DEPARTMENT OF HEALTH EVALUATION OF CAPE YORK WELLBEING CENTRES FINAL EVALUATION REPORT

SEPTEMBER 2014







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ABBREVIATIONS

ABS	Australian Bureau of Statistics	HoNOS	Health of the Nation Outcome Scales
AOD	Alcohol and other drugs	IRIS	The Indigenous Risk Impact Screen
ATODS	Alcohol Tobacco and Other Drug Services	ISO	International Organisation for Standardisation
ATSIHS	Australian Aboriginal and Torres Strait Islander Health Survey	LAG	Local Advisory Group
AUDIT	Alcohol Use Disorders Identification Test	МН	Mental Health
COAG	Council of Australian Governments	MH & ATODS	Mental Health and Alcohol Tobacco and Other Drug Services
CYHHS	Cape York Hospital and Health Service	MMEx	Health client record system
СҮР	Cape York Partnerships	PCYC	Police and Citizens Youth Club
CYWR	Cape York Welfare Reform	PIR	Post implementation review
D&A	Drug and Alcohol	QAIHC	Queensland Aboriginal and Islander Health Council
DoH	Department of Health (formerly Department of Health and Ageing)	QH	Queensland Health
FRC	Family Responsibilities Commission	RFDS	Royal Flying Doctor Service
FTE	Full-time equivalent	SDOT	Single Desk Officer Trial
GEM	Growth and Empowerment measure	SEWB	Social and emotional well being
HAT	Health action teams (Apunipima)	WBC	Wellbeing Centre
HOI	Health Outcomes International	YOTEM	The RFDS client data system





EXECUTIVE SUMMARY

E.1 INTRODUCTION

BACKGROUND

The Cape York Wellbeing Centres (WBCs), jointly funded by the Australian (78%) and Queensland Governments (22%), were established to meet the broad social and emotional wellbeing (SEWB) needs of the communities of Aurukun, Coen, Hopevale and Mossman Gorge (combined population 2815). WBCs were to deliver a new and unique integrated, community based and culturally appropriate social health service with a focus on drug and alcohol, gambling, family violence, general counselling and mental health. In relation to mental health, the visiting specialist mental health services of Queensland Health would continue to provide services and work in an integrated way with WBC clinical staff and counsellors. Additionally, the WBCs were to collaborate with the full range of relevant agencies in the community in order to facilitate improved SEWB outcomes.

While not initiated to support the Cape York Welfare Reform (CYWR) exclusively, the WBCs were intended to contribute to the change in behavioural and social norms as an enabler and significant support service to the Reform strategy and in particular the Family Responsibilities Commission (FRC). The Royal Flying Doctors Service (RFDS) was contracted as an interim auspice to operate the WBCs with a view to transitioning to a community-controlled arrangement over time. Local Advisory Groups (LAGs) were established in each community to partner with the RFDS to ensure active community participation in the recruitment, planning, development and monitoring of WBC service delivery. The WBCs have been fully operational for approximately 5 years. [Section 1.5]

EVALUATION AIMS

The Australian Government appointed Health Outcomes International (HOI) to assess the effectiveness of the WBCs in terms of processes implemented and individual and community-wide outcomes achieved to date. The specific aims of the project were to:

- Provide evidence on whether the WBCs are being successful in reducing alcohol and substance abuse and its impact on families, safety and community wellbeing in the four communities
- Provide evidence on whether the WBCs are achieving success in addressing related mental health and social and emotional well-being issues in each of the four communities
- Provide evidence on whether the work of the WBCs is contributing to achievement of the Closing the Gap targets, particularly those that relate to the life expectancy gap and mortality
- Identify which prevention, intervention and treatment approaches are successful and the key factors that are contributing to this success
- Recommend any improvements which will enhance health outcomes and contribute to best practice service delivery. [Section 1.2]

EVALUATION METHODOLOGY

The evaluation commenced in July 2012 and was completed in July 2014. An evaluation framework had previously been developed by HOI and approved by the Department of Health. The evaluation process involved: extensive ongoing consultation at the community and regional level with community members, clients, key partners and other relevant stakeholders; collection and analysis of service and outcome data; and review of relevant reports and literature. [Section 1.3]

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Progressive reporting to the Department and service provider throughout the evaluation facilitated service improvements and strengthening. The final report directly addresses the key objectives of the evaluation. A steering committee and expert reference group were established to oversee the evaluation. [Section 1.1]

E.2 OVERALL ASSESSMENT

The evaluation assessed the effectiveness of the WBCs in terms of processes implemented and individual and community-wide outcomes achieved to date.

CONTEXT

When considering the impact of the WBCs, as noted in the independent Cape York Welfare Reform (CYWR) evaluation 'there can be no quick fix to rectify challenges that have been decades in the making.' Contextual challenges to achieving significant change include: the recognition that Cape communities were suffering from significant social problems, caused not only by dispossession, racism and systematic and generational abuse, but also a social norms deficit; the entrenched disadvantage of Indigenous community members; a comparatively high burden of psychosis particularly amongst males; and increasing recognition that a compromised neuro-developmental environment significantly effects an adults' general and mental health. [Section 2.6]

ASSESSMENT

The WBCs provided a new, unique and well-resourced approach to the provision of SEWB services that provided a high level of service access and resulted in significant levels of community engagement.

The findings indicate that the WBCs are having significant success in helping some individuals through immediate crises and in dealing with their immediate problems and that sustained positive behaviour change is occurring in some clients in relation to alcohol use and cannabis dependency and other social behaviours. This includes those clients referred by the Family Responsibilities Commission (FRC), the single largest referrer to the WBCs. Furthermore, there is some anecdotal evidence of individual change having a positive effect on some families within the communities. However, with the exception of Coen, individual-level improvements are not translating into sustained, consistent and clearly observable improvements in outcomes at the community level. Furthermore, unless the number of individuals making behaviour change increases substantially (including the most challenging community members), it is unlikely that sustained significant change will be observable at the community level unless there was another significant positive enabler of change in the communities (e.g. availability of employment).

Overall, the level of impact demonstrated over five years from the current service model, (particularly at the community level), does not appear to justify the current level of resourcing over the longer term, not-withstanding the significant contextual influence described previously. Embedding and integrating Cape York SEWB services within a primary health care (PHC) setting offers an evidenced base opportunity to improve SEWB outcomes and strengthen service delivery and client referral under a unified governance structure, reducing service duplication and improving performance monitoring.

To achieve this shift from stand-alone SEWB services to an integrated PHC service, will require the development of a transition plan over the next six months in order for implementation to occur in 2015/16. Relevant components of the plan will need to be tailored to the specific communities including taking account of referrals from the ongoing FRC.

E.3 SPECIFIC FINDINGS

Specific findings from the evaluation are:

Review finding #1: The WBCs are having a clinically and statistically significant effect on their clients in reducing the level of risky drinking and the level of cannabis dependency.

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Specifically the Alcohol Screen (AUDIT) mean score reduced by 10% (effect size change – small), the cannabis related Severity Dependence Scale (SDS) mean score reduced by 8% (effect size change – small), and the Indigenous Risk Impact Screen (IRIS) mean reduced by 8% (effect size change – small to medium). [Section 2.2]

Review finding #2: In relation to mental health the WBCs are having a clinically and statistically significant positive effect on their clients. Specifically the Kessler Psychological Distress Scale (K10) mean score for Coen and Hopevale reduced by 8.96% (effect size change - medium) and the Health of the Nation Outcome Scale (HoNOS) mean score of health and social functioning reduced by 5% (effect size change - medium), excluding Aurukun. One reason for the lack of improvement in Aurukun is likely to be the broader community environment (there have been a number of major community-wide incidents in the last couple of years) which in turn has a disruptive impact on individuals.

Achieving successful longer term behaviour change is occurring in some clients and helping to transform their lives. However this is not the norm. [Section 2.3]

Review finding #3: With the exception of Coen, individual-level improvements are not translating into sustained, consistent and clearly observable improvements in outcomes at the community level. The community level changes can be summarised as follows: [Sections 2.2 and 2.3] However, it should be noted that these issues are not the sole remit of the WBCs and other welfare reform programs have also had challenges realising change in these areas.

	Aurukun	Coen	Hopevale	Mossman Gorge
Alcohol related issue	Same or worse	Improved	Same	Same
Drug related issues	Worse	Same/marginally worse	Same/marginally worse	Same
Community safety	Same	Improved	Same	Improved
As a place to live	Same/marginally better	Better	Same/marginally better	Same/marginally better

Review finding #4: In relation to Closing the Gap targets, given there are multiple factors impacting upon life expectancy and mortality, and the long lead time required to observe change, as anticipated there is no direct evidence that the WBCs have contributed to observable changes in the life expectancy and mortality gaps to date. [Section 2.7]

Review finding #5: The WBCs have to a large extent been able to enhance the delivery of other services at the local level through collaboration with partner agencies.

Of significance, regular meetings and collaboration between child safety services and WBC staff to discuss common clients and support case management has contributed to preventing separations and/or facilitating reunifications that child safety services advise have not previously been achieved. This is a very significant achievement and it is proposed that any future SEWB service model should include extensive collaboration with Child Safety. [Section 3.6.1]

The partnership between the WBC and the FRC has developed and improved over time having commenced from a relatively poor starting point due to some lack in clarity of WBC role and differing service expectations. However, it is reasonable to conclude that the WBCs are fundamental to the FRC as a point of referral and hence the future availability of SEWB services where the FRC are operational will be important in any future service delivery decisions. [Section 3.6.1]

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Review finding #6: The WBCs provide a new and unique approach to the provision of SEWB services. Each WBC is addressing the range of service expectations of the community and other stakeholders relatively well. What is unique about the WBC is that it allows for SEWB services (including mental health and drug and alcohol services) to be provided in combination seamlessly. [Section 3.17]

Review finding #7: Service access to SEWB services is greatly enhanced in WBC communities when contrasted to other communities in Cape York. Overall, 48% of the entire community, 57% of the adult community (>19 years) and 26% of the population <20 years are currently, or have been, WBC clients. Violence (21%), mental health (21%), alcohol (20%) and welfare/other support (16%) together make up 78% of the diagnosed assessment issue categories (the primary issue for the client). Many clients have multiple issues. [Sections 3.4 and 3.17]

Review finding #8: The key success factors for the WBCs have included: the level of integration between the core areas of activity (i.e. counselling, drop-in and groups); capacity to work with clients across a wide range of issues that impact upon SEWB; drop-in element; recognition that it takes time for staff to establish relationships; ability to be a key point of contact and referral; capacity to work with non-voluntary (FRC) referred clients; development of effective partnerships in many cases; employment and provision of appropriate levels of training and support for local indigenous staff; recruiting the right non- indigenous staff; and allowing flexibility to respond to local issues and needs.

Key challenges have included: successfully obtaining structured community input on an ongoing basis, a problem shared with other agencies; capacity building efforts in underpinning a longer term intention of community control (which to date have not been successful); and building successful working relationships with the FRC (noting substantial improvements in the last 12 to 18 months). [Section 4.2]

Review finding #9: The current service model is resource intensive and therefore could not feasibly be replicated in the numerous Indigenous communities across Australia who might require SEWB services. [Section 5.1]

Review finding #10: Based on the level of impact demonstrated over five years, the Cape York SEWB model does not appear to justify the current level of resourcing over the longer term. [Section 5.1]

Review finding #11: There is a wide body of literature highlighting the link between SEWB and physical health and the need for health services to continue to work towards embedding SEWB into all aspects of PHC. It is also reported by the World Health Organisation to be the only sustainable option in the long term.

If the integration of SEWB services is accompanied by a strengthening of the skill and knowledge of all PHC practitioners in SEWB issues, and a building of their capacity to assess, provide brief interventions, refer and coordinate (i.e. provide holistic health and wellbeing interventions), it is likely to significantly strengthen PHC delivery and enhance outcomes for clients. [Section 5.2]

Review finding #12: Integration of the existing WBC functions within a PHC setting could potentially reduce service duplication and fragmentation, improve secondary referral pathways and improve client outcomes. [Section 5.2]

Review finding #13: Prior to rolling out SEWB services in a community, a needs assessment should be undertaken to assess the appropriate mix of individual therapeutic counselling and support, drop-in/safe place, groups and community development that are required and how these services may best be 'positioned', targeted and implemented in the context of the particular community (i.e. where centred, what is already available, existing service providers, community need and community commitment). [Section 5.3]

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Given the significant contextual challenges faced by each of the communities and their influence on achieving individual and community change, it is considered that there should be a focus on children and young people to enable generational change. An example of a specific response to a particular SEWB need is the recently commenced Intensive Youth Support Program that is being trialled in Aurukun with 14 extremely challenging youth. Consensus of partners is that this is a critical issue for the wellbeing of the individuals, their families and also the community and is showing early signs of promising results.

E.4 RECOMMENDATIONS

The following recommendations arise from the key findings:

Recommendation 1: On a national basis the direction of policy and implementation should be focused on the integration of SEWB services within PHC, ideally under community control and with the level of resourcing aligned to the level of identified community need.

[Note: There is evidence that community control of service delivery to Indigenous communities realises improved outcomes. Consideration does need to be given to the level (e.g. local, regional) at which services can be most appropriately managed and where there is a community controlled organisation with a proven capacity to deliver health related services.] [Section 5.2]

Recommendation 2: That the WBCs no longer be funded as stand-alone services and that the WBC functions be transitioned into a comprehensive PHC service setting. To support this, a transition plan should be developed in the next six months, to facilitate implementation in 2015/16. Communities and key partners will need to be consulted during the development of the transition plan and the role of the Queensland Health clinics in Aurukun, Coen, and Hope Vale will need to be determined given a greater focus on managing emergency and acute issues. Key factors to be considered in transition planning and which are more fully outlined in the report include items such as governance, service mix, workforce planning, funding and phasing-in different approaches for each WBC. [Section 5.4]





OPPORTUNITIES FOR IMPROVEMENT

Whilst it is yet to be determined what form the WBCs will have into the future, the following opportunities for improvement have been determined for the current structure and service model. Some of these will of course be applicable to the delivery of any WBC service model.

1. **It is proposed** that the service model description be updated in the second half of 2014.

The update should incorporate the following key areas:

- the need for a clear description of the services provided by the WBCs in the mental health and ATODS service lines and the associated interface with Queensland Health
- the need for a clear description of the services provided by the WBCs in relation to FRC clients and how the WBC and FRC can work more closely together to improve outcomes for clients
- aligned to the above points, the need to clarify how and when modules and specific topics are used and for whom
- the need to strengthen description of the approach to non SEWB primary health care services
- the need for a clear description of the skills and qualification required to work in the WBC and associated workforce development strategies.
- 2. **It is proposed** that opportunities for formally integrating welfare and support services into social and emotional wellbeing services including appropriate funding be considered on a community by community basis.
- 3. **It is proposed** that the RFDS continue to focus effort on integrating non-SEWB primary health care into its service. The RFDS should continue to work in conjunction with Apunipima and the local clinic in WBC communities to further integrate SEWB and Non-SEWB services (in the case of Apunipima as part of that organisations strategy to embed a SEWB approach across their family and community centred primary health care model).
- 4. **It is proposed** that any future SEWB service model should include extensive collaboration with Child Safety given the contribution the WBC has been able to make in relation to Child Safety preventing separations and/or facilitating reunifications not previously achieved.
- 5. **It is proposed** that the RFDS develop a service agreement with CYHHS Mental Health and a memorandum of understanding with FRC, which provides an appropriate level of detail as to how the organisations will work in partnership to strengthen the management of clients and enhance the effectiveness of both services.
 - In the case of CYHHS Mental Health, this will strengthen the service model by clarifying the service interface in relation to roles and responsibilities for joint client management, how information is shared and conducting joint case reviews. Aligned with this is the need for more transparency in relation to how the WBCs manage their clients. This would build on the service flowchart that has been developed.

