contact with PHC workers in community generally takes the form of “just a brief introduction”. More generally, the ongoing pattern of outreach workers and other services visiting remote communities means that in some cases residential remote area health professional may perceive RACYMHS workers in terms of “it’s just one of those people coming in coming out….it won’ be long and she won’t be coming”. It was suggested that over a longer period resident remote colleagues perceive outreach staff as having more credibility.

The comments indicated a general awareness of RACYMHS among PHCC staff and that “RACYMHS liaise with staff as well as clients” when present in the community and at other times via phone.
MHS Performance Indicators

Continuous: ‘Ability to provide uninterrupted, coordinated care or service across programs, practitioners, organisations and levels over time’

Community Engagement

Clinical Care

Continuity between providers

Continuity over time (across the course of an illness)

a) Initial contact time after referral and post discharge from hospital
b) All clients discharged from CBH have a discharge management plan and copy is sent to RACY MHS.
c) Evidence of regular liaison between RACYMHS, PHC and other relevant specialists e.g. DCS/schools etc
d) Participation in relevant network groups (e.g. child health) for client care

a) Regular case reviews (CESA)
b) Timely documentation and follow-up reports
c) Evidence of inter-sectorial collaboration in client care plans
d) Visits occur as per schedule
e) Use of ‘Outcomes’ database
Continuous:

Ability to provide uninterrupted, coordinated care or service across programs, practitioners, organisations and levels over time

One of the factors which impacts on continuity of service provision and which was mentioned by more than one respondent was flights being “mismanaged” and travel arrangements not being confirmed on time. Another commented “you have to be flexible and patient…our travel is not always running smoothly”.

Community Engagement stream (CE)

CE (c) evidence of regular liaison between RACYMHS, PHCC and relevant specialists e.g. Schools, Department of Community Services

There was substantial comment recognising increases in the frequency and regularity of RACYMHS visits, for example, “the increase in time spent in the community is beneficial”, “increase in RACYMHS presence in the community”, “regular visits” “RACYMHS spends 3-4 days per month in the community”. This regularity of service provision was reiterated by the RACYMH team “our team is very consistent with community trips….except in cyclones nothing holds us back”. On the other hand, there were comments that “once every month or three weeks is not sustainable” and that there were times when there was no worker available.

Overall, the feedback indicated a general awareness regarding RACYMHS’ regular community visits and presence within the communities, especially among Primary Health Care Centre staff in remote areas. One respondent stated “previously would only know they [RACYMHS] were in the community when someone saw them out and about I am not sure whether their service delivery to the clients has changed or not, but we have more relevant contact with them than we did previously”. Community contact and liaison is also influenced by shifts in community need. For example, one respondent noted an increase in services following a “suicide crisis” in one community.
In terms of liaison there was feedback on the length of time it takes to “build relationships with Indigenous people who are already working in the system”.

Clinical Care (CC)

CC a) and b) Regular CESA reviews and timely documentation.

There has been a significant improvement in recording, monitoring and documenting reports and other relevant information. This has occurred through regular supervision sessions and through review meeting with District management. The RAMH team leader’s position has been instrumental in overseeing these processes.
MHS Performance Indicators

**Responsive:** ‘service provides respect for persons and is client orientated. Includes respect for dignity, confidentiality, participation in choices, promptness, quality of amenities, access to social support networks, and choice of provider’

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**Community Engagement**

- Client and family perceptions of service
  - a) Appropriate evaluation of consumer and/or carer perceptions of the service
  - b) Incorporation of cultural and social norms in clinical and collegial practice
  - c) Ensuring clients are given information regarding available options/alternative resources

**Clinical Care**

- Perception of service by relevant workers and stakeholders
  - a) Interviews/ survey regarding perceptions of service responsiveness for PHC staff and other relevant community stakeholders and agencies
  - b) CESA/OUTCOMES data results
  - c) Complaints are dealt with in a timely manner discrimination
  - d) Integration of cultural models of care
Responsive:

Service provides respect for persons and is client orientated. Includes respect for dignity, confidentiality, participation in choices, promptness, quality of amenities, access to social support networks, and choice of provider

One of the sub-domains for Responsiveness is ‘client and family perceptions of care’. The 2005 to 2006 RACYMHS evaluation focused upon developing and measuring service performance, rather than client or carer perceptions of service performance. For this reason the questionnaires did not specifically focus on Responsiveness. The limited amount of feedback regarding this domain is therefore consistent with the approach to the service evaluation. Even so, the questionnaires and interviews did provide some indication as to RACYMHS performance in terms of Responsiveness.

Clinical Care stream (CC)

CC (a) interviews /survey re perceptions of service responsiveness for PHCC and other relevant community stakeholders and agencies.

Some of the comments which fell within the domain of Responsiveness included “No discrimination at any time” and “Mental health care is accessible, affordable and appropriate. This is made possible because the RACYMHS workers are dedicated and have a real understanding of the community”. Those consulted also mentioned respect for the professionalism of RACYMHS and service reliability: “Trust that RACYMHS will always follow through”. There was comment that RACYMHS needs “to increase its response to community need”.

Practitioners responsiveness in the context of remote CYMHS requires flexibility and the breadth of RACYMHS activities within remote communities provided evidence of service responsiveness. Some examples include comments that RACYMHS demonstrates “team flexibility to meet community needs”. “Sometimes it needs to be earthy contact with real
issues like food in your belly…you don’t have good food in your belly you don’t stay awake in class, you don’t learn, your brains not functioning” and “I’ve developed to the point where I come from a solution orientation and I want to work in an environment that is about solutions., yes, it [the situation] is difficult”. 
**MHS Performance Indicators**

**Capable**: ‘An individual’s or service’s capacity to provide a health service based on skills and knowledge’

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**Community Engagement**

- Provider knowledge and skills
  - a) Identification of needs, priorities and strategies for professional development to work in remote Indigenous settings
  - b) Regular individual and peer supervision
  - c) Worker capacity reflect community needs
  - d) Indigenous cultural advisors/consultant for the team
  - e) Cultural mentoring structure in place.
  - f) Capacity building of stakeholders re CYMH

**Clinical Care**

- Service capacity and core competencies
  - a) Staff are recruited on basis of core competencies criteria in job description
  - b) Regular supervision monitors and facilitates learning
  - c) Staff competence in responding to crisis, clinical presentations and community engagement
  - d) Roles and lines of communication within RAMHS are clearly defined
  - e) CESA and OUTCOMES
**Capable**

**An individual’s or service’s capacity to provide a health service based on skills and knowledge**

Feedback tended to focus on provider knowledge and skills in relation to community engagement and community development. This is understandable as questionnaire respondents were asked their perception as to the role of Community Development in remote area CYMH work. Generally, comments were very positive in regards to RACYMHS’ current capacity. For example “There is understanding of RACYMHS’ skills”, “staff have the appropriate skills”, “the work of RACYMHS is highly valued”, “the RACYMHIW is good” and “RACYMHS has a role in capacity building other agency staff”.

**Community Engagement (CE)**

**CE (a) identification of needs, priorities and strategies for professional activities**

As this Performance Indicator sits under the Community Engagement stream the feedback obtained in relation to this aspect of service provision was summarised in order to develop a profile of the type of professional development activities that RACYMHS might initiate, co-facilitate or undertake over the next year or two.

