Integrated Atlas of the social and emotional wellbeing services for Aboriginal and Torres Strait Islander children and youth in Yarrabah

June 2022

The Integrated Atlas of the social and emotional wellbeing services for children and youth in Yarrabah is part of the research project titled: *Systems Integration to Promote the Mental Health of Indigenous Children and Youth*

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This Atlas is a research collaboration between:

Central Queensland University, Jawun Research Centre

Australian National University | University of Canberra

Gurriny Yealamucka Health Services Aboriginal Corporation, Yarrabah

Deadly Inspiring Youth Doing Good (DIYDG), Cairns

Disclaimers:

The language used in some of the service categories mapped in this report (eg outpatient, day care, non-acute) may read as being very hospital-centric, especially for Indigenous wellbeing approaches, or advanced community-based mental health services, which are recovery oriented and highly developed. However, these terms reflect the category nomenclature employed within the Description and Evaluation of Services and Directories in Europe for Long Term Care (DESDE-LTC) classification system rather than a description of services. The consistent application of standardised category labels, which have been used for some years in Europe for health service mapping studies, provides a common language for meaningful comparisons of service across regions (nationally and internationally).

Whilst permission from the Queensland Department of Education was obtained for this research and multiple schools participated, this publication does not necessarily represent the views of the Queensland Department of Education. The department however remains both sensitive and respectful of the cultural, religious and other diversities amongst research participants.

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GURRINY YEALAMUCKA
HEALTH SERVICE ABORIGINAL CORPORATION

ARRABAH LEADERS FORUM

UNIVERSITY OF CANBERRA

CQUniversity AUSTRALIA

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Abbreviations

Abbreviation	Name
ACCO	Aboriginal Community Controlled Organisation
ACCHO	Aboriginal Community Controlled Health Organisation
BSIC	Basic Stable Input of Care
CYMHS	Queensland Health - Child and Youth Mental Health Service
CQI	Continual Quality Improvement
CQU	Central Queensland University
CYAG	Community Youth Advisory Group
CYJMA	Queensland Department of Children, Youth Justice and Multicultural Affairs
DIYDG	Deadly Inspiring Youth Doing Good
DESDE	Description and Evaluation of Services and DirectoriEs
FTE	Full Time Equivalent
FAIT	Framework For Assessment Impact and Translation
GIS	Geographical Information System
GP	General Practitioner
HHS	Hospital and Health Services
HREC	Human Research Ethics Committee
ICD-10	International Classification of Diseases, Tenth Revision
ICF	International Classification of Functioning, Disability and Health
MHN	Mental Health Nurse
MTC	Main Type of Care
NIAA	National Indigenous Australians Agency
NGO	Non-Government Organisation
NQPHN	North Queensland Primary Health Network
PCYC	Police and Citizens' Youth Club
PHN	Primary Health Network
RSAS	Remote School Attendance Scheme
RN	Registered Nurse
SEWB	Social and Emotional Wellbeing
YLF	Yarrabah Leaders' Forum

Executive summary

This *Integrated Atlas of the social and emotional wellbeing services for Aboriginal and Torres Strait Islander children and youth in Yarrabah* provides, for the first time, baseline data to inform decision making about social and emotional wellbeing (SEWB) service delivery in Yarrabah. The Atlas responds to the need to promote and protect the mental health and social and emotional wellbeing of young Aboriginal and Torres Strait Islander people (herein respectfully termed Indigenous) in Yarrabah. Achieving this requires the availability and accessibility of a comprehensive range of services providing culturally and clinically appropriate programs and supports.

Current evidence states that Indigenous peoples' social and emotional wellbeing (SEWB) is influenced by protective factors identified by the *Gayaa Dhuwi* (Proud spirit) Declaration (1). The seven interconnected domains of social and emotional wellbeing collectively identified - country, culture, spirituality, community, family and kinship, mind and emotions, and body represent "a cultural understanding of Aboriginal and Torres Strait Islander relationality, identity, and holistic individual, family, and community health"(2).

Gathering evidence on how services address and embed these protective SEWB factors into Indigenous child and youth program delivery, and how they influence outcomes, is challenging, especially as the current system of mental health and SEWB services and supports is complex, inefficient and fragmented (3).

Indigenous community leaders' priorities for improvement of mental healthcare services and systems have met with limited government support and resourcing (4). In one remote Queensland Indigenous community, for example, evaluators found a complex and disjointed network of 39 distinct programs delivered by 21 providers to the community's 330 children, with little evidence of service delivery coordination or case management. Federal and State Governments' competitive and short-term funding structures compel service providers to 'stick to their own turf'; and the overall effects of children's programs (positive or negative) could not be determined (5).

There is a clear need for a comprehensive system of Indigenous youth service provision based on appropriate community models of care. The Queensland Mental Health Commission strategic plan advocates that "a more balanced approach requires a shift towards the community as the key place where mental health …services and support are provided..."(6) (p.31). The first and necessary step in the planning and provision of such a system is to know what the current picture of service provision is: that is, to identify and map the services available in a region, what they are doing, and where the strengths and gaps in the system lie.This requires a holistic approach that includes the mapping of services for young people not only in the health sector, but also across all sectors of care - education, social care, housing, justice, community and cultural, as well as other relevant sectors of service provision.

An Integrated Atlas provides a snapshot of the whole health and social care system in a defined region using a healthcare ecosystem approach (7). Key to this approach is the service classification instrument- Description and Evaluation of Services and DirectoriEs for Long Term Care (DESDE-LTC or DESDE), which provides a standardised and validated method of describing and classifying services in all care sectors (8). The use of a standardised tool enables comparison, both with other jurisdictions, and in the same jurisdiction over time.

Integrated Atlases developed by the DESDE research team have mapped patterns of service provision for mental health, psychosocial support, services for chronic health conditions, and for people experiencing homelessness, in 20 Primary Health Network (PHN) regions in Australia, including the Kimberley region and Far West New South Wales. The DESDE instrument has also been used to map service provision for people living in remote areas

overseas, including Nunavik (Canada) and Lapland as part of the "Glocal" (Global and Local Observation and mapping of CAre Levels) project (https://www.canberra.edu.au/research/institutes/health-research-institute/glocal). These projects include a data repository on local service provision collected using DESDE and its antecedent, the European Service Mapping Schedule (ESMS). This atlas, *The Integrated Atlas of the social and emotional wellbeing services for Indigenous children and youth in Yarrabah* describes and classifies the services across all sectors that are available for Indigenous young people between the ages of 5 and 18 years in Yarrabah, Far North Queensland.

The *Integrated Atlas of the social and emotional wellbeing services for Aboriginal and Torres Strait Islander children and youth in Yarrabah*, and its companion, the *Integrated Atlas of the social and emotional wellbeing services for Aboriginal and Torres Strait Islander children and youth in Cairns,* constitute the service mapping component of the Systems Integration to Promote the Mental Health of Indigenous Children and Youth research project (SIP). The SIP aims to conceptualise, co-design and evaluate community-driven systems-level integration to promote the mental health and wellbeing of Indigenous school-aged children and youth (5-18 years). Systems integration is defined as the development of a spectrum of effective, community-based services and supports that are organised into a coordinated network that build meaningful partnerships with families and address their cultural and linguistic needs, to help children and youth to function better at home, in school, in the community, and throughout life (9). Research for these Atlases has been done in collaboration with the community based research partners. In Yarrabah the SIP research partner is Gurriny Yealamucka Health Services. In Cairns, the research partner is Deadly Inspiring Youth Doing Good (DIYDG), an Indigenous youth empowerment organisation.

Data for the Yarrabah and Cairns Atlases were collected between July 2021 and February 2022. Data were obtained from interviews with service managers of organisations, or leaders of programs, providing mental health and/or social and emotional wellbeing programs or support to Indigenous young people in each region. This included health, education, justice, child protection, social services, and the community services sectors. The Atlas maps those services that are universally available to the population; that is, it does not map fee-for-service care, or services which require a significant out of pocket cost.

The five key issues for consideration for communities and planners of Indigenous health and wellbeing services that have emerged from this research are:

- Gaps that have been identified in service availability in both Cairns and Yarrabah: including in relation to the availability of residential services and education or employment related services
- The extent to which services are Aboriginal Community Controlled in each region
- The extent to which available services support young people "upstream" to prevent the need for more high intensity "downstream" support
- Workforce composition, in particular the representation of Indigenous people in the health workforce
- Implications for service delivery and accountability of funding patterns

The information in this Integrated Atlas can be used in:

- strategic service planning
- modelling for system development
- analysis of strengths and gaps in the system

The Integrated Atlas also provides a baseline from which future comparison can be made to evaluate the effects of policy and planning interventions.

Introduction

Aboriginal and Torres Strait Islander social and emotional wellbeing: historical and cultural context

Aboriginal Community Controlled Health Organisations (ACCHOs) had already been providing primary health care services to their communities for nearly two decades, when the landmark National Aboriginal Health Strategy in 1989 (10) became the first national policy document to recognise and articulate an Indigenous holistic world view. This Strategy acknowledged the importance of Aboriginal decision making and self-determination: of "the local community having control of issues that directly affect their communities"; and of the concept of health and wellbeing "in all aspects of life - including control over the physical environment, of dignity, of community self-esteem and of justice", with a focus on spiritual, cultural, emotional, social and physical wellbeing, and the connection between health and land"(p.xiv).

A series of reports over the next decade highlighted the impact on Aboriginal health and wellbeing of past and present social policy and actions. These reports included the 1991 Royal Commission into Aboriginal Deaths in Custody (11), which expressed the urgent need to address Indigenous mental health and overrepresentation in the justice system; the 1993 Burdekin Inquiry (12) describing the impact of dispossession of land, the removal of children from their families and of continuing social and economic disadvantage; and the 1997 Bringing Them Home report (13), which highlighted the consequences of child removal, and the inadequacy and inaccessibility of appropriate services.

The Way Forward in 1995 (14) was the first policy response to acknowledge the historical aspects of colonisation and dispossession on Indigenous mental health. The associated Action Plan Ways Forward, the Aboriginal and Torres Strait Islander Emotional and Social Well Being (Mental Health) Action Plan (1996-2000) was introduced in 1996, creating a policy framework that aimed to ensure a coordinated approach to service delivery. Drawing from this first Plan, Strategic Frameworks (15,16) have progressively articulated the following principles for the delivery of health and wellbeing support to Aboriginal and Torres Strait Islander Peoples:

- Emphasis on a holistic view of health
- Importance of self determination
- Culturally valid understandings shaping service provision
- The impacts of inter-generational trauma
- A human rights-based approach
- Ongoing effects of social and economic disadvantage and of racism, and
- Centrality of Aboriginal and Torres Strait Islander family and kinship

The importance of Aboriginal and Torres Strait Islander leadership, and of cultural respect in service delivery was echoed in the 2016 National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families (17).This report called for partnership and collaboration between all levels of government, and between health and other sectors in the planning and delivery of child and family health services. It stressed the importance of keeping the child at the core of an integrated multidisciplinary collaborative service delivery system. This system should be built around a holistic primary health care model, providing continuity of care and the ability to

access the services required: not just health services but also comprehensive educational and social support services.

Several of these goals had already been set out eight years earlier in the Coalition of Australian Governments (COAG) 2008 National Indigenous Reform Agreement-Closing the Gap (18). Its target of closing the life expectancy gap within a generation included:

- Halving the gap in mortality rates for Indigenous children under five within a decade
- Ensuring access to early childhood education for all Indigenous children aged four years living in remote communities within five years
- Halving the gap in reading, writing and numeracy achievements for children within a decade
- Halving the gap for Indigenous students in year 12 attainment rates by 2020
- Halving the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade

Specifically, the areas of early childhood, schooling, health, economic participation, healthy homes, safe communities and governance and leadership were seen as key to achieving these aims.

By 2019, only two Closing the Gap targets had been met, and the National Indigenous Australians Agency was established to take over its responsibilities, in partnership with Indigenous Australians. In 2020 a new National Agreement (19) was developed with a revised framework. This had four priority areas and 16 new targets, including increasing education levels and employment, reducing detention, reducing out of home care, and decreasing suicide rates. These reforms aim to build the Community Controlled sector; adapt government organisations to work better with Aboriginal and Torres Strait Islanders; and improve and share access to data and information to enable Aboriginal and Torres Strait Islander communities to make informed decisions.

Targeted outcomes of the National Agreement include to:

- Reduce the rate of over-representation of Aboriginal and Torres Strait Islander children in out-of-home care by 45 per cent by 2031
- Reduce the rate of Aboriginal and Torres Strait Islander young people (10-17 years) in detention by 30 per cent by 2031
- Achieve significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander people towards zero
- Provide Aboriginal and Torres Strait Islander people with access to information and services enabling participation in informed decision-making regarding their own lives.

The National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031 (20), developed in consultation with Aboriginal and Torres Strait Islander health leaders, has also set a target for Aboriginal and Torres Strait Islander people to represent 3.43% of the national workforce by 2031.

Queensland Aboriginal and Torres Strait Islander social and emotional wellbeing: policy context

Intersectoral collaboration is a key goal of the Queensland Aboriginal and Torres Strait Islander Mental Health Strategy 2016-21 (21). The Strategy also acknowledges the effectiveness of ACCHOs in providing primary health care. It targets outcomes including: the strengthening of relationships between Hospital and Health Services (HHS) and primary health care providers, especially ACCHOs; continuity of care; addressing needs and service gaps; and increasing the quality and availability of data.

The key population health priorities for North Queensland PHN include: maternal and child health; chronic disease management and prevention; sexual health; healthy ageing; Aboriginal and Torres Strait Islander health; and multicultural health (22). The PHN's stated objectives are to work to improve people's health and wellbeing throughout their lifespan, and focus on addressing both health and social determinants which lead to poor health outcomes.

The most recent report of the Queensland Mental Health Select Committee acknowledged the intergenerational trauma and harm done by colonisation and subsequent government policies, and recommended the funding of a scholarship to support the accreditation of Aboriginal and Torres Strait Islander peoples in mental health and drug and alcohol service workforce roles (23).

National Mental Health and Suicide Prevention Plans and the role of Primary Health Networks (PHNs)

The 2013 National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (24) articulated several goals including reducing the incidence and impact of suicide and suicidal behaviour; adequate resources for prevention strategies; addressing specific risk factors; and increasing Aboriginal and Torres Strait Islander presence in the mental health workforce. These goals should be achieved through actions such as building the capacity of Aboriginal and Torres Strait Islander communities, supporting children and families, in particular, in ways of building social and emotional competencies; provision of targeted suicide prevention services; and co-ordination between state and federal governments, and between the different social sectors, to provide a coordinated and integrated system of services.

The Fifth National Mental Health and Suicide Prevention Plan 2017-2022 (The Plan) (3) identified mental health and suicide prevention in Aboriginal and Torres Strait Islander populations, and the provision of services across the stepped care spectrum including social, emotional and wellbeing services for both the well population and those at risk of mental illness, as key priorities.

The Plan acknowledged the importance of strong Aboriginal Community Controlled Health Organisations (ACCHO), and of Indigenous leadership in mental health services, as fundamental to building culturally capable models of care: …."ACCHOs can play a vital role in: prevention and early intervention in mental health, providing access to primary and specialist services, and of community-based social support services, the transition of consumers through the primary/specialist system, and working with mainstream services to improve their cultural capability"(p.31). Building a culturally competent service system requires a well-supported Indigenous mental health workforce.

A key plank of The Plan is the development of a stepped care model of service provision. This is a hierarchy of interventions from the least to most intensive care, matched to individual need. However, a fully implemented

integrated care system, that has no major gaps in service delivery, is necessary if a stepped care model is to achieve its aims and not produce further fragmentation. This model needs to include the provision of a range of different types of services, and include the capacity for young people to move easily between these services as needed, rather than the development of a system marked by the division of services into separate defined layers or "steps". PHNs and Local Health Networks have been tasked to develop integrated, whole-of-community approaches to suicide prevention, and to work together to map providers across the service system, develop stronger referral pathways and build community knowledge of the range of available services and how to access them. This requires a whole systems approach, to identify all the services available and the critical relationships and connections within a system.

Research Project: Systems Integration to Promote the Mental Health of Indigenous Children and Youth

This *Integrated Atlas of the social and emotional wellbeing services for Aboriginal and Torres Strait Islander children and youth in Yarrabah*; and its companion, the *Integrated Atlas of the social and emotional wellbeing services for Aboriginal and Torres Strait Islander children and youth in Cairns* constitute the service mapping component of the Systems Integration to Promote the Mental Health of Indigenous Children and Youth project (SIP)(9). The research project is being conducted through the Jawan Research Centre, Central Queensland University, Cairns Campus, and led by Professor Janya McCalman. It is a five-year (2019 – 2024) NH&MRC funded project.

In partnership with Indigenous Primary Health Care (PHC) services in two diverse communities, and an Indigenous youth leadership organisation, the SIP study aims to conceptualise, co-design and evaluate community-driven systems-level integration to promote the mental health and wellbeing of Indigenous school-aged children and youth (5-18 years). The three partners on this research project are: Gurriny Yealamucka Health Services, Yarrabah, Far North Queensland; Bulgarr Ngaru Medical Aboriginal Corporation, Northern NSW; and, Deadly Inspiring Youth Doing Good (DIYDG), Cairns, Far North Queensland.

A first principle of the project's governance structure is that Aboriginal and Torres Strait Islander co-leadership is active across all levels of the research, project functions and community partnership for the life of the project.

Taking a placed-based approach with each community partner, the aim of the SIP is to co-design and evaluate interventions that integrate services and systems between organisations, and across sectors, to support the wellbeing and mental health of Indigenous children and youth.

The research activities and engagement with research participants has been through the key activities outlined below:

- Yarning Circles: Community-based yarning circles were held with community health services, community members – children, youth, families - and other child and youth service providers. Information was gained about the services and supports that currently exist to promote child and youth mental health and ideas on how these could be improved
- Community Youth Advisory Groups: A critical element of the research is for it to be youth-informed and proactively seek, listen and include youth voices. Each research partner invited youth to participate in their Community Youth Advisory Groups (CYAG). Several group meetings were held in each community, and each was facilitated by a Deadly Inspiring Youth Doing Good (DIYDG) representative. CYAGs will continue to be held with youth for the life of the project

- Service evaluation: Using the DESDE-LTC evaluation measure, quantitative data about service availability and capacity was collected through individual interviews with identified service providers
- Health and other data: the research partner PHC services and schools have agreed to provide data on their child and youth mental health and wellbeing activities and systems
- Culturally Responsive, trauma informed care systems assessment tool (CRTIC-SAT) will be used to identify the appropriateness and integration of child and youth wellbeing services
- Framework for Assessment of Impact and Translation (FAIT) will be used to assess the impact and economic effects of the project

A complete summary of the systems integration project can be found in Annex C of this report.

The collective findings from these research activities will be used to inform the co-design of agreed strategies to improve the integration of child and youth mental health and wellbeing services and supports. The co-design of an integrated youth mental health and wellbeing service model will be specific to each community. The outcomes of each community's co-designed systems integration model will then be evaluated using CQI tools.

Yarrabah – Community Research Partner

Yarrabah

Yarrabah is a discrete Aboriginal community in Far North Queensland. The Yarrabah community is in an idyllic location, situated in a coastal valley on Cape Grafton, with the major settlement within Mission Bay (Mira Wun Gula), 10kms due east of Cairns. However, Yarrabah is a 60 kilometres drive south-east of Cairns along a sealed and steep mountain road, winding up and over the Murray Prior Range. Immediately offshore from Yarrabah are the tourist locations of Fitzroy Island and Green Island and the Great Barrier Reef. These waters are part of the traditional fishing and hunting grounds of Yarrabah's people.

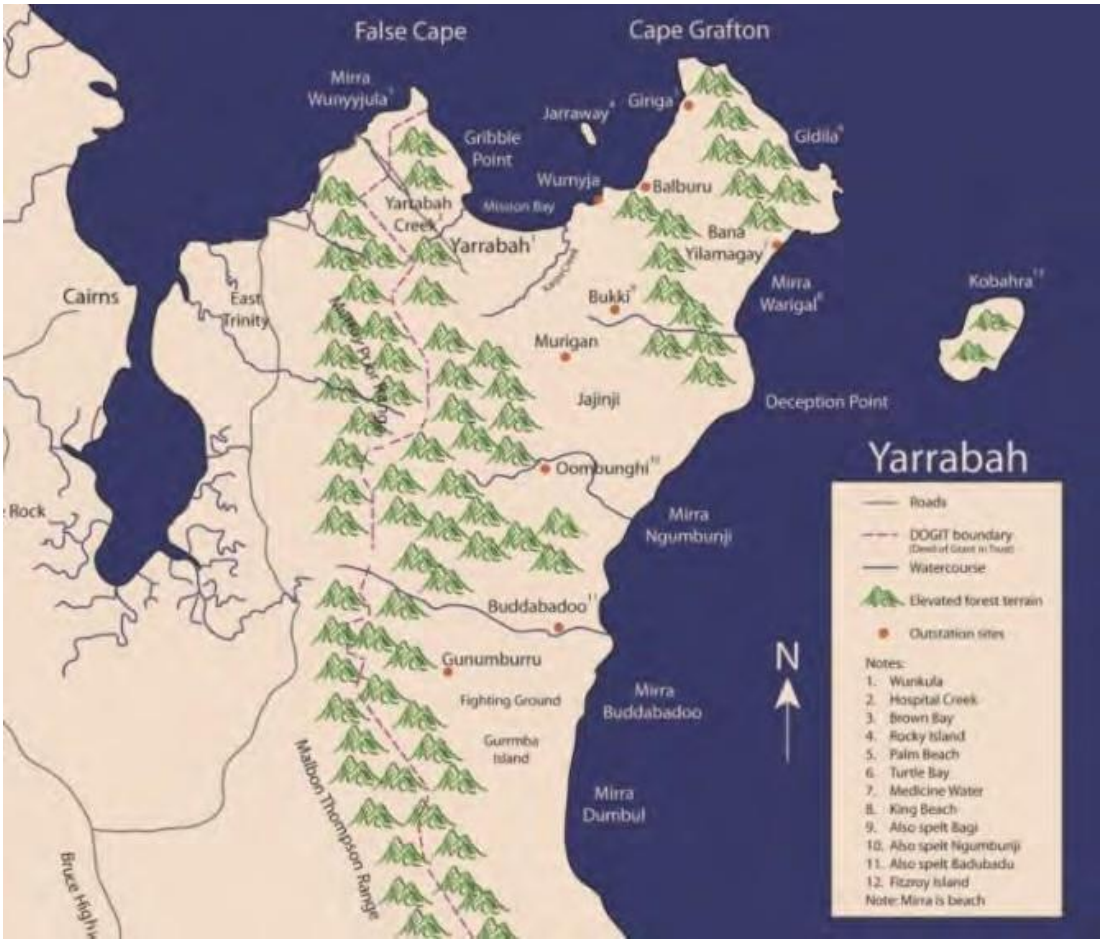

FIGURE 1 MAP OF YARRABAH AND REGION

Yarrabah is the traditional country of the Gunggandji and Yidinji people, who have lived here since the beginning of the Dreamtime. Today, many families in the community claim historical and traditional ties to the area, having been brought to Yarrabah from various locations by past government policies. The modern day Yarrabah community is made up of descendants from the Gunggandji, Yidinji and many other tribal groups, who continue to live and work together for the betterment of the community.

FIGURE 2 AERIAL PHOTO OF THE YARRABAH REGION

Yarrabah is acknowledged to be Australia's largest discrete Aboriginal community. At the time of the last (2016) Census, Yarrabah was reported to have a population of 2,559, with over 97% of respondents identifying as

Aboriginal or Torres Strait Islander (https://www.abs.gov.au/websitedbs/censushome.nsf/home/2016). The median age of the population was 22 years.

The population data from the 2016 Census recorded that:

- 97.3% of the population identified as Aboriginal and/or Torres Strait Islander
- 34.4% of Aboriginal and Torres Strait Islander persons were aged 0 to 14 years
- 59.4% of Aboriginal and Torres Strait Islander persons were aged 15 to 64 years
- 3.5% of Aboriginal and Torres Strait Islander persons were aged 65 years and over

The accuracy of these official figures is questioned. Members of the Yarrabah Local Disaster Management Group (LDMG) promote a population figure of closer to 4,500 permanent residents. This figure is based on data collected by both the Queensland Police Service and Gurriny Yealamucka Health Services Aboriginal Corporation.

Yarrabah Aboriginal Shire Council

The Yarrabah Aboriginal Shire Council was established in the mid-1960s, principally as an advisory body. The community received a Deed of Grant in Trust (DOGIT) land tenure status in 1986. The Yarrabah Aboriginal Shire Council is now self-governing and covers an area of 159 square kilometres.

History

Between 1950 and 1960 there was persistent public criticism of the management of Yarrabah Mission. In 1957 the Yarrabah residents staged a strike to protest inadequate rations, poor working conditions, and the autocratic rule of the superintendent. The incident was the culmination of a decade of internal and external dissatisfaction with the mission. Approximately 200 residents of Yarrabah, many of them supporters of the strike, were quickly given exemption from the 'Safety Act' and left the mission over the next two years.

On 1 July 1960, the Queensland State Government officially took over control of the Yarrabah mission from the Anglican Church. Yarrabah was now a settlement under which all aspects of Aboriginal lives were controlled and regulated by the State.

In 1984, the Yarrabah Council was established under the Community Services (Aborigines) Act.

On 27 October 1986 Yarrabah received status as a Deed of Grant in Trust (DOGIT) community.

In 2005, the Yarrabah Aboriginal Shire Council came into being under the Local Government (Community Government Areas) Act 2004.

Today the Gunggandji people are party to two active Native Title Claims related to the peoples' traditional land at Fitzroy Island and mainland areas near Yarrabah.

The Council today

Yarrabah Aboriginal Shire Council's commitment is to foster unity, respect elders, celebrate courage, facilitate connection, refine for efficiency and acknowledge equality and govern with integrity.

Council's Mission: A better quality of life through sponsoring a sense of purpose, respect and pride.

Council's Vision: Working in unison and empowering the community to determine its own future.

As the executive arm, Yarrabah's Mayor and Councilors make local laws and determine policy and other matters at a strategic level. They are responsible for determining and setting the overall direction of the local government, and are ultimately directly responsible to the community for the council's performance.

The following statistics and infographics were presented by the Yarrabah Mayor (Yarrabah Aboriginal Shire Council) at a community meeting addressing social infrastructure in November 2020.

Yarrabah Aboriginal Shire Council is the major employer in the region. Most employed people in Yarrabah work either for the Council, Gurriny Yealamucka Health Service or for State Government agencies. There is a small number of retail and tourism businesses.