In the case of the FRC, the current strategy being trialled at Aurukun includes: the development of a memorandum of understanding; providing the FRC access to the RFDS client information system; the RFDS to attend FRC case conferences; the RFDS regular summary report including more

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feedback in relation to a client's progress and engagement issues (above what has been agreed previously); and using a shared data system to track client progress.

6. **It is proposed** that a joint agency/community approach to obtaining more structured community input into social services/primary health care specifically that is unique to each community be established.

It is proposed that the interagency meetings in each community be the vehicle for 'kick-starting' this process. In establishing a joint approach the following principles should apply:

- Community members should be paid appropriately for their participation.
- Membership should be clear and determined locally.
- The chairman of the group should be determined locally but joint chairs (one agency, one community member) would be ideal.
- The role of the group should focus on:
 - o needs identification
 - o developing appropriate responses
 - monitoring results
 - o providing feedback on service performance
- The group should have a clear (funded) support structure.
- The group should have clear reporting and accountability lines.
- Meetings should not be too frequent, for example bimonthly initially then quarterly.
- Funders will need to accept that this approach is suitable in the context of governance requirements for specific programs.
- 7. **It is proposed** that the WBC develop specific materials promoting the WBC service. This could be done after the service model is updated.
- 8. **It is proposed** that the WBCs establish therapeutic discussion groups to analyse and discuss experiences and results achieved with particular therapies and approaches.
 - This will be facilitated by information now able to be provided by the upgraded client information system.
- 9. **It is proposed** that the SDOT continue to June 2015 as per the current agreement.
 - HOI is aware of the Australian Government Machinery of Government changes that will impact upon the source of funding streams for the WBC. The SDOT has improved service outcomes indirectly, and significantly enhanced service responsiveness and service integration, while from the RFDS perspective at least, maintaining integrity of existing relevant program and financial accountability requirements. Any cessation of the agreement would limit the RFDS capacity to respond to emerging or changing community needs.
- 10. **It is proposed** that HoNOS, K5, AUDIT C and SDS (in relation to a person's cannabis usage and associated risk factors) be utilised on an ongoing basis. It is considered this combination of tools best represents the key foci of the WBCs (i.e. mental health, SEWB and drug and alcohol).
 - The evaluators consider that the number of outcome indicators collected and reported systematically should be minimised to reduce the burden on clinical staff in a challenging service environment.
 - The HONOS has generally adequate validity and reliability. It has been thoroughly evaluated and extensively used across a range of populations (incl. Indigenous Australians and mental health

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clients). The AUDIT is widely used and is the preferred tool of the Australian Government for funded alcohol and other drug services. There is concern about utility in Indigenous populations and the AUDIT–C has been developed which could be used.

The K10 is widely accepted, validated and used nationally and the K5 is used in Australia for Indigenous populations by the Australian Bureau of Statistics and the Australian Institute of Health and Welfare. The SDS has generally adequate psychometrics and can be utilised for a range of substances.²

The Indigenous Risk Impact Screen (IRIS) has a high degree of convergence with the K10 and the AUDIT and should not be required as an outcome tool.

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¹ NADA (Network of alcohol and other drug agencies). Review of Screening, Assessment and Outcome Measures for Drug and Alcohol Settings. 2009

² Ibid.





1 Introduction

This chapter sets out the purpose and context of the Final Evaluation Report, the evaluation methodology including the limitations, the structure of this report and some background to the establishment of the Cape York Wellbeing Centres (WBCs).

1.4 PURPOSE AND CONTEXT OF THIS REPORT

This report (the fifth evaluation report) aims to provide a summary of the effectiveness of the WBCs in terms of processes implemented and outcomes achieved to date in accordance with the evaluation framework and key evaluation objectives.

Table 1.1: Sequence and purpose of evaluation reports

Date	Report	Focus
July 2012	Evaluation framework and ethics approval	Development of evaluation framework in conjunction with a wide range of stakeholders
November 2012	Post Implementation Review (PIR) Report	An analysis of currently available service data and management feedback focusing on processes
April 2013	Phase One Evaluation Report	Effectiveness of the WBCs in terms of processes implemented and a preliminary analysis of outcomes based on client and community interviews
October 2013	Interim Data Report	Presentation and analysis of available of available service and preliminary outcome data
January 2014	Phase Two Evaluation Report	Focus on the effectiveness and outcomes based on all available qualitative and quantitative information incorporating additional outcome data and information from further client and community consultations
May 2014	Draft final evaluation report	Summative, effectiveness and outcome focused

It is important to note that the recommendations in this report and highlighted in the executive summary are focused on the key strategic recommendations. In addition a number of opportunities for improvement which are more operationally focused have been identified in the context of ongoing provision of the current service model. These are highlighted throughout the report and aggregated and presented in Section 4.3 Opportunities for Improvement.



1.2. EVALUATION OBJECTIVES AND KEY QUESTIONS

The key objectives for the evaluation were:

- Providing evidence on whether the WBCs are being successful in reducing alcohol and substance abuse and its impact on families, safety and community wellbeing in the four Cape York communities
- Providing evidence on whether the WBCs are achieving success in addressing related mental health and social and emotional well-being issues in each of the four Cape York communities
- Providing evidence on whether the work of the WBCs is contributing to achievement of the Closing the Gap targets, particularly those that relate to the life expectancy gap and mortality
- Identifying which prevention, intervention and treatment approaches are successful and the key factors (such as clinical tools, delivery approaches, governance arrangements etc) that are contributing to this success
- Recommending any improvements which will enhance health outcomes and contribute to best practice service delivery.

The key evaluation domains and questions developed in the evaluation framework to address the evaluation as a whole are set out in Table 1.2.

Table 1.2: Key evaluation questions by domain

Domain	Key Evaluation Questions
Outcome	The key outcome hypotheses listed in the evaluation framework are to be tested. The overarching outcome evaluation questions are: • What outcomes are being achieved, for what groups and why and at what cost? • What are the contexts, mechanisms and treatment methods that bring rise to positive client outcomes?
Service model	 Has a service model been documented that aligns with the key service elements and is in alignment with the program theory? Do staff understand the service model? Has the service model as agreed been implemented? If not what are the variations and what was the rationale for any change? Is the service model and treatment method(s), as has been implemented, motivating individuals to change and contributing to enhanced individual, family and community functioning and wellbeing? If so how and if not, why not? How should the service model be changed to enhance its contribution to individuals, families and communities functioning and wellbeing? Has the service model resulted in better access to services than in other comparable communities and how does the service profile and approach compare?
Service management	 Are the processes, systems, structures and people (i.e. the service management) facilitating the efficient and effective delivery of the WBC service model? If so, how and if not, why not? How should the service management be changed to enhance its contribution to individuals, families and communities functioning and wellbeing? Have community capacity building efforts been effective in underpinning a longer term enhancement of community control?



Domain	Key Evaluation Questions
Community engagement	 Is the WBC effectively engaging the community? If so, what has or is working and why, and what has not worked and why? How could community engagement be improved to enhance the WBC's contribution to individuals, families and community functioning and wellbeing?
Partnerships	 Is the WBC establishing effective partnerships of the type required with respective partner stakeholders? If so, what has worked or is working and why, and what has not worked or is not working and why? How could partnerships be strengthened to enhance the WBC's contribution to individuals, families and community functioning and wellbeing?
Value for money/program expansion	 Is the model that has been adopted for the WBC appropriate or the preferred option for any roll out? If not what could be considered for roll out? If this was the preferred model, what are the feasibility issues with respect to rolling out the model to other communities? What are the critical success factors that would need to be included in any subsequent plan to roll out the model elsewhere What are the barriers to effective implementation that would need to be addressed in any planned roll out?

1.3 METHODOLOGY

Phase One of the evaluation involved development of the evaluation framework. The framework was developed after extensive consultation with community and non-community based stakeholders and incorporated a stakeholder workshop to present a draft evaluation framework and obtain final feedback.

Phase Two involved undertaking the evaluation in accordance with the methodology discussed below.

1.3.1 METHODOLOGY

The methodology utilised for informing the evaluation included:

- Obtaining ethics approval from the, Cairns and Hinterland, Cape York, Torres Strait and Northern Peninsular Hospital and Health Services Human Research Ethics Committee and Site Specific Assessment and approval from Cape York Hospital and Health Service (CYYHS)
- Developing and circulating a consultation framework consistent with the evaluation framework
- Conducting three rounds of site visits (February/March 2013, September 2013 and March/April 2014, to all four WBC communities and consulting with:
 - The RFDS management team and staff responsible for the delivery and operation of the WBCs at the local level
 - A wide range of partners and other organisational stakeholders at the community level, for example Queensland Health clinic, Queensland Health Mental Health and Alcohol Tobacco and Other Drug Services (ATODS staff), Apunipima, FRC Coordinators and available Commissioners, Cape York Partnerships, Child Safety, Police, Probation and Parole, Local Program Office (refer to Appendix 2 for details of stakeholders consulted)

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- Clients of the service who had consented to participate in a more detailed interview and review of their referral status, reason for attendance, services received, impact/outcomes and overall satisfaction with the service
- Overall 51 distinct clients have been interviewed. Where applicable data presented in this
 report is based on the total number of clients interviewed. Four clients were interviewed in
 both evaluation rounds and only data from their latest interview has been included in this
 report.
- Details of the clients interviewed included:
 - o Aurukun 19, Hopevale 6, Coen 11 and Mossman Gorge 15
 - o Age ranged from 17 69 years with the average age being 38.5 years
 - o 34 males and 17 females
 - o 64% of clients attended regularly or frequently
 - o Major reasons for attendance were mental health disorders, alcohol and other drug dependence, anger management/domestic violence and welfare support. A more detailed profile of the clients who were interviewed is contained in Appendix 3.

Clients were recruited by the local WBC team leaders who were asked to recruit and consent a cross section of clients who presented for different reasons and with varying levels of complexity e.g. alcohol and or other drugs, mental health, were both male and female, who were from different age groups, and including some clients who were initially mandated to attend and some who were voluntary attendees.

Clients selected had to have the capacity to consent and their participation was not to present any known risk or be detrimental to them. In addition the client to be interviewed had to be locatable and available on the days the interviews were conducted, which proved challenging particularly when trying to conduct repeat interviews. The aim was also to interview immediate family members or significant others, however, this did not occur for most of the clients we interviewed.

Based on the profile of clients interviewed HOI is satisfied that the profile of clients interviewed adequately reflects the broad profile of WBC clients with the exception of young people under the age of 25. We interviewed 7 people 25 years of age or younger (14% of those interviewed) compared to the 26% of WBC clients who are under the age of 25.

It was not intended that a statistically significant number of clients would be interviewed. The intent was to interview 30 to 50 clients to obtain qualitative information about the services they received and the outcomes achieved. The information obtained was to supplement other data sources to increase confidence in the overall findings

Undertaking a survey with community members. Overall 351 community members have been interviewed over the three community visits which exceeds a 95% confidence level based on the combined total adult population. We were satisfied that there was minimal overlap. Of the 351 community members interviewed 186 (53%) were male and 165 (47%) female and a total of 284 (81%) had been to the WBC but not necessarily as clients. We interviewed 130 community members in Aurukun, 46 in Coen, 134 in Hopevale, and 41 in Mossman Gorge.

Community members were selected opportunistically by the consulting team with the support of WBC Indigenous, other staff and supportive members of the community. They were chosen because they were available, generally in public spaces and were prepared to talk to the consulting team. A number of people were approached who did not want to complete a survey interview. Some people were also interviewed in their own home. HOI considers the mix of males and females interviewed was satisfactory.

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No specific record was maintained of people's ages however based on our records approximately 25% of community members interviewed were younger (say under 30 years) and 25% were older (say greater than 50 years) with 50% being between 30 and 50 years.

- Consulting with key Cairns based stakeholders including the Family Responsibilities Commission (FRC) and Queensland Health, presenting to and obtaining feedback from the Cape York Welfare Reform Trial Advisory Board on the Phase One Evaluation Report and conducting a stakeholder workshop (24 March 2014) to present and obtain feedback on the findings from the Phase Two Evaluation Report (refer Appendix 2 for stakeholders consulted).
- Administering a WBC staff survey for both those working in the community and at Cairns base.
 Fourteen staff responded to the survey, a response rate of approximately 45%. (For a more detailed profile of the respondents refer to Appendix 4.) While staff survey data is informative it cannot be considered definitive given the limited number of responses. It was supplemented by conducting staff and management interviews during community visits and at Cairns base.
- Analysis of available RFDS service and outcome data including drawing on relevant data presented in the Interim Data Report (October 2013) and subsequent information made available by RFDS.
- Analysis of Cape York Hospital and Health Services clinic data in the four WBC communities in relation to presentations related to alcohol, other drugs and assault since 2004/5.
- A review of the key indicators presented in the Annual Bulletin for Queensland's Discrete Indigenous Communities: 2011/12 published in April 2013 by the Queensland Government.

This report also makes reference to the Cape York Welfare Reform Evaluation (2012) which was an extensive evaluation commissioned by the Australian Government led by the then Department of Families, Housing, Community Services and Indigenous Affairs. The WBCs were not directly included in this evaluation. However, given they were established in part as a key enabling project to support the Cape York Welfare Reform (CYWR) trial and that they were a key referral agency for the FRC, feedback on their role and function including a community perspective was included in that evaluation. In addition some of the community feedback on the extent of social change is also of relevance to this evaluation.

1.3.2 LIMITATIONS

In presenting the findings of these evaluation processes, the following limitations must be taken into consideration:

CLIENT INTERVIEWS

- The client interview questions were purposefully designed not to ask leading questions, however, there was a necessity on occasion to prompt around specific aspects of the WBCs to facilitate engagement and discussion with local people.
- There is the possibility that the WBC team leaders may have selected clients who had good outcomes thus biasing the results. It should be noted that this opportunity was limited to the extent that some clients the WBC selected were not available on the interview days and other clients were substituted opportunistically on the day.
- There is always the possibility that participants will be more positive in their reporting, particularly
 where they highly value a service and perceive a possible risk to its continuity if negative responses
 are provided.



COMMUNITY SURVEY

- The community survey questions were purposefully designed not to ask leading questions, however in some cases, there was a necessity to prompt around specific aspects of the WBCs to facilitate engagement and discussion with local people.
- There is always the possibility that participants will be more positive in their reporting, particularly where they highly value a service and perceive a possible risk to its continuity if negative responses are provided.
- There were only a limited number of people under the age of 20 who were surveyed so the views of this age group are not adequately reflected in this evaluation report. Note that ethics approval was not sought to consult with people under 18 years of age.
- The methodology used to conduct the survey did not ensure the participants were representative
 of the community. Having said this, a broad representation of community views was obtained and
 the results presented have been used where possible in this report in conjunction with other lines
 of enquiry.

STAFF SURVEY

• The staff survey response profile provides a good basis for analysis, however, it must be noted that only half the staff responded and of those 48% of respondents were working at the WBCs for less than 12 months. The survey was supplemented by staff interviews.

OUTCOME DATA

- Health of the Nation Outcome Scales (HoNOS) is being used in the evaluation as it is widely used in Australian mental health services including in Indigenous populations. HoNOS has not been validated for use in Indigenous Australian populations and there are questions in relation to interrater reliability. Its use is supported with appropriate training and support for raters (which has occurred at the RFDS) pending the introduction of a more suitable tool in the sector in the long term.^{3 4} Systematic collection of the HoNOS and Kessler (K10) commenced in November 2012.
- The Alcohol Use Disorders Identification Test (AUDIT), the Severity Dependence Scale (SDS) and IRIS screens where completed were contained in client files, or relevant information for some clients was recorded in the file notes. This information was recently collated by the RFDS. We were advised by the RFDS that in the majority of cases, this information was on the relevant form in the file. In some instances the information where possible and available had to be extracted from the file. In those cases that is not strictly in accord with the relevant protocol, which indicates the screen should be completed at the time. Accordingly the data for those tools should be considered as indicative and considered in the context of the other outcome measures presented. There is no benchmark data available to make any comparisons.