Activities related to Community Development were seen as a competency for CYMH and an essential element within the RACYMHS model. Some respondents identified that those undertaking studies or training in Community Development (CD) require locally based mentoring. In relation to Community Development one respondent stated “if RACYMHS is to continue to view its role as one containing a CD practice then…its capacity to deliver needs serious review to enable such CD approaches”. Training undertaken in the area of CD would need to be balanced against the need to develop clinical skills. These have to be complementary in nature and not viewed as substitutive.
Several respondents emphasised a need within remote communities for CYMH education, health promotion and early prevention activities, including prevention of dual diagnosis. There was also a suggestion that a monthly or bi-monthly clinical case conference /review meeting be established between the RAMH teams i.e., adult and child and youth.

**Clinical Care (CC)**

**CC d) Staff competence in responding to crisis and clinical presentations**

RACYMHS team members reported improvements in confidence and problem solving skills. There was feedback that “the team is professional and everything is on time and structured” and of increased accountability.

**CE (b) regular individual and peer supervision activities**

The importance of supervision was validated in both questionnaires and interviews. Some of the feedback regarding the role of supervision included “need clinical supervision for remote workers” and “communities need good role models and support groups”. There was recognition of RACYMHS’ role in joint facilitation of the peer group supervision network.

The structured supervision for the team has improved performance in several service areas, for example:

“My file notes have improved as a result of…supervision….I have probably gained a lot from supervision as far as diagnosis and therapeutic supervision”. “the cultural supervision , that’s working really well….that need to be ongoing, health workers need to keep getting cultural supervision as well as peer supervision and with the clinician, [health workers] need to be really involved in cultural training”. “I actually wouldn’t want to do this work if I didn’t have that [supervision] support. It is important that you always have someone who is doing the Indigenous work, as well as the clinical work”. “I have gained a great deal, particularly through clinical supervision….I gained a better understanding of my strengths and weaknesses”.

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“All the ongoing supervision that’s really made me grow”. “I suggest regular reflective debriefing amongst our team as an extraordinary strength”.
MHS Performance Indicators

Safe: ‘The avoidance or reduction to acceptable limits of actual or potential harm from health care management or the environment in which health care is delivered.

Community Engagement

Client related

a) Evidence of service advocacy for safety/security for children within serviced communities
b) Safe transport of clients
c) Cultural engagement protocol includes cultural safety
d) Parenting skills education includes keeping children safe
e) RAMH safety protocols are followed during home visits and clinical consultations
f) Community member is present at all CYMH group activities involving children

Clinical Care

Service provider related

a) Staff have received training in aggressive behaviour management
b) Staff have received training in managing the suicidal client
c) Staff receives psychological support and debriefing post traumatic events
d) Staff demonstrates competence/compliance re cultural safety protocols.
e) Team members demonstrate competency in community engagement and group facilitation
Safe:

The avoidance or reduction to acceptable limits of actual or potential harm from health care management or the environment in which health care is delivered

At the time of publication of the Key Performance Indicator report the national PI Drafting Group had deferred consideration of the Safety domain (2005:37) and awaited the development of a National Mental Health Safety Policy, Framework and Action Plan by the Safety and Quality in Mental Health Partnership Group.

This domain was not assessed within this evaluation cycle. In addition to indicators related to client care the RACYMHS PI also emphasised the concept of cultural safety and worker professional development in the area of reducing risk for clients and within episodes of client contact. RACYMHS has current safety protocols for example, in relation to mobile phones, home visits, and consultations with children. RACYMHS orientation also includes a range of resources that inform, and educate on cultural protocols for engagement with Indigenous communities, for example, One Talk (Queensland Health, 2005); ‘Bringing them home’ report (Commonwealth, 1997); Our right to take responsibility (Pearson, 2000).

Some aspects of cultural safety practices were mentioned by RACYMHS workers during the evaluation “during sorry time you don’t go into communities…its not respectful to go to the community as an outsider during sorry time” and “I am more wary about covering my body instead of leaving it open…its important for indigenous people, especially Indigenous women”.

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**MHS Performance Indicators**

**Sustainable**: ‘System or organisation’s capacity to provide infrastructure such as workforce, facilities and equipment, and be innovative and respond to emerging needs’

**Workforce planning and development (WPD)**

**Research Investment (RI)**

**Individual service related**

**Systems related (area, regional, national)**

- a) Expedient recruitment of vacant RACYMHS positions
- b) Evidence that performance appraisals have been completed in the last 12 months.
- c) A needs based professional development plan has been developed and includes essential competencies
- d) Evidence that professional development activities are evaluated
- e) Recurrent funding is available for professional development activities
- f) Job satisfaction and motivation
- g) RACYMHS has the infrastructure to support workers when they do remote travel eg. Mobile phones

- a) Service develops by a process of regular evaluation utilising an action research approach.
- b) Service evaluation informs professional development plan and activities
- c) Service develops qualitative indicators for measurement of community outcomes
Sustainable:

System or organisation’s capacity to provide infrastructure such as workforce, facilities and equipment, and be innovative and respond to emerging needs

Generally, comments in relation to sustainability linked service sustainability with service capacity. The feedback calls for a substantial increase in skilled CYMH human service capacity in far north Queensland, as is evident in the following comments:

- Need another clinical and Advanced health worker position to decrease workload
- Need funding for a Child and Youth Psychiatrist to support remote area work.
- Need a position to be based in Cooktown
- Often no MH trained nurses at PHCC
- Need mental health workers on the ground and based in the community instead of visiting from another centre/town
- Need more IHW around the Cape to improve collaboration
- Need to get a bigger team ……more people and more Indigenous staff

WPD a) Expedient recruitment of vacant RACYMHS positions

There was acknowledgement that it is difficult to recruit people with the necessary CYMH skills. One of the reasons for staying in the job was that the experience led to greater employment opportunities.

WPD e) job satisfaction and motivation

All the feedback on this Performance Indicator comes from the RACYMH team interviews. A question related to this PI was included in the RACYMHS team interview questions

The evaluation feedback indicated that generally it took some time for a RACYMHS worker to develop a sense of job satisfaction.

Factors cited as enhancing job satisfaction included

- Rapport with the community
- The challenges association with remote area work are not available in the mainstream.
• Being well managed by supervisors
• One’s spouse being comfortable with the amount of time their partner spends away from home.
• Three years as an appropriate period of time in a given position for worker longevity “it seems 2 – 3 years, that’s the maximum we can expect”
• Getting feedback from other professionals
• Pay – increases in bank account
• Gaining knowledge

Issues detracting from job satisfaction
• Being personally affected by conflict in the community or workplace
• Voicing opinions regarding issues and observing no change in the issue
• Lack of support for workers on the ground
• Having to go away from your family.
• Exhaustion associated with travel “you are sleeping in different beds all the time…I would wake up and I think, ‘where am I, which community am I in’?”

WPD f) less staff turnover

Perceptions ranged from those that observed that positions seemed to be filled for other than brief periods to comments that there were ‘lots of new faces on the job’. An objective assessment of this PI would require an audit of RACYMHS employment records.

RI a) Service evaluation informs professional development plan and activities

Within this evaluation cycle the focus was on the competencies required for remote area CYMH work and the definition of worker roles and scope of practice. Much of the feedback consisted of the identification of the type of values required for effective work in remote settings.

These were, gaining trust and confidence of the people; flexibility; understanding and empathy; respect for and from local staff; non-judgmental behaviour; listening and communication skills; to be known in the community and a willingness to work hard.
With regards to the type of skills needed, community development skills were identified as a key skill. In addition the following were iterated: Versatility in dealing with problems; relationship building; advocacy skills - to mobilise other services to develop the skills of the individual and negotiation skills.