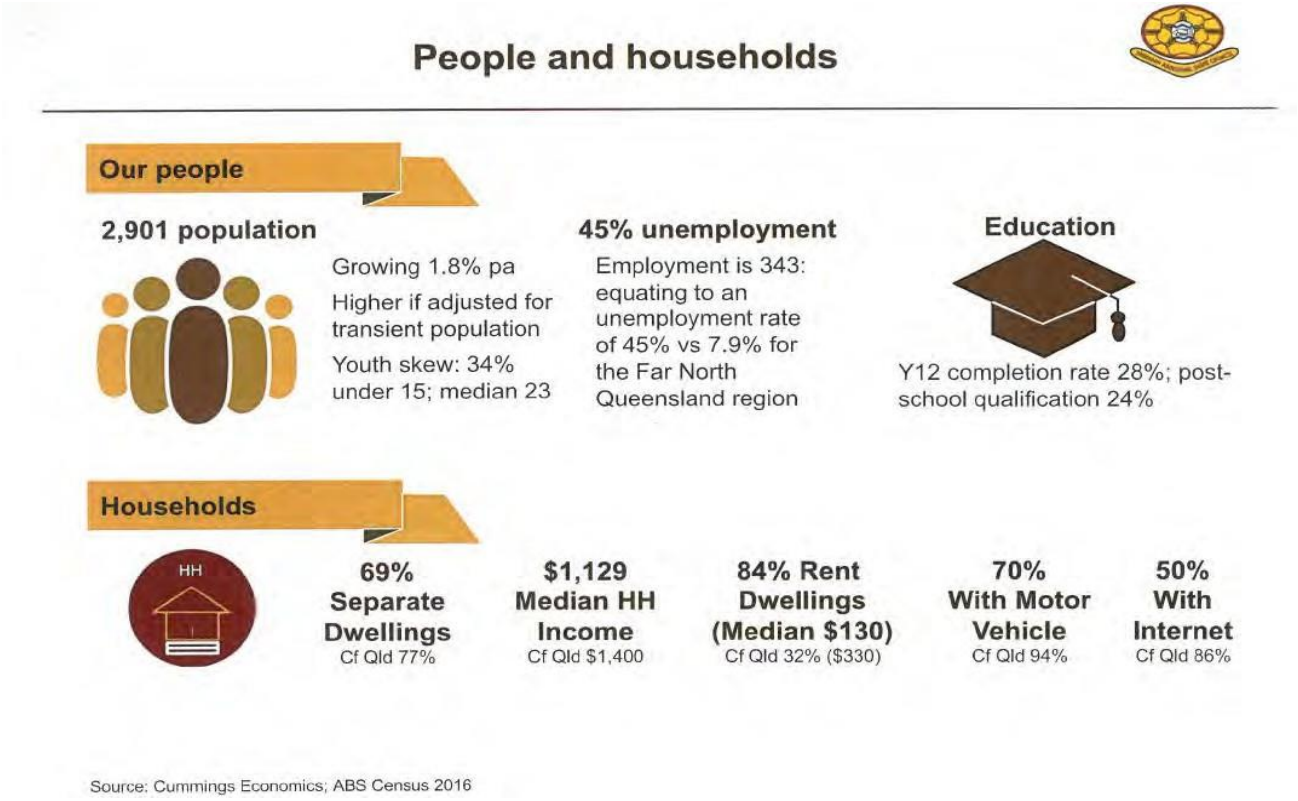

FIGURE 3 PEOPLE AND HOUSEHOLDS IN YARRABAH

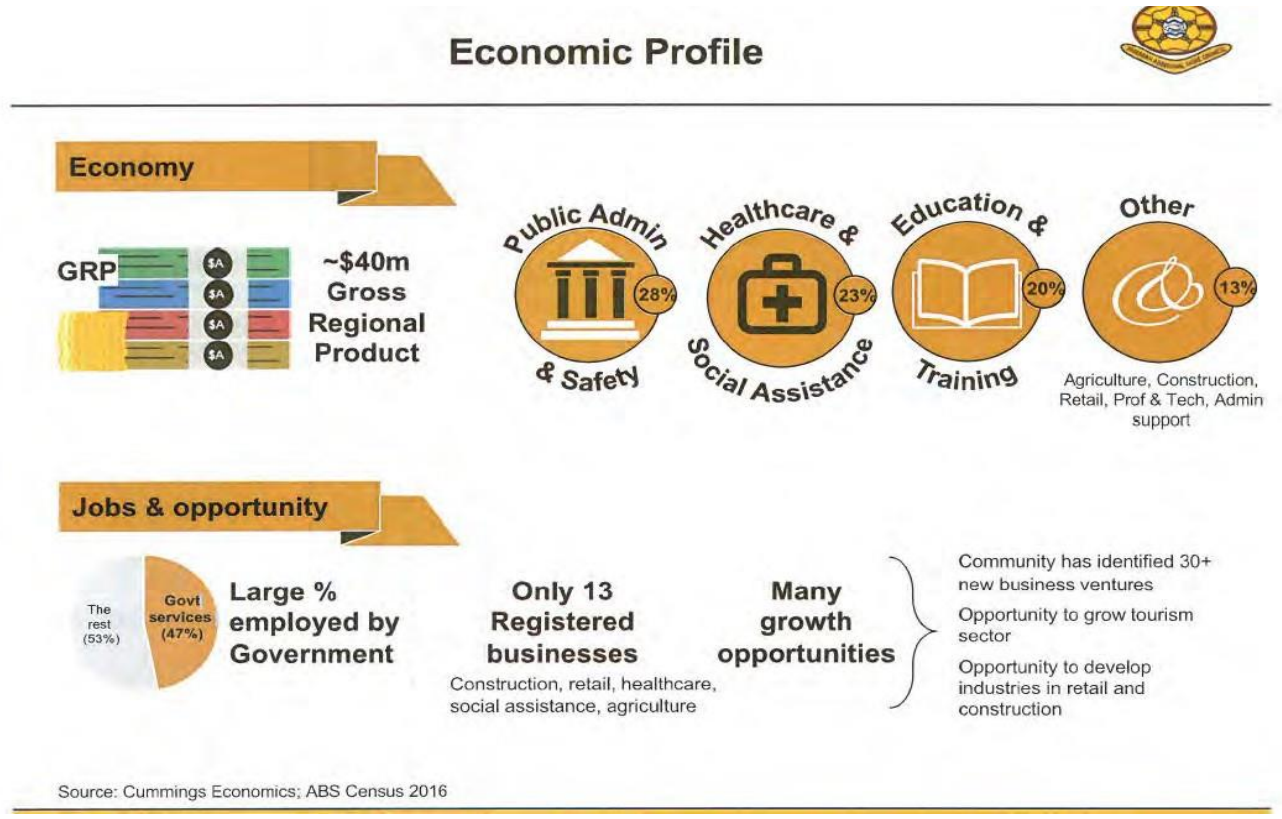

FIGURE 4 ECONOMIC PROFILE OF YARRABAH

Yarrabah Leaders' Forum

The Yarrabah Leaders' Forum has a shared vision for *One People, One Fire, One Journey*

The Yarrabah Leaders' Forum (YLF) is comprised of leaders from 15 member community-based organisations with a common vision for the community. The YLF's work on developing a common agenda amongst the member organisations commenced in 2013 and was endorsed by the community in 2015.

The YLF's agenda is firmly set on developing cultural, community and spiritual values for everyone in Yarrabah: *One people, One fire, One journey*. A representation of the YLF's priorities is illustrated by a six-pillar model of the vision and mission the YLF share for Yarrabah (figure 6). This vision was presented to the State Government in 2016, and in 2017 the YLF received funding from the Queensland Department of Prime Minister and Cabinet. The YLF worked with the government to:

- Address local issues within a cultural, community framework
- Share data between agencies
- Gain support to actively address community issues
- Increase resources to Yarrabah

The YLF's role has progressively developed: it is a now a forum that:

- Provides united leadership and community level discussions
- Identifies and co-ordinates solutions for social determinants
- Provides central co-ordination between government and the community
- Supports lobbying and advocacy with and for member organisations

Speaking about the importance of the YLF, Yarrabah's Mayor Ross Andrews said in 2019: "*Underpinning the work of the YLF has been a strong desire to maintain and revitalise our own culture and lore, so it is always there to guide the community. We want to restore cultural, community and spiritual values and be better, well-rounded people undertaking lifelong journeys. To help achieve this, Yarrabah needs to improve its economy and infrastructure as this will lead people to have better control over their lives, and increase their personal and community pride. The YLF, together with our community, want everyone to be healthy, have thriving families not impacted by disease and illnesses".*

The current membership of the YLF includes the organisations and community groups below (figure 5). Queensland Police and Yarrabah State School are quasi members.

FIGURE 5 MEMBERS OF THE YARRABAH LEADERSHIP FORUM

The YLF 6 Pillars *One People, One Fire, One Journey*

The YLF as a collective demonstrates unified community leadership. To build a stronger community with a positive future, the YLF operates under 6 Pillars (figure 6). The members' collective aims are to address common ground between the Six Pillars.

The 6 Pillars of our *One People, One Fire, One Journey* were first conceived at the 2015 Community Summit. The 6 Pillars is a living document and since inception, the pillars have been adapted and shaped to meet the dynamic needs of, and changes in, the Yarrabah community.

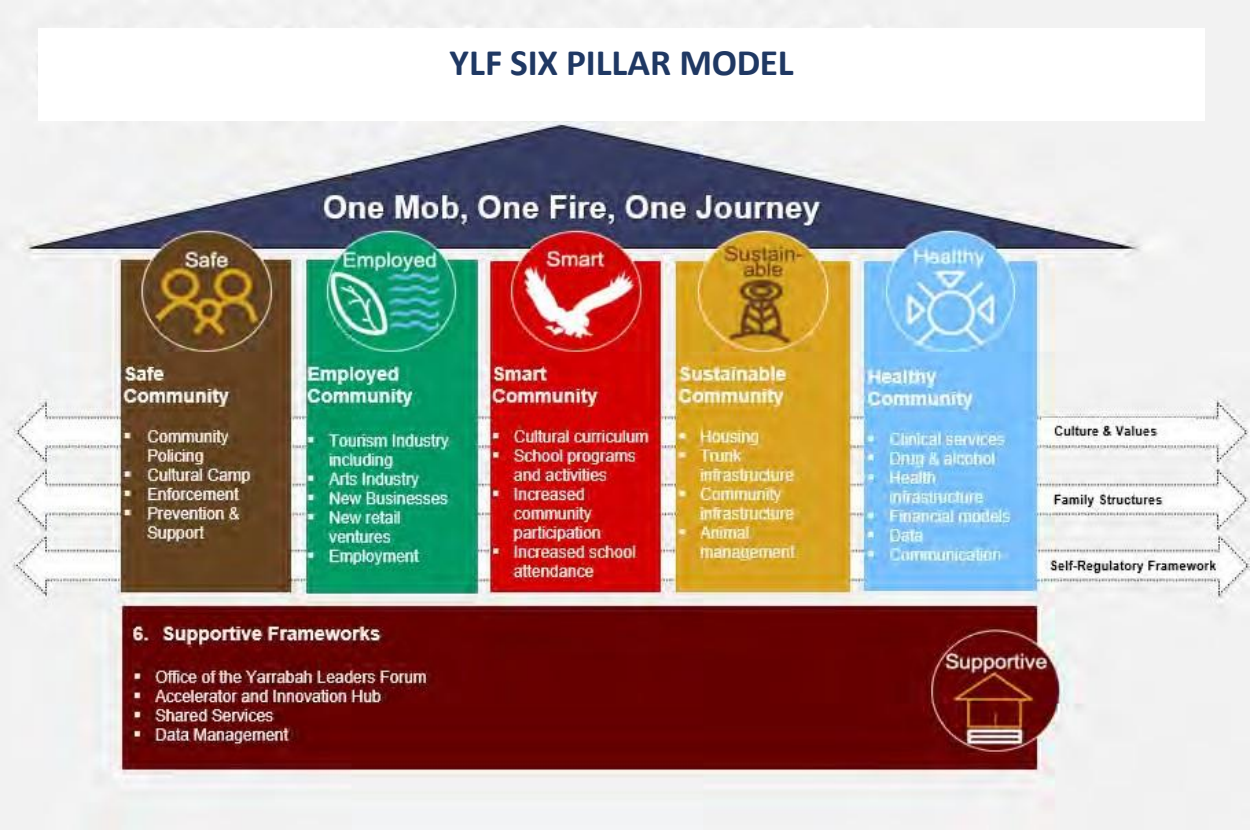

FIGURE 6 THE SIX PILLARS

PILLAR 1: SAFE COMMUNITY - Make our community safe

- Better support families to look after children
- Increased community based activities
- Safe space if not available at home
- Being accountable for actions

PILLAR 2: EMPLOYED COMMUNITY - Help people to be financially secure and off welfare

- Get people ready for work
- Place into jobs
- Encourage and support into further training | studies
- Support new and existing businesses
- Focus on tourism opportunities

PILLAR 3: SMART COMMUNITY - Everyone has the capacity to do the things they want

- Students finishing school and going to university, into a job or into business or tourism
- Opportunity for anyone to further themselves

The YLF recognises the need to support our *Cuddi Cuddis* to work with the school to embed cultural ways of learning in the teaching of the curriculum. Driving and influencing this cultural change can be achieved by community members actively participating in decision-making about our children's education and how the school engages with community.

PILLAR 4: SUSTAINABLE - We have the infrastructure that meets our community's need

- Explore different ways to get more houses
- Public spaces encourage more family use
- Develop local businesses to do future infrastructure work
- Prepare for future tourism opportunities

PILLAR 5: HEALTHY COMMUNITY - Everyone is healthy and our community is free of disease

- Health services delivered by our community
- Services are resourced to meet the health needs
- Public spaces encourage healthy lifestyles

PILLAR 6: SUPPORTIVE FOUNDATIONS - We have the support foundations to help establish the community we want

- We have values / principles / standards for our community
- Families have the support they need
- Funding for Yarrabah is given to local organisations

The YLF's Supportive Foundation pillar underpins the need to ensure all the member organisations are guided by the 6 Pillars. This means the YLF is working collectively to develop and grow Yarrabah's shared cultural, community and spiritual values. It also ensures that external funding to organisations ultimately ends up with local organisations that contribute to achievements across the 6 pillars. The YLF supports local organisations with their general compliance, governance and accountability, and in meeting their reporting and corporate requirements.

The Supportive Foundations pillar ensures the YLF is working effectively and efficiently across all the 6 Pillars to enable long term and sustainable change and to the YLF's accountability to Yarrabah. Collectively, as *One People, One Fire, One Journey* the YLF and community strive for Yarrabah to be a safe, smart, sustainable and healthy community.

Gurriny Yealamucka Health Services Aboriginal Corporation

Gurriny Yealamucka Health Services Aboriginal Corporation (Gurriny) is an Aboriginal Community-Controlled Health Organisation (ACCHO) that delivers primary healthcare services within the Yarrabah Aboriginal Shire.

Gurriny Yealamucka means *good healing water* in the language of the Gunggandji Peoples of Yarrabah. Gurriny's culturally appropriate model-of-care is developed by its doctors and Aboriginal Health Workers and encompasses all aspects of clinical and social healthcare delivery.

Gurriny was established as an ACCHO in 2000. The following ten years saw a continual progression of the number and type of primary care services that Gurriny provided to the community. In 2010 Gurriny co-located with Queensland Health and Queensland Ambulance Service to a new purpose-built, primary healthcare centre at Bukki Road. The site was chosen to accommodate the expanding community, and so health services were centrally located to provide better accessibility.

On 1 July 2014 all healthcare services to Yarrabah people were transitioned across to community-control under Gurriny Yealamucka Health Services Aboriginal Corporation. This meant that the Yarrabah community could be more involved in the strategic direction and decisions for improved healthcare, and how services were to be delivered in the community.

Gurriny strives to empower the people of Yarrabah by assisting individuals identify, manage, and prevent chronic diseases. The clinic is committed to providing preventative care that starts with regular health checks supported by ongoing health education and management.

Gurriny's services

The Clinical Team is led by Senior Aboriginal Medical Officer and a team of GPs, nurses, health workers and administrators who care for over 3000 clients from the Yarrabah and broader Aboriginal community who may live outside the community. The Care Coordination team focuses on encouraging community to have Health Checks and

regular chronic disease check-ups and provides ongoing education and support directly to clients to assist in the management of their chronic health conditions.

Gurriny currently provides the clinical services listed below:

- Medical | clinical team – 8 doctors
- Child Health
- Maternal Health
- Public Health
- Sexual health programs and clinics
- Visiting and allied health services

To apply the holistic nature of Aboriginal health and wellbeing, Gurriny operates a number of Wellbeing programs that meet the life span needs of the community's families, children and youth:

- Family healing and wellbeing services
- Social and emotional wellbeing services
- Health promotion
- Youth Hub

The Gurriny Care Coordination Team provides access to:

- A multi-disciplinary team of health professionals through coordinating and operating 15-20 Visiting Services Clinics each month
- A number of allied health clinics and visiting specialist clinics
- Specialist services include: paediatrician; cardiologist (adult and paediatric); dental; gynaecologist; ophthalmologist; geriatrics specialist; audiologist; podiatrists; speech pathologists; physiotherapists; exercise physiotherapists; and psychologist and counsellors.

Integrated Atlases of Health Care

Introduction

The *Integrated Atlas of the social and emotional wellbeing services for Indigenous children and youth in Yarrabah* is a tool co-created and developed for planners of youth services in the region. It includes detailed information on social and demographic characteristics and health-related needs, as well as data on service availability and care capacity. The maps and graphics which are used as a main form of presenting the data allow policy planners and decision makers to strengthen linkages and partnerships between the different sectors.

The information about youth services provided in this Atlas has been developed to: support decision makers to more comprehensively understand the landscape in which they work; make connections between the different sectors to improve the alignment of services to meet local needs; and identify duplications and gaps in the system. The information can also support decision making about the balance of services across the spectrum of prevention, early intervention and treatment/care; and between Community-Controlled, non-government and/or government services. This information is vital for future integrated care planning.

It is expected that the *Integrated Atlas of the social and emotional wellbeing services for Indigenous children and youth in Yarrabah* will promote more holistic, systems-based approaches to planning, and thus improve the provision of care by facilitating increased integration and coordination of services. Ultimately, this expectation will be reflected in assessments of the quality of care provided in the region; and in the longer term, improved health and wellbeing outcomes for youth in Yarrabah.

In this context, it is crucial to provide policy and service decision makers with every tool and opportunity to make informed choices about future investments in mental health care. This includes knowing which services are needed and where, and how they can be most effectively delivered. In other words, what is needed is a map to help guide services through the reform journey. This Atlas has been designed as a tool to help in this process.

A total of 20 atlases using this method have been completed across Australia since 2015, including the 2020 Integrated Atlas of Youth Mental Health Care in the Australian Capital Territory, and the Integrated Atlas of Mental Health of the Kimberley region. The DESDE instrument which is used to describe and classify services in this Atlas has also been used to describe and compare the pattern of mental health service provision in Kimberley region, Nunavik (Canada) and Lapland (Norway). These are just a few of the 585 uses of the DESDE system (and the earlier ESME system) in 34 different countries to describe services at local, regional and national levels. The DESDE/ESME-system's metric properties have been extensively analysed, and the usability of the system has been demonstrated around the world (25).

This Atlas, and *the Integrated Atlas of the social and emotional wellbeing services for Indigenous children and youth in Cairns,* are the first global Integrated Atlases of social and emotional wellbeing services for Indigenous youth using the DESDE instrument. They will provide a valuable snapshot of the services available to young people in these regions, along with the opportunity to assess strengths and gaps in the system; to evaluate the availability of services in relation to state and national policy objectives; and to inform advocacy for service delivery for Indigenous youth.

Method

Unlike systems of service classification which focus only on health services, the “whole system” or “ecosystem" approach of the DESDE model allows for the classification and description of services in any sector of care. This holistic approach makes it uniquely suitable for providing a description of the pattern of care following a social and emotional wellbeing model. The standardised model compares “like for like” services, and thus will provide a unique opportunity to compare with other patterns of social and emotional wellbeing care in other Indigenous communities, both in Australia and overseas. Additionally, it provides a baseline picture of service availability from which the impact of future service planning and policy initiatives can be assessed.

DESDE Instrument

The instrument used for data collection was the Description and Evaluation of Services and DirectoriEs for Long Term Care (DESDE-LTC or DESDE), an internationally validated instrument for the standard description and coding of services (8). DESDE-LTC offers a multi-level way of classifying and coding the services and types of care that are provided to the target population in any relevant care sector. It organises these classifications according to six main branches of care types (Residential, Outpatient, Day Care, Self-help and Voluntary Care, Information and Assessment, and Accessibility to services); and according to characteristics such as acuity, mobility, and intensity of service provision; to provide a finely detailed description of the type of care provided by care teams working within services.

These teams of professionals (known as Basic Stable Inputs of Care or BSICs) are the lowest units of production of care. In providing a common unit of analysis, this method addresses methodological problems inherent in mental health services research : (i) terminological variability (different terms may be used for the same type of service and vice versa); and (ii) a commensurability bias (different units of analysis may be used which do not provide true like for like comparison). The use of a common unit of analysis thus enables cross country, cross regional and longitudinal comparison of service provision at the local level.

Once BSICs are identified, the Main Types of Care (MTC) they provide are examined and classified. Each BSIC is classified by using one or more codes based on the MTC they deliver. Some services might include a principal MTC code (for example a ‘Residential’ code) and an additional MTC code (for example, a ‘Day Care’ code), where the service provides more than one Main Type of Care according to DESDE criteria.

There are six main classifications of care within the DESDE-LTC, as described below. (See Annex D for detail of the DESDE-LTC taxonomy and Annex B for a glossary of terms)

1. Residential Care - used to classify facilities which provide beds overnight for clients for a purpose related to the clinical and social management of their health condition. These include inpatient hospital wards, crisis shelters, residential rehabilitation services and inpatient withdrawal units. Residential Care is divided into Acute and Non- Acute branches
2. Day Care - used to classify facilities which: (i) are normally available to several clients at a time (rather than delivering services to individuals one at a time); (ii) provide some combination of treatment for problems related to long-term care needs (e.g. providing structured activities or social contact/and or support); (iii) have regular opening hours during which they are normally available; and (iv) expect clients to stay at the facility beyond the periods during which they have face to face contact with staff: these include the more traditional long-stay day programs
3. Outpatient Care - used to code care provided by service delivery teams which: (i)involves contact between staff and clients for some purpose related to the management of their condition and associated clinical

and social needs; and (ii) is not provided as a part of delivery of Residential or Day services. These include outreach services. Quite often, Outpatient Care also involves the provision of information and support to access other types of care

4. Accessibility to Care -classifies service delivery teams whose main function is to facilitate access to care for clients with long- term care needs. These services do not provide any therapeutic care, and include Care Co-ordination services
5. Assessment and Information for Care -used for service delivery teams whose main function is to provide clients with information and/or assessment of their needs. Services providing information are not involved in subsequent monitoring/follow- up or direct provision of care. These include telephone information and triage type services
6. Self-Help and Voluntary Care -used for teams which aim to provide clients with support, self- help or contact, with un- paid staff that offer any type of care as described above (ie Residential, Day, Outpatient, Accessibility or Information).

Inclusion criteria

Inclusion criteria for services providing mental health care to young Indigenous people in Yarrabah were as follows.

The service:

- Targets children, adolescents, or young adults up to the age of 18 years or their families/carers
- Fits within the Social and Emotional Wellbeing framework: that is, supports the SEWB of Indigenous youth in the region
- Provides direct care or support to the target population
- Is located in Yarrabah or has been identified in the referral pathways of services that are located in Yarrabah
- Is universally accessible: without significant out-of-pocket expenses or under a fully private insurance scheme

Data collection

Ethics approvals were submitted by the CQU research team and granted as per the following:

- Central Queensland University (0000021644)
- Queensland Department of Education (550/27/2319)
- Queensland Department of Children, Youth Justice and Multicultural Affairs, Child Safety (04458-2021)
- Queensland Department of Children, Youth Justice and Multicultural Affairs, Youth Justice (02361-2021)
- Queensland Health, Cairns Hinterland Hospital Health Service (1557 / 04458-2021)

DESDE Data collection commenced in July 2021 and was completed in February 2022. The CQU researchers (McCalman, McDonald), in consultation with the research partner team, identified eligible services meeting the inclusion criteria. The CQU team made initial contact by phone and email with service providers/managers to request a face-to-face interview. Written consent from interviewees for interview and recording was obtained at, or prior to, the interview.

Initial face to face interviews in Yarrabah and Cairns in July and August 2021 were conducted by members of the ANU/UC team (Salvador-Carulla, Furst) supported by the CQU team. Subsequent interviews were conducted by CQU primarily face to face, or when requested (or required to meet COVID regulations) by phone or Zoom Video. All interviews were recorded and securely electronically stored in line with the CQU data management protocols. Following interview, interviewees were sent summaries of the interview for their confirmation that the recorded data was accurate.

The following information was requested at interview:

- Team name, location and area of coverage
- Main Type of Care provided by the team including its target population, acuity, mobility and intensity of service provision as described above.
- Workforce providing direct support, in Full Time Equivalents
- Links with other services

Using the DESDE system, the information that is used to assess and code the type of care a service provides is gathered from the managers of the services themselves. The "bottom up" information collected in this way thus provides the real picture of the care or support currently provided by the service.

Data coding

The data collected from services was entered into a master spreadsheet for each region, analysed, and allocated a DESDE code (where the service delivery team meets the inclusion criteria) by the UC team.

The Main type of Care delivered by each service delivery team was coded following the criteria defined in the DESDE- LTC, according to the main type of care the service provided. Codes can be split into four different components and follow a standard format:

i) Target population

This first part of the DESDE code represents the main target population for whom the service is intended, or by whom it is currently accessed. There are two elements to this part of the code: (a) the age group of the people for whom the service is primarily intended or accessed; and (b) their diagnostic category, or SEWB related reason for using the service.

(a) Target population according to age group.

The following letter codes are used to represent the specific age groups to whom the service provides support

GX	All age groups
CX	Child & Adolescents (eg, 0 - 17 years)
CC	Only children (eg, 0 -11 years)
TC	Transition from child to adolescent (eg, 8 - 13 years)
CA	Only adolescent (eg, 12 - 17 years)
CY	Adolescents and young adults (eg, 12 – 25 years)
AY	Young adults (eg, 18 – 25 years)
TA	Transition from adolescent to adult (eg, 16 – 25 years)
AX	Adults 18 – 65 years

An additional letter is added to the age code where a service is for a specific population: if the service is gender specific; for example, GX[M] is used to indicate a service is specifically targeted at males of any age; or GX[IN] where a service is specifically for Aboriginal and Torres Strait Islander people.

(b) Target population code according to the person's diagnosis or to the reason related to the individual's SEWB for accessing the service.

This second element of the target population code is described using the International Classification of Diseases (ICD-10) Code. The ICD is a coding system which describes mental and physical illnesses, as well as a range of social or psychosocial situations which describe the main reason an individual may seek support from a health or social support service. ICD-10 codes appear in brackets after the age group code in the final DESDE code. If the client of the service is a child, but the professional is working with the family, or if the service is for carers, or the family, the code [e310x] (immediate family or carers) from the International Classification of Functioning (ICF) is used. The target population codes used in this report are described in Table 1 below:

TABLE 1 ICD-10 DIAGNOSTIC CODES USED IN THIS ATLAS

Diagnostic code	Explanation of code
F00-F99	**All types of mental disorders**
Z55.9	**Support of education and literacy**
Z62	**Support with upbringing of children**
Z62.21	**Support of family with child in Welfare Custody including maintenance of connection to culture**
Z65.0	**People who have a conviction in criminal or civil proceedings**
Z65.9	**Wellbeing support for people in unspecified psychosocial circumstance**
Z72.81	**Persons demonstrating antisocial behaviour**
ICD	**Used to indicate general health services**

ii) Main Type of Care

The next part of the DESDE code describes the Main Type of Care the service provides (MTC).

As explained above in the description of the DESDE instrument, the services were classified according to their Main Type of Care. This Main Type of Care is represented by the following letters:

- R Residential care
- D Day care
- O Outpatient care
- A Accessibility to care
- I Information for care
- S Self-help and voluntary care

iii) Extension codes (also called Qualifiers)

In some cases, a fourth component may be added to the final DESDE code to facilitate a quick appraisal of those characteristics of the services which may be relevant to local policy. Not all available qualifiers have been relevant for use in this Atlas. The qualifiers used in this report are:

b - bundled**:** This qualifier describes episode-related care provision, usually provided for non-acute patients within a time limited plan (eg, three months of brief psychotherapy).

g - group: This qualifier refers to outpatient services where most of the support is provided through group activities (typically over 80% of their overall care activity).

j - justice: This qualifier describes facilities whose main aim is to provide care for crime & justice users. This qualifier can also be used for youth detention, where the provider may be related to child safety rather than a correction service.

m - management: This qualifier describes services whose main aim is defined as management, planning, coordination or navigation of care but which also include several forms of clinical care as part of the coordination of their activity (e.g., the care team typically provides therapeutic counselling as part of its case management activities)

v - variable: This qualifier is used when the code applied could vary significantly in the near future (for example from acute outpatient care to non- acute). For example, a crisis accommodation team may fluctuate in its capacity to provide acute care within 24 hours depending on the demand and the availability of places. This code can be also applied to services under transition due to a health reform, a change in the whole financing system of health or social care, or the development of a new disability scheme. This variability in the pattern of service provision is independent of the time continuity of the service. For example, a continuous service can have a 'v' code due to a health reform while a care program limited to two years may show organisational stability during the period when it is funded.