Overall there were 199 matched scores for the HoNOS, 129 for the K10, 153 for the AUDIT, 127 for the SDS and 106 for the IRIS. Whilst not at a statistically significant level in terms of the percentage of clients who have matched scores, in our view it represents a sufficient sample upon which to draw general conclusions for the purpose of this report about the profile of clients and impact on individuals on average, particularly when considered in the context of other lines of enguiry.

• It had been intended that the Growth and Empowerment Measure (GEM) would be administered and analysed in select clients as part of the evaluation. To date there have only been seven GEM

³ Deady, M. Deady M. A Review of Screening, Assessment and Outcome Measures for Drug and Alcohol Settings. Sydney: Network of Alcohol and Other Drugs Agencies, 2009.

⁴ Daw S et al. Assessing substance use and mental health in indigenous clients: what appears to work and where to next. Griffith University. Funded by Alcohol and Other Drugs Treatment Strategy Unit, Queensland Health. April 2010

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observations for WBC clients and no repeat observations. Accordingly no data is included in this report.

SERVICE DATA

Analysis undertaken for this report and confirmed by the RFDS reveals that it is likely that a significant level of activity particularly unstructured client activity such as drop in (likely involving brief intervention), is not being captured sufficiently. RFDS is working to strengthen data recording practices including the client information system upgrade in April 2014 which should allow more accurate information to be provided. The RFDS was instructed by the Department of Health on 18 December 2013 to immediately commence collection of all contacts. We understand that the RFDS commenced capturing drop-in activity as a category (numbers and estimated demographics only) on a structured basis with the implementation of the upgraded data system (i.e. April 2014). This data was not available for evaluation purposes, however, we would emphasise the importance of ongoing collection of this data.

ATODS DATA

ATODS data was requested from Queensland Health in relation to service contacts and clients to determine whether the WBCs had any impact on Alcohol, Tobacco and Other Drug Services (ATODS) activity and to assist with comparisons between communities. As demonstrated in Appendix 12 there are significant gaps in the Queensland Health data set, in fact it is insufficient to allow any meaningful analysis of that data.

OTHER DATA

Community level data is available for different periods. Queensland Health Admitted Patient Data Collection is available to June 2013, Cape York Hospital and Health Service clinic presentation data is available to December 2013 and annual Queensland Government Indigenous Discrete Indicators data is available to June 2012.

Whilst these limitations exist, HOI considers that a high level of reliance can be placed on the results given the congruence of views and results between the various evaluation processes undertaken.

1.4 STRUCTURE OF THIS REPORT

The structure of this report is set out in Table 1.3.

Table 1.3: Report Structure

Chapter	Content
Chapter 1	Sets out the purpose of this report, its context and the methodology used to develop it, and some background in relation to the establishment of the WBCs.
Chapter 2	Examines evidence of success in terms of the impact on alcohol and substance-abuse, mental health and SEWB and relevant Closing the Gap targets. It also addresses the impact if there were no WBC, the challenges associated with achieving individual and community change, a comparison to other communities and proposed future use of outcome measures.
Chapter 3	Examines the service model and its implementation. It incorporates an analysis of the key evaluation questions related to the service model, service management, partnerships and community engagement evaluation domains.
Chapter 4	Identifies key success factors i.e. which prevention, intervention and treatment approaches are



Chapter	Content
	successful and the key factors (such as tools, delivery approaches governance arrangements etc.) that are contributing to this success.
	The chapter also proposes improvements which will enhance health outcomes and contribute to best practice service delivery in the context of the current service model and delivery mechanisms.
Chapter 5	This chapter considers the evaluation aim of recommending any improvements which will enhance health outcomes and contribute to best practice service delivery. This chapter focuses more strategically on where to from here.

1.5 CAPE YORK WELLBEING CENTRES

This section sets out the background to the establishment of the WBCs, and the link to the other reforms. It also outlines the program theory for the WBC.

1.5.1 BACKGROUND

The Department of Health (DoH) has established WBCs in the Cape York communities of Aurukun, Coen, Hopevale and Mossman Gorge. The aim of the WBC is to implement and deliver an integrated, community based and culturally appropriate social health service with a focus on alcohol and other drugs, gambling, family violence, mental health and general counselling in each of the four sites. ⁵ The WBCs are jointly funded by both the Australian (78%) and Queensland Governments (22%).

The RFDS was contracted as an interim auspice to operate the WBCs with a view to transitioning to a community-controlled arrangement over time. Local Advisory Groups (LAGs) were established in each community to partner with the RFDS to ensure active community participation in the recruitment, planning, development, monitoring and evaluation of the WBC service delivery. The LAGs, which consist of local Aboriginal and Torres Strait Islander community members, were established as the mechanism to strengthen community input into the operational aspects of the WBCs and to assist with building health literacy within communities.

The four communities in which the WBCs have been established are also Cape York Welfare Reform (CYWR) Trial Sites. They are subject to the Queensland Government Alcohol Reform Initiative and are priority communities under the Council of Australian Governments (COAG) National Partnership Agreement on Remote Service Delivery (RSD).

1.5.2 RELATIONSHIP TO DESIGN OF THE CAPE YORK WELFARE REFORM

Whilst not initiated to support the CYWR exclusively, the WBCs are intended to provide a significant support service to the Trials. That is, the WBC is expected to contribute to the change in behavioural and social norms of each community through providing a variety of services including alcohol and other drugs, mental health, family violence and in some cases through a compliance order made by the Families Responsibilities Commission (FRC).

In the form they have been established, the role and focus of the WBCs do reflect some of the key support initiatives seen as essential in the design of the CYWR, documented by the Cape York Institute

⁵ Department of Health and Ageing 2011, Request for Tender-Evaluation of Cape York Wellbeing Centres, Brisbane Queensland

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for Policy and Leadership in *From Handout to Hand Up volume 2*. The WBCs also reflect to some degree the vision, concept and characteristics of Village Hubs outlined in the same Cape York Institute paper.

Whilst the WBCs do not precisely reflect the concepts outlined in the design of the CYWR design, they do, to a reasonable extent, reflect the philosophy of the reform trials, the basic vision of a community hub (albeit established and 'operated' by Government currently) and are designed to reflect the key support needs (e.g. mental health, alcohol and other drugs counselling) seen as essential for rebuilding social norms. In a pragmatic sense, they do receive mandatory referrals from the FRC and are expected to partner with other community based government and non-government agencies and local community groups to address the objectives and support the implementation of the CYWR.

1.5.3 RELATIONSHIP TO QUEENSLAND GOVERNMENT INITIATIVES

The WBCs are linked to Queensland Government initiatives in that they assumed responsibility for ATODS in those communities at least to some degree.

The Queensland Government Alcohol Reforms (currently under review) are a major initiative to achieve sustained reduction in alcohol-related harms through alcohol restrictions, improved services, partnerships between government and community and support for positive community leadership and actions of which the WBCs are a key part.

1.5.4 PROGRAM THEORY FOR THE CAPE YORK WELLBEING CENTRES

The program theory for the WBC identified during the course of the evaluation is, where individuals participate in WBC programs appropriate to their specific need (regardless of the motivation being compliance, identification or internalisation), and take responsibility for personal and family SEWB and functioning, this will have a broader change effect through the community that over time will encourage and reinforce the benefits of behavioural change and contribute to rebuilding social norms. The evaluation is seeking to understand how the WBC 'program' contributes (or not) to the social change process.

There are a number of essential components underpinning this process of behavioural change that have been identified through: gaining a clear understanding of what constitutes Indigenous SEWB, the documented key elements of the WBCs, consultation with a range of service/program delivery and research 'experts' in the field of Indigenous SEWB, and consultation with community based stakeholders including community members. These essential components include:

- Engagement with the community
- A culturally appropriate service model
- Partnerships with other agencies
- Service governance and management.

In addition they give rise to a number of key hypotheses that underpin the establishment of the WBC and are tested as part of the evaluation.

The WBC program theory documented by HOI and presented previously is at Appendix 5. The key program elements documented in the DOH service contract with the RFDS are set out in Appendix 6.



2

2 EVIDENCE OF SUCCESS

This chapter provides evidence on whether the WBCs are being successful in relation to:

- Reducing alcohol and substance abuse and its impact on families, safety and community wellbeing in the four Cape York communities
- Addressing related mental health and social and emotional well-being issues in each of the four Cape York communities.

There is also discussion on whether the work of the WBCs is contributing to achievement of the Closing the Gap targets, particularly those that relate to the life expectancy gap and mortality.

The chapter also presents:

- What stakeholders think would be the impact if there were no WBC
- The challenges associated with achieving individual and community change
- A comparison to other communities
- Outcome measures proposed for the WBC, post-evaluation.

Evidence is drawn from: client interviews; the community survey; staff surveys and interviews; partner interviews; outcome measures; CYYHS local clinic and Queensland Health state-wide hospital data; and the *Annual Bulletin for Queensland's Discrete Indigenous Communities: 2011/12*.

Case studies are also presented in Appendix 13 to supplement the information presented in this chapter. They provide examples of how the WBC, including working with other partners can have real and demonstrable benefits for clients. They also highlight the enormous challenge faced by clients.

2.1 ATTRIBUTION OR CONTRIBUTION

When considering the impact on clients, families and communities, a key issue is the extent to which the WBC has contributed to any impact. This is particularly complex in social change programmes where there are many confounding factors, both current and historical, impacting on the client, family or community and there are or may be a number of services working with a client or in a community to address common issues.

At the individual level, it is our conclusion that it is the work of the WBC that is making the greatest impact on the outcomes for their clients. This is concluded based on:

- Key aspects of the service model are structurally sound and evidence based recognising there are opportunities for further improvement
- It is being relatively well implemented for individuals
- Multiple lines of enquiry with partner agencies reflect that the WBC is having a direct impact on clients
- Clients report that the WBCs are directly contributing to the impacts and outcomes they have achieved.

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At the community level it is much more complicated. Our approach has been to ask community members and partners whether there had been any changes in the community and if so has the WBC contributed to that. It is the ability to use multiple lines of enquiry that allow some confidence in interpreting the data.

2.2 ALCOHOL AND SUBSTANCE ABUSE

This section presents for alcohol and substance abuse the impact of WBC services on clients and communities. We have included community safety in this section although it also relates to SEWB. The conclusion to this section contains a summary table of the indicators presented in this section.

2.2.1 INDIVIDUAL OUTCOMES - ALCOHOL AND OTHER DRUGS

This sub-section analyses individual outcomes in relation to alcohol and other drugs (AOD).

OUTCOME MEASURES

The Alcohol Screen (AUDIT), the Severity Dependence Scale (SDS) and the Indigenous Risk Impact Screen (IRIS) were incorporated into the *RFDS Adapted State-wide Standardised Suite of Clinical Documentation, User Guide* to be used by clinician's where indicated. This chapter includes an analysis of available data for these indicators.

The AUDIT is a 10 question screen about a person's level of alcohol consumption and associated risk factors. While a shorter Indigenous version has been developed (AUDIT – C), the Department of Health requested the 10 question version be utilised. The SDS component which has been utilised, is a five question screen in relation to a person's cannabis usage and associated risk factors. The IRIS is an Indigenous risk impact screen used to measure a person's risk factors in relation to alcohol and mental health. There is a high degree of convergence with the K10 and the AUDIT. There is no benchmark data available in relation to these measures.

The data presented in this sub- section examines the difference in scores between the first (initial) and latest observation for matched scores. It is important to note that the first and latest available outcome scores do not reflect when the client entered and exited the WBC program. Outcome measurement commenced at different times but generally not before July 2012. While it is possible that some of the benefit to be obtained by the client may have already occurred before it could be measured in the initial score, we have we have undertaken regression analysis which demonstrated no statistically significant link between the number of days between first contact and initial outcome observation and changed outcome scores (HoNOS, K10 and AUDIT). This indicates that the evaluation is not systematically underestimating any client benefit).

Table 2.1 presents a statistical summary of changes in the AUDIT, SDS and IRIS (AOD component) scores. More detailed data is presented at Appendix 7.



Table 2.1: Statistical summary of changes in AUDIT, SDS and IRIS scores

	Aurukun	Coen	HV	MG	Total	FRC clients
AUDIT	(n= 5)	(n= 45)	(n= 39)	(n= 44)	(n= 133)	(n= 43)
% Reduction in mean	8.50%	8.10%	8.53%	12.23%	9.60%	8.53%
Effect size ¹	0.62 (medium)	0.31 (small)	0.33 (small)	0.44 (small to med)	0.34 (small)	0.32 (small)
Statistically significant ¹	*	✓	✓	✓	✓	✓
SDS	(n= 5)	(n= 47)	(n= 31)	(n= 45)	(n= 127)	
% Reduction in mean	1.67%	2.40%	10.80%	13.60%	8.40%	NA
Effect size	0.07 (none)	0.15 (none)	0.44 (small to med)	0.47 (small to med)	0.33 (small)	NA
Statistically significant	*	*	✓	✓	✓	
IRIS	(n= 5)	(n= 46)	(n= 40)	(n= 15)	(n= 106)	
% Reduction in mean	3.57%	8.71%	5.36%	14.29%	8.00%	NA
Effect size	0.2 (small)	0.53 (medium)	0.34 (small)	0.87 (large)	0.45 (small to med)	NA
Statistically significant	*	✓	✓	✓	✓	

Note (1): Cohen's d was calculated to establish the clinical significance and size of effect, where a value of >0.2 indicates a small clinical significance and effect, 0.5 a medium effect and 0.8 large effect. A two tailed paired t test was then undertaken. The t value represents statistical significance, with a value of <0.05 indicating statistical significance.

Table 2.1 shows that for:

- AUDIT overall WBCs demonstrated a small or small to medium clinically significant effect on clients except Aurukun (which had very small numbers and was statistically not significant). Overall WBC clients moved from a score of higher risk or harmful drinking (a score between 16 and 19) to a lower level of risky or hazardous drinking (a score between 8 and 15), with variations between WBCs. WBC FRC clients also demonstrated a small clinically and statistically significant effect (there were no statistically significant changes at individual WBCs for FRC clients due to small numbers). Overall 89 clients (67%) improved their score.
- **SDS** across all WBC clients there was a small clinically significant effect which was statistically significant. Overall 75 clients (59%) had a zero initial and review score. At Hopevale and Mossman Gorge, both had a clinically and statistically significant small to medium effect. In the case of Hopevale clients on average moved from the cannabis dependent to the non-dependent category. Coen clients rated very lowly on the dependence scale.
- IRIS Overall there was clinically significant effect which was statistically significant (small to medium). All WBCs demonstrated either small medium or large effect (with Aurukun being not statistically significant due to small numbers).

In conclusion based on this data, overall the WBCs (excluding Aurukun) are having a clinically and statistically significant positive effect on the level of risky drinking and the level of cannabis dependency and these changes are being replicated with FRC clients. At Aurukun small sample sizes do not allow any conclusion to be drawn.

2.2.2 COMMUNITY OUTCOMES - ALCOHOL

This sub-section analyses community outcomes in relation to alcohol.



COMMUNITY MEMBERS PERSPECTIVE

Figure 2.1 presents the community members (n=351) view on whether there has been a change in the number of alcohol related issues in the community over the last 3 to 4 years and the direction of that change. Ninety six community members (27%) believed that the situation in relation to alcohol issues had got better and 70 community members (20%) believed that the situation had got worse. Thirty nine per cent felt it was the same (50%) or they didn't know (14%).