With regards to ethical and personal values, cultural sensitivity emerged as a critical theme. For example:

- In depth awareness and appreciation of indigenous culture
- To have a good understanding of the Community and its people, the resources available to them, that care must be culturally appropriate and the need for good support structures and mechanisms left in place after each visit.
- Cultural awareness
- Need to have male and female workers
- Understand the context in which families live
- Develop strategies that allows individuals and families to work together
8. Discussion

The key outcomes of the 2005 to 2006 RACYMHS evaluation were the establishment of RACYMHS Performance Indicators and a considerable progress in defining an appropriate service model. The data collected will also make a substantial contribution to the development of a professional development pathway for the RACYMH workers, Indigenous health worker and clinician positions (Indigenous and non-Indigenous).

8.1 Limitations of this report

An obvious limitation of this report is that the evaluation analysis has relied upon a relatively small number of informants. 30 questionnaires were distributed and 18 were returned. Seven RACYMHS team members were interviewed. Hence, this report is based on data provided by 25 people working with children families either in remote area health, or a related service field such as education, in far north Queensland. Due to a distinct lack of feedback provided by management staff at the district level, the health management perspective is not strongly represented or considered within these evaluation results. The lack of feedback may indicate the staff turnover and lack of constancy at the district management level for an informed feedback to occur.

One patent gap in RACYMHS feedback is the Torres and NPA Health Service District. With regards to practitioner’ feedback, although there are now RACYMHS workers in Torres area, these positions were filled relatively late within the evaluation process (March 2006 and June 2006) and were therefore not included in interviews. The number and geographical scope of the Torres Strait islands and lack of RACYMHS presence during the evaluation period in the Torres made it unfeasible to attempt to obtain questionnaire feedback from Primary Health Care Centres.
The small sample in this evaluation cycle was, to some extent, countered by the level of detail provided in the responses. It was evident that those responded made significant effort to provide meaningful and well considered comment.

The other identified limitation of the project is that the evaluation has not generated outcome data or client/care perceptions of the service. Reporting on mental health service delivery may be monitored at a variety of levels. The *Key Performance Report* categorises these, in ascending order of aggregation as the client, the unit/service, the mental health service organisation, regional groups and states/Territories. (2005: 19). This RACYMHS evaluation at this stage has focused upon service development and service indicators. The consumer/care dimensions (i.e. client and community perceptions and client outcomes) need to be incorporated into the next evaluation cycle.

Despite these limitations, the depth and range of evaluation data, the process of action research and the RACYMHS PI structure offers a valid foundation.

**8.2 Answering the “where to now?” question**

At the outset of the RACYMHS evaluation we proposed the “where to now?” question. To answer this question the evaluation took the form of action research, with the process set against Flyvberg’s (2001) ‘phronetic social science’.

The evaluation explored the RACYMHS service model and teased several of the conceptual tensions facing, and sometimes frustrating, the service. Options and priorities have been identified regarding service direction for the immediate future. The data collected provided evidence as to RACYMHS’ current performance. However, beyond this and in terms of broader lessons learnt, three broad themes emerged:
8.2.1 Community Development versus Community Engagement

As part of the questionnaire respondents were asked to provide feedback on the role of Community development and RACYMHS role within this. The issue also arose during the RACYMHS practitioner interviews. Overall, the feedback affirmed that many collaborative partners, stakeholders, primary health care workers and RACYMH team members perceived Community Development activities as an important if not essential element of the RACYMHS model. For example, one respondent commented that this is “the most important aspect in order to improve Mental Health in communities”. Another saw Community Development as a competency for CYMH workers and “an essential element of the RACYMHS model”. Another explained “I would be looking at a community development model…no more than two communities. An educational model….you are building capacity from an individual level, family level to the community level to a societal level, working ground up…in my view capacity building is winning the trust of that community…to build those links with them and assist them in their empowerment process”

The RACYMHS evaluation demonstrated that many of the health service providers working or involved in remote community work shared the perception that part of RACYMHS role was to participate in what can broadly be defined as community development activities. The view was reiterated by RACYMHS team members, some of whom expressed the opinion that non-clinical, community based activities are as important part as clinical activities of the service role. There was also general agreement within RACYMHS steering committee that the RACYMHS model encompassed a broad role within remote communities.
Brod Osborne, Psychologist, Royal Flying Doctors Service, North Queensland Section, challenged the use of the term “Community Development” (CD) and raised the question as to whether RACYMHS, as an outreach service, could effectively undertake CD activities. It was suggested that service activities might be more accurately described as ‘Capacity Building’ and not ‘Community Development’ as CD requires a ‘bottom-up’ approach to projects and activities and is generated by local community people. This was a valid critique. To resolve the issue we consulted the RACYMHS evaluation committee as to the difference between Community Development and Capacity Building. We also consulted relevant literature to clarify the meanings of these terms and considered the definitions in light of the several factors including current service aims, objectives and the state of service development, the vision for the future and feedback from communities obtained during the earlier project stages.

In relation to clarifying terms Cavaye observes

“Community development often is associated with terms such as community capacity building, vitality, empowerment, rural development or self-reliance. The basic elements of collective action, ownership and improved circumstances are common to all these ideas. There may be slight differences in emphasis. For example while community capacity building focuses on enhancing assets and abilities of the community, the term is essentially synonymous with community development” (2001:3).

The evaluation committee suggested posing questions such as:

- What types of non-clinical work do the RACYMH team members undertake to complement their clinical roles?
- What are the hoped-for or facilitated consequences of engaging with people within the community?
- Based on currently available evidence what are the ideal non-clinical roles for the service in the future?
After describing the current non-clinical RACYMHS activities and in light of the fact that RACYMHS is in its early stages of its development, there was consensus that the current activities were generally aimed at engaging and building a trusting relationship with each community. No doubt, the first step towards community development is engaging a group of people.

Further discussions within the RACYMHS steering committee and project evaluation team indicated a need to clarify that the community capacity and clinical care do not refer to two separate roles within the service. The RACYMHS model involves each team position integrating clinical and community development activities into their scope of practice. The manner in which these aspects are balanced will depend upon the individual’s qualifications, experience, the community priorities and service deliverables.

After reviewing the literature and considering these various perspectives we concluded that:

1. Effective engagement with community is necessary in order to provide effective clinical services.
2. In order to have a positive effect on the social and emotional wellbeing of children and young people in remote areas, RACYMHS needs to have a broader role than solely clinical interventions
3. At this point the community activities in which RACYMHS are involved are to be defined as “community engagement”.

Like capacity building, community engagement is part of a broad community development approach. Although the current focus is on Community Engagement, increases in RACYMHS human resource and skill capacity have the potential to allow the development of a more facilitative role and a stronger participatory partnership to practice community development in its fundamental and fullest form.
8.2.2. Ethics as conduct versus Ethics as process

The feedback obtained from both questionnaires and RACYMHS team interviews described a vast range of ethical challenges related to working in remote Indigenous communities. Although a rich source of information and insight into issues such as worker retention, it was difficult to categorise this feedback under broad PI domains or to decide how to link this data to the local RACYMHS PI. On reviewing the intention of the national PI framework and exploring this dilemma we concluded that “Ethics” is probably best understood as referring to a process which is implicit to all the national PI domains. Essentially, the national template is broad enough to cater for holistic service provision. This not withstanding, the evaluation feedback described ethical dimensions of practice which were often unresolved, constituting an evaluation theme which deserved further attention.