Example of a DESDE code

The figure below (figure 7) shows the components of a code to demonstrate how a service may be coded

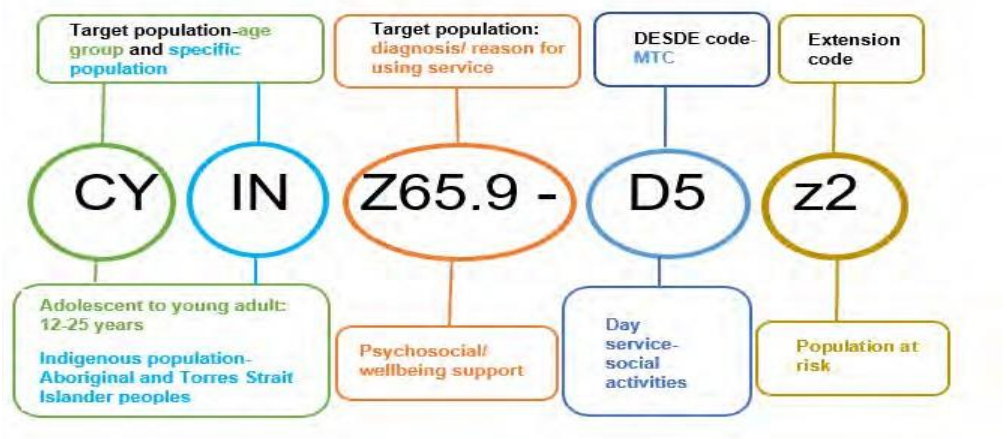

FIGURE 7 EXAMPLE OF A DESDE CODE

Analysis

The availability of service provision in the region was analysed according to the Main Types of Care provided by care teams (BSICs). Availability is defined as a service being operable upon demand to perform its designated or required function. The availability rate for each MTC was calculated per 100,000 people under 18 years of age. Data was coded according to the DESDE coding system.

To understand the balance between the different types of care offered in an area, a radar chart tool, also referred to as a spider diagram, is used. The spider diagram is essentially a tool to visually depict the pattern of care in an area. Each of the 21 points on the radius of the diagram represents the number of MTC for a particular type of care per 100,000 population.

Figure 8 is an example of a spider diagram describing and comparing the pattern of care in the Australian Capital Territory and Western Sydney PHN regions in New South Wales.

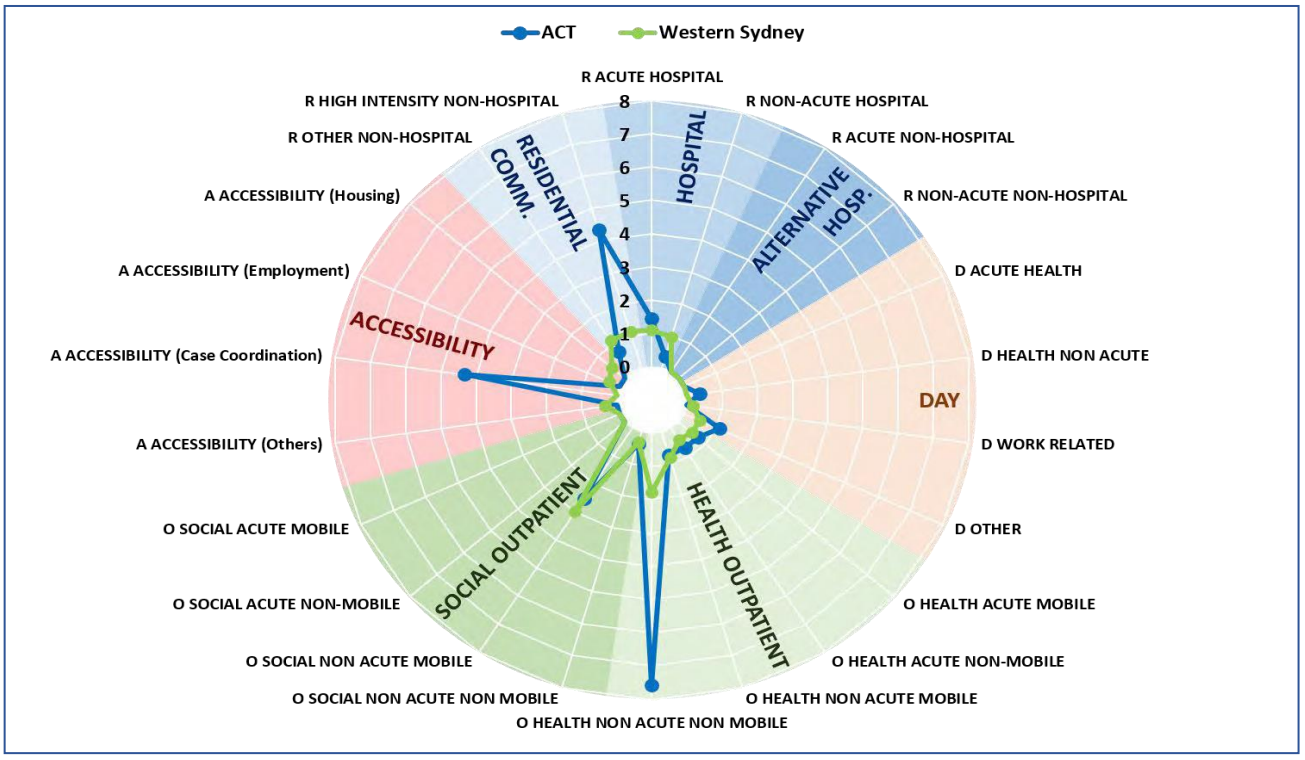

FIGURE 8 DISTRIBUTION OF MAIN TYPES OF CARE: COMPARISON ACT 2016 AND WESTERN SYDNEY 2015

How an Atlas is developed

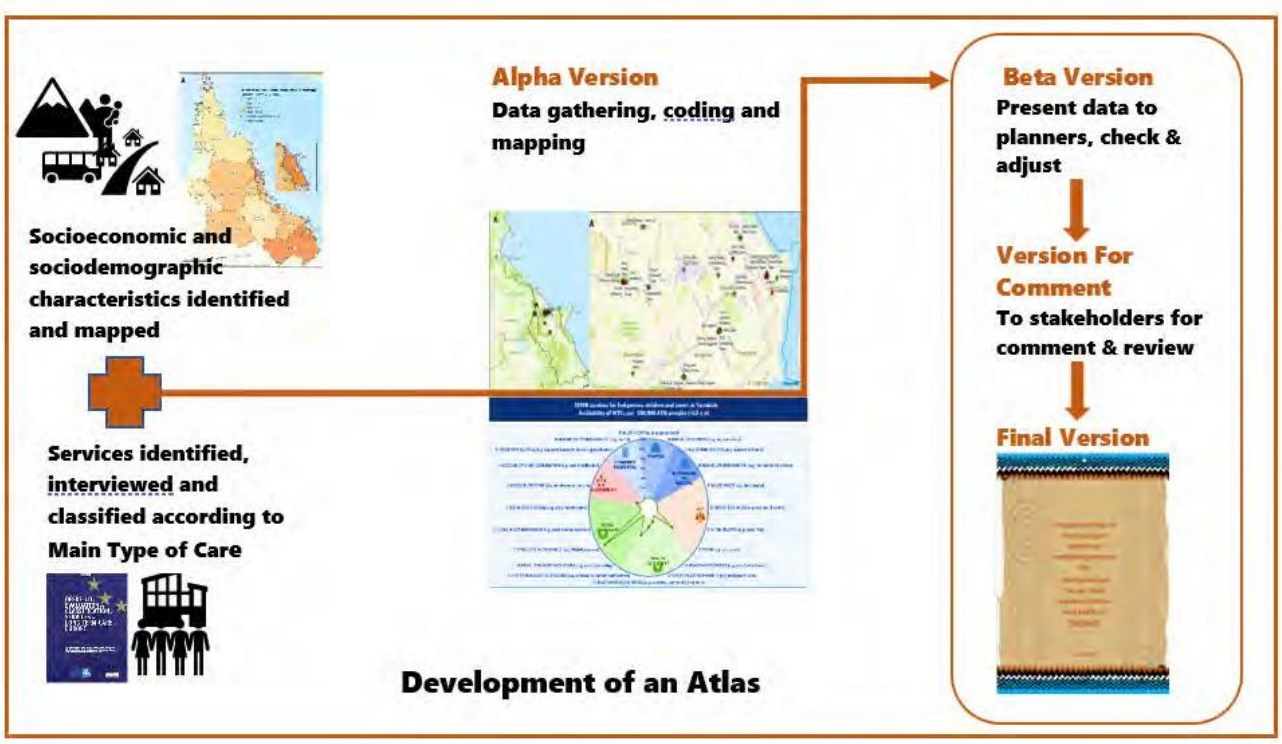

FIGURE 9 DEVELOPMENT OF AN ATLAS

Figure 9 shows the process of developing an atlas. Following the coding of the services and development of a draft Atlas (Phase 1 or Alpha version), the Atlas is presented to planners or research partners in order for them to review and adjust the data or codes presented when necessary (Phase 2, or Beta version). The Draft is then prepared by the research team for release to stakeholders. Time is allowed for stakeholders to review the service data and coding and provide any further comment. After further revision based on the received feedback, a Final Version is released.

Results

The following sections provide the findings of this research as follows:

Mapping the area

- The Social and Demographic Context

Mapping the Services

- Description of Service Availability for Youth in Yarrabah: Overview
- Tables of Services Coded with DESDE
- Description and Comparison of the Overall Pattern of Care

Discussion

Mapping the Area
Social and Demographic Context

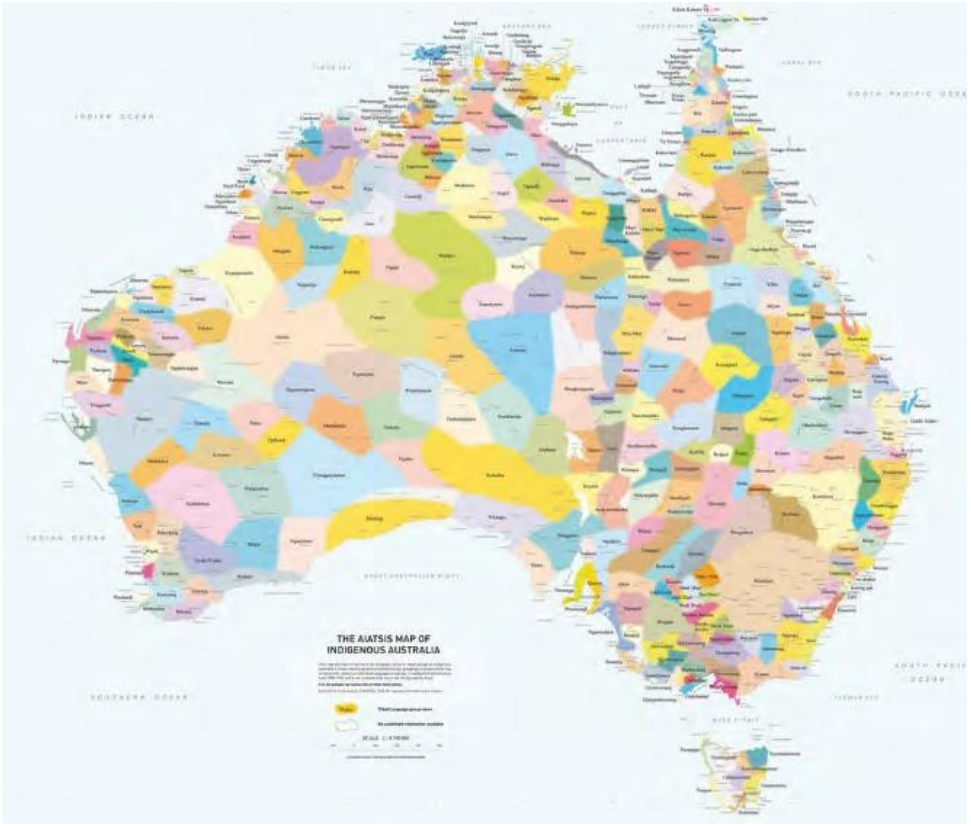

FIGURE 10 MAP OF INDIGENOUS AUSTRALIA

Yarrabah is an Aboriginal community located 60 kilometres east of Cairns in Far North Queensland, from which it is separated by the Murray Prior Range and Trinity Inlet, an inlet of the Coral Sea. It occupies an area of 159 km2 (61.4 sq mi). The traditional owners of Yarrabah are the Gunggandji people. Of the 2559 people identified as living in Yarrabah at the 2016 census, 97.4% identified as Aboriginal or Torres Strait Islander. The median age of Yarrabah residents was 23, compared with 38 nationally.

The following section provides a series of figures and maps showing the social, demographic and economic context of the Yarrabah population, sourced from the Australian Bureau of Statistics 2016 census.

Figure 11 shows the proportion of the population in Yarrabah aged less than 20 years of age

Yarrabah Population

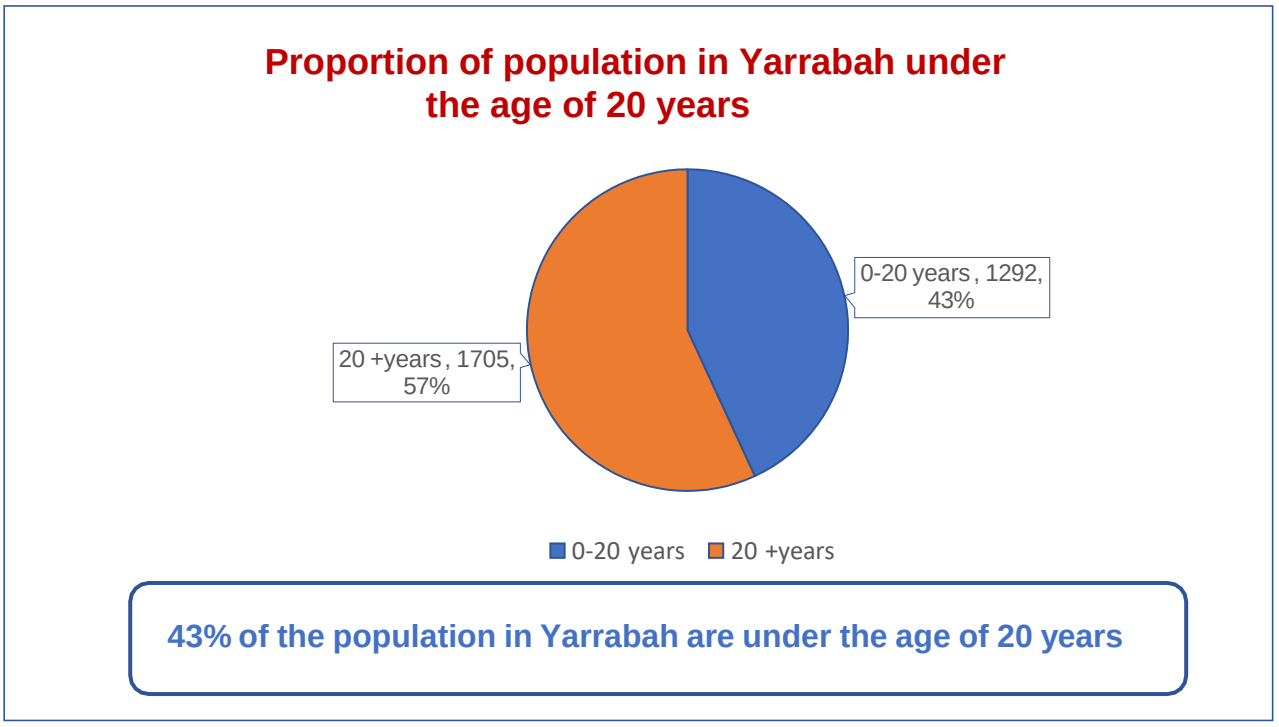

FIGURE 11 PROPORTION OF POPULATION < 20 YEARS, YARRABAH

Figure 12 shows the **number of Indigenous people in Yarrabah according to age and gender**

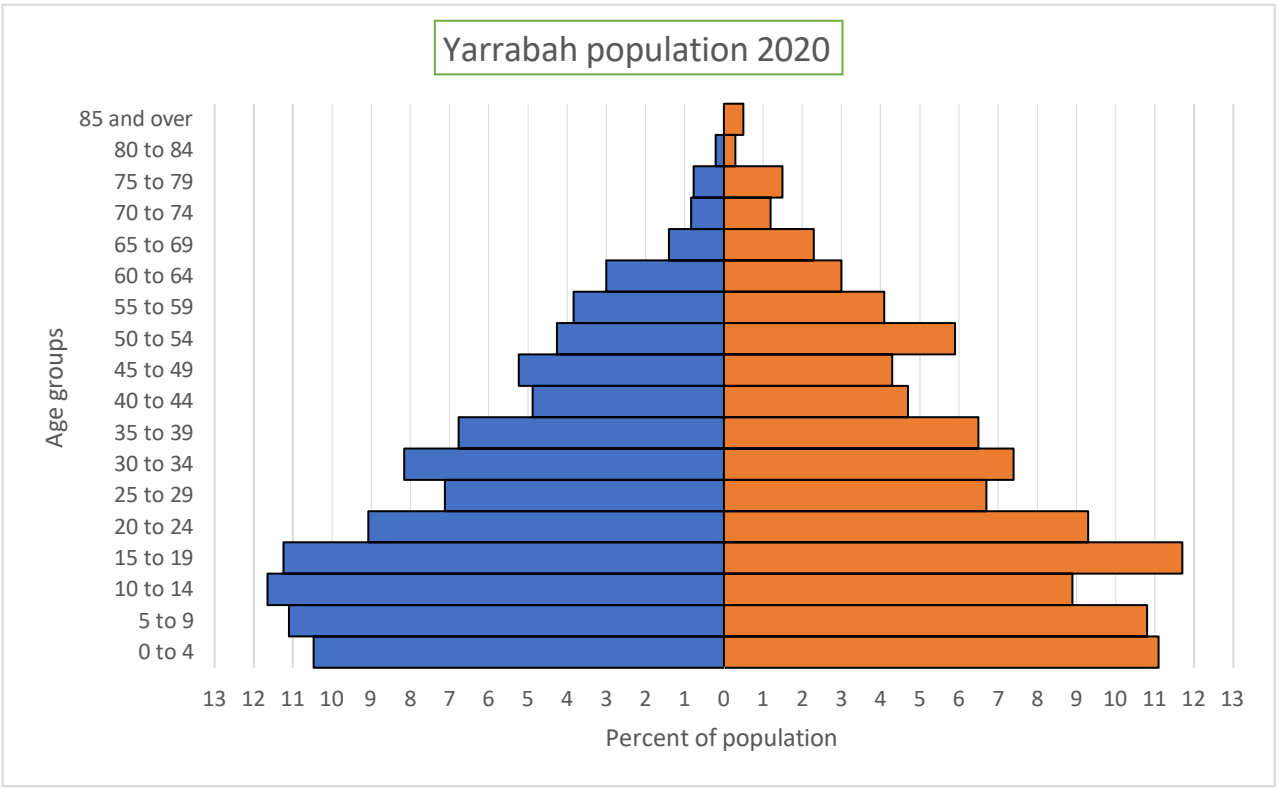

FIGURE 12 POPULATION DISTRIBUTION OF YARRABAH ACCORDING TO AGE AND GENDER

Figure 13 shows the proportion of the population in Yarrabah with access to the internet in their home. The figure on the left shows this information as it relates to the whole population, and to the right is the proportion of children in Yarrabah under the age of 15 years with access to the internet.

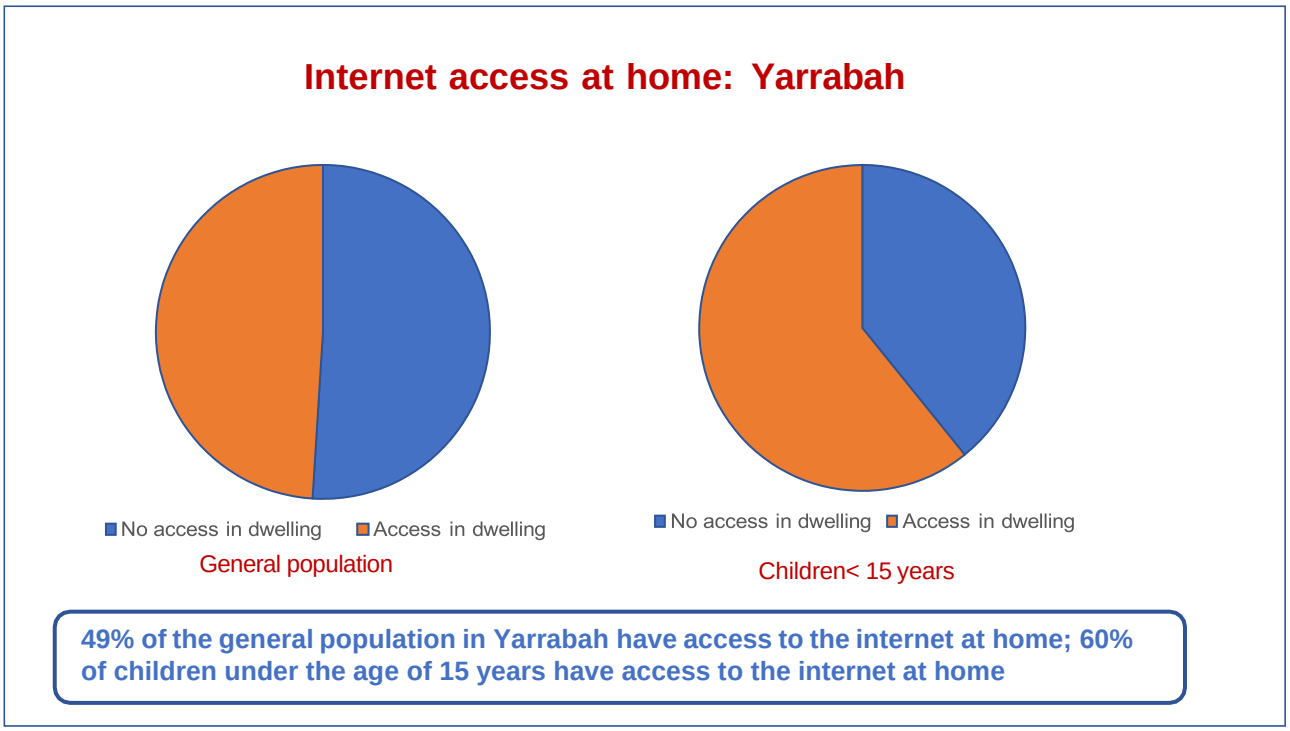

FIGURE 13 PERCENTAGE OF THE POPULATION WITH HOME INTERNET ACCESS, YARRABAH

Figures 14--17 in the following pages map a range of socio-economic indicators in the region.

Distribution of relevant indicators of childhood and adolescent development and mental health and wellbeing in Yarrabah (inset), Cairns and other regions of the Far North Queensland PHN.