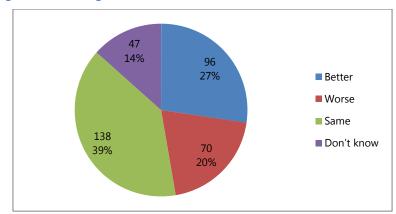


Figure 2.1: Change in the number of alcohol related issues (n=351)

As shown in Figure 2.2 there are variations between communities. Sixty five percent of Coen respondents believed the situation with respect to alcohol issues had improved, whereas the other communities ranged from 16% at Hopevale to 34% at Mossman Gorge. One quarter of respondents at both the Aurukun and Hopevale believed the situation had got worse.

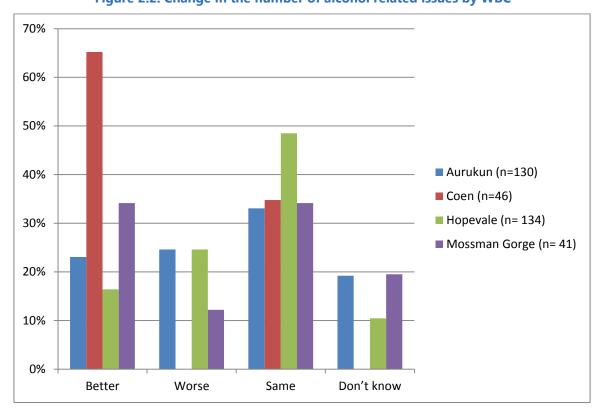


Figure 2.2: Change in the number of alcohol related issues by WBC

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The Cape York Welfare Reform Evaluation⁶ found that 24% felt that more people were trying to give up grog, smoking or gambling. It also found that reductions in social problems such as drinking, drug use and petrol sniffing was identified as the most significant change by 5% of people in Aurukun, 9% in Coen 2%, in Hopevale, and 4% in Mossman Gorge. It also found that ganja, gambling and grog still continued to cause problems within families (about 40% reported at least one of these issues in their family) with a quarter choosing not to answer this question.

LOCAL PRIMARY HEALTH CARE CLINIC PRESENTATIONS - ALCOHOL

Appendix 8 presents local primary health care clinic presentations where alcohol is a primary or contributing factor.

The appendix shows that the number of presentations to the relevant local primary health care clinics where alcohol was listed as a primary presenting reason has declined overall, driven by downward trends at both Coen and Hopevale, with a small increase at Aurukun since 2004/5. There has been a decline in this type of presentation in all clinics since the commencement of the WBCs around the mid-2009 calendar year.

The appendix also shows that the number of presentations to the relevant local primary health clinics where alcohol was listed as a contributing factor has declined at Hopevale and Coen and increased at Aurukun, particularly in 2012/13.

This is suggestive of a reduced number of alcohol related incidents in Coen and Hopevale. The increase in Aurukun is likely to be associated with the overall increase in violence and other incidents in that community which has been widely reported.

QUEENSLAND HEALTH ADMITTED PATIENT DATA COLLECTION

Appendix 8 presents hospital admission data where the principal diagnosis is mental health and behavioural disorders due to the use of alcohol. This demonstrates that there has been an upward trend in this admission type since July 2002 to July 2012. Since the establishment of the WBCs that has largely been driven by Hopevale and to a lesser extent Aurukun.

Appendix 8 also presents admissions where a secondary diagnosis was mental health and behavioural disorders due to the use of alcohol. This means that it was not the primary reason for the admission to hospital but it was noted as another diagnosis. The trend for this other diagnosis has been upward since the January 2011 to June 2011 period.

While this indicator is suggestive that the impact of alcohol use on individuals may have deteriorated, it should be noted that there is a lag between increased alcohol use and associated mental illness, making it difficult to draw any conclusion in relation to this specific indicator.

QUEENSLAND GOVERNMENT KEY INDICATORS

The Queensland Government key indicators as published in the *Annual Bulletin for Queensland's Discrete Indigenous Communities: 2011/12 (April 2013)* indicate that there has been no evidence of statistical change in charges resulting in convictions for breaches of Sections 168B and 168C of the *Liquor Act 1992* the period 2010/11 to 2011/12 at Aurukun or Hopevale. The level and direction of statistical change for the last four complete years of published data are presented in Table 2.2. More detailed data is included at Appendix 14. There has been a decrease in convictions from 2008/09 level in Hopevale and 2009/10 level in Aurukun, to 2011/12.

⁶Ibid. The Cape York Welfare Reform Evaluation - page 128,129,136



Table 2.2: Annual changes in charges resulting in a conviction for breaches of sections 168B and 168C of the Liquor Act, 1992

	Change 2007/08 to 2008/09	Change 2008/09 to 2009/10	Change 2009/10 to 2010/11	Change 2010/11 to 2011/12	Annual % change 2010/11 to 2011/12
Aurukun	\leftrightarrow	1	1	\leftrightarrow	-5%
Coen			NA		
Hopevale	1	1	\leftrightarrow	\leftrightarrow	-26.5%
Mossman Gorge			NA		

Note (1): ↑ indicates statistical evidence of an increase, ↓ indicates statistical evidence of a decrease, ↔ indicates no statistical evidence of detectable change.

Note (2): NA not applicable.

2.2.3 COMMUNITY OUTCOMES - OTHER DRUGS

This sub-section analyses community outcomes from the perspective of other drugs. In the context of the WBC communities this relates to cannabis.

COMMUNITY MEMBERS PERSPECTIVE

Figure 2.3 presents the community members (n=351) perspective on whether there has been a change in the number of other drug related issues in the community over the last 3 to 4 years and the direction of that change. Only 9% (32 respondents) believed that the situation in relation to other drug issues had improved, 33% (116 respondents) believed that the situation had got worse and 33% (115 respondents) believed it had stayed the same. One quarter of respondents stated they didn't know. There was a view that more cannabis was available and that being cheaper than alcohol and due to supply limitations of alcohol, its use had become more prevalent.

32 9% 88 25% Better ■ Worse 116 33% Same ■ Don't know 115 33%

Figure 2.3: Change in the number of other drug related issues (n=351)

On a community basis, as shown in Figure 2.4 the percentage of respondents who felt the number of other drug related issues had got better was relatively consistent and low overall. At both Aurukun and Hopevale 39% and 36% of respondents respectively believed the number of other drug related issues had got worse compared to 26% at Coen and 12% at Mossman Gorge.



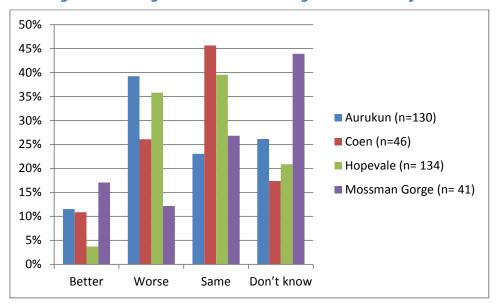


Figure 2.4: Change in the number of drug related issues by WBC

LOCAL PRIMARY HEALTH CARE CLINIC PRESENTATIONS

Appendix 9 shows that the number of presentations to relevant local primary health care clinics where other drugs were listed as a primary presenting reason has declined overall and in each clinic. Of note is that both Hopevale and Aurukun increased in 2012/13 although there are significant annual fluctuations and small numbers.

Appendix 9 also shows the number of presentations to relevant primary health care clinics where other drugs were listed as a contributing factor has declined at Hopevale and Coen and remained static at Aurukun, with significant yearly fluctuations. The overall trend is downwards. Note there are small numbers.

QUEENSLAND HEALTH ADMITTED PATIENT DATA COLLECTION

Appendix 9 presents admissions where the principal diagnosis and other diagnosis related to mental health and behavioural disorders due to the use of cannabinoids. The numbers are very small.

2.2.4 COMMUNITY OUTCOMES - COMMUNITY SAFETY

This sub-section analyses community outcomes from the perspective of community safety.

COMMUNITY MEMBERS PERSPECTIVE

Figure 2.5 presents whether community members (n=351) felt that there has been a change in how safe and secure the community is as place to live over the last 3 to 4 years and the direction of that change. Thirty seven per cent (131 respondents) believed the safety and security of the community had got better and only 12% (41 respondents) believed that the situation had gotten worse. Forty per cent of respondents felt there was no change (40%).

This is consistent with the *Cape York Welfare Reform Evaluation*⁷ which found around a third of the community members felt that there was less fighting between families (33%) and less fighting in families (36%) but similar proportion felt that this had not changed overall (36% fighting between families and 40% fighting in families).

⁷ Ibid. The Cape York Welfare Reform Evaluation - page 132



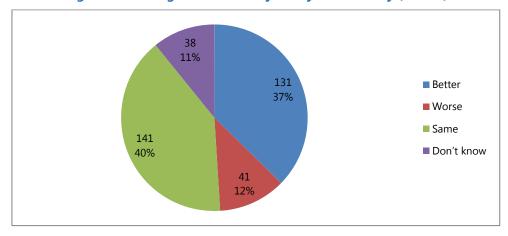


Figure 2.5: Change in community safety and security (n=351)

As shown in Figure 2.6 there are variations between communities. Very few respondents in Coen, Hopevale and Mossman Gorge felt community safety was worse. Seventy six per cent of respondents in Coen and 54% in Mossman Gorge felt community safety had got better compared to Aurukun (25%) and Hopevale (31%).

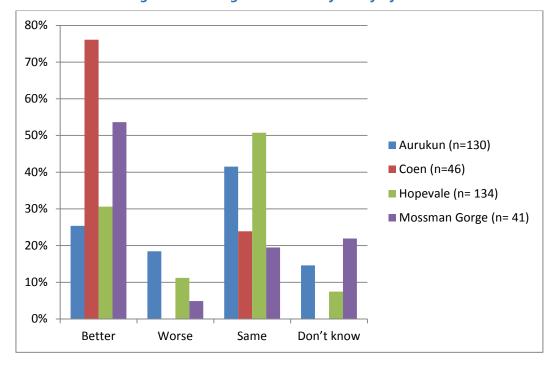


Figure 2.6: Change in community safety by WBC

LOCAL PRIMARY HEALTH CARE CLINIC PRESENTATIONS

Appendix 10 shows that the number of presentations to the relevant local primary health clinics where assault was listed as a primary presenting reason has declined since the year 2004/5 which has been driven by small downward trends at both Coen and Hopevale. Aurukun has remained relatively static with significant annual fluctuations although it has got worse since 2008/9.

Appendix 10 also shows that the number of presentations to the relevant local primary health clinics where violence was listed as a contributing factor has marginally declined at Hopevale, remained static at Coen and increased at Aurukun. Note there are small numbers.



QUEENSLAND HEALTH ADMITTED PATIENT DATA COLLECTION

Appendix 10 presents admissions where assault by any means was mentioned as being a factor in the admission. The table shows that admissions where assault was a factor has been increasing in all communities since January to June 2011. This is suggestive that incidences of assault that required hospitalisation have increased since June 2011.

QUEENSLAND GOVERNMENT KEY INDICATORS

- Aurukun there has been evidence of a statistical decline in reported offences against the person. Trend data for hospital admissions for assault related conditions has not been reported at Aurukun due to data gaps in 2010/11 and 2011/12. However looking at the raw data in Appendix 15 there has been a decline in numbers since 2005/06 with a small increase in 2011/12. In the first six months of 2012/13 a similar level of admissions has occurred. There has been no evidence of improvement in children subject to substantiated notification of harm or child protection orders since 2010/11 and this trend has continued in the first six months of 2012/13.
- **Coen** there have been significant declines in hospital related admissions for assault conditions with no statistical change in the other indicators.
- **Hopevale** hospital admissions for assault related conditions have declined since 2002/03 with no statistical change in the other indicators.
- Mossman Gorge there has been no significant change in the indicators. While trend lines were not available for reported offences, the raw data shows there were 18 offences in 2011/12 which was similar to previous years.

2.2.5 SUMMARY OF FINDINGS

Review finding #1: The WBCs are having a clinically and statistically significant effect on their clients in reducing the level of risky drinking and the level of cannabis dependency. Specifically the Alcohol Screen (AUDIT) mean score reduced by 10% (effect size change 0.34 – small), the cannabis related Severity Dependence Scale (SDS) mean score reduced by 8% (effect size change 0.33 – small), and the Indigenous Risk Impact Screen (IRIS) mean reduced by 8% (effect size change 0.45 – small to medium).

Note: At Aurukun the small sample size does not allow any conclusion to be drawn.

Review finding #3: With the exception of Coen, individual-level improvements are not translating into sustained, consistent and clearly observable improvements in outcomes at the community level. The community level changes can be summarised as follows:

	Aurukun	Coen	Hopevale	Mossman Gorge
Alcohol related issues	Same or worse	Improved	Same	Same
Drug related issues	Worse	Same/marginally worse	Same/marginally worse	Same



SUMMARY OF INDICATORS

Table 2.3 presents a snapshot of AOD related indicators discussed above by community.

Table 2.3: Snapshot of AOD impact indicators by community

Alcohol related								
	Aurukun	Coen	Hope Vale	Mossman Gorge				
Individual change – impact on AUDIT score	0.62 (medium) not significant	0.31 (small)	0.33 (small)	0.44 (small to med)				
Individual change – impact on IRIS	0.2 (small) not significant	0.53 (medium)	0.34 (small)	0.87 (large)				
Community perspective on number of alcohol related issues – <i>improvement</i>	23%	65%	16%	34%				
Community perspective on number of alcohol related issues – <i>same</i>	33%	35%	49%	34%				
Community perspective on number of alcohol related issues – <i>worse</i>	25%	0%	25%	12%				
Trend in overall clinic presentations - alcohol primary reason since 2008/09	Improve	Improve	Improve	NA				
The trend in clinic presentations where alcohol was listed as a contributing factor since 2008/9	Worse	Improve	Static	NA				
Charges resulting in convictions for breaches of Sections 168B and 168C, 2010/11 to 2011/12 ¹	↔, sig improvement in 2010/11, 5% improve 2011/12	n.a.	↔, 26.5% improve 2011/12	n.a.				
Trend in hospital admissions where principal diagnosis is mental health and behavioural disorders due to use of alcohol to 2008/09 to Dec 12.	Worse	Static (low)	Worse	Fluctuations				
Trend in hospital admissions where other diagnosis is mental health and behavioural disorders due to use of alcohol	Worse	Static (low)	Worse	Worse				

Other drug related									
	Aurukun Coen Hope Vale Mo								
Individual change – impact on SDS	0.07 (none) not significant	0.15 (none) not significant Low overall	0.44 (small to med)	0.47 (small - med)					
Community perspective on number of other drug related issues – <i>better</i>	4%	0%	0%	8%					



Other drug related								
	Aurukun	Coen	Hope Vale	Mossman Gorge				
Community perspective on number of other drug related issues – <i>same</i>	23%	46%	40%	27%				
Community perspective on number of other drug related issues – <i>worse</i>	39%	26%	36%	12%				
Trend in overall clinic presentations - other drugs primary reason since 2008/09	Improve	Very low numbers	Improve	NA				
The trend in clinic presentations where other drugs was listed as a contributing factor since 2008/9	Static	Very low numbers	Low numbers	NA				

Community safety and security								
	Aurukun	Coen	Hope Vale	Mossman Gorge				
Community perspective on change in safety and security – <i>better</i>	26%	53%	3%	52%				
Community perspective on change in safety and security – <i>same</i>	42%	24%	51%	20%				
Community perspective on change in safety and security – <i>worse</i>	18%	0%	11%	5%				
The trend in clinic presentations where assault was listed as a primary presenting since 2008/9	Worse	Improve. Very low numbers	Static	NA				
The trend in clinic presentations where assault was listed as a contributing factor 2008/9	Worse	Static. Very low numbers	Static	NA				
Hospital admissions for assault-related conditions 2002/03 to 2011/12 ¹	n.a.	1	1	\leftrightarrow				
Reported offences against the person 2002/03 to 2011/12 ¹	ļ	\leftrightarrow	\leftrightarrow	n.a.				
Children subject of a substantiated notification of harm 2010/11 to 2011/12 ¹	\leftrightarrow	\leftrightarrow	\leftrightarrow	\leftrightarrow				
Children admitted to child protection orders 2010/11 to 2011/12 ¹	\leftrightarrow	\leftrightarrow	\leftrightarrow	\leftrightarrow				
Hospital admissions relating to assault from 2008/09 to December 2012	Worse	Static (low)	Static (low)	Worse				

Note (1): Queensland Government discrete indigenous community key indicator.