Ethics can be defined as “the systematic rules or principles governing right conduct” (Miller and Keane, 1997: 559). The application of ethical principles involves judgments, made from a particular position within a web of, often competing, power relations. Such decisions are therefore highly context-dependent. The development of an increasingly in-depth understanding of the role of context often underpins the pathway from beginner to clinical expert (Flyvberg, 2001). To a beginning health practitioner, the rationale for decisions made by an expert may not be immediately perceptible, or may at times seem to challenge received opinion. Generally, with experience and mentoring, the complex nature of applying ethical principles within different contexts becomes apparent.

The difficulties for this project in engaging with the concept of ethical practice, reflects the complexities arising from different constructions of ethics in health and social practice, and operating within a particular social domain (i.e., remote area Indigenous populations). In terms of constructions, ‘ethics’ is too often distilled to two polarised conceptions. The first are
principles of social justice consistent with a universal ethical orientation, to which most professions ascribe without necessarily operationalising. The second are practitioner codes of conduct mandated by professional bodies, generally to uphold the good standing of the profession itself (through peer accountability). However, what this misses is an intervening ‘level’ which is the responsibility of the profession or service to obtain outcomes for those served which advances their opportunities to fairly participate in society. It is at this level that the profession or service is ultimately accountable (rather than the individual). This has been described by George Hampel (Hampel, cited in Hunter, 2006) in a three-levelled view of professional ethics.

In relation to this intervening level, context is critical. For human services, particularly working in settings of rapid social change in which there are historical tensions between institutional providers and recipient populations, this context demands that ethics be considered as both developmental (evolving in response to social and service circumstances) and interactional (relational) process. Highlighting this essential element, the values and ethics document (NHMRC, 2003) clarifies that successful models promote local relationships to ensure that the nuances of judgement and practice necessary to promote trustworthiness and trust are created and maintained. They also illustrate important aspects of accountability and transparency in standards, processes and structures.

Finally, RACYMHS evaluation activity in and of itself was an ethical process by which RACYMHS was able to more clearly define its responsibilities and role within the big picture of remote area Child and Youth Mental Health. In doing so, the service has identified its relative powerlessness in relation to fixing broad social issues from within the health system (Hunter, 2002). Following this, there is an imperative to advocate for an inter-sectorial approach to improving the social and emotional wellbeing of Indigenous children in far north Queensland. It has also defined its role as one of Community Engagement rather than
Community Development. This conceptual shift has implications for service responsibility. These insights will inform identification of appropriate service activities for RACYMHS workers within communities and the regional health system.

8.2.3 The critical role of the RACYMH Indigenous worker

Following the restructure in 2003, the first ever full time remote area child and youth Indigenous worker position commenced. Since then two more full time positions have been added to the RACYMH team (one located in Thursday Island). The essential structure of RACYMHS is to have teams of Indigenous and non Indigenous workers providing service to communities as a collaborative team where both practitioners have equal legitimacy and share knowledge and skill in a reciprocal way. Having Indigenous health workers as part of RACYMHS has significantly altered the visibility and acceptance of the service in communities. It has been a highly valuable collaboration for the non-Indigenous workers within RACYMHS as it has accomplished a shared vision and building together of ideas and solutions to address pertinent issues.

In far north Queensland the Indigenous health worker role generally focuses on community engagement liaison, cultural support for consumer, carer and case manager. Feedback indicated that Indigenous Health workers:

“Should have more leadership in their role - having more say in what should be done in the community”.

“Feel disempowered within, and at times frustrated with, the health care system in which they work (for example, limited time on the ground; when medical model is applied)”.

“Need enhanced recognition by and stronger links with, Primary Health Care Centre staff and health workers”.
The value of the concept of *Phronesis* in exploring the place of Indigenous health workers is in its acknowledgement of the complex dynamics of power within the health system and remote communities and the relative and shifting position of the Indigenous health worker within these dynamics. Evaluation feedback provided illustrates some of the ways in which Indigenous health workers might be socially excluded and/or professionally excluded within the regional health system. For example, one evaluation respondent commented that when visiting remote communities PHC staff contact with RACYMH Indigenous workers generally takes the form of “just a brief introduction”. These informal patterns of interaction may result in broader patterns of exclusion.

If exclusion can be perpetuated via daily practice it might also be remedied by conscious changes in practice. Within the RACYMHS model the Indigenous health worker role is in the process of development and currently incorporates cultural assessments, community engagement and education. There are attempts to develop more clinically based skills, appropriate to the individual’s qualifications and relevant experience. In the ongoing development of the role of Indigenous workers within RACYMHS there are structured opportunities for cross fertilization of knowledge and skills across cultures and professions within the RACYMHS team as part of its current professional development activities.

Developing the capacity of RACYMH Indigenous worker implies that the work of others must also adjust in order to accommodate shifts in RACYMHS practice as a whole. This has implications for how IMHW interact and work with clinicians. RACYMHS contribution to addressing some aspects of RACYMH Indigenous worker disempowerment is through its commitment to work towards realising a “collaborative practice” model. This model is based on mutual respect and acknowledgement of each profession’s role, scope of practice and unique contribution to health outcomes (Queensland Health and Royal Flying Doctor Service, 2005).
In moving towards a truly collaborative practice partnership all parties deserve respect and support in reflecting upon, and possibly adapting their philosophy and practice.

Another theme that emerged in relation to the role of the remote area CYMH Indigenous health workers was the complexities faced by Indigenous health workers based on Indigenous cultural diversity in the region. Some examples

For indigenous people they have to sus you out, they have to look at your families too, they have to know who you are where your from, who you married to, they gotta look at all those issues, all these things before they make any connection with you.

Another commented

If there’s been trouble or there have been all sorts of other things happen through those family linkages then they’re not going to accept that Indigenous worker either. It can be tricky ground...we don’t live in an ideal world.

With the Australian health system and bureaucracies, the distinction between ‘non-Indigenous’ and ‘Indigenous’ is pragmatic and well accepted. Nonetheless, where this distinction functions as an assumption that the Indigenous population constitutes a homogenous, bounded entity some of the complexities inherent in engaging with local Indigenous communities are discounted.

As demonstrated by the above quotes, RACYMHIW may carry a heavy burden if it is assumed that, on the basis of their Indigenity, they are immune from encountering barriers in their attempts to engage with remote Indigenous communities. Thus, the capacity to effectively engage with a given community may be dependent on “belonging” on the basis of kinship, ‘vouching’ (vicary and westerman, 2004) that seem to also happen between Indigenous people or other locally defined criteria. Such issues may not be readily apparent or recognisable to non-Indigenous members of a health team.
RACYMHS has responded to this by advocating and implementing a cultural mentoring program (see page 44 of this report for details), where RACYMH Indigenous workers have a regular opportunity to reflect upon their role, responsibilities and aspirations under the guidance of an Indigenous elder. Preliminary feedback indicates this is a valuable form of support for RACYMHIW providing outreach services to remote communities. One participant commenting on learnings from cultural mentoring said, “there are many things pertaining to culture and I don’t know them all”; “I realised how words should be chosen carefully whether you are talking to families or to your colleagues”.