FIGURE 14 PERCENTAGE OF ABORIGINAL AND TORRES STRAIT ISLANDER BY SA2 AREA

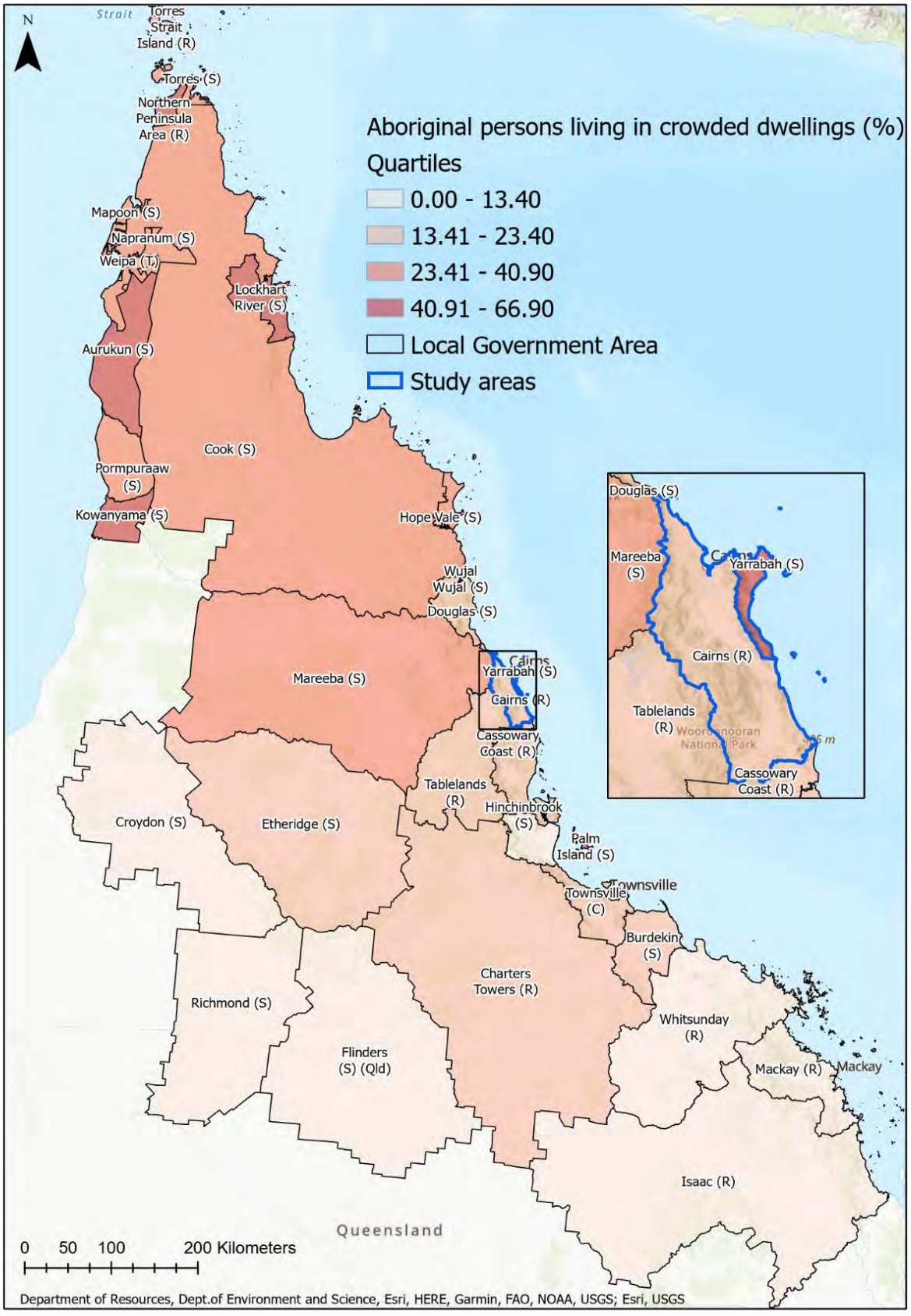

FIGURE 15 ABORIGINAL AND TORRES STRAIT ISLANDER PERSONS LIVING IN CROWDED DWELLINGS

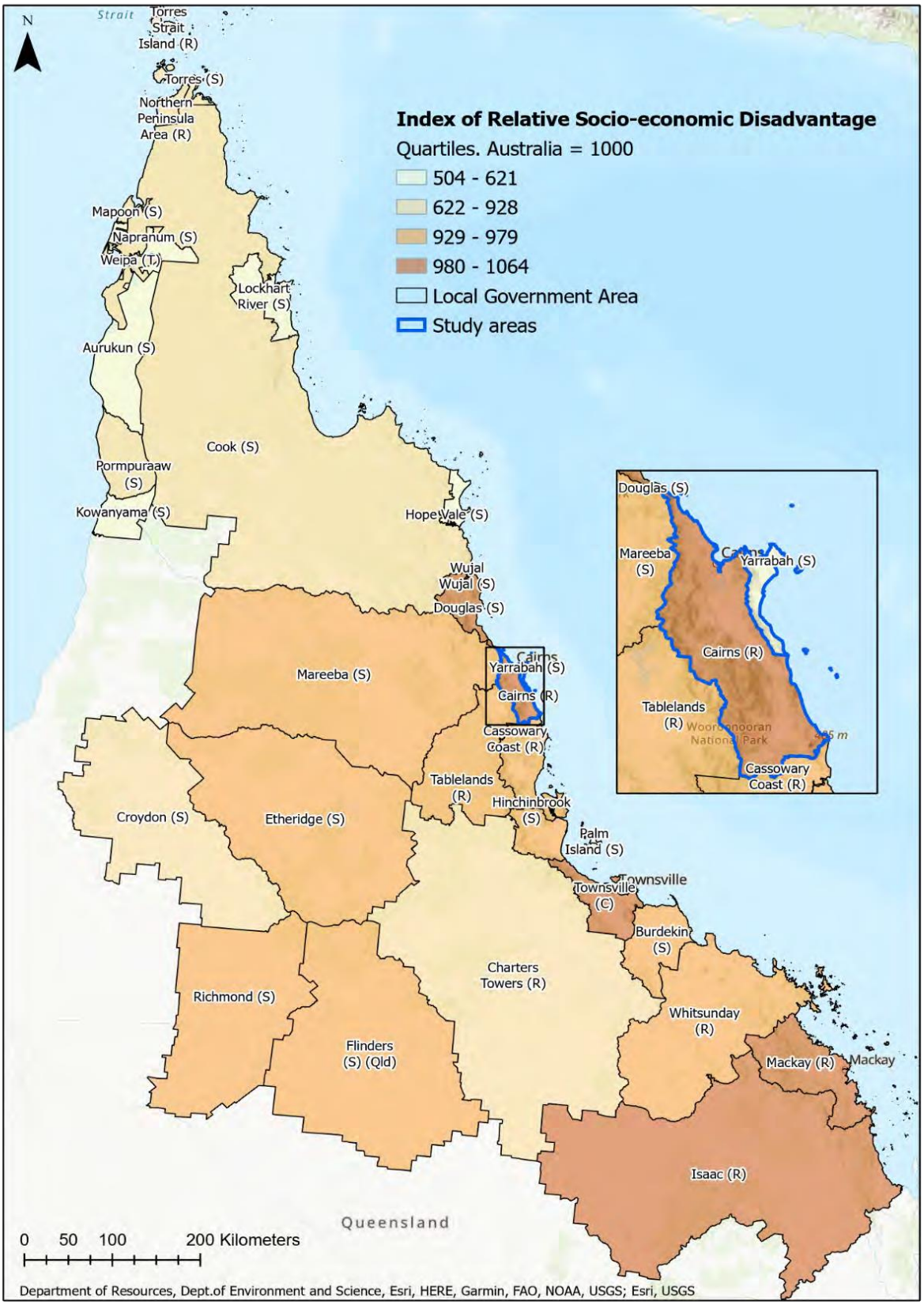

FIGURE 16 INDEX OF RELATIVE SOCIO-ECONOMIC DISADVANTAGE

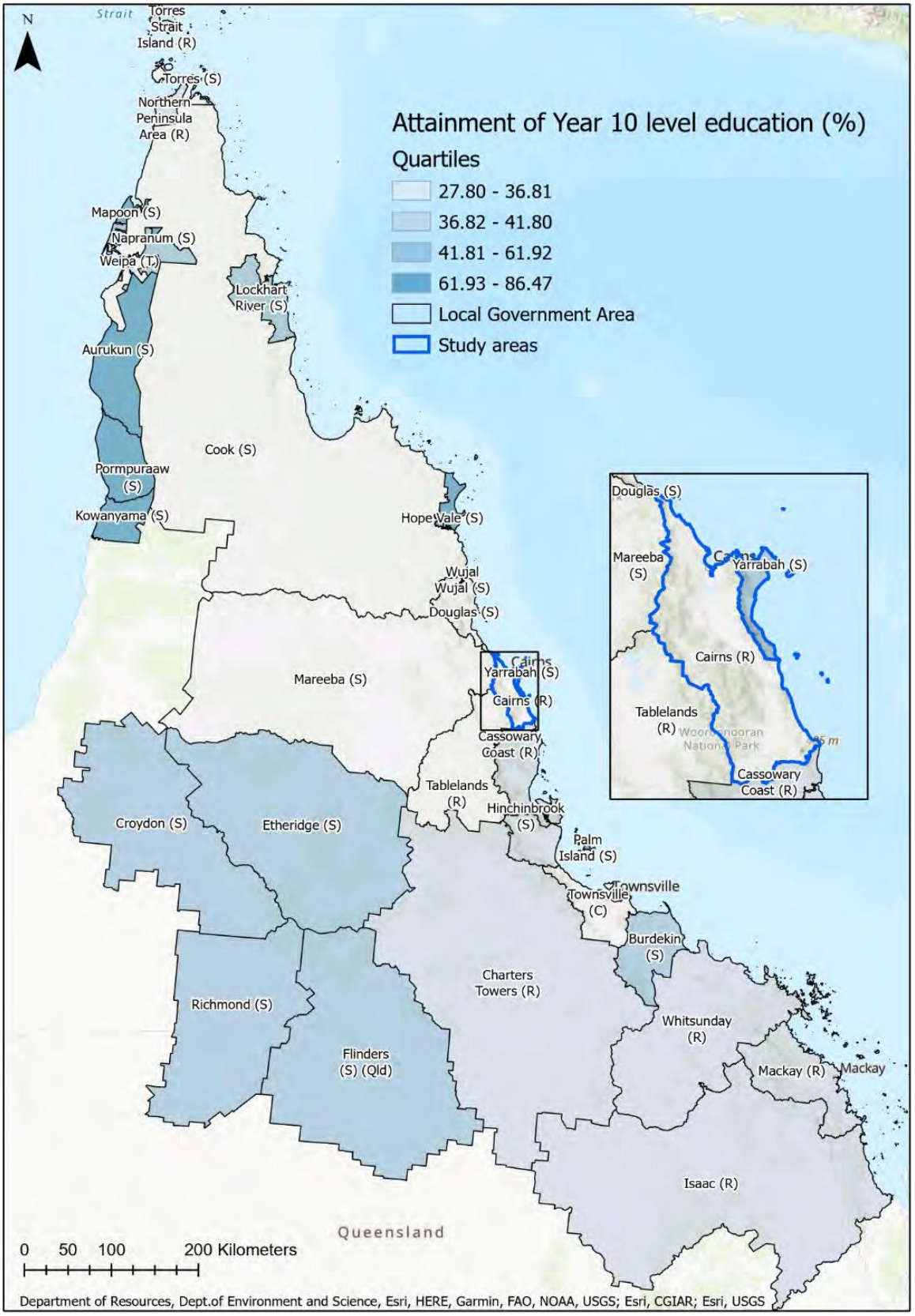

FIGURE 17 LEVEL OF ATTAINMENT OF YEAR 10 (%)

Mapping the Services

Description of Service Availability in Yarrabah: Overview

The data identified 10 service providers (organisations) providing 23 care teams (or BSICs) in Yarrabah.

These 23 care teams delivered 24 Main Types of Care (MTCs).

Six of these MTCs provide support to people of all ages; and 18 provide support specifically to young people (figure 18).

The diversity of care, or number of different unique DESDE MTC codes is 8.

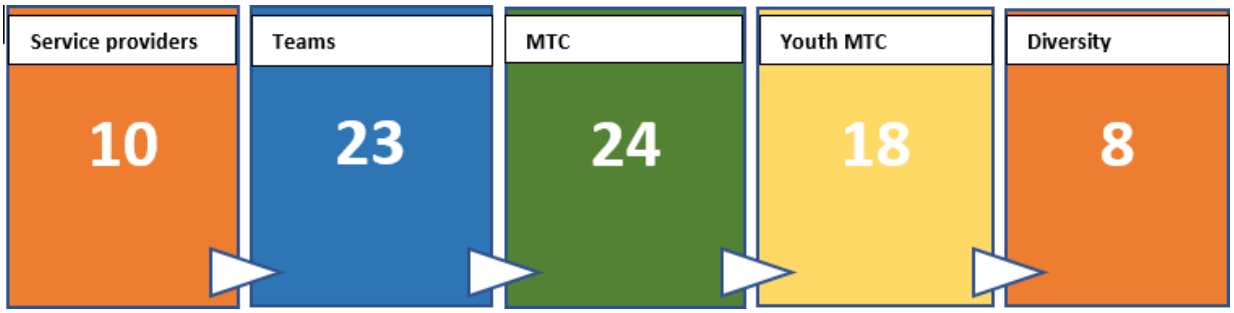

FIGURE 18 NUMBER OF SERVICES INCLUDED IN THE RESEARCH

In most of the figures below, the information provided is for:

(i) all 24 MTCs (including both services for people of all ages and both youth services

(ii) those services that are specifically targeting young people (youth specific services) only (18MTCs)

Of the 24 MTCs – (as shown in figure 19):

- 9 (38 %) were provided by Non-Government Organisations (NGOs)
- 8 (34%) were provided by Aboriginal Community Controlled organisations
- 4 (16%) were provided by the Queensland Department of Children, Youth Justice and Multicultural Affairs (CYJMA) (two related to youth justice and two to child safety)
- 2 (8%) were provided through Queensland Health
- 1 (4%) was provided through the education sector (Queensland Department of Education)

Looking at youth specific services only (figure 20):

- NGOs comprise a larger proportion of the services available (50% compared to 38% of all services)
- Aboriginal Community Controlled organisations provide 17% of care, down from 34%
- Public sector services (delivered by the Queensland Departments of CYJMA; Health; and Education make up 33% of the services delivered specifically to young people in Yarrabah, compared to 28% when including the services that are available for people of all ages.

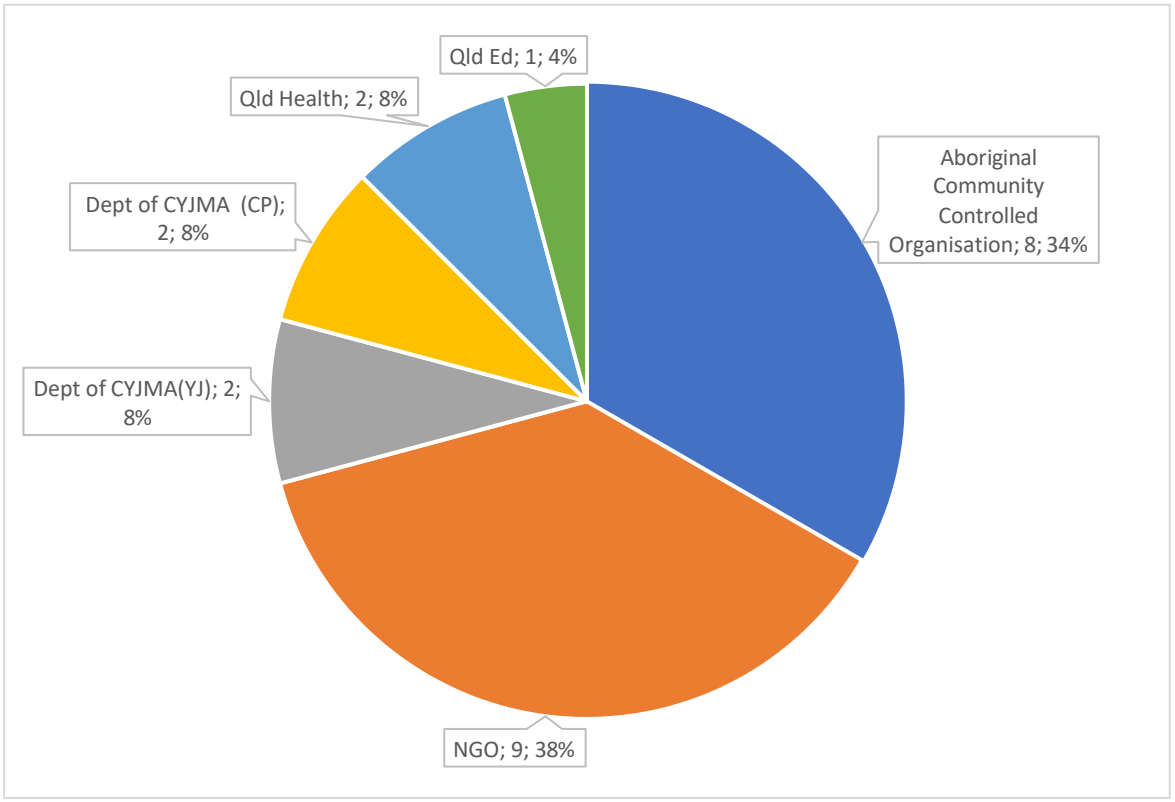

FIGURE 19 TYPE OF PROVIDER DELIVERING SERVICES-INCLUSIVE OF SERVICES FOR ALL AGES

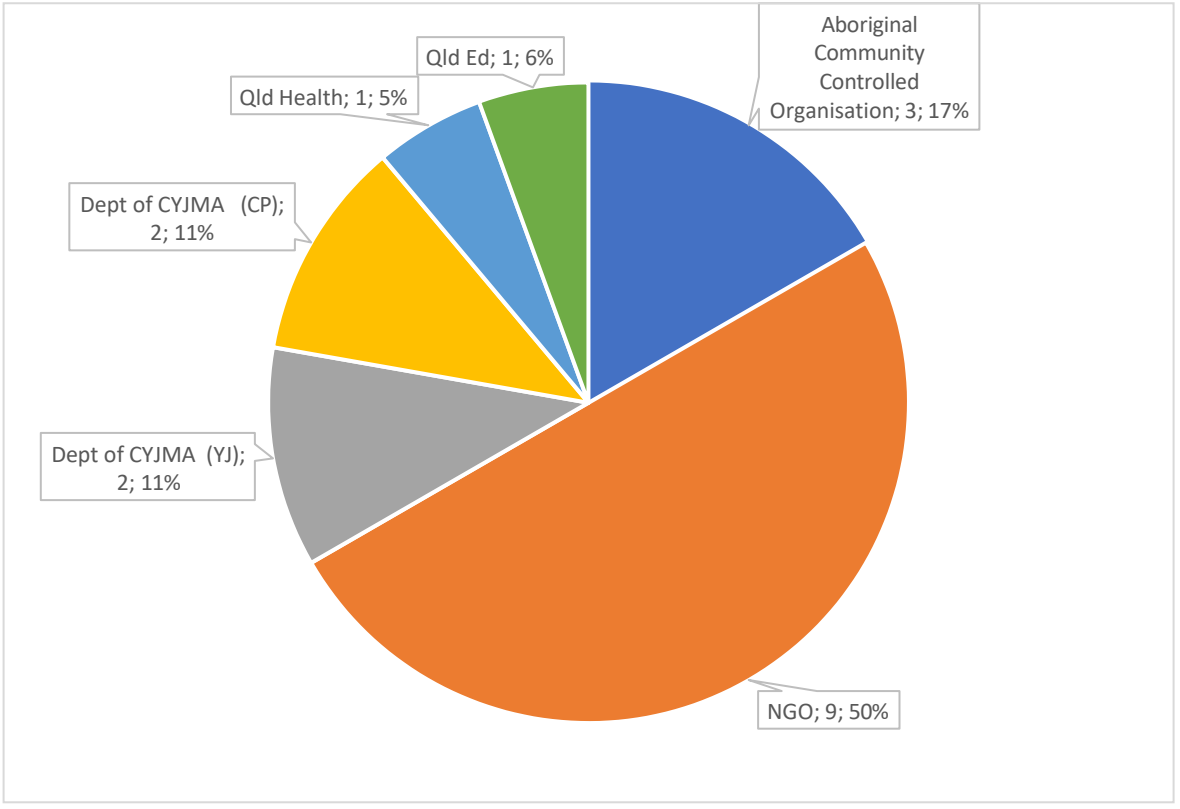

FIGURE 20 TYPE OF PROVIDER DELIVERING SERVICES-YOUTH SPECIFIC SERVICES ONLY

Services providing non-health related outpatient care were the most common type of care, followed by health related outpatient care. Day services comprise 21 percent of services when including services for all ages, and 28 percent of youth specific services (figures 21 & 22).

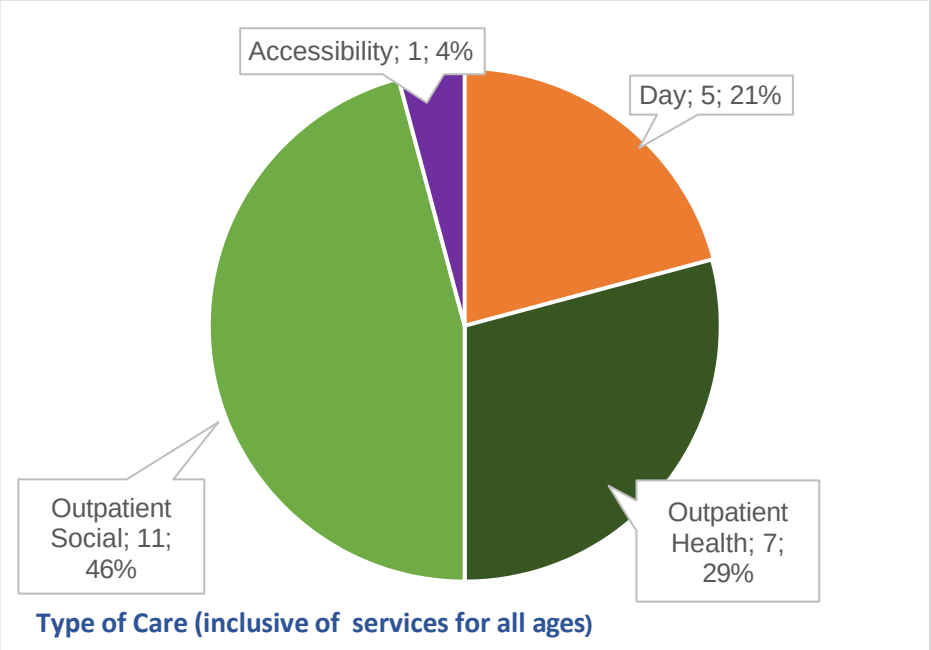

FIGURE 21 NUMBER AND PERCENTAGE OF SERVICES ACCORDING TO MAIN TYPE OF CARE

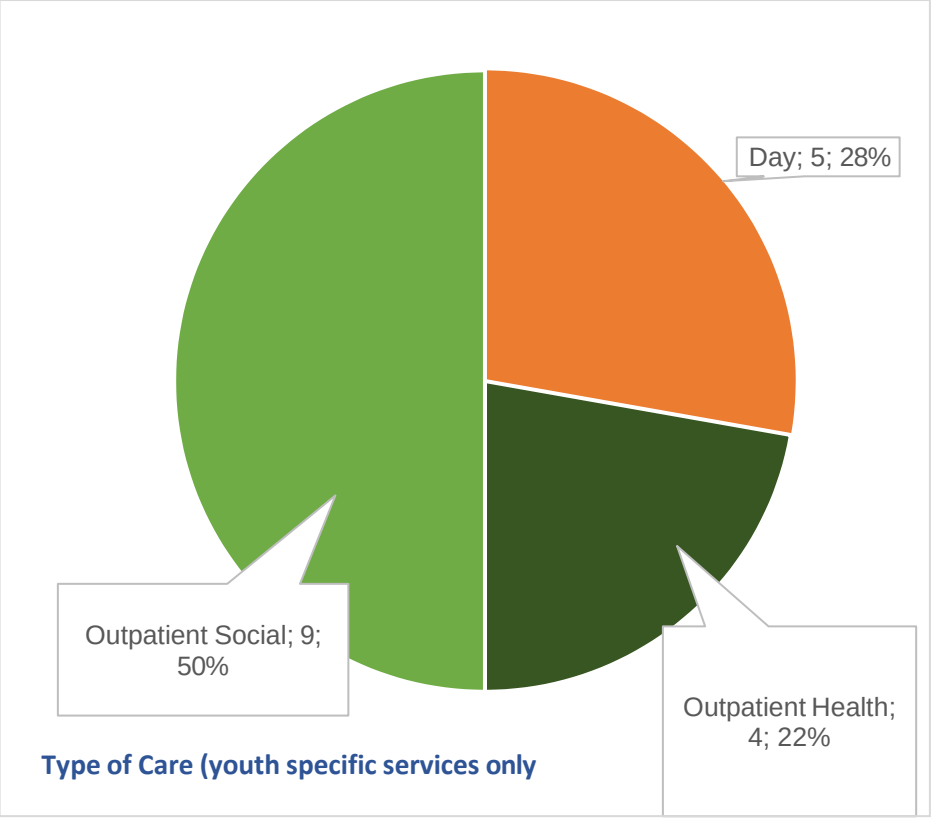

FIGURE 22 NUMBER AND PERCENTAGE OF SERVICES ACCORDING TO MAIN TYPE OF CARE

The proportion of services whose direct care staff includes >10% registered health professionals with at least 3 years' tertiary health training (eg nurses, doctors, psychologists) make up 29 percent of all services available to young people in Yarrabah (Gurriny health services, CYMHS, ED), and 22 percent of youth specific services (figures 23 & 24).

The remaining services are delivered by a range of direct care staff including youth workers, community workers, health support staff, and counsellors.

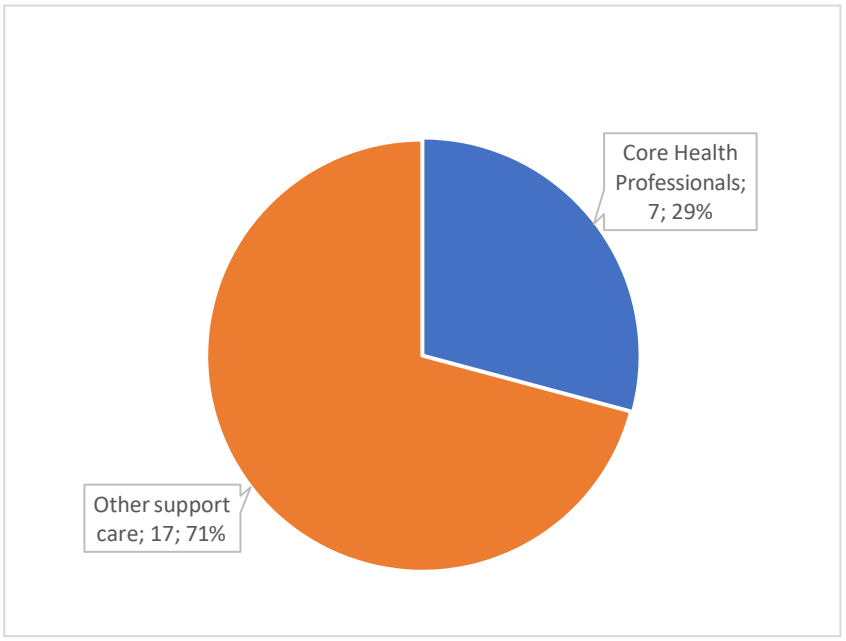

FIGURE 23 BALANCE OF CARE: NUMBER OF SERVICES STAFFED BY HEALTH PROFESSIONALS OR BY OTHER SUPPORT STAFF - INCLUSIVE OF SERVICES FOR ALL AGES

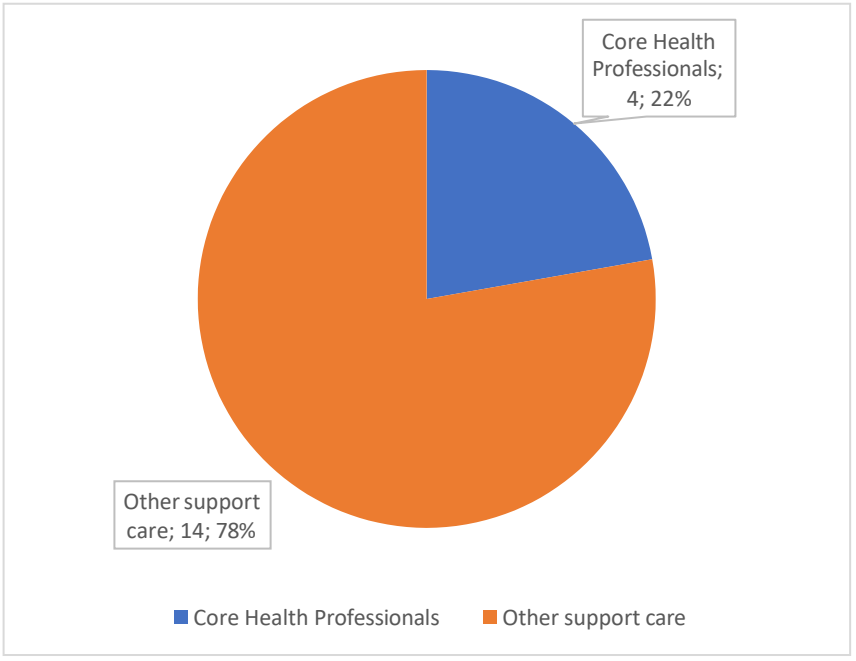

FIGURE 24 BALANCE OF CARE: NUMBER OF SERVICES STAFFED BY HEALTH PROFESSIONALS OR BY OTHER SUPPORT STAFF-YOUTH SPECIFIC SERVICES

38 percent of services are provided for children and young people 0-17 years. The next most common target population is adolescents aged 12-18 years. There are 3 services (12%) for younger children aged 0-11 years, and one service for adolescents and young adults aged 12-25 years (figure 25).

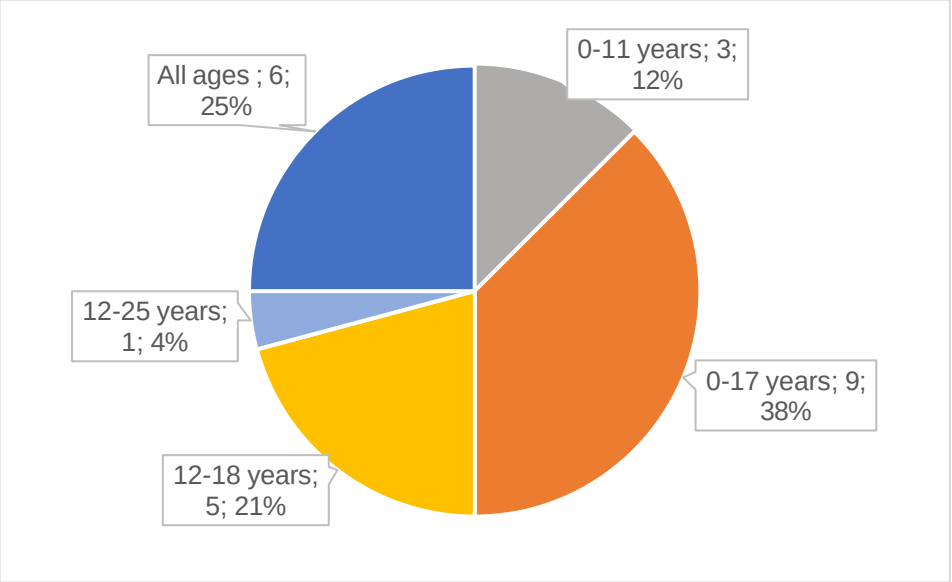

FIGURE 25 NUMBER OF MAIN TYPES OF CARE ACCORDING TO AGE GROUP

Services providing unspecified psychosocial/wellbeing support were most common, followed by those related to a child's upbringing (these services are primarily supporting children and families in the child safety system) (figure 26). Three services were for young people in contact with, or at risk of contact with, the justice system. Most of the services included in the study providing general health care were for people for all ages: ie not youth specific. Mental health related services were also more likely to be provided in all age services. There was one education related service.