In conclusion based on individual outcome measures overall the WBCs (excluding Aurukun) are having a clinically and statistically significant positive effect on the level of risky drinking and the level of cannabis dependency and these changes are being replicated with FRC clients.

2.3 MENTAL HEALTH AND SEWB

This section presents for mental health and SEWB the impact of WBC services on clients. As no community wide measures of SEWB were available to the evaluation we have also presented the perspective of community members on how the whole community has changed in this section.



2.3.1 INDIVIDUAL OUTCOMES

OUTCOME MEASURES

This sub-section presents the impact on clients mental health and SEWB as measured by the Health of the Nation Outcome Scales (HoNOS), the Kessler Psychological Distress scale (K10) and the relevant section of the Indigenous Risk Impact Screen (IRIS). This sub-section also reports individual impacts reported by clients and community members where relevant.

The K10 is a 10-item questionnaire intended to yield a global measure of psychological distress based on questions about anxiety and depressive symptoms that a person has experienced in the most recent 4-week period. RFDS clinicians report that by and large the K10 is accepted, but as it is a self-report tool and a number of clients are illiterate, it has its difficulties. At times it has been reported that the K10 interferes with the counselling session with Indigenous clients. The K10 process can be slow for these reasons.

The HoNOS was developed to become a standardised assessment tool to be used routinely by all mental health practitioners to measure health outcomes. The developers of HoNOS state that it is acceptable, clinically useful, reliable, sensitive to change and useful for administration and planning within such settings.⁸

HoNOS is being used in the evaluation as it is widely used in Australian mental health services including in Indigenous populations. HoNOS has not been validated for use in Indigenous Australian populations and there are questions in relation to inter-rater reliability. Its use is supported with appropriate training and support for raters (which has occurred at the RFDS) pending the introduction of a more suitable tool. The HoNOS is a clinician rated tool and the client does not need to contribute. It takes approximately five minutes to complete.

Additionally there was on average 168 days between the date of the initial and latest review observations (for both the HoNOS and K10) thus allowing sufficient time for any benefit to accrue (within the context of client fluctuations that can and do occur).

K10

Table 2.4 presents the percentage change in K10 mean scores and the associated clinical and statistical significance by WBC and for FRC clients and the RFDS Cairns and Far North SEWB team which delivers services to remote indigenous communities for comparative purposes. In the case of Mossman Gorge, whilst a number of entry or baseline K10 scores were available for analysis, there were an insufficient number of follow-up scores available to allow for any potential change in score to be reliably interpreted.

As shown in Table 2.4 the WBC clients of Coen and Hopevale showed statistically (p<0.05) and clinically significant changes (Cohen's d>0.2) in the K10 scale. Across the WBCs of Coen and Hopevale there was a medium effect (0.5). FRC clients also showed a small clinical significance effect but not at a statistically significant level. Overall 76 WBC clients (59%) improved their score.

There were variations between WBCs. Aurukun had no clinically significant effect, Coen had a small effect, and Hopevale had a large effect. The changes were statistically significant at the Coen and Hopevale WBCs but not at Aurukun.

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Wing, J. K., Beevor, A. S. & Curtis, R. H. (1998) *Health of the Nation Outcome Scales (Ho NOS). Research and development.*British Journal of Psychiatry, 172, 11-18.

⁹Ibid, Deady M.

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These findings indicate a positive improvement in the anxiety and depressive symptoms of the clients, with WBC clients remaining on average in Risk Zone II (Likely to have a moderate disorder, K10 score 16-21). More detailed level of information is provided at Appendix 7.

Table 2.4: K10 – Statistical overview of score changes (n=153)

	Aurukun (n=46)	Coen (n=46)	Hopevale (n=37)	Total (n=129)	FRC (n= 38)	SEWB Cairns (n=43)
% reduction in mean	-0.22%	5.84%	12.86%	5.69% (8.96% excl Aurukun)	3.69%	8.42%
Clinical Significance (Effect Size)	-0.01 (none)	0.33 (small)	0.85 (large)	0.31 (small) (0.5 medium excl Aurukun)	0.23 (small)	0.46 (small to med)
Statistically Significant	*	✓	✓	✓	*	✓

Note (1): 13% of the adult population will score 20 and over and about 1 in 4 patients seen in primary care will score 20 and over. 11,12

Note (2): Cohen's d was calculated to establish the clinical significance and size of effect, where a value of >0.2 indicates a small clinical significance and effect, 0.5 a medium effect and 0.8 large effect. A two tailed paired t test was then undertaken. The t value represents statistical significance, with a value of <0.05 indicating statistical significance.

HoNOS

Table 2.5 presents the percentage in mean scores by HoNOS subscales and the associated clinical and statistical significance by WBC and for FRC clients (and the RFDS Cairns SEWB team for comparative purposes).

As reflected in Table 2.5 and Appendix 7, in aggregate WBC clients showed no clinically significant effect changes (effect size <0.2) and the change demonstrated was not statistically significant (p>0.05). This was replicated at subscale level. Of the 199 matched scores, 112 clients (57%) improved their score.

However there are significant differences between WBCs as discussed below. On a total score level, there was a medium statistically significant clinical change at Coen and Hopevale and a small change at Mossman Gorge. Scores at Aurukun did not improve and in fact they deteriorated. Overall excluding Aurukun there was a statistically significant medium clinically significant effect changes (effect size 0.5))

Excluding Aurukun, the behaviour, symptoms and social subscales were the areas where there was greatest level of improvement although there was a statistically significant improvement in the impairment subscale at Coen, which is to be expected given the focus of the WBCs in behaviour and social areas. One reason for the lack of improvement in Aurukun is likely to be the high level of recent community disruption in that community which in turn has a disruptive impact on individuals.

Table 2.5: Statistical overview HONOS score changes

	Aurukun (n=71)	Coen (n=47)	Hopevale (n=53)	Mossman Gorge (n=28)	Total (n=199)	Total FRC (n= 46)	SEWB Cairns (n=77)
Behaviour							

Australian Bureau of Statistics. Information paper: use of the Kessler psychological distress scale in APS health surveys. 4817.0.55.001.

Kessler, R.C., Andrews, G., Colpe, .et al (2002) Short screening scales to monitor population prevalence and trends in non-specific psychological distress. *Psychological Medicine*, *32*, 959-956.

¹² Andrews, G., Slade, T (2001). Interpreting scores on the Kessler Psychological Distress Scale (k10). *Australian and New Zealand Journal of Public Health*, 25, 494-497.

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	Aurukun (n=71)	Coen (n=47)	Hopevale (n=53)	Mossman Gorge (n=28)	Total (n=199)	Total FRC (n= 46)	SEWB Cairns (n=77)
% reduction in mean	-3.52%	7.45%	5.50%	4.17%	2.55%	0.49%	2.92%
Clinical Significance (Effect Size) ¹	23 (none)	.48 (small to med)	.39 (small)	.24 (small)	.16 (none)	.03 (none)	.19 (small)
Statistically Significant ¹	*	✓	✓	*	✓	×	×
Impairment							
% reduction in mean	-4.23%	5.05%	0.24%	4.46%	0.38%	0.74%	2.76%
Clinical Significance (Effect Size)	29 (none)	.40 (small)	.02 (none)	.27 (small)	.03 (none)	.05 (none)	.14 (none)
Statistically Significant	✓	✓	*	*	×	×	×
Symptoms							
% reduction in mean	-2.82%	5.14%	2.04%	3.57%	1.26%	0.65%	13.31%
Clinical Significance (Effect Size)	19 (none)	.36 (small)	.18 (small)	.31 (small)	.09 (none)	.05 (none)	.88 (large)
Statistically Significant	×	✓	×	×	×	×	✓
Social							
% reduction in mean	-8.69%	8.16%	10.58%	7.14%	2.64%	-0.65%	4.00%
Clinical Significance (Effect Size)	28 (none)	.48 (small - med)	.63 (med)	(.35 small)	.10 (none)	.03 (none)	.18 (none)
Statistically Significant	✓	✓	✓	×	×	×	×
Total							
% reduction in mean	-4.46%	6.03%	4.56%	4.46%	1.67% (5% excl Aurukun)	0.25%	5.52%
Clinical Significance (Effect Size)	32 (none)	.58 (med)	.56 (med)	.37 (small)	.14 (none) (excl Aurukun 0.5 med)	.02 (none)	.43 (med)
Statistically Significant	✓	✓	✓	✓	✓ (excl Aurukun)	×	✓

Note (1): Cohen's d was calculated to establish the clinical significance and size of effect, where a value of >0.2 indicates a small clinical significance and effect, 0.5 a medium effect and 0.8 large effect. Where the review score is higher than initial score the effect size has been listed as none. A two tailed paired t test was then undertaken. The t value represents statistical significance, with a value of <0.05 indicating statistical significance.

INDIGENOUS RISK IMPACT SCREEN (IRIS)

Table 2.6 presents the IRIS profile of WBC matched clients for the mental health and emotional well-being risk. Note there is a high degree of convergence in the questions asked in this screen with the K10 tool. Overall there was clinically significant effect which was statistically significant (medium). All WBCs demonstrated either a small, medium or large effect (with Aurukun being not statistically significant due to small numbers).



Table 2.6: IRIS profile of WBC clients – mean scores

	Percentage reduction in mean	Clinical significance ¹	Statistically significant ¹
Aurukun (n= 5)	16.67%	0.83 (large)	×
Coen (n= 46)	7.22%	0.43 (small – med)	✓
Hopevale (n= 40)	5.00%	0.35 (small)	✓
Mossman Gorge (n=15)	20.72%	2.11 (large)	✓
Total (n=106)	8.72%	0.49 (medium)	✓

Note (1): Cohen's d was calculated to establish the clinical significance and size of effect, where a value of >0.2 indicates a small clinical significance and effect, 0.5 a medium effect and 0.8 large effect. A two tailed paired t test was then undertaken. The t value represents statistical significance, with a value of <0.05 indicating statistical significance.

CLIENT REPORTED CLIENT LEVEL IMPACT

Appendix 11 presents what clients reported as the most significant change(s) to occur in their lives in the last 6 to 12 months as a result of attending the WBC or that the WBC has contributed to. The majority of clients reported a range of significant benefits with the most common benefits being: feeling less stressed (77%); feeling better emotionally and mentally (74%); feeling more in control of my life (72%); better relationships with family (60%); feeling better about life (62%); taking more responsibility for my actions (51%) and using less alcohol (47%). Note that very few interviews were also attended by family members. Where family members did attend their reporting was consistent with the client.

The Cape York Welfare Reform evaluation reported that if a social change survey respondent or their family had used the WBC, they were 1.49 times more likely to state that their life was on the way up. 13

Case studies presented in Appendix 13 also reflect a range of impacts influencing the SEWB of clients including improved medication compliance, ability to cope with highly stressful situations better, increased engagement with groups and services, reunification with children previously removed, assistance with adherence to parole conditions and keeping out of jail, and improved behaviour both at school and in the community.

One case study incorporates the positive impact on the client and family arising from the more recently implemented Intensive Youth Support Program in Aurukun. This program is working with disengaged youth (identified by the school principal) whom the WBC staff are working intensively with in a before and after school program. Additionally, space has been made available within the school for WBC staff to utilise when needed during the school day. This program involves close collaboration between the school, truancy officers and WBC staff.

COMMUNITY REPORTED CLIENT LEVEL IMPACT

Figure 2.7 presents what community members reported had been the impact on them as individuals as a result of the WBC (239 people out of the 351 interviewed thought this question was applicable). Almost all relevant community members believed that the WBC had either had a 'big impact' (100 people, 42%) or 'some impact' (126 people, 53%) on themselves. Only 13 people (5%) felt that there had been 'no impact'.

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¹³ Ibid. Cape York Welfare Reform Evaluation, p 133.



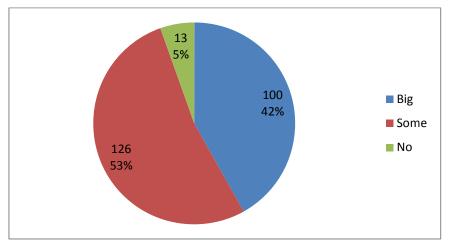


Figure 2.7: Impact on self (n=239)

As highlighted in Figure 2.8 the data shows some variation between communities in respect to the scale of the impact, with 51% of Aurukun respondents and 43% of Coen respondents reporting a big impact on self, compared to 34% and 35% at Hopevale and Mossman Gorge respectively.

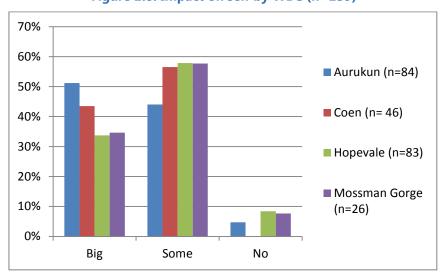


Figure 2.8: Impact on self by WBC (n=239)

WBC staff also felt the WBC was having either some or a significant positive impact on most clients.

PARTNER REPORTED CLIENT LEVEL IMPACT

Where they felt they were in a position to comment, partners generally thought that the WBC was having a significant impact in helping clients to deal with their immediate problems. It was felt they have developed sufficient trust within their community through facilitating attendance and providing services. Some partners are not clear that the WBC is achieving long-term behavioural change, although others felt circumstances had changed for some clients, for example less homelessness, less time in jail, less domestic violence, more kids in school and parents spending more time with their children, with a number of agencies contributing to this. The FRC in particular believed the WBC could do more to engage difficult clients that they have referred.

Partners were relatively consistent in reporting that changes and assistance at the individual level are not necessarily correlating with improved community level outcomes.

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The child safety team leader of the ongoing intervention team servicing Aurukun, noted they had 'reunified at least 12 children back to their family or kin in the last 2.5 years and this was more than she had done in 20 years elsewhere (Gladstone and Hobart)'. Hopevale reported less people going through child safety and less children housed out of community. Parental supervision orders are being issued rather than removing children. This was strongly attributed to the WBC support and input and their ability to work within child safety requirements. Similarly good outcomes in the area of child safety were expressed by child safety staff responsible for other communities and this has been a consistent message throughout the evaluation. Schools are very supportive of outcomes being achieved with school children and the contribution to school attendance.

Partners reported that the WBCs were providing a range of services that would otherwise not be available to the community or would overload existing services including their own.

2.3.2 IMPACT ON FAMILIES

This sub-section presents the impact of WBC services on families of clients as reported by clients, community members and staff.

Twenty nine clients (62%) reported having better relationships with family as an outcome of attending the WBC. (Note that very few interviews were also attended by family members. Where family members did attend, their reporting was consistent with the client). Of the 22 clients interviewed who were attending the WBC for management of relationship problems (includes domestic violence), all but five reported that their attendance was having a positive impact (and those five related to domestic violence cases).

The broader positive impact on families was supported by examples provided by partners including the police, justice group, school and child safety. For example, the work of the WBC with parents had supported improved school attendance or improved behaviour amongst the children of these clients.