In the current structure RACYMHS is providing the Indigenous health workers in the team with regular clinical and peer supervision program; participation in professional development activities, such as workshops and conferences; access to regular cultural mentoring; opportunities to provide training to remote area workers within and outside the team. These are in concurrence with and working towards fulfilling the strategic directions outlined in the social and emotional well being framework national document (Commonwealth Australia, 2004: 36). The above factors also indicate the need for a well–supported, appropriate professional development program for Indigenous worker in the child and youth mental health area that is accredited and contribute to a career structure and pathway.

On final reflection, the development and evaluation cycle of RACYMH service that began in December 2001 has reached a critical phase. The basic service infrastructure is in place and support structures to sustain and enhance the service are being strengthened. At this stage there is a need for prudence in matching goals with capacity, i.e., service goals with service capacity. When a service functions in a complex environment characterised by social disadvantage compounded by political and locational challenges, it demands robust intersectorial collaboration in order to achieve the broader and ultimate aim of social and emotional well being of children and families. The metaphorical staircase that Noel Pearson
(2006) argues for includes restoration of a strong foundation of social and cultural norms, generous investment in capabilities supports (improving education, opportunity and choices) and a reformed set of incentives (for employment). In this backdrop a small, nevertheless significant, service such as RACYMH has to responsibly and ethically act (including advocacy) in fulfilling its role of providing crisis management, core clinical duties, community engagement, and where possible sustainable community development activities for families of Indigenous children in far north remote region.

Thus the ongoing evaluation activity is a modest step towards achieving the priority themes (NMHWG, 2005) identified in the new National Mental Health Plan 2003 – 2008, of increasing service responsiveness; strengthening quality and fostering research, innovation and sustainability.
9. **Recommendations**

9.1 Action research evaluation framework for service development be continued for all activities of RACYMHS across the three districts, remote Cairns, Cape York and Torres Strait.

9.2 RACYMH service capacity to be built to support the model where one team (comprising of an Indigenous and a non Indigenous worker) services three communities. In the current structure this would entail service enhancement of two more teams i.e., four more positions, one team to cover Eastern Cape communities and one team to cover Torres outer islands region.

9.3 RACYMHS to be funded for a child psychiatrist position that clinically supports remote Cairns, Cape York and Torres Strait districts.

9.4 That the current RACYMHS multi-level professional development program (including supervision) continues for Indigenous and non Indigenous workers.

9.5 National Performance Indicators adapted to RACYMHS in this phase be used to comprehensively evaluate RACYMHS in the next phase.

9.6 RACYMHS evaluation activity in the next phase to expand to include consumer and carer perspectives.

9.7 RACYMHS identify and utilise opportunities to advocate for inter-sectorial approaches to the improvement of social and emotional wellbeing of Indigenous children in remote far north Queensland.
10. References/Bibliography


11 Acknowledgements

RACYMHS team, past and present members for their contribution to the RACYMHS evaluation during 2005 and 2006:

Frances Ahwang; Jackie Brown; Judy McKeown; John Kelly; Claire Rabaa; Radhika Santhanam; Denise Sebasio; Melinda Staunton; Ivy Wapua.

Annita Virzi, Karen Bradd and Whendi Rogers for excellent administrative support during the preparation of this report.

The contribution of all of those who provided the project team with feedback during the RACYMHS evaluation is gratefully acknowledged.

Sincere appreciation to The Mental Health Branch, Queensland Health for recurrent funding of the RACYMHS project.

A special word of thanks to Melissa Haswell, Trudi Sebasio and Komla Tsey for providing critical feedback on sections of the report and to Judy Skalicky for proof reading the report.

This project would not have been possible without the guidance, support and vision of Ernest Hunter, Regional Psychiatrist, Queensland Health and Yvonne Wilkinson, Team Leader, Mental Health, Northern Zone, 2001 – 2005.
12. Appendices

A. Steering committee membership list
B. Evaluation committee minutes.
C. eCYMHS review documents
D. Interview consent form
E. Interview questions
F. Project newsletters
## Appendix A: RACYMHS Steering Committee (November 2006)

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
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<tbody>
<tr>
<td>Chairperson</td>
<td>Kevin Freele</td>
</tr>
<tr>
<td>Research Co-ordinator, UQ</td>
<td>Radhika Santhanam</td>
</tr>
<tr>
<td>Senior Research Officer, UQ</td>
<td>Alexandra McEwan</td>
</tr>
<tr>
<td>Acting Team Leader</td>
<td>Tony Swain</td>
</tr>
<tr>
<td>Acting Team Leader, Northern Area Mental Health Team</td>
<td></td>
</tr>
<tr>
<td>Principal Project Officer Indigenous Mental health</td>
<td>Trudi Sebasio</td>
</tr>
<tr>
<td>NQWU</td>
<td>Cheryl Belbin</td>
</tr>
<tr>
<td>Royal Flying Doctor Service</td>
<td>Brod Osborne</td>
</tr>
<tr>
<td>Northern Zone Indigenous Mental Health</td>
<td>Mercy Baird</td>
</tr>
<tr>
<td>Apunipima</td>
<td>Carol Fyffe</td>
</tr>
<tr>
<td>Wuchopperen</td>
<td>Greg Pratt</td>
</tr>
<tr>
<td>Torres and NPA HSD</td>
<td>Odette Gibson</td>
</tr>
<tr>
<td>Cape York HSD</td>
<td>Alanah O’Brien</td>
</tr>
<tr>
<td>Team Leader RAMH</td>
<td>Judy Skalicky</td>
</tr>
<tr>
<td>Regional Psychiatrist, Queensland Health</td>
<td>Ernest Hunter</td>
</tr>
<tr>
<td>Team Leader CYMHS, Cairns</td>
<td>Guiliana Morogovich</td>
</tr>
<tr>
<td>Clinical Director, Mental Health</td>
<td>Janet Bayley</td>
</tr>
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Appendix B.

RACYMHS Evaluation Meeting Minutes
Monday 13th November
Environmental Health mtg room

1. **performance indicators (PI)**
Where to now with the PI? These will be used to evaluate RACYMHS next year.
Structure is good. Tony Swain and Kevin Freele are keen for this document to be a template for other mental health services.

How were the PI incorporated into the questionnaires? They were explicitly referred to in the Primary Health Care and District Contact questionnaires. These questionnaires asked the respondent to give feedback on RACYMHS’s performance against the definitions for the domains. They were

- Effective,
- Sustainable,
- Appropriate and
- Accessible.

**How did we decide on these categories? Need to discuss this in the report.**

**The process**
We took our original draft questionnaires to the evaluation committee. The feedback from this meeting (March 2006) indicated that we needed to link the questions to the PI. We went through the draft questionnaires and looked at which domains were already being addressed in the questions. We then attempted to incorporate the domain into the questions. This resulted in some fairly cumbersome questions because we had to try to retain the meaning of the domain as it was expressed in the National MH strategy document within the question. We could see that the questions would not be very accessible or easy to answer, so we then decided to be transparent about what the aim was and give the respondent all of the background as to why we were asking about these domains and the official definition etc.

In terms of content of the domains chosen R had advice from Harvey Whiteford that the domains were not intended to be hierarchical. We then looked at the content of the questions asked and chose the domains that would complement though not necessarily cover the current questions. Some categories were clearly more abstract than others, for e.g. “Safety” - the definition in the national PI document seemed quite abstract when considered from the perspective of a primary care worker in a remote setting. The domains chosen seemed to be those with a relatively clear meaning and relevant to the practice context.