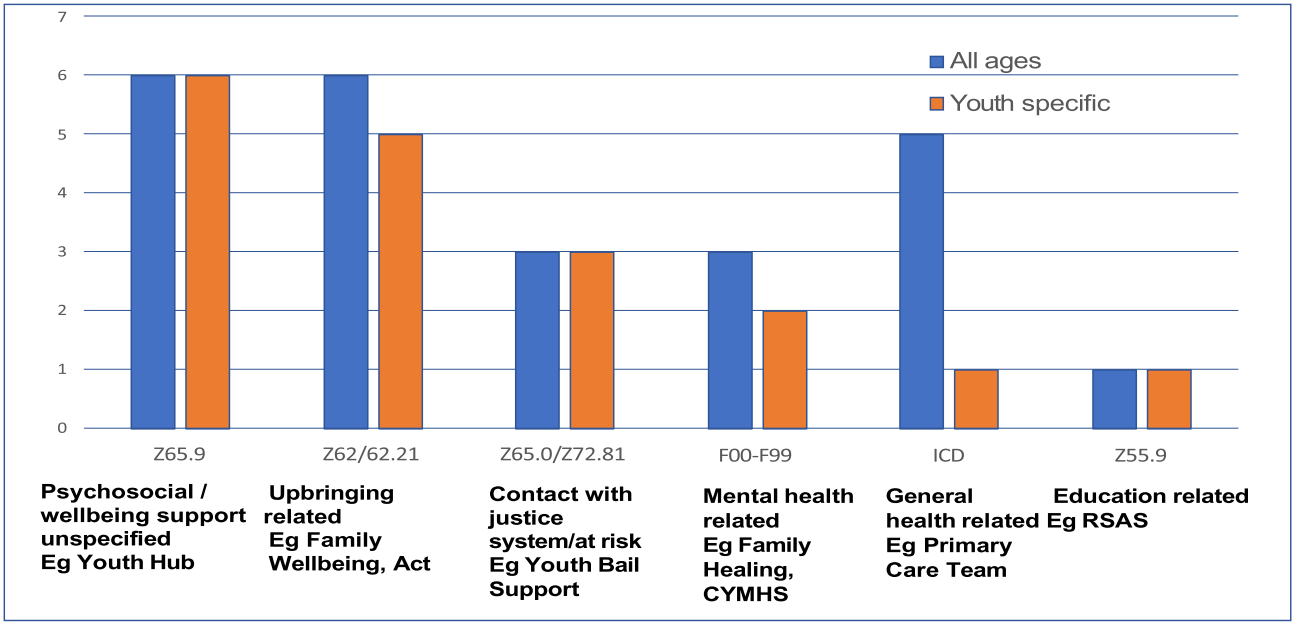

FIGURE 26 TARGET POPULATION DIAGNOSIS/REASON FOR ENGAGEMENT WITH SERVICE (ICD-10 CATEGORIES)

Ten of the 24 services were provided by visiting teams. Of the 14 services located in Yarrabah, eight were provided by Aboriginal Community Controlled Organisations (figure 27). When looking at youth specific services only, there were more visiting than Yarrabah community-based services. Three Yarrabah services were provided by Aboriginal Community Controlled Organisations (figure 28).

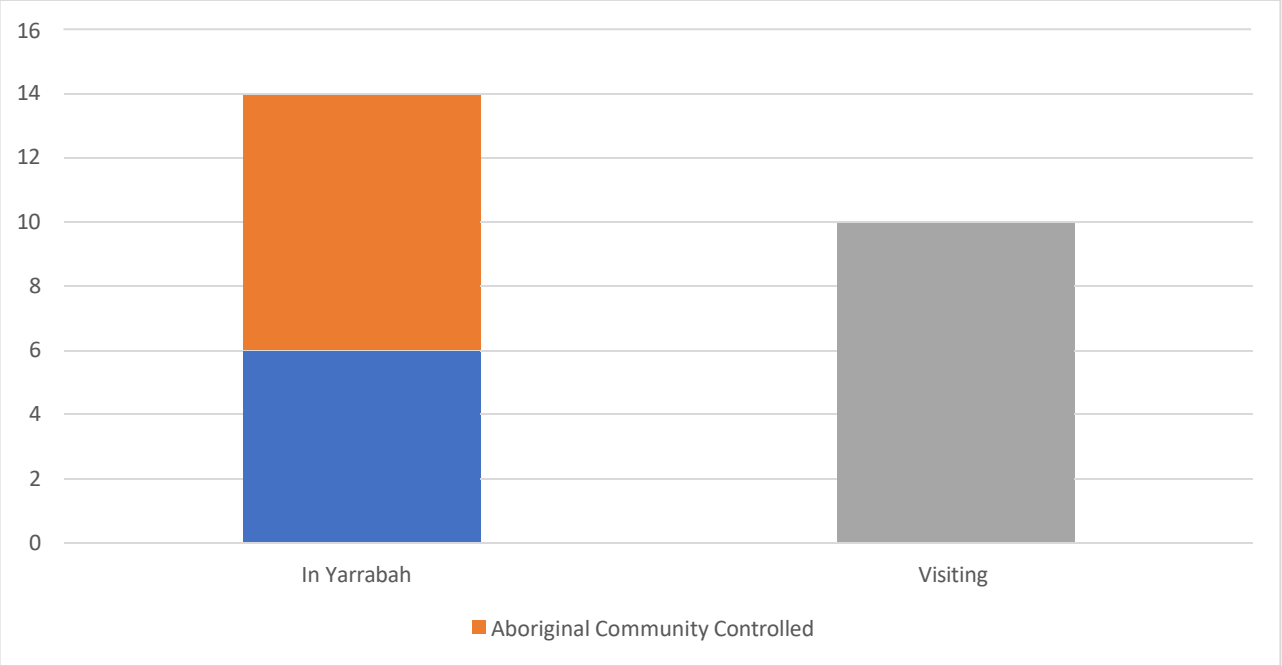

FIGURE 27 NUMBER OF SERVICES: ABORIGINAL COMMUNITY CONTROLLED; AND VISITING-INCLUSIVE OF SERVICES FOR ALL AGES

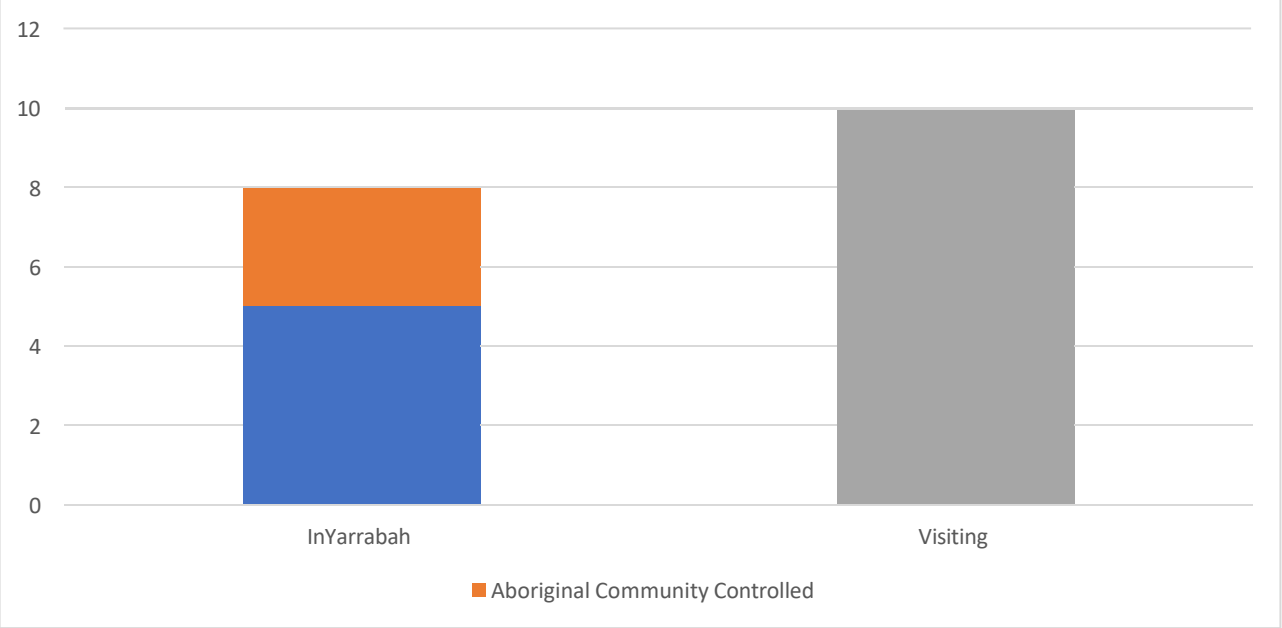

FIGURE 28 NUMBER OF SERVICES: ABORIGINAL COMMUNITY CONTROLLED; AND VISITING- YOUTH SPECIFIC SERVICES ONLY

The most common type of care provided by Aboriginal Community Controlled Organisations in Yarrabah was related to general health related care. NGOs were most likely to provide general psychosocial/wellbeing (preventive) type support, followed by child safety related services. Mental health related services were provided by the NGO sector and Queensland Health (figure 29).

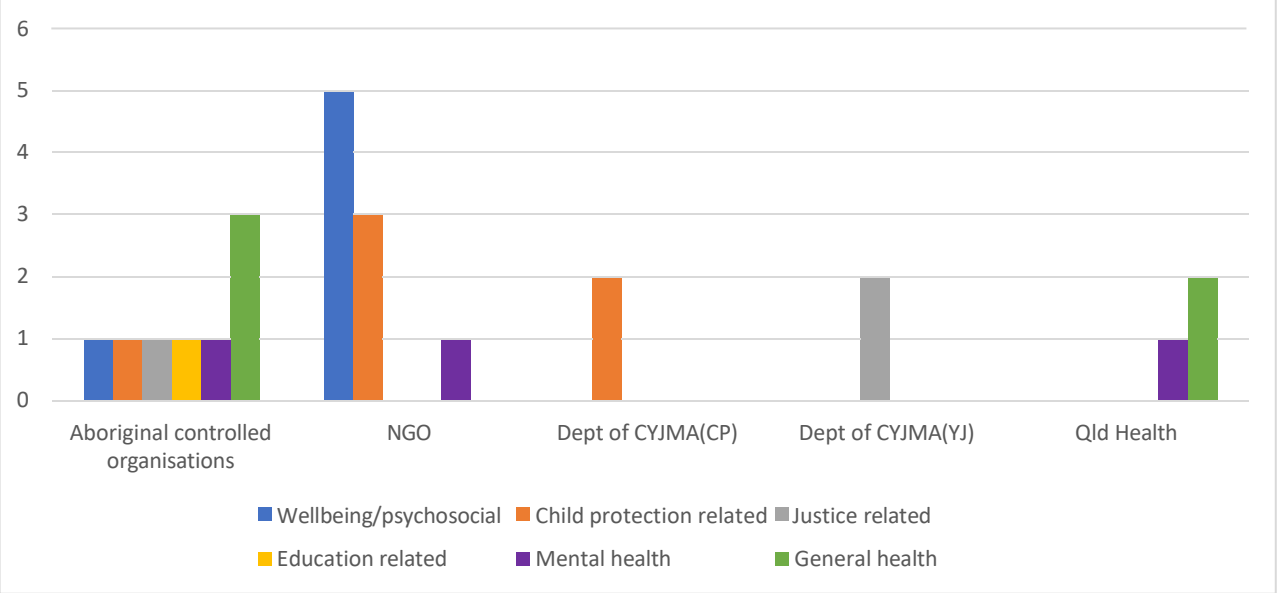

FIGURE 29 DIAGNOSIS/REASON FOR USING SERVICE ACCORDING TO TYPE OF SERVICE-INCLUSIVE OF SERVICES FOR ALL AGES

When looking at youth specific services (figure 30), Aboriginal controlled organisations provide one each of general psychosocial/wellbeing (preventive) type support, justice related and education related support. NGOs provide the same distribution of services as when including services of all ages.

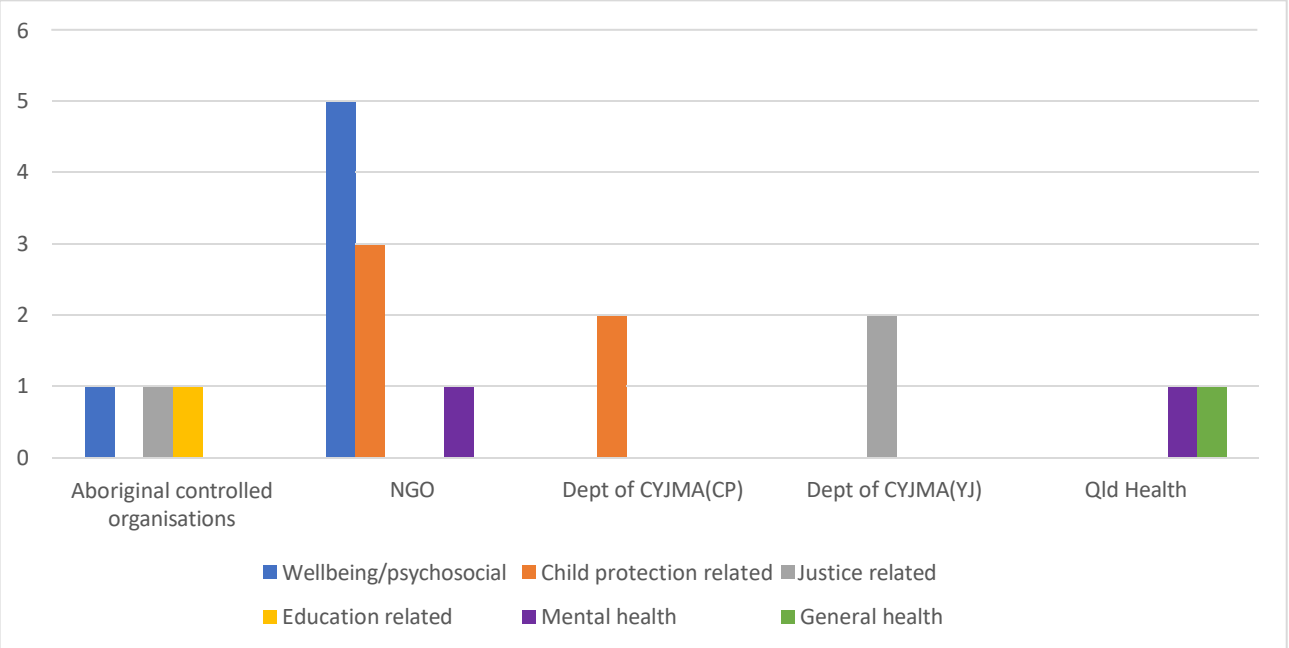

FIGURE 30 DIAGNOSIS/REASON FOR USING SERVICE ACCORDING TO TYPE OF SERVICE-YOUTH SPECIFIC SERVICES ONLY

Tables of Services coded with DESDE (**Aboriginal Controlled Organisations are shown in red text)**

Day services

Five Day services were identified (tables 2 & 3).

Gurriny Yealamucka Health Service Aboriginal Corporation (Gurriny) Youth Hub has been running since 2014, moving into the purpose built Youth Hub in 2019. It offers a range of activities: video games, cooking, computers and scheduled programs. At the Youth Hub, young people have access to life essentials, a shower, the washing machine and a feed - the fridge and cupboards always open.

Mission Australia's Dream Girls is for girls in Grades 5 and 6, and is part of their Circles of Care program. Two full-time local staff are located in a dedicated classroom which the girls are able to use at lunchtime. Each student has their own toiletries bag and wellbeing products, and food is available. Grades 5 and 6 students have weekly sessions, and can attend the annual camp. Staff take the grade 4 girls for team building, resilience, self-esteem and craft activities.

Police and Citizens Youth Club (PCYC) provides a soft entry to crime prevention though youth engagement. It is a safe place to come which offers positive role models and mentors, as well as opportunities to participate in sport and recreation activities that act as diversionary activities. The centre is well resourced with an indoor basketball court, a table tennis activity space and outdoor activity area.

The Clontarf Academy program at the local schools is for boys in primary school grades 5 and 6, and secondary school years 7 to 10. The Clontarf program and staff have their own dedicated space at the primary and secondary schools. The room is open to the boys during school breaks. They hold morning training sessions followed by breakfast, run footy competitions, and give attendance awards. Activities include footy training, cooking, going to the beach, and football matches with other Clontarf Academies in Cairns. The activities are divided between schools and off campus locations.

JT Academy program is for secondary female students. It offers specific programs around building confidence, developing leadership skills, and conducts camps.

The following tables (2- 7) provide detail of the DESDE coding and workforce information of each service

TABLE 2 DAY SERVICES-AVAILABILITY

Provider	Name	Main DESDE code	Additional code	Location	Area of Coverage
Clontarf Academy	Clontarf Foundation	CX[IN][M][Z65.9] -D4.3z2		Yarrabah	Yarrabah
Gurriny	Youth Hub	CY[IN][Z65.9]-D5z2		Yarrabah	Yarrabah
JT Academy	JT Academy	CA[IN][F[Z65.9] -D5.1z2		Yarrabah	Yarrabah
Mission Australia	Dream Girls/Circles of Care	CC[IN][F][Z65.9]-D4.3z2	CC[IN][Z65.9]-O5.2g	Yarrabah	Yarrabah
Police-Citizens Youth Welfare Association	Police and Citizens' Youth Club	CX[IN][Z65.9] -D4.3z2		Yarrabah	Yarrabah

TABLE 3 DAY SERVICES-WORKFORCE CAPACITY

Provider	Name	FTE Total	Youth workers	Child care worker	Police workers
Clontarf Academy	Clontarf Foundation	4			
Gurriny	Youth Hub	3	3		
JT Academy	JT Academy	1.5	1.5		
Mission Australia	Dream Girls/Circles of Care	2	2		
Police-Citizens Youth Welfare Association	Police and Citizens' Youth Club	8	1	4	3

Outpatient Services (health related)

Seven health related Outpatient teams were identified (tables 4&5).

Act For Kids Individual Support Packages Team provides targeted support for children and families on orders where there is a refusal to go to residential care and/or who are self-placing.

Gurriny provides centre based clinical and primary health care for the general population of Yarrabah**.** **Primary Health Care** services are open to everyone as often as they need – no restrictions apply. Gurriny conducts the Central Wellbeing Intake team; this is a meeting of all the service teams for information sharing, gathering, and activating referrals to relevant services.

Family Healing is a NQPHN funded multidisciplinary mental health service. This service uses psychological interventions and psychometric testing, yarning, structured parenting programs and psycho-educative/social and emotional wellbeing groups. There is no age restriction to access the service.

The local School Nurse is provided by Queensland Education (funded by Queensland Health) (this is a State wide program). The Registered Nurse has their own room, and checks students' physical health, general wellbeing, conducts health promotion and sexual health programs. The RN works collaboratively with the Guidance Office and liaises with RSAS team. Students can self-refer.

Mission Australia Therapeutic Counselling is a service that funds Innate Therapies to provide individual psychological counselling. The service operates one day a week. Nominated students must be attending school regularly: low attenders are not eligible for this program. Students are nominated by the guidance officer, Principal or Mission Australia.

Queensland Health provide an Emergency Department in Yarrabah, staffed by a multidisciplinary team providing 24 hour accident and emergency care; and transfer to Cairns by helicopter if required following stabilisation in Yarrabah. Queensland Health also provide a Child and Youth Mental Health Service (CYMHS) team based in Cairns, scheduled to visit Yarrabah one day a week.

TABLE 4 OUTPATIENT SERVICES (HEALTH RELATED)-AVAILABILITY

Provider	Name	Main DESDE code Additional code	Location	Area of Coverage
Act For Kids	Individual Support Packages Team	CX[Z62][e310x]-O5.1.2v	Cairns	Cairns, Yarrabah to Gillies Range & Cow Bay
Gurriny	Family Healing	GX[IN][F00-F99]-O5.1	Yarrabah	Yarrabah
Gurriny	Primary Health Care	GX[IN][ICD]-O8.1	Yarrabah	Yarrabah
Mission Australia	Therapeutic Counselling Workshops	CC[IN][Z65.9]-O10.1g	Cairns	
Queensland Education	State High School (RN)	CA[IN][ICD]-O8.1u	Yarrabah	Yarrabah
Queensland Health	Child and Youth Mental Health Service	CX[F00-F99]-O7.1	Cairns	Cairns and Hinterland
Queensland Health	Yarrabah Emergency Department	GX[IN]]ICD]-O3.1	Yarrabah	Yarrabah

TABLE 5 OUTPATIENT SERVICES (HEALTH RELATED)-WORKFORCE CAPACITY

Provider	Name	FTE Total	GP	RN/ MHN*	Psychologist	Aboriginal health workers	Social worker	Other
Act For Kids	Intensive Packages Team	26 (not FTE)	0	0		0		26 (not FTE)
Gurriny	Primary Health Care	15	7	8	0	0	0	0
Gurriny	Family Healing	4.65	0	0.85		1	0.8	2
Mission Australia	Therapeutic Counselling	0.05	0	0	0	0	0	0.05
Queensland Education	State High School (RN)	1	0	1	0	0	0	0
Queensland Health	CYMHS	0.2	0	0	0.2	0	0	0

*Registered Nurse/Mental Health Nurse

Outpatient Services (non-health related)

Ten non-health related outpatient services were identified (tables 6 &7).

Act For Kids provides two services. Family and Child Connect is funded by Department of Children, Youth Justice and Multicultural Affairs (CYJMA) to help prevent people entering the Child Safety system. Families may be identified by police and health services, but people can also self-refer. The period of engagement with the services is usually 4-6 weeks, and the service works with the whole family. Intensive Family Support

provides direct support to the family, with the family's consent. The multi-disciplinary team includes social workers, Speech and Language Therapists, and educational and health specialists. Referrals come predominantly from Child Safety. Engagement with families is usually around 9-12 months but can be as short as 2-3 weeks.

The Department of Children, Youth Justice and Multicultural Affairs (CYJMA) also provides two visiting Child Safety teams. The Child Safety Service Centre at Edmonton provides a visiting Ongoing Intervention Team (OIT) and Intervention with Parental Agreement (IPA) Team which both visit Yarrabah. Families are referred to IPA following an initial assessment by an Assessment and Investigation team in Cairns. The OIT Team become involved if an application has been made to place the child into out of home care, and if the child is also subject to orders, in kinship/foster/care, and working towards reunification with family and carers. Engagement with the service may be short term, particularly if the child is not in care (eg 6 months to 2 years) or longer term (2 years +-up to adulthood) where the child is in care. A Transition to adulthood process starts around the age of 15.

Youth Justice Teams from the Department of CYJMA based in Atherton and Innisfail visit Yarrabah at least weekly. Case workers and youth workers support young people on orders, and work with their justice related needs. They run programs including A Rethinking Our Attitude to Driving (ROAD) program for offenders or young people identified as at risk. A Restorative Justice convenor based in Atherton is responsible for working with young offenders, their victim and family -through the process of RJ conferencing.

Gindaja Treatment and Healing Centre (Gindaja) is an Aboriginal Community Controlled Organisation providing Alcohol and Other Drugs (AOD) services to clients across the country. Funding for **Youth Bail Support Service (YBS)** is from Department of Youth Justice and auspiced through YETI to Gindjara. The service is for youths aged 10 to17 years who are referred by the court. Gindjara employs a local YBS officer who works closely with the Yarrabah youth, including attending court with them, to ensure a youth meets their bail conditions and to help prevent them being incarcerated.

Gurriny provides several non-health related outpatient services. The **Integrated Care Team (ICT)** is a mobile team that visits people in their home as often as needed. It provides general health care such as blood pressure checks, assistance with medications, diabetes management, mobility aids, and health education and information. **Family Wellbeing** is a referral based service funded by Child Safety (auspiced through Wuchopperen to Gurriny) to support the families of children in care, or at risk of being taken into care. Participation in the service is voluntary. The Family Wellbeing team conducts weekly home visits with the consent of the family, and educates families to empower themselves to make a positive change for their children**. Remote School Attendance Scheme (RSAS)** is funded by NIAA and operates through **Gurriny.** The aim is to increase school attendance and engagement in learning. RSAS assistance includes picking up students from home and taking them to school, and transporting them to medical appointments from school. The team can also provide food for students. The secondary school also runs programs such as gardening projects with the RSAS team. There is uncertainty around the funding continuing (post 2021).

TABLE 6 OUTPATIENT SERVICES (NON-HEALTH RELATED)-AVAILABILITY

Provider	Name	Main DESDE code	Location	Area of Coverage
Act For Kids	Family and Child Connect	CX[Z62][e310x]-O7.2b	Cairns	Cairns, Yarrabah to Gillies Range and Cow Bay
Act For Kids	Intensive Family Support	CX[Z62][e310x]-O5.2.1m	Cairns	Cairns, Yarrabah to Gillies Range and Cow Bay
Queensland CYJMA	Intervention with Parental Agreement	CX[Z62][e310x]-O6.2	Edmonton	Edmonton to Wooree, includes Yarrabah
Queensland CYJMA	Ongoing Intervention Team	CX[Z62.21][e310x]-O6.2	Edmonton	Edmonton to Wooree, includes Yarrabah
Queensland CYJMA	Youth Justice (Atherton)	CA[Z65.0][e310x]-O6.2jm	Atherton	Yarrabah, Tablelands and Cassowary coast
Queensland CYJMA	Youth Justice (Innisfail)	CA[Z65.0; Z72.81]-O6.2jm	Innisfail	Yarrabah, Tablelands and Cassowary coast
Gindaja	Youth Bail Support	CA[IN][Z65.0]-O5.2j	Yarrabah	Yarrabah
Gurriny	Family Wellbeing Service	GX[IN][Z62.21][e310x]-O6.2	Yarrabah	Yarrabah
Gurriny	Integrated care team	GX[IN][ICD]-O5.2.1	Yarrabah	Yarrabah
Gurriny	RSAS team	CX[IN][Z55.9]-O5.2	Yarrabah	Yarrabah

TABLE 7 OUTPATIENT SERVICES (NON-HEALTH RELATED)-WORKFORCE CAPACITY

Provider	Name	FTE Total	Aboriginal health workers	Bail Support Worker	Child Safety Officer	Child Safety Support Officer	Youth Worker	Support Worker	Other
Act For Kids	Family and Child Connect	10	0	0	0	0	0	0	10
Act For Kids	Individual Support Packages	15	0	0	0	0	0	0	15
Gindaja	**Youth Bail Support**	1	0	0	0	0	0	0	0
Gurriny	**Family Wellbeing**	4	0	0	0	0	0	4	0
Gurriny	**Integrated Care Team**	4	4	0	0	0	0	0	0
Gurriny	**RSAS Team**	3	0	0	0	0	2	0	1

Provider	Name	FTE Total	Aboriginal health workers	Bail Support Worker	Child Safety Officer	Child Safety Support Officer	Youth Worker	Support Worker	Other
Queensland CYJMA	Intervention with Parental Agreement	5	0	0	3	2	0	0	0
Queensland CYJMA	Ongoing Intervention Team	14	0	0	12	2	0	0	0
Queensland CYJMA	Youth Justice-Atherton	0.6	0	0	0	0	0	0	0.4
Queensland CYJMA	Youth Justice-Innisfail	1.8	0	0	0	0	0.4	0	1.4

Accessibility Services

One accessibility team was identified (tables 8 & 19). The Transport Service Team is a non-clinical service that provides medical transport only, from health care to health centre or to Cairns based health services. The service is funded by Gurriny.

TABLE 8 ACCESSIBILITY SERVICES-AVAILABILITY

Provider	Name	Main DESDE code	Location	Area of Coverage
Gurriny	Transport Team	GX[IN][ICD]-A2	Yarrabah	Yarrabah

TABLE 9 ACCESSIBILITY SERVICES-WORKFORCE CAPACITY

Provider	Name	FTE Total	Transport worker
Gurriny	Transport Team	4	4

Workforce-summary

Table 10 is a summary of the size of the direct care workforce teams identified in Yarrabah.

Most teams were small, with less than six Full Time Equivalent direct care workers, with five very small teams (one or fewer Full Time Equivalents).

TABLE 10 TEAM SIZE

Size of Team	Very small > or = 1 FTE	Small: 1.1-5.9 FTE	Medium 6-20 FTE	Large 20+ FTE
Number of Services	5	11	6	0

The following table (table 11) shows the number of people according to occupational type.