Figure 2.9 presents what community members felt had been the impact on family or people they know. Of the community members interviewed who thought this questions was applicable or were able to answer the question, (n=269), most thought there had either been a big impact (82 people or 31%) or some impact (165 people or 61%).

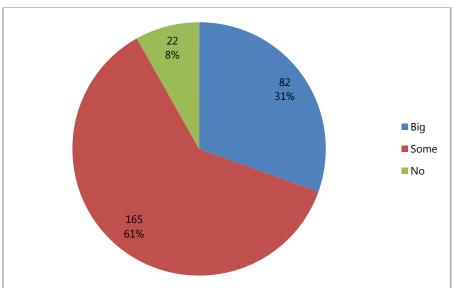


Figure 2.9: Impact on family or people you know (n=269)



As highlighted in Figure 2.10, there were variations at community level in respect to the scale of the impact with 44% of Aurukun respondents believing there had been a big impact, contrasted to 32% at Mossman Gorge, 22% at Hopevale and 20% at Coen.

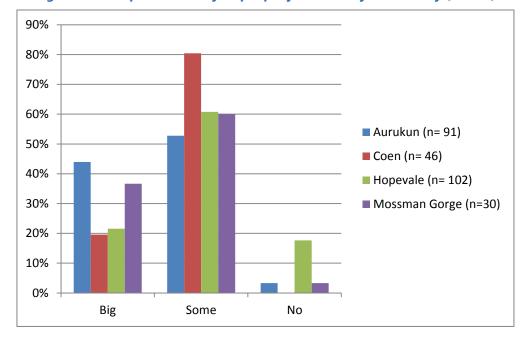


Figure 2.10: Impact on family or people you know by community (n=269)

Most staff survey respondents felt the WBC was having either a significant or some positive impact on most families or some family.

In conclusion it is apparent that the WBC are having some impact on the family of clients they work with. Where possible they work with the entire families but this is not the norm. WBC team leaders have advised that they involve the family in some capacity in greater than 50% of clients being treated.

2.3.3 IMPACT ON COMMUNITIES AS WHOLE

This sub-section presents the impact of WBC services on the community as a whole.

OVERALL IMPACT

Figure 2.11 presents the extent to which community members interviewed (n=351) consider the WBC as having had an impact on the whole community. Only 12 community members (3%) believed that there had been a big impact on the community and 102 people (29%) believed there had been some impact. Twenty seven community members (8%) believed there had been no impact and not surprisingly a large number of people (210 people or 60%) didn't know whether there had been the any impact. The most frequent positive comment was that the WBC has provided services and somewhere to go for help. Other comments from community members included:

'People used to bottle up issues – resulted in aggression'; 'Youth are using the WBC - less trouble with youth; 'Working with police on issues'; 'Still fighting between clans but all five clans are using the WBC'; 'Good things happening'; 'Kids going to school'; 'Certain people fighting'; 'Alcohol still compounds issues'; 'Helps people before problems become too big'; 'Can help people who come home from jail'.



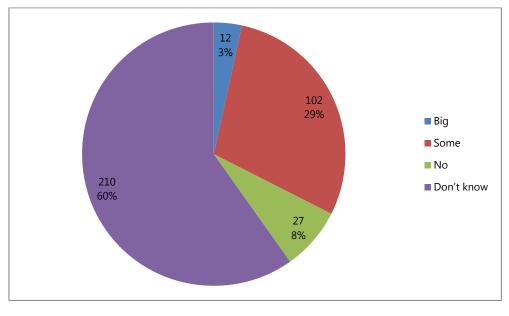


Figure 2.11: Impact on community (n=351)

As shown in Figure 2.12 the most notable variation across communities was the large percentage of respondents in Coen (72%) believing there was at least some impact on the community and the associated low number of 'don't know' responses at Coen.

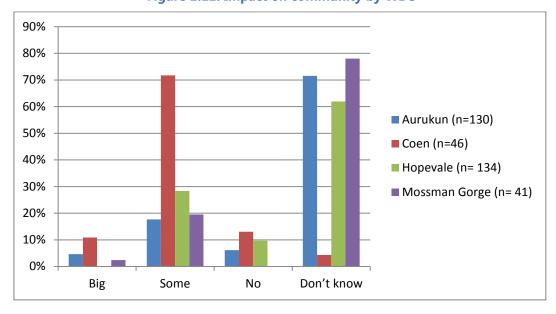


Figure 2.12: Impact on community by WBC

Figure 2.13 presents community members views in relation to whether there had been any changes in the community and the direction of that change over the last 3 to 4 years. One hundred and fifty two people (43%) responded that it was the same, 97 people (28%) felt it was better, and only 29 people (8%) felt the situation had got worse. Seventy three people (21%) did not know. In relation to the community getting better, a significant number of comments related to improved services, infrastructure and cleanliness.



These findings are broadly consistent with the *Cape York Welfare Reform Evaluation*¹⁴ which found that 58 per cent felt that the community was on the way up, 6 per cent felt that the community was on the way down and 36 per cent felt that there had been no change.

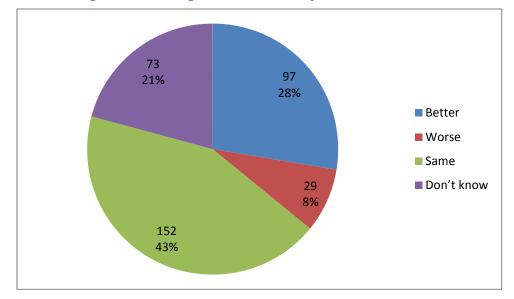


Figure 2.13: Change in the community as a whole (n=351)

As shown in Figure 2.14 the most notable variations between communities are the high percentage of respondents in Coen (65%) who felt the community had gotten better, and the relatively high number of respondents at Aurukun (18%) who felt the community as a whole was worse. This result in Coen is consistent with the high number of respondents in Coen who felt the WBC had a big (11%) or some (72%) impact.

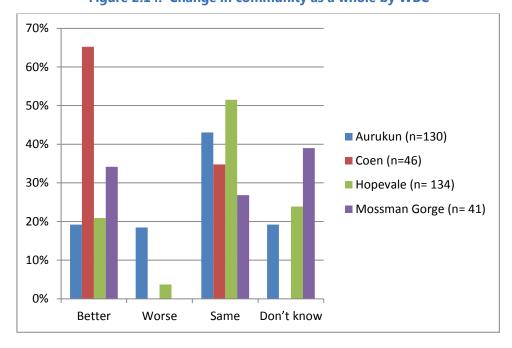


Figure 2.14: Change in community as a whole by WBC

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¹⁴ Ibid. The Cape York Welfare Reform Evaluation - page 128,129



2.3.4 SUMMARY OF FINDINGS

Review finding #2: In relation to mental health the WBCs are having a clinically and statistically significant positive effect on their clients. Specifically the Kessler Psychological Distress Scale (K10) mean score for Coen and Hopevale reduced by 8.96% (effect size change 0.5 - medium) and the Health of the Nation Outcome Scale (HoNOS) mean score reduced by 5% (effect size change 0.5 - medium), excluding Aurukun. One reason for the lack of improvement in Aurukun is likely to be the broader community environment (there have been a number of major community-wide incidents in the last couple of years) which in turn has a disruptive impact on individuals.

Achieving successful longer term behaviour change is occurring in some clients and helping to transform their lives. However this is not the norm.

This is supported by client and community feedback where significant percentages of community members considered the WBC was having an impact on both themselves where relevant and family and other members that they knew.

No community wide measures of SEWB were available to the evaluation. Using a proxy measure of whether community members felt the overall community had gotten better, worse or the same, it is clear that the majority of community members at Coen (65%) consider that community is now a better place to live. For other communities it is likely to be the same or somewhat better. Part of this improvement is made with reference to additional services, infrastructure and cleanliness.

Review finding #3: With the exception of Coen, individual-level improvements are not translating into sustained, consistent and clearly observable improvements in outcomes at the community level. The community level changes can be summarised as follows:

	Aurukun	Coen	Hopevale	Mossman Gorge
Community safety	Same	Improved	Same	Improved
As a place to live	Same/marginally better	Better	Same/marginally better	Same/marginally better



SUMMARY OF INDICATORS

Table 2.7 presents a snapshot of indicators discussed above by community.

Table 2.7: Snapshot of SEWB impact indicators by community

SEWB/ individual							
	Aurukun	Coen	Hope Vale	Mossman Gorge			
K10 - Clinical significance (effect size) of improvement - statistically significant	-0.01 (none) not statistically significant	0.33 (small)	0.85 (large)	N/A			
HoNOS total score - Clinical significance (effect size) of improvement - statistically significant	32 (none)	.58 (med)	.56 (med)	.37 (small)			
IRIS mental health - Clinical significance (effect size) of improvement - statistically significant	0.83 (large) not statistically significant	0.43 (small – med)	0.35 (small)	2.11 (large)			
Client reported client level impact	Positive	Positive	Positive	Positive			
Community members perspective on impact of self - big or some impact	95%	100%	92%	93%			
Community members perspective on the impact on family or people they know - big or some impact	97%	100%	83%	97%			
Community as a whole							

	Aurukun	Coen	Hope Vale	Mossman Gorge
Community perspective on impact on community by WBC - big or some	23%	83%	28%	22%
Community perspective on change in community as a whole - better	19%	65%	21%	34%
Community perspective on change in community as a whole - same	43%	35%	51%	27%
Community perspective on change in community as a whole - worse	18%	0%	4%	0%

2.4 IMPACT IF NO WBC

Whilst the evaluation has focused on the achievements of the WBCs, some consideration needs to be given as to what might be the case if they didn't exist.

Community members and partners were asked what would happen if the WBC was not there. There was a strong opinion that individuals and therefore the community would be much worse off and that the WBC are providing an essential and valuable service for the community.

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Very common responses included 'there would be less support and no help available'; 'people would be lost and struggle'; and 'there would be more fighting and other problems in the community'.

This view was supported by the majority of partner agencies consulted. A small number of partners felt it would not make much difference if the WBC was not there, but this was very much the exception. Partners also commented that their workloads would increase dealing with issues that are best dealt with by the WBCs. Specific partner comments included:

- 'would make my role much more difficult and leave a big gap as no other service provider fills this need'
- 'there would be more disengaged parents in parenting and children engaging in risk taking behaviour'
- 'I would lose staff as our workload would increase dramatically and we are not equipped to deal with SEWB issues'
- WBC excellent mental health provider of first resort. Previously people went to hospital and straight out of community. Now much more chance they can be managed within community. If no WBC this will change'
- 'if no WBC people would not use services as they tend not to mainstream services'
- 'significantly greater risk of some clients returning to jail'
- 'would be one key service that I would not remove early as it plays a critical role (provided it is working well which it now is'
- 'it would be very difficult for the community'
- 'school attendance would decrease, SEWB and mental health would get worse. There would be less support for people'
- 'would still be a need for a SEWB counselling and advocacy. There is a long-term role until all families engaged with welfare reform ideals. It provides a key focal point for community'
- 'ATODS would pick up some work. Provides opportunity for hope for some which if taken away could be devastating'
- 'there would be a big gap in a holistic health care. Clinic has no time or resources to help people work through their problems and ultimately become independent'
- 'WBC gives people hope to overcome their barriers of D&A abuse, depression, grief, mental illness'
- 'if no WBC we would have to use clinic indigenous health worker. This position has been periodically filled and they do not always have one'
- 'if no WBC there would be no pathway unless there is a suicide situation. There would be no way to deal with incidents except via an emergency examination order or just dumping people'

2.5 COMPARISON TO OTHER COMMUNITIES

While not in the scope of the evaluation, this section presents a comparison to outcomes experienced in other Aboriginal communities based on the very limited data that is available.



2.5.1 INDIVIDUAL LEVEL

At the individual level, the only relevant outcome data available for other communities is the K10 and HoNOS for the RFDS Cairns and Far North SEWB Team which services a range of Aboriginal communities on Cape York.

That data is presented in Section 2.3.1 and it shows that the SEWB team is achieving clinically significant (medium effect) improvements in relation to the HoNOS score and a small to medium positive clinically significant effect in relation to the K10, both at a statistically significant levels. These improvements are generally consistent with the WBCs.

In relation to the HoNOS, the Cairns SEWB team improvements are driven by the by the symptoms subscale. This is likely to reflect that the service is more focused on dealing with clients with mental health conditions. Two WBCs (Coen and Hopevale) recorded a similar medium clinical effect on total score, in the case of Hopevale driven more by the social and behaviour subscales and in the case of Coen driven by the impairment and symptoms subscale as well.

The HoNOS score change does not reflect the environment or community in which the client is situated. Table 2.8 shows that the profile of SEWB team and WBC clients is somewhat different, with WBC clients having more behavioural type problems and SEWB team clients having a higher score on the impairment and symptoms subscale, reflecting the mental health focus of that service.

Table 2.8: Comparison HoNOS first scores WBC and Cairns SEWB team

HoNOS Item	Non FRC clients mean (n-253)	FRC clients mean (n=78)	% Difference	All clients mean ¹ (n=331)	AMHOCN ²	Cairns SEWB team (n=191)
Behaviour Subscale Total	2.21	2.38	-17%	2.25	1.6	1.85
Impairment Subscale Total	0.93	0.95	-2%	0.95	1.3	1.57
Symptoms Subscale	2.12	1.83	29%	2.06	3	3.6
Social Subscale	3.41	3.53	-12%	3.44	3.3	3.07
Total Score	8.67	8.69	-2%	8.69	9.1	10.08

Note (1): Scores based on mean of clients first score. Each client is only included once.

Note (2): Scores based on Australian Mental Health Outcomes Classification Network data base and represent all ambulatory mental health scores in Australia (entry, review and discharge for 2011/12). No item scores are available.

In relation to the K 10 data presented in Section 2.3.1 the Cairns SEWB team had a small to medium statistically significant clinical effect, albeit from clients who were more psychologically distressed (an average initial score of 25 – likely to have a moderate mental disorder) compared to WBCs, where Hopevale had a large clinical effect, Mossman Gorge a medium clinical effect, Coen a small clinical effect and Aurukun no clinical effect, generally off a lower level of psychological distress (an average score 19).

2.5.2 COMMUNITY LEVEL

The only outcome data available at community level is the Queensland Government Annual Bulletin for Queensland's Discrete Indigenous Communities: 2011/12 which provides data in relation to 17 communities. Generally there are no observable differences in trend data between communities, with most (13) communities having one or two indicators that statistically improved, and one that deteriorated (six communities).

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Having said that the standout communities appear to be Kowanyama and Napranum which had the greatest number of the indicators across the various years statistically improve (four and three respectively) and no increases. Table 2.9 presents the number of indicators that improved and deteriorated for Cape communities since the relevant data was collected.¹⁵

Table 2.9: Number of indicators improving/deteriorating

Community	Number improving	Number deteriorating
WBC communities		
Aurukun	1	1
Coen	1	
Hopevale	1	
Mossman Gorge	-	-
Comparison communities		
Kowanyama	4	
Napranum	3	
Other Cape		
Lockhart River	2	1
Pormpuraaw	2	

Caution needs to be taken with interpreting overall trends as the overall level of prevalence can vary. For example in relation to annual rates of reported offences against the person, Pormpuraaw reports a statistical trend reduction from 2002/3 to 2011/12 but the overall level of reported offences is still relatively high.

Appendix 14 presents a snapshot summary of both trend data and the latest annual data for WBC and other Cape communities.

2.5.3 SUMMARY

The overall conclusion that can be drawn based on this limited analysis is that at the individual and community level, the WBC communities to do not appear to be performing noticeably better than other communities when measured against the limited outcome data available and the Discrete Indigenous Community Key Indicators up to 2011/12.