**The health practitioner’s role encompasses both community development and clinical care**
This was discussed at the recent steering committee. We had feedback that the visual impact of the PI structure could indicate that CD and clinical care were separate and that the CD and clinical stream could be construed as suggesting that the two streams related to two different positions. Clarified that both areas where part of each RACYMHS team position. We changed
the structure to reflect to merge the two areas and to clarify that the document envisages both aspects as relevant to the range of health practitioner roles within the service.

2. Theme summary
Went through the main themes. There was positive feedback re RACYMHS collaboration and skills. Need to have more workers on the ground and to be involved in community issues at a broader level (community development role)

3. Interviews
The outcome of this could be a story regarding the process. How do you take a nationally developed framework and adapt it for local/regional need. How to weave the complexity of the context?

Target the set of domains and adaptation of the indicators in the context of opportunities and challenges. The interviews could be analysed in terms of how they relate to the PIs. The PIs could provide the structure for the evaluation report, with an accompanying commentary on each one re issues that arose etc. The content of the commentary would be provided by the feedback. It would be a way to critique the ‘one size fits all’ approach.
Family Wellbeing – question - is this relevant as a theme – so, the question here is the relevance of the national PI to remote practice.
Could the process we have been through be replicated in other areas?
What are the implications for service development?
Opportunity and challenges (lessons learnt)
Map any gaps in the PI from the interviews – are there any areas not covered. But – need to keep the intention of the original document in mind – is it also meant to separately deal with ‘ethics’ – probably not, however ethics would be implicit in each of the domains.

Could also look at the 4 domains incorporated in the questionnaires and see what emerges from the interviews re these.

4 domains – how does the data speak to them
Other domains – do these get mentioned (without being asked)
Other key themes that emerge

4. Service model
“Child” should be in the centre of all of the eggs.
Add “impact and outcomes” to the surrounding circle.
Add an explanatory sheet to the service model.

5. evaluation report structure
The PI could be used for the report structure from no 5: methodology to point 8 – results and recommendations.
Add a discussion chapter

6. publication of work
Interviews also bring out ethical issues of practice. These could be the subject of separate ‘reflective practice’ paper which draws upon the interview content within the context of service evaluation.
Put aside what we have developed so far and rethink it after the feedback has been analysed.

Remote Child and Youth Health Project Evaluation Meeting Minutes
14\textsuperscript{th} November 2005
In attendance: Drs Daryl Doessel, Kolma Tsey, Melissa Haswell, Radhika Santhanam, Alex McEwan

1. Aspects of project
   1. clinical interventions/services
   2. CD initiatives – groups, health education etc
   3. supervision activities
   4. professional development
   5. cost evaluation

Current hypothesis: if achieve 1 and 2 the result will be better health outcomes. However, to get to 1 and 2 have to have 4 in place.

If 3 & 4 are not carried out 1 & 2 will not sustainable – this point has emerged from the result of evaluation activities over the last 3 years.

Need to have a clear scope re intervention.
The aim is to improve health in community ‘I’.
In the following

‘i’: given community
CS: clinical services
SC: social capital
CD: community development
SA: supervision activities
PD: professional development
MHS: mental health status

MHS ‘i’ = f (CS\textsubscript{i}, CD\textsubscript{i}, SC and other variables e.g. the weather)
Cannot measure this, unless there is a HoNOS indicator for each person in the community.

What is possible?
CS\textsubscript{i} = f (SA, DP, staff, costs etc)
SA = f ($)  
PD = f ($) 

2. Hierarchy of measurements
   1. final output – mental health status/psychological well being
   2. intermediate outputs
   3. inputs – e.g. number of people seen

Another way to conceptualise
   Enterprise, production
   - output of the R & R team
     - CS\textsubscript{i}
     - CD\textsubscript{i} with sub outputs, ie
       - SA – supervision activities and
       - PD – professional development activities

This incorporates social capital and community development.

Can formulate budget in a couple of ways
1. budget = wages/salaries/IT/travel expenses/admin/research support or
2. budget = expenditure for CSi and CDi, includes SA and PD

3. Hierarchy for the project

1. **Final output**
   - psychological wellbeing

2. **Intermediate**
   - CESA (POS) (SMA)
   - Frequency of service
   - Breadth and depth of service, what is appropriate
   - Service is regular and reliable
   - Decrease in evacuations
   - Satisfaction of workforce
   - Increased confidence

3. **Input or costs**

4. **Discussion re HoNOS**
   Need to orient staff to think about the consumer and look for outcomes measures
   Focus on SA and PD costs and savings
   Improved effectiveness – e.g. how many people feel they were helped.

5. **Final output indicators**
   PD t = professional development for the R 7 r team
   PD msc = professional development that include multi sectorial collaboration.

   CSi = f (SA, PD t and PD msc)
   CDi = f (SA, PD and variables in the community that are uncontrollable)

Hypothesis – if invest in SA = improvements in CSi.
As the workforce becomes better supervised this will improve the service quality.

**Data available to match to CSi and CDi**
- CESA (SMA and NFA on CESA), provisions of services measures
- Referral sheets (liaison work)
- Sources of referral
- Closure time (period of consultation time)
- Focus groups
  - Peer supervision
  - Clinical
  - Professional supervision
- Project reference group/steering committee
- Evaluation advisory group
- Workforce template
- Literature review
- Workshops for MH workers/remote areas
With this data a cost analysis can be done to ensure that CSi activities and CDi activities have the right balance and whether there are areas that are not being addressed.

**Process**
Describe CSi and CDi and test data against this articulate how CESA fits in – what does it contribute.

**6. Texts**
Appendix C.

RACYMHS – ECYMHS REVIEW 2006

The following findings have been informed by discussions with various stakeholders in QH; Cape York health management; RACYMHS practitioners; evaluation from ECYMHS visiting psychiatrist after each trip; RAMH (Remote Area Mental Health) team and overall RACYMHS evaluation.

Background
This is a good time to take stock of the activities and reflect what has been useful and what could change because
- In Nov ECYMHS is a year old.
- RACYMHS workers who have been using ECYMHS have both finished their team and new team is to be recruited
- RAMH and RACYMH both have grown substantially in the last 18 months.
- Cooktown area is coming under Cape District

Originally the initiative was MSOAP funded (Medical Specialist Outreach Assistance Program) and later became ECYMHS. Under MSOAP the support provided was fairly basic and did not include videoconference. ECYMHS provides:
- 3 trips a year by the child psychiatrist. The trips are a week long; the first and last days go in travelling from and to Brisbane. Tues – Thurs is spent as one day per community i.e., the visits cover three communities. Usually these are Weipa, Napranum and Coen. Eastern Cape and South Western Cape are not covered by ECYMHS.
- Monthly videoconferencing for an hour. However between Nov 2005 and Nov 2006, videoconference happened for four times and telephone link occurred twice.

Rural vs Remote
Taking into consideration the experiences from the telemedicine experiment (CAPTOS) in NSW at the Children’s Hospital at Westmead in 1999. There are fundamental differences between rural versus remote settings.