The number of Aboriginal workers here only includes Aboriginal Identified Positions. The actual number of Aboriginal and Torres Strait Islander people occupying positions will be significantly higher. It may be that most, if not all, direct care staff in Aboriginal Controlled Organisations are Aboriginal or Torres Strait Islander.

Workforce figures should be interpreted with caution, as not all services were able to provide disaggregated information, and eight services did not provide workforce data. Thus, the number of most categories will be higher than that shown here, and the absence of a particular job title here may not indicate its absence from the workforce.

Additionally, due to the number of different occupational and job titles, the "other" category includes a range of job descriptions without necessary formal qualifications such as support workers, youth workers, case managers, operations officers. The number of Aboriginal Identified staff reflects only those positions expressed as such and not the total Indigenous workforce.

TABLE 11 WORKFORCE DISTRIBUTION BY OCCUPATION

Occupation	Aboriginal Worker	Peer worker	Psychiatrist/ registrar	GP	Psychotherapist	Mental Health Nurse	Other
Number of staff	5	0	0	7	0.05	2.65	78.6

Description and Comparison of the Overall Pattern of Care

Figure 31 shows the pattern of mental health and wellbeing care availability for young people up to the age of 18 years in Yarrabah, according to the DESDE main branches of care. Each coloured sector represents a main branch of care in the DESDE classification system.

This shows that non-health related (social) outpatient services are the most available type of care, followed by health-related outpatient services (those staffed by health professionals) and social type Day services.

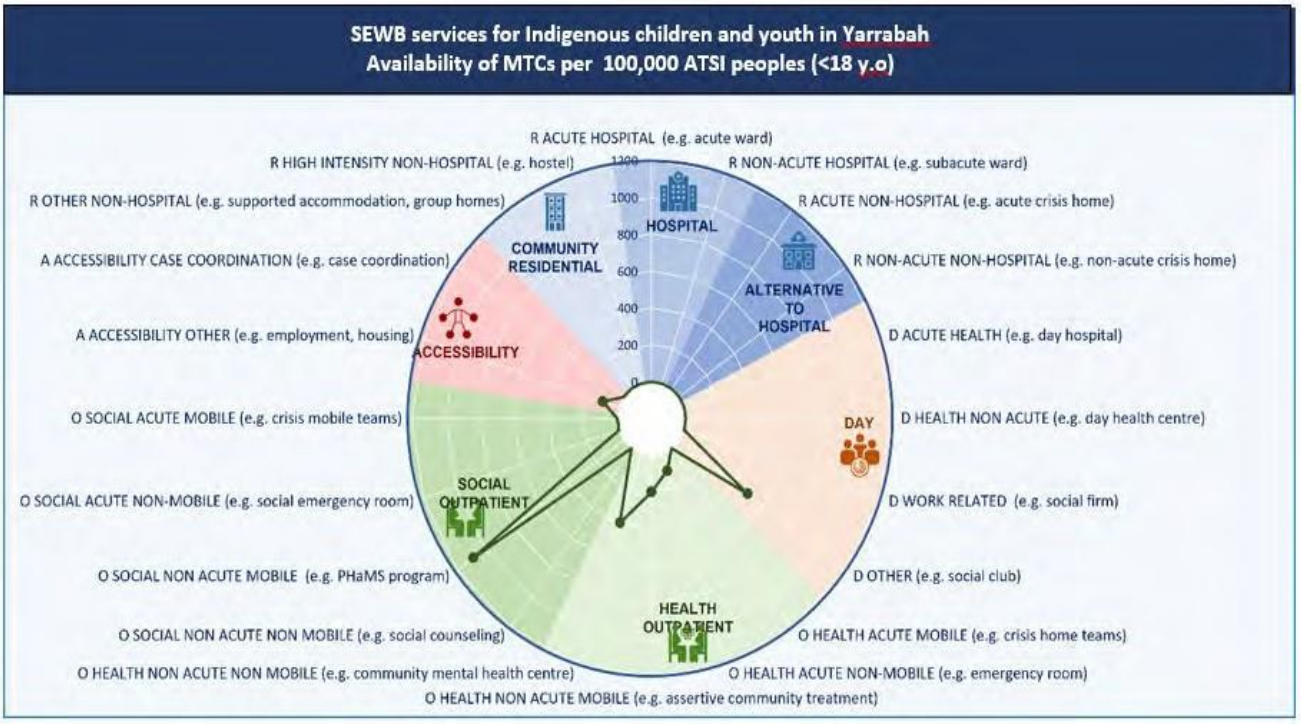

FIGURE 31 AVAILABILITY OF SOCIAL AND EMOTIONAL WELLBEING SERVICES FOR CHILDREN AND YOUTH IN YARRABAH- MTCS PER 100,000 PEOPLE AGED < 18 YEARS

When compared to Cairns (figure 32 on the following page), the patterns of care are quite similar. Outpatient, day services and accessibility services only were available in Yarrabah, while in Cairns there were also some residential, and self help/volunteer services.

Although Cairns, with a larger number of services, provided a greater diversity of types of care, the overall pattern of care in terms of rate of service per 100,000 people is similar in both Yarrabah and Cairns. Outreach non-health related outpatient services are most common, and there are gaps in work and education related day services, accessibility services and residential care of all types. Significantly, there was no acute youth residential mental health care in Cairns or Yarrabah.

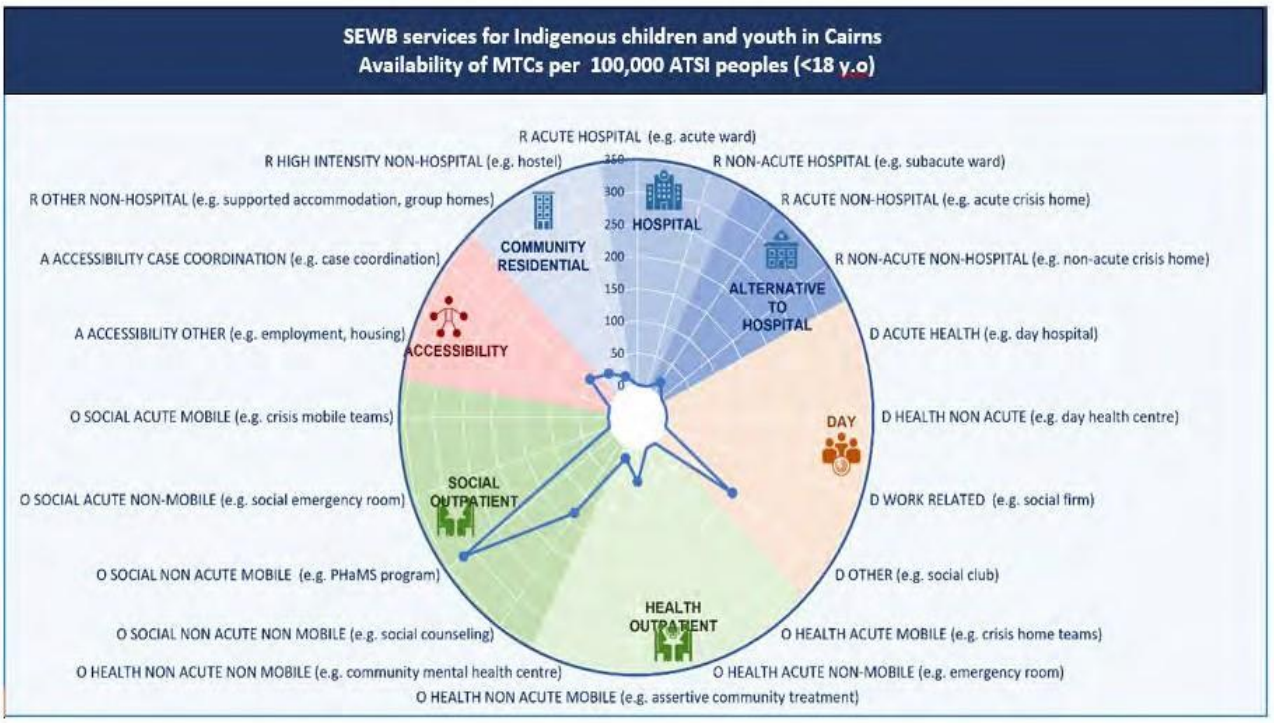

FIGURE 32 AVAILABILITY OF SOCIAL AND EMOTIONAL WELLBEING SERVICES FOR INDIGENOUS CHILDREN AND YOUTH IN CAIRNS-MTCS PER 100,000 PEOPLE AGED < 18 YEARS

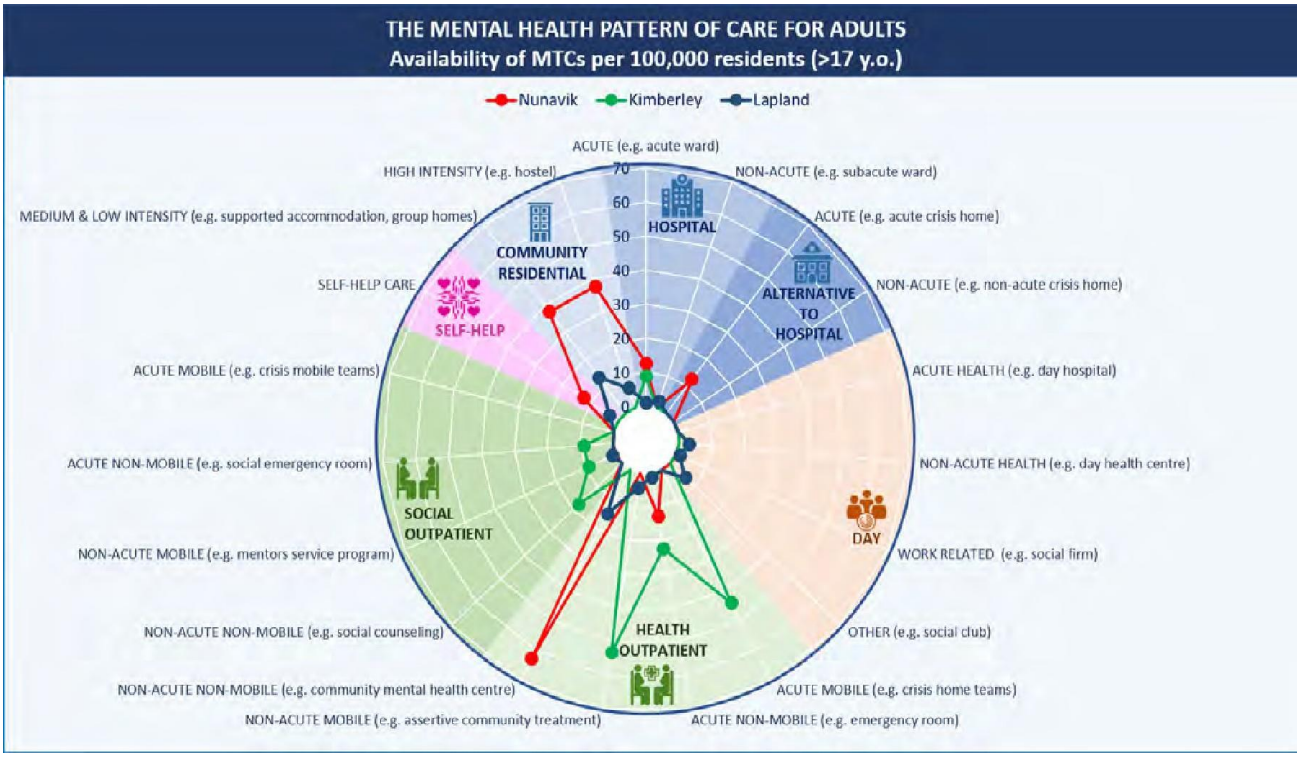

FIGURE 33 MENTAL HEALTH PATTERN OF CARE-COMPARISON NUNAVIK, KIMBERLEY, LAPLAND (POPULATION AGED > 17)

Figure 33 (previous page) shows the pattern of care of mental health services for adults in Nunavik, Canada, Lapland, Norway, and Kimberley, Australia. The pattern of care differs markedly from the services in Yarrabah and Cairns. Each region has a distinct pattern of service provision. Residential and health related care are more common in all three international areas than in the Queensland areas in this study; and day services are relatively less common. However, it is important to bear in mind that this graph shows mental health specific services only; in addition, the services in this graph are adult services.

Figure 34 below compares the number of services in Yarrabah, and Cairns provided by Aboriginal Community Controlled Organisations for young Indigenous people by Main Type of Care. As would be expected with the larger population, there is greater diversity of services in Cairns

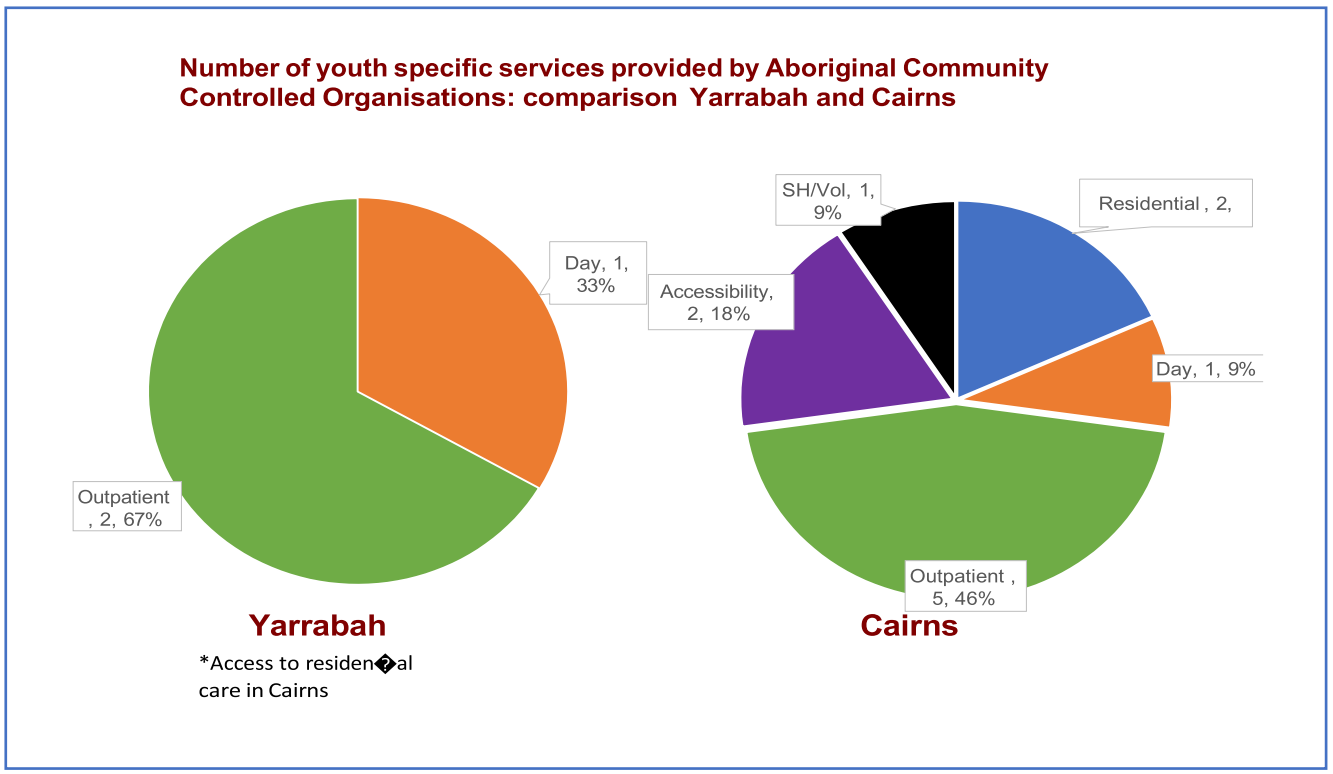

FIGURE 34 YOUTH SPECIFIC SERVICES BY MAIN TYPE OF CARE: COMPARISON YARRABAH AND CAIRNS

However, when looking at the availability of services in relation to the size of population (figure 35), Yarrabah has significantly higher availability of day and outpatient services.

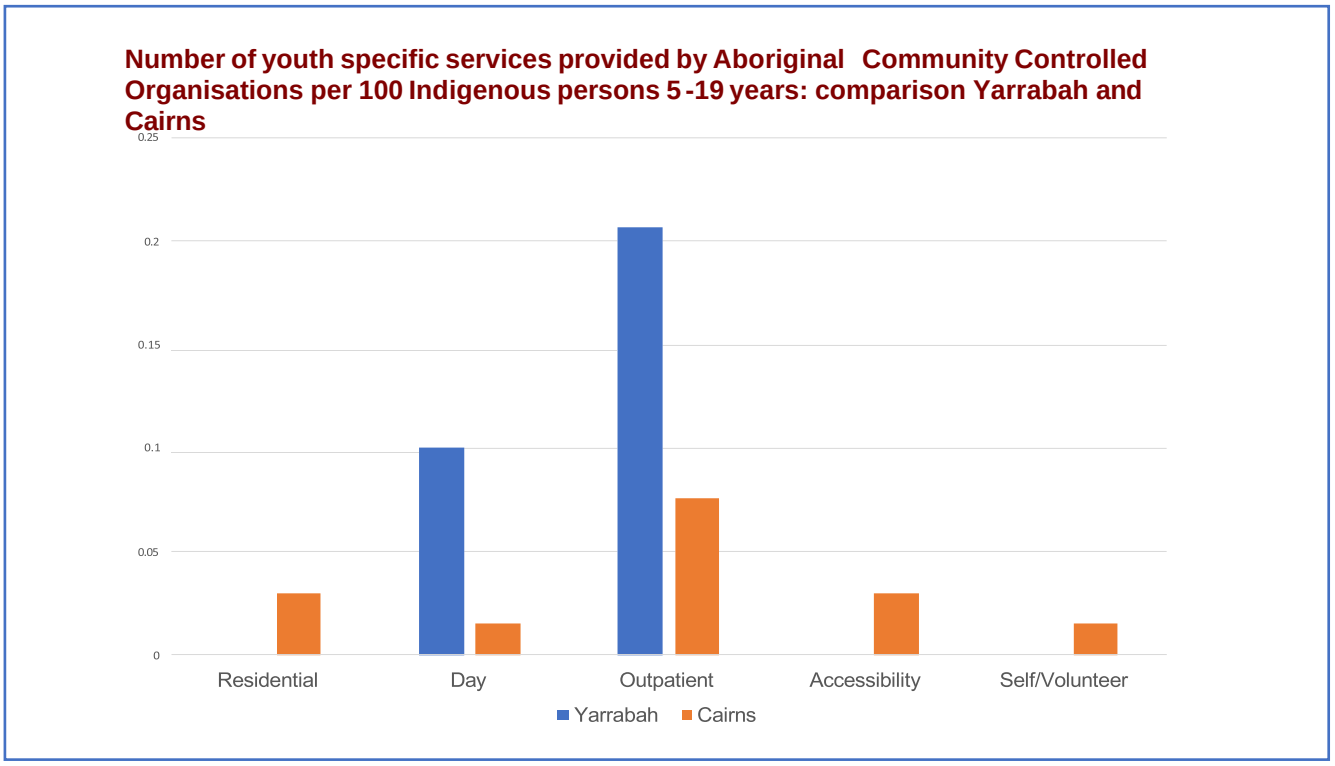

FIGURE 35 RATE OF YOUTH SPECIFIC SERVICES AS A PERCENTAGE BY MAIN TYPE OF CARE: COMPARISON YARRABAH AND CAIRNS

Discussion

This Atlas, the *Integrated Atlas of the social and emotional wellbeing services for Indigenous children and youth in Yarrabah* and the partner *Integrated Atlas of the social and emotional wellbeing services for Indigenous children and youth in Cairns* are the first Atlases of services with, and for, Aboriginal and Torres Strait Islander communities using the Description and Evaluation of Services and DirectoriEs (DESDE) classification instrument. The holistic view of Indigenous health means that any assessment of the availability of health and wellbeing services must include services not only in the health sector but in any relevant human services sector (10). DESDE's ecosystems approach means it is uniquely placed to provide this assessment of services.

Integrated Atlases are conceptually founded on a health ecosystems or whole systems model (7). Using this approach, health and wellbeing systems are seen to include all domains of human experience that have an influence on health: the places and communities in which we live; the broader social determinants of wellbeing such as the social and demographic characteristics of the environment; and behaviours and lifestyles, including religious and cultural belief systems and practices. Together, these elements form a complex and interactive system, in which interventions or behaviours in one part can have significant and unexpected consequences in another. However, this complexity creates a high level of uncertainty within the system which can confound attempts to model and plan policy interventions. The more knowledge and information about the different domains and how they interact with each other, then, the more it is possible to reduce the uncertainty about system behaviour, and to increase the accuracy and effectiveness of modelling and interventions to create change.

A scoping review of methods of mental health service classification found that DESDE was the only validated instrument available able to classify services across all sectors using a "bottom-up" approach: that is, looking at the teams actually providing care at the meso or local level, and not at an aggregated regional or national level (26). DESDE identifies care teams (Basic Stable Inputs of Care), which are the smallest unit of care production, and describes them by the Main Type of Care they provide, using a standardised terminology. This allows DESDE to provide a detailed picture of the pattern of care in a region, and to make valid comparisons across sectors, regions and over time, making it a unique aid to planning. Geographic Information Systems and other visualisation tools are used in Integrated Atlases to provide social and demographic context, and to present sometimes complex data in more readily understandable ways.

A total of 58 teams (Basic Stable Units of Care) were assessed as providing mental health and wellbeing support to young Indigenous children and youth in Yarrabah and Cairns. Yarrabah was served by 23 teams providing 24 Main Types of Care; and the Cairns region was served by 43 teams providing 48 Main Types of Care. Five public sector teams and three NGO teams based in Cairns providing youth justice, child safety and community mental health care are represented in both Atlases, but are counted individually in each.

Five key areas for consideration that emerged from this research were:

- Overall pattern of care and gaps identified in overall availability of services
- Availability of care delivered by Aboriginal Community Controlled Organisations
- Type of care delivered by Aboriginal Community Controlled Organisations
- Size and nature of the Indigenous workforce
- Funding and accountability of Indigenous youth mental health and wellbeing services

Patterns of care-including gaps or duplications in service availability

The most common type of care in both Yarrabah and Cairns was outreach type services providing non-health related care. These services provided support to a range of different target populations, and included, for example, Gindaja's Youth Bail Support in Yarrabah; and YETI's Youth Support Program funded by Child Safety (Department of CYJMA) for vulnerable adolescents and their families, and Wuchopperen's Family Wellbeing service for adolescents in contact with the justice system in Cairns.

The next most frequently identified type of care in both Yarrabah and Cairns was day type care: services such as Clontarf that provide social type support. A relatively high availability of social (non-health related) day services was identified in both regions, providing support for sport, leisure and skills development. However, in this research/assessment, no education or employment related day services were identified. Education and employment are key priority areas of the National Agreement, and the 2016 National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families also stressed the importance of educational support for children. In this study, only two teams delivered by the Education Department were identified: the school nurse in Yarrabah and the Engagement Team delivered by a regional Cairns primary school.

Few residential care services were available for Indigenous youth in Cairns, and none in the Yarrabah area. The nearest dedicated acute residential mental health care for all young people in Yarrabah and Cairns is in Townsville, although young people requiring acute inpatient support may be admitted to a general adolescent ward in Cairns. The CYMHS Step Up/Step Down sub-acute mental health unit in Cairns estimated that 14 percent of service users were Aboriginal or Torres Strait Islander young people, although this service was not identified in the referral pathways by any services in this study. In Cairns, DIYDG provided crisis care for children in the child safety system, and Jabilbina ran cultural mentoring camps for Indigenous youth in contact with the justice system. Youthlink, also in Cairns, provided specialist homelessness residential services. While Youthlink is not an Indigenous provider, the organisation estimated that around 75 percent of its service users were Indigenous youth.

Participants in the Yarrabah Yarning Circles cited a need for safe and confidential points of access and better availability of information, but no youth specific accessibility or information services were identified in Yarrabah. In Cairns, Next Steps provided by YETI and Wuchopperen worked with young people to access the supports they need as they transition from living in care; and Wuchopperen's Connecting Youth similarly supports young people who are referred primarily through the child safety and youth justice systems.

These findings suggest a need for partner organisations to work with Governments or PHNs to review how the current service mix meets the needs of Indigenous children and youth in the region.

Proportion of care delivered by Aboriginal Community Controlled Organisations

The development of the Aboriginal Community Controlled sector has been prioritised in the National Agreement (19). Despite recognition in National Policy Frameworks of the key role that Aboriginal Community Controlled Organisations play in Indigenous health and wellbeing, the data in this research indicates that currently around 80 percent of the services available specifically for young people in Yarrabah, and 75 percent of those for young people in Cairns, are delivered by non-Indigenous community controlled service providers. Approximately half of all available services were delivered by NGOs, and up to a third

delivered by the public sector, comprising the Department of Children, Youth Justice and Multicultural affairs, Queensland Health and Queensland Education.

This report provides a baseline from which the outcomes of policy objectives such as this can be measured, and data for use in advocacy aimed at improving service delivery.

The high proportion of NGOs providing services for Indigenous youth, compared to those provided by Aboriginal Community Controlled Organisations, raises concerns about equity, and how culturally safe and appropriate services are being delivered. It also raises questions about whose voices are being heard in governance or decision making in services designed and delivered for Indigenous youth. Further exploration is warranted into how community voices are included in accountability and monitoring processes in the NGO sector which currently dominates Indigenous service provision. Other critical questions this report has raised revolve around the need to address the disconnected and fragmented way that programs and services for Indigenous youth are delivered and monitored; and to build stronger relationships and partnership based decision making led by community controlled organisations.

The spectrum of care available, and the type of care Aboriginal Community Controlled Organisations are funded to deliver

ACCOs provide proportionally more high intensity services- ie those related to youth justice, child safety or mental health- than they do the general, wellbeing type services. These more general, preventative type services, which are more closely aligned with a SEWB model of care, are more likely to be delivered in both regions by non-Indigenous NGOs.

Approximately two thirds of services available to young Indigenous people in Cairns, and only slightly less than that in Yarrabah, are high intensity services providing support to young people who are already experiencing difficulties related to either youth justice, child safety, or mental health. Services provided by Aboriginal Community Controlled Organisations provide proportionally more of this “downstream” type of support than they do the more “upstream” or general wellbeing type support: that is, although ACCOs provide less than a quarter of services overall in Cairns, they currently provide more than a third of high intensity services. In Yarrabah, the picture differs slightly, with ACCOs providing proportionately fewer of these high intensity services. The visiting public sector teams (Department of CYJMA, CYMHS) were represented more strongly in the provision of this type of care.

Around a third of services available in Yarrabah and Cairns provide general wellbeing and preventative type support. This type of support is aligned with SEWB models of care, and is important in reducing the need for more higher level intensity services. In Yarrabah and Cairns this type of support includes social, housing, and education related support. However, the majority (80%) of this type of care is provided by NGOs, despite their representing around 50 percent of services available. ACCOs which are providing this general wellbeing support include Gurriny’s Youth Hub and RSAS teams in Yarrabah and DIYDG’s Level Up program in Cairns.

ACCOs were originally established to address the absence of culturally safe services for Indigenous peoples in regional areas and have evolved to provide the type of wellbeing/early interventions services that are needed. This data indicates, however, that despite policy recognition of the importance of SEWB models of care for Indigenous youth, and of ACCOs in their delivery, ACCOs are primarily being tasked with providing the more intensive higher level services rather than services at the preventative, wellbeing level of care- services which are better aligned with the SEWB model. Additionally, NGOs providing services without

Indigenous, or community control governance do not necessarily have the requisite decision-making processes and practices that are needed to provide culturally safe services for Indigenous youth.