2.6 CHALLENGES IN ACHIEVING INDIVIDUAL AND COMMUNITY LEVEL CHANGE

This section examines some of the challenges in achieving change at the individual and community level change.

2.6.1 ACHIEVING SOCIAL AND EMOTIONAL WELL-BEING

The literature describes SEWB from a number of perspectives including socio economic status, social environment/social determinants, levels of empowerment, mental health/illness and a relationship with physical health. These are discussed briefly here to provide a broad understanding and context for the challenges associated with achieving SEWB.

¹⁵ Queensland Government Annual Bulletin for Queensland's Discrete Indigenous Community's: 2011/12. Source of data Table 1.



Social Determinants and Health and Wellbeing 16

The relationship between socio-economic status and health is well established, with people at the lowest socio-economic levels experiencing the highest rates of illnesses and death. As socio-economic position improves, health status also improves. Results from the 2002 National Aboriginal and Torres Strait Islander Social Survey (NATSISS) found that behavioural and environmental risk factors were reported in higher levels among Indigenous people who reported lower socio-economic status.

However, socio-economic status alone does not explain the variations in health status that exist between groups in society. Health risk behaviours (e.g. alcohol and drug misuse) and other health risk factors (e.g. poor housing, exposure to violence) are also important determinants of health but even these do not fully explain the differential burden of disease between population groups. Research suggests that at least a partial explanation for the remaining differences lies in other determinants of health such as aspects of the social environment. These include the neighbourhood in which one lives, one's position in the workplace relative to others, the quality of one's social connections with friends, family and the community, and the degree to which one feels included or excluded by society.

Chronic Stress, Psychological Distress and Social and Emotional Wellbeing 17 18

Through numerous studies a number of risk factors for stress associated with poor SEWB, have been identified by Indigenous Australians, including: stressful life events; widespread trauma, grief and loss; child removals; cultural dislocation; unresolved grief and loss; cultural identity; economic and social disadvantage; physical health problems; incarceration; child removal by care and protection orders and juvenile justice supervision; violence; substance use and abuse. Systemic discrimination is also considered a determinant of serious psychological distress among Indigenous people and a barrier to those seeking access to support services to cope with distress.

Whilst single risk factors can have an effect, multiple risk factors over a long period of time can have a cumulative effect leading to chronic stress and if not reduced or mitigated will lead to psychological distress. Those who are psychologically overwhelmed or struggling to cope with multiple stressors are likely to exhibit higher levels of psychological distress. Regardless of the source of stress, serious psychological distress is likely to indicate that a persons' SEWB is under severe threat.

Chronic stress is increasingly seen as a key determinant of mental health problems, poor health choices and a range of general health outcomes. Additionally, international research found that high levels of generalised stress independently contributed to chronic disease, suicide and drug misuse among Indigenous people. Exposure to stress was also found to be associated with health-damaging behaviours such as drug misuse and cigarette smoking. Other manifestations of chronic stress that have been identified include; intentional self-harm, anger and aggression, and problem gambling.

Whilst the research has identified a range of risk factors, they also identify a number of important strengths or protective factors, such as social cohesion, a sense of positive wellbeing and resilience and connection to land, culture, spirituality and ancestry that can serve as sources of resilience, and can moderate the impact of stressful circumstances on SEWB at an individual, family and community level. These factors can serve as a unique reservoir of strength and recovery when Indigenous people are

¹⁶ AIHW 2011, *Socio-economic context of Indigenous health*, Australian Institute of Health and Welfare, accessed 8th February 2012, http://www.aihw.gov.au/socio-economic-context-of-indigenous-health/>

¹⁷Kelly, K., Dudgeon, P., Gee, G. & Glaskin, B. 2009, *Living on the Edge: Social and Emotional Wellbeing and Risk and Protective Factors for Serious Psychological Distress among Aboriginal and Torres Strait Islander People*, Discussion Paper No. 10, Cooperative Research Centre for Aboriginal Health, Darwin.

¹⁸Garvey, D 2008, Review of the social and emotional wellbeing in Indigenous Australian peoples – considerations, challenges and opportunities. Retrieved 9th February from http://www.healthinfonet.ecu.edu.au/sewb_review

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faced with adversity. The Australian Indigenous Psychology Association (2009), specifically note that these strengths or protective factors are currently under-researched, and further research is needed to gain a better understanding of the nature and impact of protective factors related to SEWB.

Essential too, for many Indigenous people traditionally and in contemporary contexts is the bond between person and land - a connection that constitutes one's sense of individual and social identity and responsibility. The integrity of relationships between people and spiritual entities and the clarity of connections between people and land contribute greatly to the SEWB of Indigenous people.

Conversely, ruptures to significant relationships and markers of identity including access to culturally significant sites and socially significant persons can serve to compromise the quality of an individuals' or a community's SEWB. SEWB for Indigenous people in these terms is very much a matter of the integration of the various priorities, practices and principles that comprise their lives.

EMERGING EVIDENCE

In addition there is a growing body of evidence that demonstrates the links between early experiences of the development of chronic disease, psychosocial problems and reduced educational outcomes. It is now well understood that early brain development affects lifelong health and well-being of individual and that early environmental experiences significantly shape the developing brain, with many environmental factors, including smoking, alcohol, maternal nutrition and illness and dramatics stress affecting the unborn child. ^{19 20}

Hunter has also argued that compromised neuro-developmental environments have led to higher rates of serious mental illness.²¹

This creates a significant barrier to achieving individual and population level change quickly and highlights the importance of ensuring safe environments are established and risks are minimised for younger indigenous children including in utero.

2.6.2 SOCIAL CHANGE IN THE CONTEXT OF THE CAPE YORK WELFARE REFORM

As noted in the *Cape York Welfare Reform Evaluation* social change is characterised by interconnected and interrelated causality (as discussed above) hence the breadth and scale of the reforms. The evaluation framework for the CYWR trial conceptualised a theory of change comprising a continuum from putting in place foundations and enablers, bringing about short- to medium-term behaviour change, and finally achieving sustainable improvements in the communities in the longer term.

The evaluation noted progress around the fundamental behavioural changes sought from the trial has been at the foundational level in terms of stabilising social circumstances and creating the conditions for further behavioural change. It notes that it is arguable that this extent of progress along a continuum of long-term social norm change is as much as could be expected in a three- to four-year timeframe.²²

The program theory for the WBCs aligns with the CYWR trial program theory which in turn is built on the work of Kelman and his theory of influence. That is, where individuals participate in WBC programs appropriate to their specific need (regardless of the motivation being compliance, identification or

¹⁹ Apunipima Cape York Health Council. Background document: Embedding a social and emotional well-being approach across Apunipima's family and community centred primary health care model (2014)

²⁰ Silburn, S., Nutton, G.,Arney,F., & Moss, B. The first five years: starting early. Topical paper commissioned for public consultation on the Northern Territory Early Childhood Plan. (2011)

²¹ Hunter, E. Indicators of psychoses or psychoses as indicators: the relationship between Indigenous social disadvantage and serious mental illness. Australasian Psychiatry (2012)

²² The Cape York Welfare Reform Evaluation - page 2,3

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internalisation), this will facilitate them taking responsibility for personal and family SEWB and functioning, and this will have a broader change effect through the community that over time will encourage and reinforce the benefits of behavioural change and contribute to rebuilding social norms (along with a range of other reforms being implemented as part of the CYWR trial).

The program theory does not stipulate the scale of individual community engagement or the timeframe required to achieve a significant impact at community level.

2.6.3 THE LEVEL OF CHANGE

The reasons that reported and sustained change at the community level in the areas of alcohol and other drug related issues and community safety has not been achieved to date is likely to include a combination of the following factors:

- Whilst the proportion of adult community members who have attended the WBCs in each
 community is quite high (> than 50%), it is considered that many more individuals (including those
 who are hard to reach and currently unwilling to engage) would need to seriously engage and
 commence making lifestyle changes in order to demonstrate community wide change.
- Whilst after 5 years of WBC operation it would be anticipated that some community level change might be observable, given all of the contextual factors, it may be that the timeframe is not sufficient to flow through to significant and sustained change at the community level. Additionally, the existence of compromised neuro-developmental environments may be an inhibitor to significant and broad community wide change occurring at all and that change might only occur for certain cohorts in the community. This would support a very targeted approach for wellbeing services into the future and in particular children and younger people.
- The range of confounding factors impacting upon the community and outside the WBC control, for example the time required for behavioural change to flow through to community level change, community leadership, employment, the provision of other services and historical institutional disadvantage of the nature discussed above.
- To some degree at least (perhaps until more recently) the lack of coordinated focus at the
 community level to address these issues at the local level. Although it is acknowledged that a wide
 range of individual strategies have been implemented by multiple stakeholders and the scale of
 the challenge of multiple causes mean that change at the community level will take considerable
 time to flow through.

2.6.4 SUMMARY

When considering the impact of the WBCs, as noted in the CYWR evaluation 'there can be no quick fix to rectify challenges that have been decades in the making.' Contextual challenges to achieving significant change include: the recognition that Cape communities were suffering from significant social problems, caused not only by dispossession, racism and systematic and generational abuse, but also a social norms deficit; the entrenched disadvantage of Indigenous community members; a comparatively high burden of psychosis particularly amongst males; and increasing recognition that a compromised neuro-developmental environment significantly effects an adults general and mental health.

2.7 CLOSING THE GAP

An objective of the WBCs was to contribute to improvements in the Closing the Gap indicators. This section discusses whether the work of the WBCs is contributing to achievement of the Closing the Gap targets, particularly those that relate to the life expectancy gap and mortality.

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There are only three points at which life expectancy can be assessed prior to 2030: 2016, 2021, and 2026. The COAG Reform Council has relied on mortality rates data as proxy indicators for life expectancy. Using a 1998 baseline, the COAG Reform Council's 2011-12 Report shows decreasing deaths rates in Queensland and the Northern Territory. In Queensland the average annual change in indigenous death rates per 100,000 from 1998 to 2011 was 18 deaths (compared to the non-Indigenous rate of 10.1 deaths), with the average annual change required from 2011 to meet the 2031 target of 40.7 deaths.

In 2013, noting the slow progress against the life expectancy target (in November 2013, ABS estimates for life expectancy for Indigenous people in 2010 - 2012 showed a reduction in life expectancy gap of 0.8 years for men and 0.1 years the woman since 2005 - 2007), the COAG Reform Council noted that 'efforts to improve Indigenous life expectancy may take many years to show results'.²³

There are many factors impacting on life expectancy and mortality and the timeframe for achieving change. It was noted many deaths occurring will be as a result of chronic conditions that built up in the decades prior to 2009 (per example over 2011/12 the greatest single cause of Aboriginal deaths related to circulatory disease (26.3%) that it is defined to include heart attacks and strokes.²⁴

In 2012-13, the ABS *Australian Aboriginal and Torres Strait Islander Health Survey* reflected that health outcomes continue to reflect smoking patterns in 2002, as the damage from these high levels of smoking will take some time to dissipate.²⁵

The AATSIHS survey found no significant change over time in 'lifetime risk' for consumption of alcohol over 2005-07 and 2012-13. It also highlighted the need for greater focus on reducing the rates of obesity and increasing the number of Aboriginal and Torres Strait Islander people engaging in daily exercise – areas where significant gaps with the non-Indigenous population are evident. ²⁶

The Closing the Gap Campaign Steering Committee reported that evidence that the foundations for achievement of health and expectancy by 2030 are in place. Smoking rates have declined (estimated to be the single biggest cause of death for Aboriginal and Torres Strait Islander people) and from 1998 to 2011 the mortality rate of Aboriginal and Islander children under the age of five years decreased at a faster rate than the non- Indigenous rate (by an average of 5.7 deaths per 100,000 per year compared to 1.7 deaths per hundred thousand for non- Indigenous children.²⁷

WBCs have focused on delivering services related to mental health, alcohol and other drugs (but not smoking specifically) and SEWB issues more broadly. While mental health is considered in the *Aboriginal and Torres Strait Islander Health Plan (2013 – 2023)*, there is no specific national strategy to close the gap in the area of mental health and alcohol and other drugs (which has been argued by some groups)²⁸.

Consistent with the multiple factors impacting upon the life expectancy and mortality, and the long lead time required to change, as anticipated there is no direct evidence that the WBCs have contributed to observable changes in the life expectancy and mortality gaps to date. This is a longer term objective which is consistent with the construct of the service model.

²³ COAG Reform Council, *Indigenous Reform 2011-12: Comparing performance across Australia*, 2013, p 14

²⁴ Australian Bureau of Statistics, Life Tables for Aboriginal and Torres Strait Islander Australians, 2010-2012, (cat. no. 3302.0.55.003), 2013

²⁵ Australian Bureau of Statistics, Australian Aboriginal and Torres Strait Islander Health Survey: First Results, Australia, 2012-13 (cat. no. 4727.0.55.001), 2013

²⁶ Close the Gap. Progress and priorities report 2014. The Close the Gap Campaign Steering Committee.

²⁷ Ibid.

²⁸ Ibid.



Review finding #4: Given there are multiple factors impacting upon life expectancy and mortality, and the long lead time required to observe change, as anticipated there is no direct evidence that the WBCs have contributed to observable changes in the life expectancy and mortality gaps to date.

2.8 FUTURE USE OF OUTCOME MEASURES

As highlighted previously the RFDS is administering a range of screening tools and outcome measures that were available for the purposes of the evaluation. In the RFDS Adapted State-wide Standardised Suite of Clinical Documentation, User Guide it was intended that some of these screening tools would be used at the clinician's discretion rather than systematically collected and used as outcome measures.

The evaluators consider that the number of outcome indicators collected and reported systematically should be minimised to reduce the burden on clinical staff in a challenging service environment. However, we would emphasise the importance of determining which tools are to be routinely collected and ensuring that this is systematically occurring within the WBC environment.

It is proposed that HoNOS, K5, AUDIT-C and the SDS be utilised on an ongoing basis. It is considered this combination of tools best represents the key foci of the WBCs (i.e. mental health, SEWB and drug and alcohol).

- The HONOS has generally adequate validity and reliability. It has been thoroughly evaluated and extensively used across a range of populations (including Indigenous Australians and mental health clients).²⁹
- The AUDIT is widely used and is the preferred tool of the Australian Government for funded alcohol and other drug services. There is concern about utility in Indigenous populations³⁰ and the shorter AUDIT-C has been developed which could be used³¹.
- The K10 is widely accepted, validated and used nationally. The K5 was developed for Indigenous people ³² and used in the National Aboriginal and Torres Strait Islander Social Survey 2008³³ and Aboriginal and Torres Strait Islander Health Survey 2012/13.34
- The SDS has generally adequate psychometrics and can be utilised for a range of substances.35
- The Indigenous Risk Impact Screen (IRIS) has a high degree of convergence with the K10 and the AUDIT and should not be required as an outcome tool.

²⁹ NADA (Network of alcohol and other drug agencies). Review of Screening, Assessment and Outcome Measures for Drug and Alcohol Settings. 2009

³⁰ Ibid.

³¹ Royal Australian College of General Practitioners. Guidelines for preventive activities in general practice 8th edition. http://www.racgp.org.au/your-practice/guidelines/redbook/appendices/appendix-3-audit-c/

³² Australian Institute of Health and Welfare 2009. Measuring the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples. Cat. no. IHW 24.

³³ Australian Bureau of Statistics .4720.0 - National Aboriginal and Torres Strait Islander Social Survey: Users' Guide, 2008.