<table>
<thead>
<tr>
<th>Rural</th>
<th>Remote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pretty good primary care</td>
<td>Not exactly the case</td>
</tr>
<tr>
<td>Rural setting is less challenged; have less staff turnover</td>
<td>Remote context is more challenged and staff turnover is huge</td>
</tr>
<tr>
<td>PHC staff bring broad skills (similar cultural groups)</td>
<td>PHC staff capacities compromised due to cultural differences</td>
</tr>
<tr>
<td>Predictable structures</td>
<td>Mobile and disseminated structures</td>
</tr>
<tr>
<td>Single point accountability</td>
<td>Diffuse accountability</td>
</tr>
<tr>
<td>Reasonably difficult presentations</td>
<td>Extremely complex cases</td>
</tr>
<tr>
<td>Reliable and routine outside services</td>
<td>Unreliable and unsustained services; multiple providers</td>
</tr>
<tr>
<td>Education system is fairly well functioning</td>
<td>Education system not functioning well</td>
</tr>
<tr>
<td>Ongoing relationship useful and supportive but not critical to overall success</td>
<td>Ongoing relationship is critical to establishment, outcome and overall success.</td>
</tr>
<tr>
<td>Policies and agenda rather stable</td>
<td>Constantly shifting policies and community agenda</td>
</tr>
<tr>
<td>Expertise needed to support staff is not different to secondary and tertiary training requirement</td>
<td>Expertise needed to support require substantial experience with Indigenous and remote community work</td>
</tr>
</tbody>
</table>

- Page 100 -
Medical officers are glad to case manage during a crisis | No permanent medical officer in any community

What may work in a rural setting is unlikely to mirror work for a remote setting.

Political changes
- There is both QH and CY health reform programs occurring at this time. Cape York health reform includes moving towards increased community governance and controlled health sector services and there is a strong move towards locally driven and owned initiatives and accountability to Indigenous structures.
- QH reform includes restructure of area and districts as well. Apunipima Cape York Health Council, Cape York Institute and QH are strongly arguing for bottom up capacity building approaches that show outcomes in (and for) the community.
- Review in Northern Area Mental Health Service Delivery currently being undertaken by Andy Foggart.
- Change of MH to Department of Communities.

Service Changes
- RAMH (Remote Area Mental Health) has expanded steadily to its current team structure.
- RACYMHS (Remote Area Child and Youth Mental Health Service) in the last 5 years has also undergone significant restructuring informed by the evaluation action research cycle (that is ongoing). The Cape, Torres and Remote Cairns are all satellite services of RACYMHS. The decision to locate the Torres service in Thursday Island arose from RACYMHS evaluative work and series of negotiations with the district. Torres service is an extension of RACYMHS. As we have evolved our needs keep changing.
- At this stage, RACYMHS has a structure of weekly clinical group supervision, monthly peer group supervision; monthly team case reviews; fortnightly needs based Monday morning meetings for operational/management issues; three monthly training on site or conference attendance; cultural mentoring for IMHW.
- RACYMHS also seek regular advice/guidance from RAMH Psychiatrists.
- In 2006 RAMH is going to have two full time Psychiatrists, one to the Cape. Also, a full time psychiatry registrar for RAMH.
- Cairns IMH is going to have two full time Child Psychiatrists. These additional capacities are significantly going to alter the way valuable resources like ECYMHS are utilised.

Suggestions for ECYMHS 2007
ECYMHS has helped us understand more clearly how and what kind of support we need from outreach specialist services. One way to optimise ECYMHS support for us is to change the way we engage

a) No clinical trips to Cape as these are brief, disjointed and without sustainable community contact.

b) Continued education sessions once every 2 months. Primarily for ‘state of the art’ updates of innovative programs; medicolegal issues; neurobiological advances and controversies in the field. This could be in the form of the Child Psychiatrist visiting the team for a week and spending time with the whole team in Cairns. Obviously this space can be used for clinical presentations if need arises.

c) What are the implications for funding if the structure is rearranged?
Torres
Torres Chid and youth team is an extension of RACYMHS.
It is not ‘one size fits all’ in remote communities. At some level, Torres is somewhat similar to
a rural setting than remote Indigenous setting. It is important to trial and evaluate whatever
activity is planned.

Aim
Our aim is to build a strong evidence for the need to create a Child Psychiatrist (at least 0.5)
position as part of RACYMHS, to cover the three districts by 2008.
The need is to build on local experience and enhanced frameworks of practise models.

Radhika Santhanam
OCT 2006

CC:
Kevin Freele
Paul Stephenson
Alanah O Brien
Judy Skalicky
Ernest Hunter
RACYMHS & ECYMHS
Process Evaluation and Feedback

Date and Time: 23 Oct 12.15 – 2.00 pm.

Present: Denise Best; Frank Keegan; John Varghese; Andrew Froggart; Judy Skalicky; Ernest Hunter; Radhika Santhanam and Tony Swain.

Apologies: Paul Stephenson; Kevin Freele; Mercy Baird; Alanah O’Brien

Facilitator: Radhika Santhanam

Feedback and Review

Summary of issues to date (See attached review document) (RS):
- Processes, activities and evaluation over the last year in Western Cape;
- Difference between rural and remote setting;
- Remote Area Mental Health Service growth and evolution, and
- Policy changes expected in 2007.
- Suggestions for 2007 outlined.
Issues raised in discussion:

- ECYMHS is not a crisis service
- ECYMHS has been underutilized in the Western Cape York setting (DB)
- Full potential of this service not realized (DB and JV)
- ECYMHS face to face contact predominantly non-Indigenous families (RS and JV)
- Remote area C&Y emergency issues are managed by Remote Area Mental Health psychiatrists. 3 different population groups - rural; Indigenous remote and Non-Indigenous remote (EH)
- Key question: What works for who, where, why and how. Social determinants of health most critical for any service in Indigenous communities. In terms of solutions: one size does not fit all. Focus around educational activities may suit the needs on the ground better. Taking to time to reflect is critical (EH)
- Ultimate goal - Child Psychiatrist on the ground in Cairns to support RACYMHS (JS)

Suggestions

- The nature of engagement (in relation to Cape York) to change to two monthly or three monthly visits by a child psychiatrist to do continued educational sessions. Anticipated that this will also provide a space for clinical reviews with the whole RACYMHS team in Cairns. No clinical trips. (RACYMHS)

Response

- The focus of ECYMHS is clinical support and not continued education. Will consider the suggestion (ECYMHS)
- Responding to team needs is essential (TS)

Plan

- ECYMHS will consider and inform RACYMHS re: the feasibility of the suggested alternative
- ECYMHS and RACYMHS to travel to Torres to discuss with key stakeholders. (RS visit dates in Nov are 21, 22 and 23). John Varghese will consider these dates.
- ECYMHS to contact Torres workers prior to this trip (as requested by ECYMHS)
- All communication to go through FK
INFORMATION TO THE PARTICIPANT

The RACYMHS is undergoing a service evaluation. The evaluation is being conducted by Radhika Santhanam and Alex McEwan. We are currently seeking feedback from Qld Health staff working in remote communities in Cape York, the Torres Strait and Northern Peninsula Area and remote Cairns, other relevant stakeholders and service partners. As part of the process we are also consulting with individual RACYMHS team members. The consultation with RACYMHS team members will take the form of an interview, which should take approximately one hour. The interview will be recorded. Your responses to the interview questions will contribute to service planning, including the development of a professional development plan for the RACYMHS. Some of your feedback may be included in reports related to the RACYMHS.