Workforce

The data available to map Indigenous workforce data were limited by incomplete data and inadequate identification of Indigenous staff within the workforce data systems available to this research. Not all services were able to provide or to disaggregate this information into Full Time Equivalents according to occupation; some workers who were Indigenous were not identified as such in the workforce information provided; and the workforce data for the population and the workforce data is specific for the youth workforce only. Although the figures presented should be viewed with caution, they are concerning due to: (i) the workforce caring for young Aboriginal and Torres Strait Islander people, even in a discrete community, being largely not Indigenous; (ii) the lower levels of tertiary qualifications in the Indigenous workforce; and (iii) the possible power imbalance that this data may suggest, with regard to Indigenous input into decision making in services for Indigenous youth.

Although workforce figures are imprecise and may under-represent Indigenous workers, current data suggests that in Yarrabah, and even assuming that direct care staff in ACCOs are Indigenous, approximately only 14 percent of the youth specific service workforce were Indigenous, most (approx. 63%) of whom were employed in ACCOs, and the remainder (37%) in NGOs. None were identified as tertiary qualified. Culturally safe and qualified practitioners are needed to help youth navigate service systems. These skills currently are provided by the largely unqualified Indigenous workforce.

In Cairns, Indigenous workers comprised approximately 25 percent of the youth specific workforce: the majority (75%) of these were employed in ACCOs. The others, three of whom were tertiary qualified (with at least three years' training) were employed primarily in NGOs. Two Indigenous workers were employed in the public sector services.

Tertiary qualified workers comprised approximately 65 percent of the workforce in youth specific services in Yarrabah, and just under 50 percent in Cairns; and were employed almost exclusively either in an NGO, or, to a lesser extent, the public sector.

Within their funding requirements, NGO and other organisations have a responsibility to deliver capacity building components to the community based organisations and services with whom they work. The National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031 (20) states: "To have true ownership and autonomy of health and social and emotional wellbeing, Aboriginal and Torres Strait Islander peoples must have equal representation in all roles, levels and locations across Australia's health, education and training sectors" (p.10). It has set a target of achieving 3.43 percent Aboriginal and Torres Strait Islander representation in the health workforce by 2031. To achieve this target, not only should the ACCO sector- the primary employer- be significantly developed, but NGOs and public sector services should also be funded both to provide support to Indigenous people and to greatly increase the number of Indigenous workers they employ at all levels. Achieving Closing the Gap targets to increase the number of Indigenous young people in tertiary education and in the health professions requires the availability of Indigenous role models and mentors working across a range of occupations and professional levels.

Funding and accountability

The relatively high number of services providing youth justice and child safety support in Yarrabah, and Cairns reflects the National Agreement commitment to significantly reduce the rate of over-representation of Aboriginal and Torres Strait Islander children in out-of-home care, and in detention by 2031. In addition to the CYJMA teams providing direct support; in Yarrabah, three NGO and one ACCO youth specific services were funded by CYJMA, while in Cairns, CYJMA funded eight NGO services and nine ACCO youth specific services. This finding raises two fundamental questions: 1) whether funding at this downstream level is the most effective way of delivering services for the best outcomes; and 2) what level of community control is possible where Key Performance Indicators are tied to funding from agencies whose models of care are not derived from an Indigenous perspective. This second point leads to questions of accountability for Indigenous funded programs and services delivered by non-Indigenous agencies. Questions include: who is making the decisions around how the funding is best used; and around what Indigenous youth services outcomes are valued most by service funders and non-Indigenous service providers?

Conclusion

This report provides important baseline information, and a critical first step, for further investigation into issues such as the equity, effectiveness and accountability of the service system in Yarrabah and Cairns. The findings have already raised a number of issues and questions relevant to ongoing planning and delivery of Indigenous youth mental health and wellbeing services in these communities.

The pattern of care in both Yarrabah and Cairns is very similar, as described above. However, there is a need to identify what this means specifically for each of the communities of Yarrabah and Cairns. That is: does it accurately reflect what is needed in Indigenous communities, or is it driven by other factors? Nearly all teams provided only one Main Type of Care: does this suggest that there may be inefficiencies in the system (ie that it could be more efficient for some main types of care to be combined and delivered by the same team rather than by two separate teams)? What is the role of eHealth in both communities? Comparison with patterns of care of remote communities in Norway, Canada and the Kimberley region shows quite different patterns of care: however, this comparison is limited, given the data in these other regions represents adult mental health services only.

The strengths of the approach taken in this project lie in the use of an ecosystems model, and the standardised and functionally operationalised components of analysis of the DESDE instrument and taxonomy. These enable data across all types of services, regardless of sector or of type of service delivery, to be collected and validly described and classified.

Using the data collected, all teams (BSICs) in the study were able to be identified, and their Main Types of Care coded, using DESDE. The target population component of the DESDE coding system describes the diagnosis/condition of the service user -that is the specific reason that an individual is accessing the service (eg mental health; people using the service for physical health related reasons; for skills development, and so on). The “Z” section of the International Classification of Diseases was applied to services providing social or nonspecific psychosocial related circumstances, along with a new DESDE code qualifier “z2”, when the target population was a population at risk. However, there is a clear need for a specific coding system based on a social and emotional wellbeing model for the most appropriate collection of target population data for Indigenous health and wellbeing services.

While the results of this research report provide promising data for service planning in the region, and suggest promising new area for future development of the tool, it should be noted that some services used by young Indigenous people in Yarrabah may not have been included. In addition, DESDE has not been tested in Indigenous service delivery contexts before, and has been developed from a more Westernised concept of health systems: one in which some of the domains of Indigenous wellbeing such as connection to land, or the importance of particular family and kinship systems, are not typically acknowledged or represented.

Since the 1980s, national and state health and wellbeing policies for Aboriginal and Torres Strait Islander peoples have acknowledged the critical role and effectiveness of place-based Aboriginal Community Controlled services in promoting and achieving positive health and wellbeing outcomes for Indigenous people; and the need for more integrated systems of service delivery. Current frameworks have called for increased data availability in support of this. This report provides data from a snapshot of the current system of service provision for young Indigenous people in Yarrabah and Cairns.

It has shown the critical role played by Aboriginal Community Controlled Organisations in Yarrabah and Cairns through a range of services supporting the wellbeing of their local communities, and the dominance of the NGO sector; identified gaps and strengths in the pattern of care delivery and stimulated questions; and provided reflection about current progress towards key policy goals. In doing so, the findings provide critically important baseline data to inform planning, and a foundation for further research.

Next Steps should include:

Addressing the next steps related to these findings through research and through collaboration/partnership building with ACCOs should include:

- Social Network Analysis-mapping of referral pathways and links between organisations
- Mapping of the financial networks
- Analysis of unmet needs
- Analysis of models of care and Key Performance Indicators and co-design with community-based partner organisations of improved systems of care

Limitations

Services that required a significant out of pocket cost were not included in this report. The inclusion of private providers in the mapping of universally accessible services could distort the results. These services could be included in a future analysis.

The assessment of the services was made through interviews with the managers of the services. Some information may not be accurate and should be objectively confirmed (eg the percentage of activities made outside the office in order to be classified as a mobile service).

We acknowledge that there may be services outside the area not included in this Atlas that may also be used by people in Yarrabah.

The comprehensiveness and accuracy of workforce capacity data are limited by the availability of this data and by the lack of reliable and standardised data to categorise the various roles, particularly in the non-registered professional workforce. These results however provide a baseline of workforce capacity from which analyses of future need can be monitored.

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Annex A: List of service providers and teams (BSICs)

Service Provider	Team
Act for Kids	Individual Support Packages Team
Act for Kids	Family and Child Connect
Act for Kids	Intensive Family Support
Clontarf Foundation	Clontarf Academy - local schools
Gindaja Treatment and Healing Centre	Youth Bail Support
Gurriny Yealamucka Health Service Aboriginal Corporation	Primary Health Care
Gurriny Yealamucka Health Service Aboriginal Corporation	Transport service
Gurriny Yealamucka Health Service Aboriginal Corporation	Integrated care team
Gurriny Yealamucka Health Service Aboriginal Corporation	Youth hub
Gurriny Yealamucka Health Service Aboriginal Corporation	Family Healing
Gurriny Yealamucka Health Service Aboriginal Corporation	Family Wellbeing
Gurriny Yealamucka Health Service Aboriginal Corporation	RSAS team
JT Academy	JT Academy
Mission Australia	Therapeutic counselling workshops
Mission Australia	Circles of Care and Dream Girls
Police and Citizens' Youth Club	PCYC
Department of Children, Youth Justice and Multicultural Affairs (CYJMA)	Youth Justice (Innisfail)
Queensland Department of Children, Youth Justice and Multicultural Affairs (CYJMA)	Youth Justice (Atherton)
Queensland Department of Children, Youth Justice and Multicultural Affairs (CYJMA)	Ongoing Intervention Team
Queensland Department of Children, Youth Justice and Multicultural Affairs (CYJMA)	Intervention with Parental Agreement
Queensland Health	State high school
Queensland Health	Yarrabah ED
Queensland Health	CYMHS

Annex B: Glossary

Broad category	Description	Other common terms	Main Type of Care (MTC)
RESIDENTIAL	Facilities which provide beds overnight for users for a purpose related to the clinical and social management of their health condition	Accommodation, Hospital, Residential	R
Hospital	ACUTE. Users are admitted to hospital typically within 24h because of their crisis condition. Surveillance level and length of stay varies depending on the code	High Dependency Inpatient; Acute Care Unit; Intensive Care Unit; Psychiatric Assessment and Planning Unit	R1-R3.0
Hospital	NON-ACUTE. Facilities which do not satisfy acute conditions. It can be time limited or indefinite depending on the code.	Sub-acute; Community Care Units; Extended Care Mental Health Rehabilitation Unit; Extended Treatment	R4,R6
Alternative to hospital	ACUTE. Facilities with 24-hours physician cover outside the location of a registered hospital	Crisis homes;	R0, R3.1
Alternative to hospital	NON-ACUTE. Facilities with 24h medical support on site. It can be time limited or indefinite depending on the code	Therapeutic Communities	R5, R7
Community	HIGH INTENSITY. Facilities with 24h (non-medical) support. Length of stay (4weeks to indefinite) varies depending on the code.	Step up-Step Down (SUSD); Prevention and Recovery Care (PARC); Rehabilitation residences; Supported accommodation	R8,R11
Community	MEDIUM AND LOW INTENSITY. Facilities with a range of support that varies from daily to fewer to 5 days a week depending on the code. Length of stay (4weeks to indefinite) varies depending on the code.	Psychiatric Hostel; Group Houses; Supported Accommodation	R9;R10,R12,R13
DAY SERVICES	Facilities available to several users at a time that provide some combination of planned treatment for users'	Day services	D
	needs, with regular opening hours during which they are normally available and expect users to stay at the facilities beyond the periods during which they have face-to-face contact with staff.		
Day	ACUTE HEALTH. Users are admitted to the service to because of their crisis condition. Admittance varies typically from 72h to 4 weeks, depending on the code	Day Hospital services (non-existent in Australia)	D0-D1
Day	NON-ACUTE HEALTH. Typically, at least 20% of staff are qualified health professionals with at least a four year university degree. Depending on the code it can be high (equivalent to 4 half days) or low intensity	Recovery Services; Rehabilitation Services, Therapeutic Day services (eg education services with clinical support)	D4.1,D8.1
Day	WORK RELATED. Facilities which provide users with the opportunity to work. The salary varies depending on the code: normal wage; 50% of typical wage; not paid or symbolic pay.	Disability Enterprises; Social firms; Workers Coop; Occupational centres; Integration workplace; sheltered work	D2-D3, D6-D7
Day	OTHER. Facilities providing education, social or other non-health related care. Depending on the code it can be high (equivalent to 4 half days) or low intensity.	Social Clubs; Club Houses; Vocational training;	D4.2-D4.4; D8.2-D8.4; D5;D9; D10

	Structured (activities available more than 25% o opening hours) or non-structured.	psychiatric drop-in centre, Day centres	
OUTPATIENT	Facilities providing contact between staff and users for some purpose related to management of their condition that are not provided as a part of delivery of residential or day and structured activity care teams, as defined below.	Community or ambulatory care; psychosocial support	OUTPATIENT care
Health	ACUTE MOBILE. The service provides assessment and initial treatment in response to a health related crisis, typically same day response during working hours or at least within 72 hours after the care demand. At least 50% of contacts take place outside the service (eg user's home). Depending on the code it ca be 24h or limited hours.	Crisis and Assessment Teams; Assertive Community Treatment	O1.1, O2.1

Health	ACUTE NON MOBILE. The service provides assessment and initial treatment in response to a health related crisis, the purpose is to treat the user in the service, in no case mobile attention exceeds 50% of overall activity. Depending on the code it ca be 24h or limited hours.	Emergency Units or Depts, Psychiatric Emergency; Psychiatric Liaison	O3.1, O4.1
Health	NON-ACUTE MOBILE. The service does not fulfil criteria for acute care. At least 50% of contacts take place outside the service (eg user's home). Depending on the code it can be high intensity (3times/week), medium intensity (once a fortnight), low intensity (once a moth o less)	Mobile Support and Treatment Team; Community Outreach,	O5.1, O6.1, O7.1
Health	NON-ACUTE NON MOBILE. The service does not fulfil criteria for acute care. The purpose is to treat the user in the service, in no case mobile attention exceeds 50% of overall activity. Depending on the code it can be high intensity (3times/week), medium intensity (once a fortnight), low intensity (once a moth o less)	Outpatients; Clinic services, Dual Diagnosis; Community Care/Continuing Care,	O8.1, O9.1, O10.1
Social	NON-ACUTE NON MOBILE. As in non-acute non mobile health but providing other type of care different than health (social, work)	Daily Living, Living Skills Development or Support eg: Art therapy classes, financial or budgeting support (centre based)	O8.2, O9.2, O10.2
Social	NON-ACUTE MOBILE. As in non-acute mobile health but providing other type of care different than health (social, work)	Personal Helpers and Mentors; Psychosocial outreach support	O5.2, O6.2, O7.2
Social	ACUTE NON MOBILE. As in acute non mobile health but providing other type of care different than health (social, work)	Family and sexual violence crisis services	O3.2, O4.2
Social	ACUTE MOBILE NON-HEALTH. As in acute mobile health but providing other type of care different than health (social, work)		O1.2, O2.2

Accessibility	Facilities which main aim is to facilitate accessibility to care for users with a specific condition		ACCESSIBILITY

	Services that facilitates the access to information; Services that facilitates physical mobility; services that facilitates personal accompaniment; Services that facilitates case coordination; Services that facilitates access to employment or housing.	Partners In Recovery (now ceased), Access to Employment services; Tenancy Support	A1-A5
Information	Facilities that provide users from the defined target group with information and/or an assessment of their needs. Does not entail subsequent monitoring/follow-up or direct care provision		INFORMATION
	Guidance and assessment. Information	Telephone triage; Intake & Assessment; Support helplines; Lifeline; Hotline, Information services; Leaflets; Websites	I1-I2
Self Help Volunteer		Self help groups	
Basic Stable Input of Care BSIC	A Basic Stable Input of Care (BSIC) is best described as a team of staff working together to provide care for a group of people. It could also be described as a service delivery or care team. These teams must have time stability (typically they have been funded for more than three years or have funding secured for three years) and structural stability. Structural stability means that they have administrative support, and two of the following: their own space (which can be in a shared office); their own finances (for instance a specific cost centre); and their own forms of documentation (i.e. they collect data and produce reports on their service activities).	The healthcare team on a Hospital ward -including all health professionals and allied health professionals, and other direct care staff	
Main Type of Care MTC	The main type of care provided by a BSIC. It is the care type that defines the team	The MTC of the above team is acute hospital based residential care	

Annex C: Systems Integration to Promote the Mental Health of Indigenous Children and Youth

Project summary

In partnership with Indigenous Primary Health Care (PHC) services in two diverse communities, and an Indigenous youth leadership organisation, this study aims to conceptualise, co-design and evaluate community-driven systems-level integration to promote the mental health and wellbeing of Indigenous school-aged children and youth (5-18 years). The three partners on this research project are: Gurriny Yealamucka Health Service, Yarrabah, Far North Queensland; Bulgarr Ngaru Medical Aboriginal Corporation, Northern NSW; and, Deadly Inspiring Youth Doing Good (DIYDG), Cairns, Far North Queensland.

The research project is being conducted through the Jawan Research Centre, Central Queensland University, Cairns Campus and lead by Prof Janya McCalman. it is a five year (2019 – 2024) NH&MRC funded project. The research project management team, which has oversight of the community-based research activities and engagement with the research partners, is chaired by Chief Investigator, Prof Yvonne Cadet-James and includes representatives from each research partner organisation.

Research governance

The project is governed by a project management team and the research activities are informed by the community research partners, the Community's Youth Advisory Group and a community-based project research officer in each site. A first principle of the project's governance structure is that Aboriginal and Torres Strait Islander co-leadership is active across all levels of the research, project functions and community partnership for the life of the project. The project also provides funds for the employment of a part-time community-based research officer who is the in-community communication link, especially for the engagement with youth and community organisations.

Research methods and activities

Indigenous communities have called for new responses to the high and increasing rates of Indigenous youth mental health and illnesses. But there is little evidence of what best practice Indigenous mental health services are, or how current services can be improved to provide optimal care to Indigenous children and youth.

Taking a placed-based approach with each community partner, the aim of this research is to co-design and evaluate interventions that integrate services and systems between organisations and across sectors to support the wellbeing and mental health of Indigenous children and youth.

Organisations and service providers in Yarrabah were invited to participate in yarning circles and young people were invited to participate in an advisory group and yarning circle. These participants were invited to share their stories and perspectives about the current state of mental health and wellbeing services and supports and give their suggestions on how these could be improved.

A continuous quality improvement (CQI) process is being used throughout the project and applied across all the research activities. Research findings are progressively shared with the community services and youth, and their feedback is sought to inform each stage of the research.

The project is working across multiple sectors. In addition to the community primary healthcare partners, it includes youth mental health, youth intervention programs, education, child, youth and family safety, youth justice and community cultural programs. It engages with community controlled organisations, government agencies, non-for-profit and non-government organisations and services and philanthropic programs.

The research activities and engagement with research participants has been through the key activities outlined below:

- Yarning Circles: Community-based yarning circles were held with community health services, community members – children, youth, families - and other child and youth service providers. Information was gained about the services and supports that currently exist to promote child and youth mental health and ideas on how these could be improved

- Community Youth Advisory Group: A critical element of the research was for it to be youth-informed and proactively seek, listen and include youth voices. Each research partner invited youth to participate in their Community Youth Advisory Groups (CYAG). Several group meetings were held in each community, and each was facilitated by a Deadly Inspiring Youth Doing Good (DIYDG) representative. CYAGs will continue to be held with youth for the life of the project

- Service evaluation: Using the DESDE-LTC evaluation measure, quantitative data about service availability and capacity, was collected through individual interviews with identified service providers

- Health data: the research partner PHC service have agreed to provide data on their child and youth mental health and wellbeing activities and systems

- CRTIC-SAT will be used to identify the appropriateness and integration of child and youth wellbeing services

The collective findings from these research activities will be used to inform the co-design of agreed strategies to improve the integration of child and youth mental health and wellbeing services and supports. The co-design of an integrated youth mental health and wellbeing service model will be specific to each community.

The outcomes of each community's co-designed systems integration model will then be evaluated using CQI tools, administered in collaboration with the community and service providers. The key performance improvements that will be assessed are the:

- availability of services that are community-driven, youth-informed and culturally competent
- identification by primary healthcare services of children and youth social and emotional wellbeing concerns
- the appropriateness and integration of child and youth wellbeing services

Community research engagement

Youth participation: The youth living in Yarrabah were invited to participate in a number of research activities, all held in Yarrabah in a culturally safe and familiar environment. The initial connection with children and youth was through their participation in a Yarning Circle. Following this Gurriny, through the Youth Hub, invited youth 16 – 24 years to be a member of the Community Youth Advisor Group (CYAG). The breakdown of the participates involvement in these activities is shown in the table below.

Yarrabah youth meetings	Number of participants	Age range	Gender	
			Female	Male
Youth yarning circle	12	11-16	11	1
CYAG 1	6	18-24	2	4
CYAG 2	9	16-24	5	4
CYAG 3	5	16-24	3	2
TOTAL	47	11 - 24	30	17

Service providers participation

Yarrabah based service providers of child and youth mental health and wellbeing services were invited to a number of meetings that was held in Yarrabah. The initial invitation was to participate in a Yarning Circle. The findings from this meeting and from the youth meetings was presented to service providers. Each service provider was invited to participate in an individual interview.

Yarrabah service provider engagement	Number of service providers	Indigenous	Non-Indigenous
Yarning circle participants	10	8	2
Community Service provider consultations	5	4	1
CYAG Service provider consultations	4	4	0
DESDE organisation interviews	13	2	11
Totals	32	18	14

Service provider | organisation interview

The DESDE interviews with organisations were arranged by the CQU research team and conducted in collaboration and partnership with the DESDE research team from the Australian National University and University of Canberra. The interviews were face to face, although to adhere to the Covid safe practices of one organisation, this interview was completed via video link.

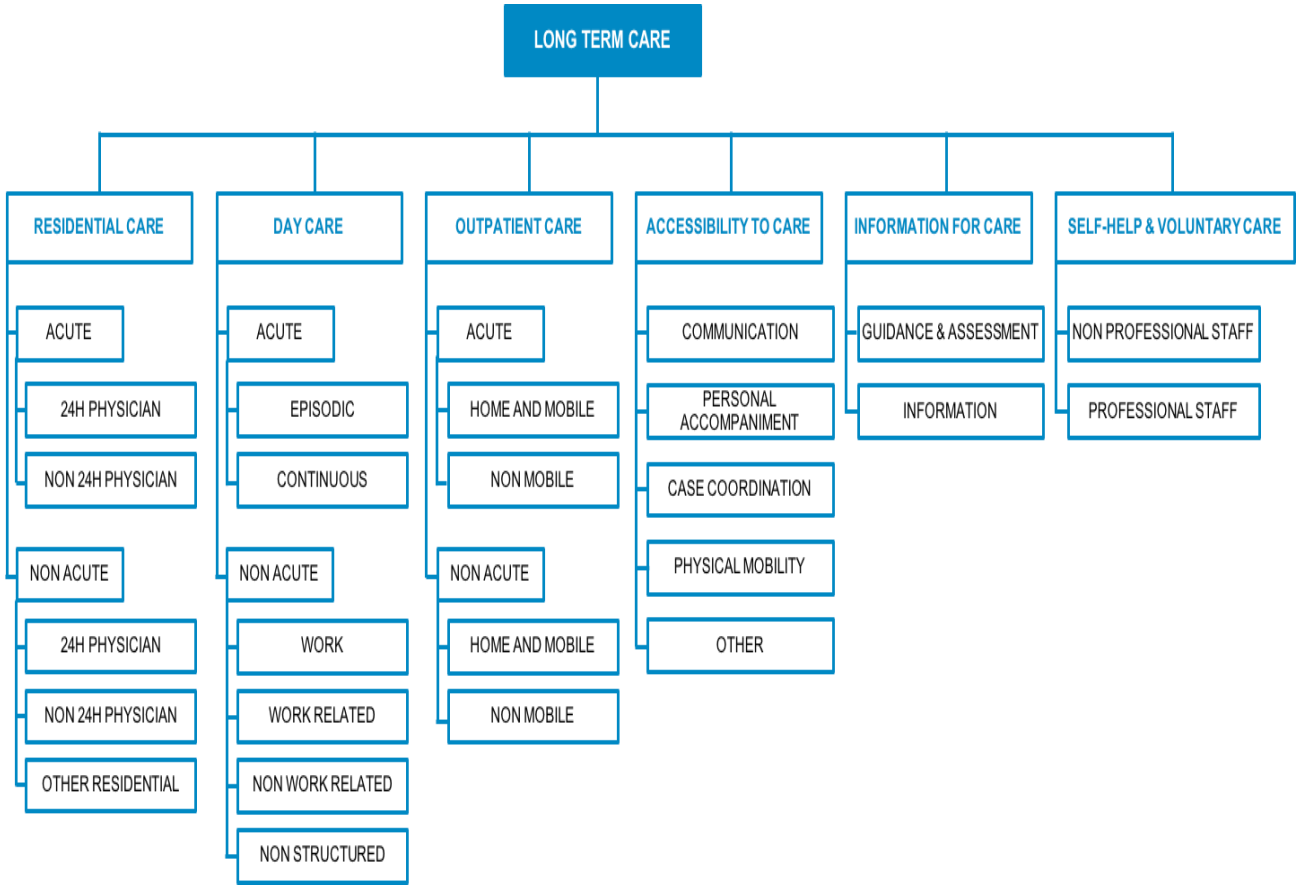
Thirteen organisations participated in interviews however, some organisation had multiple teams providing different programs. Two organisations were community controlled (Gurriny and Gindaja) that offered a number of community, family or health and wellbeing or referral programs. The other eleven organisations were conducted by agencies funded to provide services in or to the community. For example, the school is located in community and funded by Queensland Education while other agencies visit the community, for example Act for Kids is funded to visit the community to provide child safety services.