Radhika Santhanam and Alex McEwan

SHOULD YOU HAVE ANY QUESTIONS OR REQUIRE ANY EXPLANATIONS PLEASE ASK ALEX or RADHIKA

CONSENT TO PARTICIPATE IN RESEARCH PROJECT

Do you consent to take part in this interview, as part of the evaluation of RACYMHS? Yes ☐ No ☐

Have you read and/or had read and explained to you the information above? Yes ☐ No ☐

Do you understand the contents of the information above? Yes ☐ No ☐

Do you understand that:-

(i) Your responses, the results and any report arising from this research project will remain confidential? Yes ☐ No ☐

(ii) Would you object to your responses that you provide may be included in project reports or other relevant documents. Yes ☐ No ☐

(iii) Do you understand that you will be identified as a service in the publication of the results and findings of the research project? Yes ☐ No ☐

Do you voluntarily agree to take part in the research project? Yes ☐ No ☐
SIGNED this day of 2006

Signature of the Participant

RESEARCHERS STATEMENT

I have explained to the Participant the nature and purpose of the interview

Signature of the Researcher Date
Appendix E. Interview questions – for Practitioner

Remote Area Child and Youth Mental Health Service
Professional Development Questionnaire

Introduction:
Your responses to the following question will contribute to an evaluation of the Remote Area CYMHS.

Location _____________________                            Date_____________________

1. What work do you do?

2. In the past year/2 years can you think of any moments when you felt a sense of satisfaction with your work and/or how you had managed a situation? (What was it about the situation or the way that you managed it that gave you the sense of satisfaction)

3. What had been hard or not so good at work?

4. What frustrations have you had with
   a) health care system you work in
   b) communities you work with

5. How have you grown professionally i.e., changed or gained independence in the way you work? What sort of things happened to support this?

6. Have others around you noticed any change? If so, what do you think they have noticed?

7. Have there been times when you have thought of working in a completely different way? If you could make those changes what would it look like?
8. In what ways has the work you do affected you in terms of your
   • Personal life i.e. your relationships
   • Your confidence
   • Your beliefs
   • Your bank balance
   • Your future employment.
   • Your ethical outlook

9. Could you give an example of a situation where your personal values were bought you into conflict with your work? How did you manage the situation? How did this experience change your practice?

10. How connected do you feel with the communities you work in? What motivates you?

11. Can you describe a particular interaction where you were able to link the knowledge, experience or values of the client with your own practice or journey?

12. In terms of team development, what do you see as two main priorities for your team over the next year?

13. Are there any other comments you would like to make?
Appendix E: Interview questions – for District Management

Remote Area Child and Youth Mental Health Service (RACYMHS) Evaluation
District Contacts Questionnaire

Could you please respond to the following questions in as much detail as you feel is appropriate. This should take approximately 40 minutes to complete. After you return the completed questionnaire we will contact you by phone to provide you with the opportunity to add further comment.

Location _____________________                            Date_____________________

14. Briefly describe how RACYMHS works with you and your staff?
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15. When you look back over the last 2 years, have there been any changes to Child and Youth Mental Health service delivery in your district? Please describe the changes.
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16. Part of the aim of this questionnaire is to measure RACYMHS against National Mental Health Performance Indicators. The following definitions are taken from “Key Performance Indicators for Australian Public Mental Health Services”.

a) Effective: “care, intervention or action achieves desired outcome in an appropriate timeframe”
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7 (2005) Australian Government Department of Health and Aging
b) Sustainable: “the service’s capacity to provide the workforce, facilities and equipment, and be innovative and respond to emerging needs”

c) Appropriate: “care intervention or action provided is relevant to the client’s need and based on established standards”.

d) Accessible: “the ability of people to obtain health care irrespective of income, remote setting or cultural background”
17. Acknowledging that there are gaps between RACYMHS’ current activities within your district and what needs to be done to improve the mental health and well being of children and young people, please explain briefly what you see as the gaps and how these can be addressed within your district?

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18. The RACYMHS model of care includes community development as an important part of service activities. How important do you believe community development is to the delivery of child and youth mental health services in remote communities?

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19. What do you believe are the essential skills or competencies a Child and Youth Mental Health worker requires when working in a remote indigenous community?

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20. Given the fact that a variety of social determinants contribute to the well being of children (for example, housing, education, employment) what do you believe are the priorities for children and young people in your district? What do you see as the role of RACYMHS within this ‘big picture’?

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21. Are there any other comments you would like to make?

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Thank you for completing this questionnaire. Please return to Alexandra McEwan, Senior Research Officer in the addressed envelope provided.
Appendix E: Interview questions – for Stakeholders

Remote Area Child and Youth Mental Health Service Evaluation
Collaborative Practice/stakeholder Questionnaire

Could you please respond to the following questions in as much detail as you feel is appropriate. This should take approximately 40 minutes to complete. After you return the completed questionnaire we will contact you by phone to provide you with the opportunity to make further comment.

Location _____________________                            Date____________________

22. Briefly describe how the RACYMH service works with you and your staff?

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23. In terms of collaborative practice with RACYMHS, what you think is going well?

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3. Are there any changes that you believe need to made in order to improve you collaboration with RACYMHS?

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4. What kind of interagency or feedback activities are you engaged in with RACYMHS?

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5. The RACYMHS model of care includes community development as an important aspect of service activities. How important do you believe community development is to the delivery of child and youth mental health in remote communities?

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6. What do you believe are the essential skills or competencies a Child and Youth Mental Health worker requires when working in a remote indigenous community?

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7. Given the fact that there are several social determinants contributing to the well being of children (for example, housing, education, employment) what do you believe are the priorities for child and youth mental health in remote communities? What is the RACYMHS’ role in this ‘big picture’?

8. Are there any other comments you would like to make?

Thank you for completing this questionnaire. Please return to Alexandra McEwan, Senior Research Officer in the addressed envelope provided.
Appendix E: Interview questions – for PHC

Remote Area Child and Youth Mental Health Service (RACYMHS) Evaluation
Primary Health Centre Questionnaire

Could you please respond to the following questions in as much detail as you feel is appropriate. This should take approximately 40 minutes to complete. After you return the completed questionnaire we will contact you by phone to provide you with the opportunity to add further comment.

Location _____________________                            Date____________________

24. Describe how the RACYMH service works with you and your staff?
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25. When you look back over the last 2 years, have there been any changes to Child and Youth Mental Health service delivery in your community? Please describe these changes.
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26. Part of the aim of this questionnaire is to measure RACYMHS against National Mental Health Performance Indicators. The following definitions are taken from “Key Performance
Indicators for Australian Public Mental Health Services”. Could you please provide feedback regarding RACYMHS’ contribution or performance over the last 2 years as it relates to each definition.

a) Effective: “care, intervention or action achieves desired outcome in an appropriate timeframe”

b) Sustainable: “the service’s capacity to provide the workforce, facilities and equipment, and be innovative and respond to emerging needs”

c) Appropriate: “care, intervention or action provided is relevant to the client’s need and based on established standards”.

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(2005) Australian Government Department of Health and Aging
d). Accessible: “the ability of people to obtain health care irrespective of income, remote setting or cultural background”

27. Acknowledging that there are gaps between what RACYMHS is currently doing in your community and what needs to be done in relation to improving the mental health and well being of children and young people, please explain briefly what you see as the gaps and how these could be best addressed in your community?

28. The RACYMHS model of care includes community development as an important aspect of service activities. How important do you believe community development is to the delivery of child and youth mental health services in remote communities?
29. What do you believe are the essential skills or competencies a Child and Youth Mental Health worker requires when working in a remote indigenous community?

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30. Given the fact that a variety of social determinants contribute to the well being of children (for example, housing, education, employment) what do you believe are the priorities for children and young people in your community? What do you see as the role of RACYMHS within this ‘big picture’?

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31. Are there any other comments you would like to make?

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Thank you for completing this questionnaire. Please return to Alexandra McEwan, Remote Area Mental Health, in the addressed envelope provided.