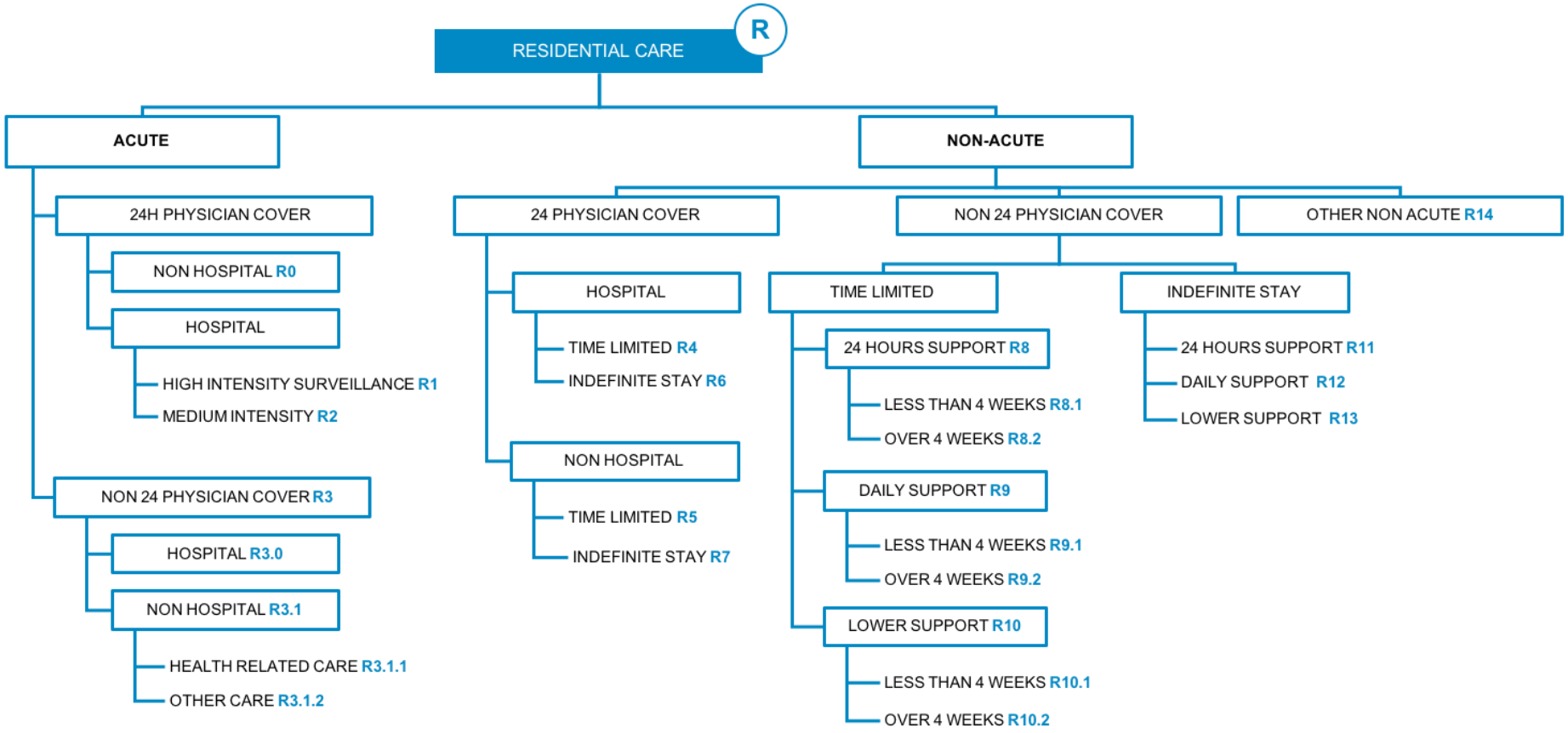
Benefit of the Research

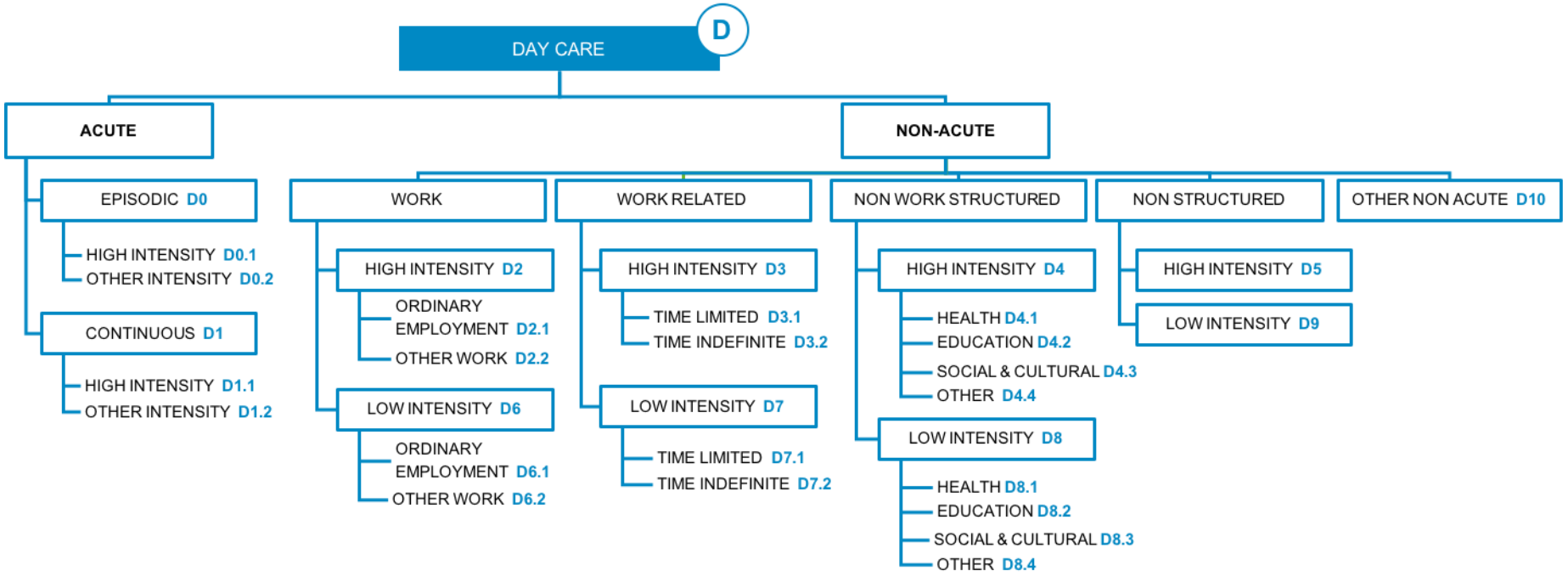
This study will contribute to the development of Indigenous family and community, primary healthcare and government agendas for quality improvements in Indigenous youth mental health and wellbeing services and supports. It provides evidence of youth-informed, community-driven, and tested co-designed models that can be used for implementing systems integration to promote the mental health and wellbeing of Indigenous children and youth. It will identify the situational enablers and barriers that impact systems integration and determine the extent to which the Indigenous co-design approaches can improve child and youth mental health service availability, appropriateness and integration.

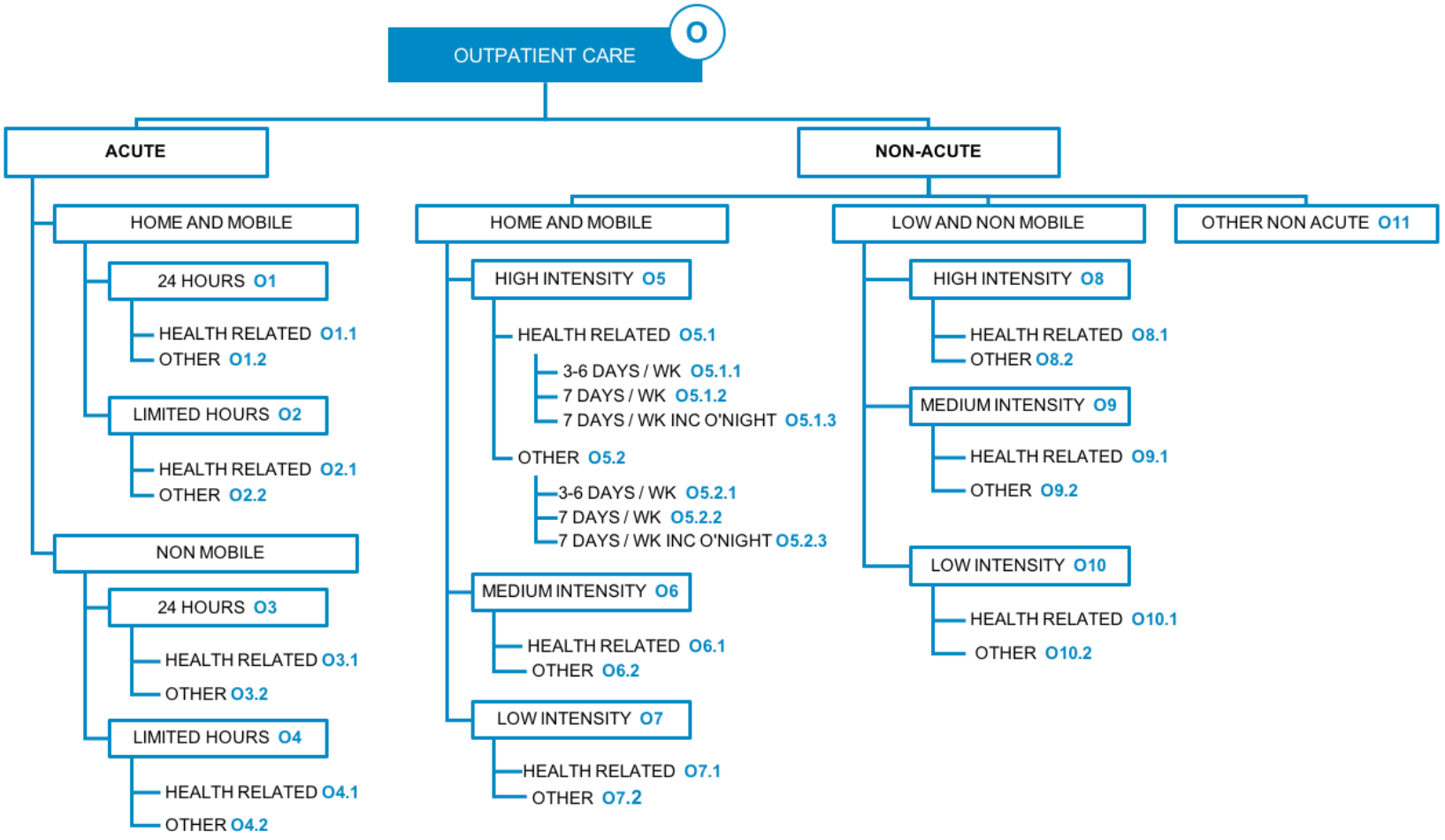
The study identifies new models for community-based and integrated youth mental health promotion and early interventions that are based on knowledge produced from each of the communities and thereby contributes to supporting and enhancing Indigenous children's and youth mental health. These improvements are underpinned by partnerships, engagement, collaboration, agreed values, participatory CQI, and systems integration approaches.

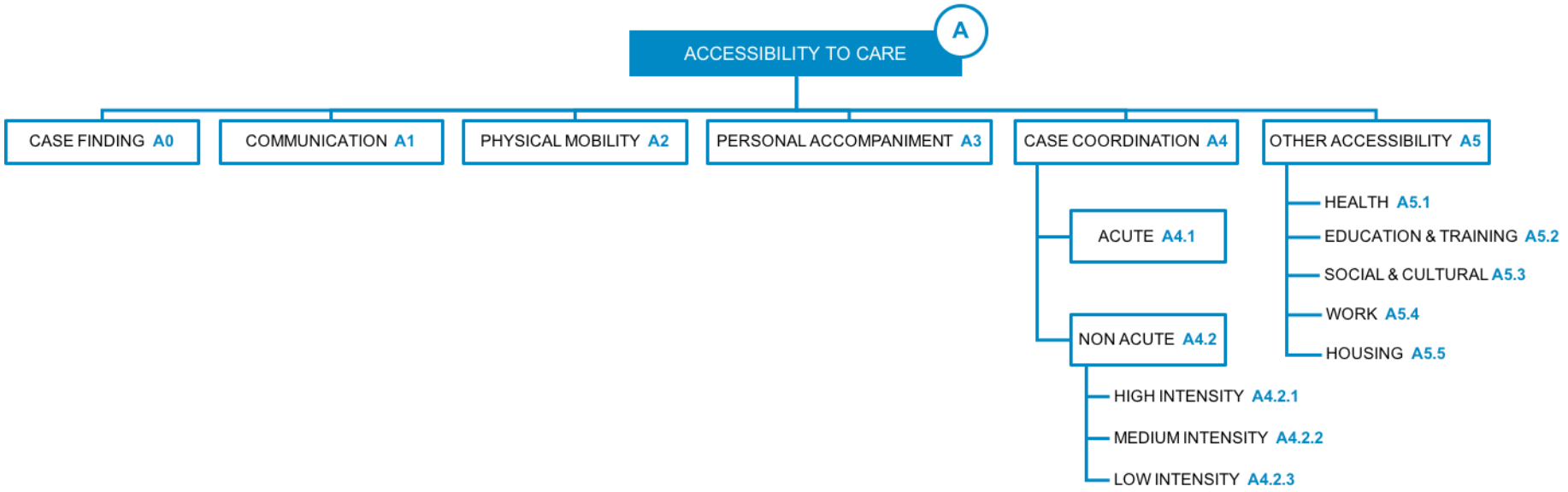
Annex D DESDE-LTC Main branches of care

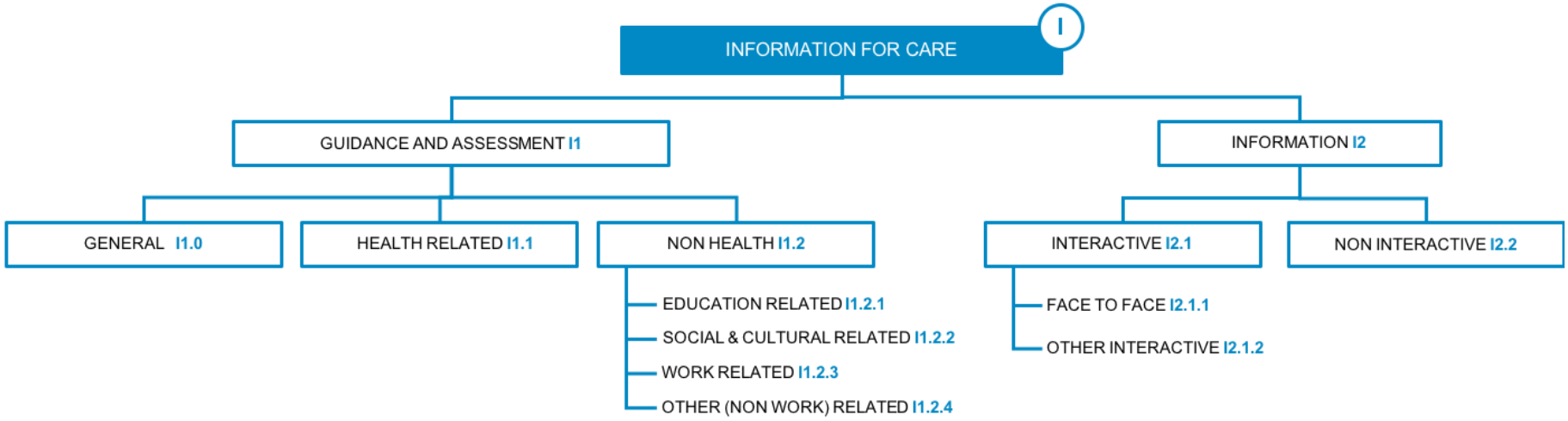


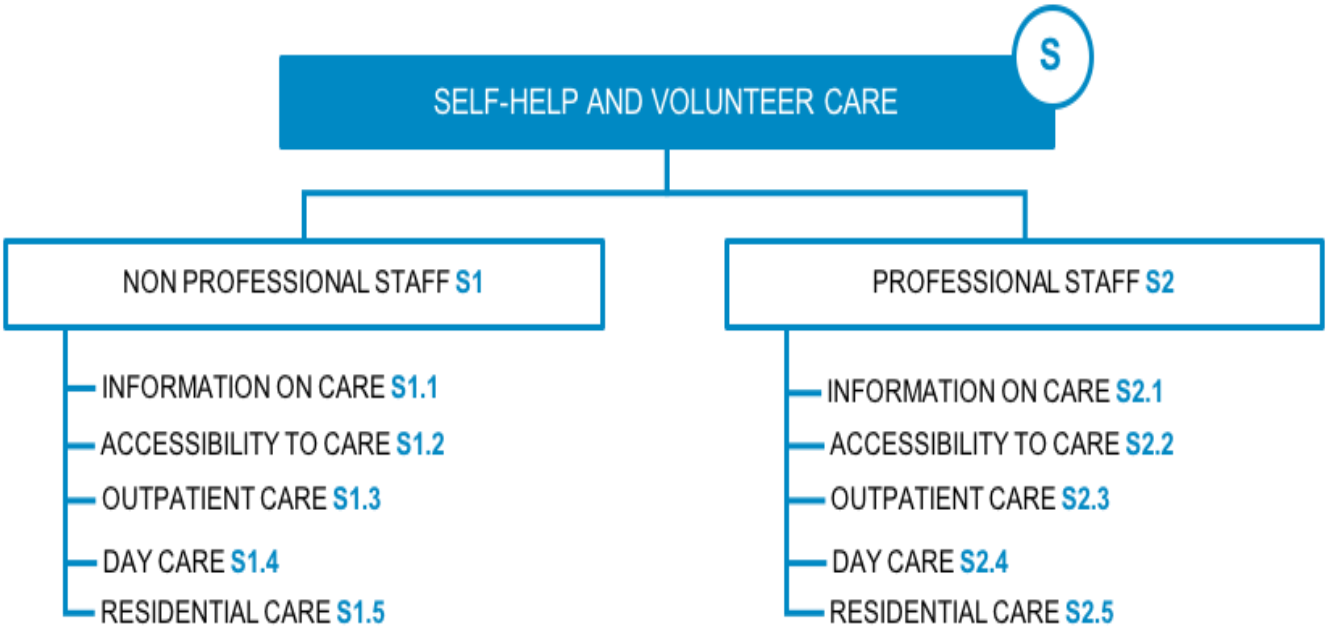

RESIDENTIAL CARE
R
ACUTE
NON-ACUTE
24H PHYSICIAN COVER
NON HOSPITAL R0
HOSPITAL
HIGH INTENSITY SURVEILLANCE R1
MEDIUM INTENSITY R2
NON 24 PHYSICIAN COVER R3
HOSPITAL R3.0
NON HOSPITAL R3.1
HEALTH RELATED CARE R3.1.1
OTHER CARE R3.1.2
24 PHYSICIAN COVER
HOSPITAL
TIME LIMITED R4
INDEFINITE STAY R6
NON HOSPITAL
TIME LIMITED R5
INDEFINITE STAY R7
NON 24 PHYSICIAN COVER
TIME LIMITED
24 HOURS SUPPORT R8
LESS THAN 4 WEEKS R8.1
OVER 4 WEEKS R8.2
DAILY SUPPORT R9
LESS THAN 4 WEEKS R9.1
OVER 4 WEEKS R9.2
LOWER SUPPORT R10
LESS THAN 4 WEEKS R10.1
OVER 4 WEEKS R10.2
INDEFINITE STAY
24 HOURS SUPPORT R11
DAILY SUPPORT R12
LOWER SUPPORT R13
OTHER NON ACUTE R14


DAY CARE
D
ACUTE
NON-ACUTE
EPISODIC D0
HIGH INTENSITY D0.1
OTHER INTENSITY D0.2
CONTINUOUS D1
HIGH INTENSITY D1.1
OTHER INTENSITY D1.2
WORK
HIGH INTENSITY D2
ORDINARY EMPLOYMENT D2.1
OTHER WORK D2.2
LOW INTENSITY D6
ORDINARY EMPLOYMENT D6.1
OTHER WORK D6.2
WORK RELATED
HIGH INTENSITY D3
TIME LIMITED D3.1
TIME INDEFINITE D3.2
LOW INTENSITY D7
TIME LIMITED D7.1
TIME INDEFINITE D7.2
NON WORK STRUCTURED
HIGH INTENSITY D4
HEALTH D4.1
EDUCATION D4.2
SOCIAL & CULTURAL D4.3
OTHER D4.4
LOW INTENSITY D8
HEALTH D8.1
EDUCATION D8.2
SOCIAL & CULTURAL D8.3
OTHER D8.4
NON STRUCTURED
HIGH INTENSITY D5
LOW INTENSITY D9
OTHER NON ACUTE D10


OUTPATIENT CARE
O
ACUTE
NON-ACUTE
HOME AND MOBILE
24 HOURS O1
HEALTH RELATED O1.1
OTHER O1.2
LIMITED HOURS O2
HEALTH RELATED O2.1
OTHER O2.2
NON MOBILE
24 HOURS O3
HEALTH RELATED O3.1
OTHER O3.2
LIMITED HOURS O4
HEALTH RELATED O4.1
OTHER O4.2
HOME AND MOBILE
HIGH INTENSITY O5
HEALTH RELATED O5.1
3-6 DAYS / WK O5.1.1
7 DAYS / WK O5.1.2
7 DAYS / WK INC O'NIGHT O5.1.3
OTHER O5.2
3-6 DAYS / WK O5.2.1
7 DAYS / WK O5.2.2
7 DAYS / WK INC O'NIGHT O5.2.3
MEDIUM INTENSITY O6
HEALTH RELATED O6.1
OTHER O6.2
LOW INTENSITY O7
HEALTH RELATED O7.1
OTHER O7.2
LOW AND NON MOBILE
HIGH INTENSITY O8
HEALTH RELATED O8.1
OTHER O8.2
MEDIUM INTENSITY O9
HEALTH RELATED O9.1
OTHER O9.2
LOW INTENSITY O10
HEALTH RELATED O10.1
OTHER O10.2
OTHER NON ACUTE O11


A
ACCESSIBILITY TO CARE
CASE FINDING A0
COMMUNICATION A1
PHYSICAL MOBILITY A2
PERSONAL ACCOMPANIMENT A3
CASE COORDINATION A4
OTHER ACCESSIBILITY A5
ACUTE A4.1
NON ACUTE A4.2
HIGH INTENSITY A4.2.1
MEDIUM INTENSITY A4.2.2
LOW INTENSITY A4.2.3
HEALTH A5.1
EDUCATION & TRAINING A5.2
SOCIAL & CULTURAL A5.3
WORK A5.4
HOUSING A5.5


I
INFORMATION FOR CARE
GUIDANCE AND ASSESSMENT I1
INFORMATION I2
GENERAL I1.0
HEALTH RELATED I1.1
NON HEALTH I1.2
INTERACTIVE I2.1
NON INTERACTIVE I2.2
EDUCATION RELATED I1.2.1
SOCIAL & CULTURAL RELATED I1.2.2
WORK RELATED I1.2.3
OTHER (NON WORK) RELATED I1.2.4
FACE TO FACE I2.1.1
OTHER INTERACTIVE I2.1.2


S
SELF-HELP AND VOLUNTEER CARE
NON PROFESSIONAL STAFF S1
INFORMATION ON CARE S1.1
ACCESSIBILITY TO CARE S1.2
OUTPATIENT CARE S1.3
DAY CARE S1.4
RESIDENTIAL CARE S1.5
PROFESSIONAL STAFF S2
INFORMATION ON CARE S2.1
ACCESSIBILITY TO CARE S2.2
OUTPATIENT CARE S2.3
DAY CARE S2.4
RESIDENTIAL CARE S2.5

Annex E: Detailed description of DESDE codes identified in Yarrabah

Table 2 provides a detailed summary of the Main Types of Care provided in the Yarrabah for young people up to the age of 18 years, according to the individual DESDE codes.

MTC	Definition	Sector						
		Health	**NGO**	**Child Safety**	**Justice**	**Education**	**Aboriginal Controlled**	**TOTAL**
DAY CARE: Facilities that involve contact between staff and users for some purpose related to management of their condition and its associated clinical and social difficulties								
D2.1	Non-acute, work, high intensity, ordinary employment	0	0	0	0	0	0	0
D2.2	Non-acute, work, high intensity, other work	0	0	0	0	0	0	0
D3.1	Non-acute, work related care, high intensity, time limited	0	0	0	0	0	0	0
D4.1	Non-acute, non-work structured care, high intensity, health related care	0	0	0	0	0	0	0
D4.2	Non-acute, education related care, high intensity	0	0	0	0	0	0	0
D4.3	Non-acute, social & cultural	0	4	0	0	0	0	4

MTC	Definition	Sector						
		Health	**NGO**	**Child Safety**	**Justice**	**Education**	**Aboriginal Controlled**	**TOTAL**
	related care, high intensity							
D5	Non-acute, non-structured care, high intensity	0	0	0	0	0	1	1
D5.2	Other day care, high intensity, non-structured care	0	0	0	0	0	0	0
D7.1	Non-acute, work related care, low intensity, time limited	0	0	0	0	0	0	0
D8.1	Non-acute, non-work structured care, low intensity, health related care	0	0	0	0	0	0	0
D8.2	Non-acute, education related care, low intensity, health related care	0	0	0	0	0	0	0
D8.3	Non-acute, non-work structured care, low intensity, social and	0	0	0	0	0	0	0

MTC	Definition	Sector						
		Health	**NGO**	**Child Safety**	**Justice**	**Education**	**Aboriginal Controlled**	**TOTAL**
	cultural related care							
D8.4	Non-acute, non-work structured care, low intensity, other non-work structured care	0	0	0	0	0	0	0
D9	Non-acute, non structured care, low intensity	0	0	0	0	0	0	0
D10	Other non-acute day care not classified anywhere else	0	0	0	0	0	0	0
TOTAL D		0	4	0	0	0	1	5

MTC	Definition	Sector						
		Health	**NGO**	**Child Safety**	**Justice**	**Education**	**Aboriginal Controlled**	**TOTAL**
OUTPATIENT: Facilities that involve contact between staff and users for some purpose related to management of their condition and its associated clinical and social difficulties								

MTC	Definition	Sector						
		Health	NGO	Child Safety	Justice	Education	Aboriginal Controlled	TOTAL
O1.1	Acute, mobile, 24h, health related care	0	0	0	0	0	0	0
O2.1	Acute, home and mobile, limited hours, health related care	0	0	0	0	0	0	0
O3.1	Acute, non-mobile, 24h, health related care	1	0	0	0	0	0	1
O4	acute, non-mobile, time limited	0	0	0	0	0	0	0
O4.1	acute, non-mobile, time limited, health related care	0	0	0	0	0	0	0
O5.1	Non-Acute, Home & Mobile, High Intensity	0	0	0	0	0	1	1
O5.1.1	Non-Acute, Home & Mobile, High Intensity, 3 to 6 days a week care	0	0	0	0	0	0	0
O5.1.2	Non-Acute, Home & Mobile, High Intensity, 3 to 6 days a week care	0	1	0	0	0	0	1

MTC	Definition	Sector						
		Health	NGO	Child Safety	Justice	Education	Aboriginal Controlled	TOTAL
O5.2	Non-Acute, Home & Mobile, High Intensity, other care	0	1	0		0	2	4
O5.2.1	Non-Acute, Home & Mobile, High Intensity, other care, 3 to 6 days a week care	0	1	0	0	0	1	1
O5.2.2	Non-Acute, Home & Mobile, High Intensity, 7 a week care	0	0	0	0	0	0	0
O6.1	Non-Acute, Home & Mobile, Medium Intensity	0	0	0	0	0	0	0
O6.2	Non-Acute, Home & Mobile, Medium Intensity, other care	0	0	2	2	0	1	5
O7.1	Non-Acute, Home & Mobile, low Intensity	1	0	0	0	0	0	1
O7.2	Non-Acute, Home & Mobile, low	0	1	0-	0	0	0	1

MTC	Definition	Sector						
		Health	NGO	Child Safety	Justice	Education	Aboriginal Controlled	TOTAL
	Intensity, other care							
O8.1	Non-Acute, non-mobile, High intensity , health related care	0	0	0	0	1	1	2
O8.2	Non-Acute, non-mobile, High intensity , other care	0	0	0	0	0	0	0
O9.1	Non-Acute, non-mobile, Medium intensity , health related care	0	0	0	0	0	0	0
O9.2	Non-Acute, non-mobile, Medium intensity , other care	0	0	0	0	0	0	0
O10.1	Non-acute, non-mobile, low intensity, health related care	0	1	0	0	0	0	1
O10.2	Non-Acute, Home & Mobile, Medium Intensity, other care	0	0	0	0	0	0	0
O11	Other non-acute care	0	0	0	0	0	0	0

MTC	Definition	Sector						
		Health	NGO	Child Safety	Justice	Education	Aboriginal Controlled	TOTAL
TOTAL O		2	5	2	2	1	6	18

MTC	Definition	Sector						
		Health	NGO	Child Safety	Justice	Education	Aboriginal Controlled	TOTAL
ACCESSIBILITY: Facilities whose main aim is to provide accessibility aids for users with long term care needs								
A1	Communication	0	0	0	0	0	0	0
A3	Personal Accompaniment by non-care professionals.	0	0	0	0	0	0	0
A2	Physical Mobility	0	0	0	0	0	1	1
A4	Case Coordination	0	0	0	0	0	0	0
A4.1	Case Coordination: Acute care	0	0	0	0	0	0	0
A4.2	Case Coordination: Non-acute care	0	0	0	0	0	0	0
A4.2.1	Case Coordination: Non-acute care, High intensity	0	0	0	0	0	0	0
A4.2.2	Case Coordination: Non-acute care,	0	0	0	0	0	0	0

MTC	Definition	Sector						
		Health	NGO	Child Safety	Justice	Education	Aboriginal Controlled	TOTAL
	medium intensity							
A5	Other accessibility care	0	0	0	0	0	0	0
A5.2	Other accessibility care - Education & training related	0	0	0	0	0	0	0
A5.3	Other accessibility care - Social & culture related	0	0	0	0	0	0	0
A5.4	Other accessibility care - Work related	0	0	0	0	0	0	0
TOTAL A		1	0	0	0	0	0	1

Electronic copies of the Atlas are available at the research partner's website:

GURRINY YEALAMUCKA
HEALTH SERVICE ABORIGINAL CORPORATION

https://www.gyhsac.org.au/research

YARRABAH LEADERS FORUM

UNIVERSITY OF CANBERRA

https://www.canberra.edu.au/research/institutes/health-research-institute

CQUniversity AUSTRALIA

https://www.cqu.edu.au/research/organisations/jawun-research-centre/publications

For further information, contact:

Research Project: Prof Janya McCalman: Jawun Research Centre, Central Queensland University. E: j.mccalman@cqu.edu.au

DESDE – LTC: Prof Luis Salvador-Carulla, University of Canberra: E: Luis.Salvador-Carulla@canberra.edu.au

Integrated Atlas of the social and emotional wellbeing services for

Aboriginal and Torres Strait Islander children and youth in Yarrabah

June 2022