³⁴ Australian Bureau of Statistics, Australian Aboriginal and Torres Strait Islander Health Survey: First Results, Australia, 2012-13 (cat. no. 4727.0.55.001), 2013

³⁵ Op cit. NADA



3

3 THE SERVICE MODEL AND ITS IMPLEMENTATION

This chapter examines the following key evaluation questions for the service model, service management, partnerships and community engagement evaluation domains:

- 1. Has a service model been documented that aligns with the key service elements and is it in alignment with the program theory? Do staff understand the service model?
- 2. Has the service model as agreed been implemented? If not what are the variations and what was the rationale for any change?
- 3. Has the service model resulted in better access to services than in other comparable communities and how does the service profile and service approach compare?
- 4. How should the service model be changed to enhance its contribution to individuals, families and communities functioning and wellbeing?
- 5. Is the WBC establishing effective partnerships of the type required with respective partner stakeholders? If so, what has worked or is working and why, and what has not worked or is not working and why?
- 6. How could partnerships be strengthened to enhance the WBC's contribution to individuals, families and communities functioning and wellbeing?
- 7. Are the WBCs effectively engaging the community? If so, what has or is working and why, and what has not worked and why?
- 8. How could community engagement be improved to enhance the WBC's contribution to individuals, families and community's functioning and wellbeing?
- 9. Have community capacity building efforts been effective in underpinning a longer term enhancement of community control?

3.1 SERVICE MODEL DESCRIPTION

The aim of this section is to provide a brief overview of the current service model and supplement the information provided in Section 1.5.

As stated in the WBC service model, WBCs deliver a community based model through a capacity development and empowerment lens that:

- Provides a service that supports and involves community input while focusing on addressing alcohol and other drug use issues, gambling, family violence, and SEWB
- Aims to ensure a high level of local decision-making
- Is flexible in provision of services in community or on country including traditional views of health and healing
- Focuses on empowering individuals and communities as a whole to take responsibility for making positive choices about their health and wellbeing.

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Following referral or presentation at a WBC, a comprehensive holistic assessment and engagement process is undertaken with relevant clients to determine the most appropriate programs and activities from which that particular client would benefit most.

The model of care recognises that the needs of each community are different and that the type or mix of services may therefore be different within the context of the overall service provision framework. Hence, whilst there is a core range and type of services being offered, the target and focus of individual and group activities and the type of partners and how they work with particular partners do differ.

The model of care highlights the importance of working in partnership and coordinating services with other key service providers but provides little guidance or detail in this area. The service model does highlight that for mandated clients there is need for clarity around confidentiality and that harm minimisation will be a major focus which should be communicated clearly with the client/family the referrer and other relevant providers. It also notes that client resistance may be experienced and home visits may be required.

The service model discusses the relevance of, but does not mandate, particular approaches or therapies (e.g. cognitive behaviour therapy, motivational interviewing, narrative therapy). Our consultations to date note that the range of approaches and therapies is broad, largely influenced by the fact the teams consist of professionals from varying backgrounds (e.g. mental health nursing, psychology, social work).

The clinical practice framework within the model of care (based on the previously developed *Foundation of Well-Being Framework*), emphasises the importance of screening and assessment. The framework identifies four psycho-social modules namely for use with the client group:

- Alcohol and other drug misuse
- Domestic violence
- Mental health and well-being
- Relationships/family and parenting.

There are no plans to develop any further modules at this stage. In fact the RFDS is currently considering the role of these modules and a further explanation of how they are to be used within the proposed update to the model of care.

Each module has a number of specific topics within it and links are provided to relevant support materials to assist staff in delivery. Clinical staff select the specific topics they believe appropriate to the client need. Note that each module does not consist of a fully developed suite of program delivery materials and it is this lack of clarity that HOI believe has contributed to the frustration of some stakeholders, notably the FRC, to understand exactly what activities the WBC undertakes with its referred clients.

In a practical sense there is an expectation that the WBCs will:

- Provide a key point of contact and referral including receiving mandatory referrals from the FRC
- Provide clinical and general counselling both at individual and family level that meets the assessed need of the client
- Conduct regular group activities targeted at particular age groups or gender focusing on relevant issues and responding to community need

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- Lead or participate in community wide campaigns to address relevant key social issues and provide leadership at a community level in relation to responding to relevant social issues
- Focus on drug and alcohol problems and clients with mental health issues as well a wide range of other SEWB issues
- Work closely with key partners and coordinate services accordingly at the individual, group and community level. This would include referral to/from the Cape York Family Centre being developed in Cooktown, however, this service is still in a relatively early stage of establishment during the period of the evaluation.
- Act as a key referral service for the FRC and respond appropriately to both voluntary and mandatory referrals
- Effectively engage the community
- Be available for use as a drop-in centre (at least by some stakeholders in some locations)
- Be part of an integrated approach to primary health care.

The service model provides a new and unique approach to the provision of SEWB services.

3.2 SERVICE MODEL DEVELOPMENT

During the evaluation design stage (first half of 2012), it was evident through our consultations and review of key documentation that there was no clear program theory documented and the service model was not comprehensive nor was it broadly understood by partners. While evident that the program theory for the WBCs had been discussed at great length, it had not been formally documented or agreed with key partners. Further, stakeholders consulted during the design stage reported to HOI that they were not clear on the WBC service model and the Family Responsibilities Commission (FRC) in particular felt that the then *Foundation of Wellbeing Framework* was not particularly helpful or informative for their needs (even though it had been designed largely with their needs in mind). Feedback from stakeholders also suggested that this had led to inconsistencies of practice and approach between the four WBCs.

In response to this stakeholder feedback and early evaluation work, the RFDS invested significant time and effort in developing a new document entitled 'Model of Care – Wellbeing Centre, September 2012' to replace the former 'Wellbeing Centres, the Foundation of Wellbeing Framework, version 2, 2010'.

This model included a requirement for a more systematic and consistent approach in assessment and outcome measurement in particular using tools such as the Indigenous Risk Impact Screen (IRIS) and the Alcohol Use Disorders Identification Test (AUDIT) as well as the Health of the Nation Outcome Scale (HoNOS) and the Kessler (K10).

A large part of the feedback concerning the need for the documentation of a more comprehensive service model arose from partner 'criticism' regarding 'clinical service provision and standards'. The sense at the time was that the early focus had been on the provision of a broad SEWB service and that 'clinical' work (1:1 counselling/therapy) was not being afforded a sufficient priority and there were questions concerning the relevant skills and experience of WBC staff to provide these services. In response, RFDS have adopted a purposeful strategy to employ people with psychology qualifications and/or strong mental health backgrounds. In addition relevant policies and procedures for outcomes measures and client assessment have now been incorporated into the RFDS (Qld) Well Being Services, Adapted State-wide Standardised Suite of clinical documentation - User Guide. The approaches are consistent with Queensland Health.

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RFDS plan to review, update and republish the service model in 2014. The ongoing development of the model of care is fully supported by stakeholders.

Feedback from recent stakeholder consultations indicates that the model of care document has not been proactively used as much as it could have been to promote the service and educate staff.

Key areas identified by stakeholders for service model enhancement include:

- The need for a clear description of the services provided by the WBCs in the mental health and ATODS service lines and the associated interface with Queensland Health and the newly established Family Centre in Cooktown.
- The need for a clear description of the services provided by the WBCs in relation to FRC clients and how the WBC and FRC can work more closely together to improve outcomes for clients
- Aligned to the above points, the need to clarify how and when modules and specific topics are used and for whom
- The need to strengthen description of the approach to non SEWB primary health care services.
- The need for a clear description of the skills and qualification required to work in the WBC and associated workforce development strategies.

It is proposed that the service model description be updated in the second half of 2014. The update should incorporate the key areas identified above.

3.3 ALIGNMENT WITH PROGRAM THEORY AND KEY SERVICE ELEMENTS

Appendix 5 presents the WBC program theory and Appendix 6 sets out the key elements of the service agreement and whether they have been integrated into the WBC service model. The service model as currently documented aligns with the WBC program theory which itself is aligned to the Cape York Welfare Reform Trial theory and the WBC service agreement.

One key area of difference in implementation has been the provision of non SEWB primary health care brief interventions which until more recently has not been built into the WBC activities in a structured way. Examples of how the WBCs have now integrated non-SEWB primary health care are discussed in Section 3.5.8.

3.4 SERVICE ACTIVITY AND CLIENT PROFILE

This section presents an overview of service activity and the client profile. A more detailed presentation of service activity and client profile is presented at Appendix 15.

3.4.1 SERVICE ACTIVITY

Overall, 48% of the entire community, 57% of the adult community (>19 years) and 26% of the population <20 years are currently or have been WBC clients. As at 31 March 2014 13% of the entire community were recorded as being WBC clients (based on 2011 census, 2815 people residing in WBC communities as follows: Aurukun 1294, Coen 416, Hopevale 1005, and Mossman Gorge 100).

The percentage of the community who have been clients is relatively consistent in the communities of Aurukun, Coen and Hopevale. Mossman Gorge has the highest percentage of the community as clients, although the population is considerably less than the other three communities. This high percentage will be attributable to the transient nature of the Mossman Gorge population.



Figure 3.1 presents the number of all service contacts and actual contacts by year for all WBCs. Overall there have been 26,661 service contacts and 15,787 actual client service contacts recorded since inception to 30 March 2014. The figure includes an estimate for the last 3 months of 2013/14 to facilitate yearly comparisons.

7000
6000
4000
3000
2008/09 2009/10 2010/11 2011/12 2012/13 2013/14
estimate

Figure 3.1: Service contacts by year all WBCs¹

Note (1): Service contacts include all contacts or discrete activities relating to a client by WBC staff. They do not necessarily mean face to face contacts. They include non-client contact activity e.g. relevant phone calls, case meetings

Note (2): Actual service contacts are primarily face-to-face contacts.

Note (3): 2013/14 estimate based on extrapolation of nine months actuals from July 13 to March 14.

Actual service contacts are trending upwards. An examination of the underlying data presented in Figure 3.2 by WBC shows that Aurukun was lower in the 2010/11 due to difficulties experienced in the community during that period. While there had been a steady decline in service contacts at Mossman Gorge in 2012/13 this has been reversed in 2013/14 with the introduction of new management at that WBC. A decline in Hopevale in the 2012/13 year is attributed to a vacant clinical position for much of that year. The steady increase in Coen until 2012/13 has been attributed to the ongoing engagement with that community.

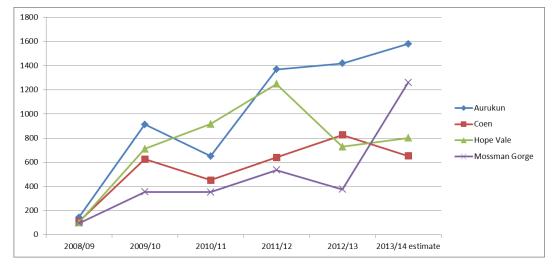


Figure 3.2: Actual service contacts by year per WBC

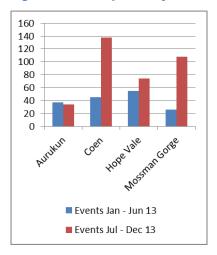
Note (1): 2013/14 estimate based on extrapolation of nine months actuals from July 13 to March 14.

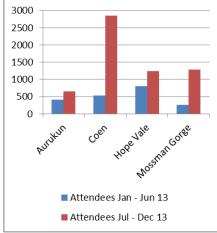
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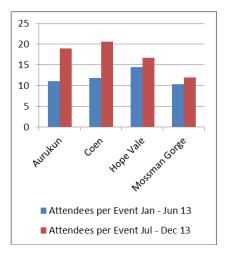


For the period January to June 2013 there were a total of 6.3 events per week (average of 1.6 per community) and 12 attendees per event. For the period July to December 2013 there were a total of 13.6 events per week (average of 3.4 per community) and 17 attendees per event. As illustrated in Figure 3.3 the number of events and the number of attendees increased substantially in the July to December 2013 period compared to the previous six months all sites except Aurukun where only the number of attendees increased by small margin.

Figure 3.3: Group activity - events, attendees and attendees per event - Jan- Jun 13, Jul - Dec 13







3.4.2 CLIENT PROFILE

The total HoNOS scores for all WBC clients is similar to the national profile of mental health ambulatory clients (8.69 compared to 9.1). On a subscale basis, behaviour scores are greater than the national profile (2.25 to 1.6) and the impairment and symptoms subscale are less (0.95 compared to 1.3 and 2.06 compared to 3 respectively). This result is not surprising given the behavioural problems evident in these Aboriginal communities. In relation to impairment and symptoms the national profile is based on people with diagnosed mental illness whereas the WBC is a SEWB service seeing a much broader range of clients and hence a lower score might also have been expected. The non-FRC and FRC client profile is of a similar score.

The K10 score for all WBC clients is similar to the national profile of mental health ambulatory clients. This result is to be expected given the WBC clients are attending a SEWB service that sees a broad range of clients many of whom can be stressed. The score indicates that on average clients are in Risk Zone II (likely to have a moderate disorder, K10 score 16-21) at the time their first score is collected.

The percentage of WBC clients at high or very high distress levels is marginally greater than the general Indigenous population (33% compared to around 27% to 30%) and significantly greater than the non-Indigenous population. This level of distress is to be expected given the presenting circumstances of the WBC clients.

Overall WBC clients fell in the risky or hazardous level of drinking category on initial score and FRC clients were in the same category. There were variations between WBCs with Mossman Gorge clients on average being in the high risk category and all other WBCs being in the risky or hazardous level of drinking. Unfortunately, there is no benchmark data on which comparisons could be made.

Based on the SDS 36% of clients demonstrated a dependence on cannabis with significant variations between WBCs. Mossman Gorge and Aurukun had the highest percentage of clients recorded as being dependent upon cannabis and consequently the highest average score.

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Whilst many clients present with more than one issue, Figure 3.4 presents the primary diagnosed assessment issue for those clients with a service contact in the July to December 2013 period (the only period for which this data is available)³⁶. The graph below demonstrates that violence (90 clients, 21%), mental health (89 clients, 21%), alcohol (85 clients, 20%) and welfare and other support (69 clients, 16%) together make up 78% of the diagnosed assessment issue categories. More detailed data is provided in Appendix 15. An examination of underlying issues for all clients since inception indicate that 53% and 43% of clients had at least one presentation where alcohol or other drugs, or mental health was an underlying issue respectively (this data not necessarily equate with the number of clients with a formal mental health diagnosis as this data was not available).

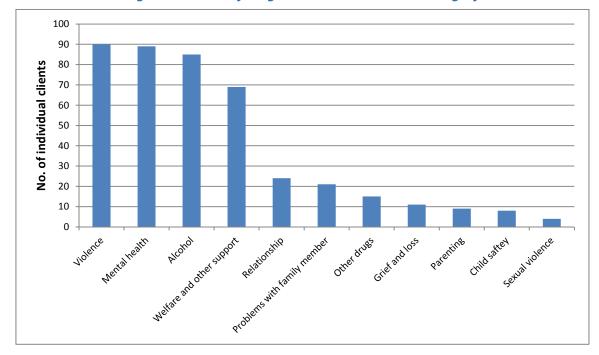


Figure 3.4: Primary diagnosed assessment issue category

Note (1): This data has been collected manually by the RFDS. From April 2014 it will be captured in the upgraded information system. The total number of clients on which this graph is based was 425.

Note (2): Each client only has one diagnosis assessment category allocated being the primary issue. In reality other presenting reasons usually exist.

Figure 3.5 presents a comparison of primary diagnosed assessment issue categories between WBCs. The figure shows that Mossman Gorge has relatively less clients who have violence and mental health as the diagnosed assessment issue category, but relatively more clients where welfare and other support and relationships are the primary issues.

³⁶ Funders and the service provider have utilised reasons for presentation to help understand who is using the well-being centre and why. Whilst this is a reasonable proxy, it has now been agreed that diagnosed assessment issue will be collected on an ongoing basis. This limited data availability has not impacted upon capacity to undertake the evaluation.



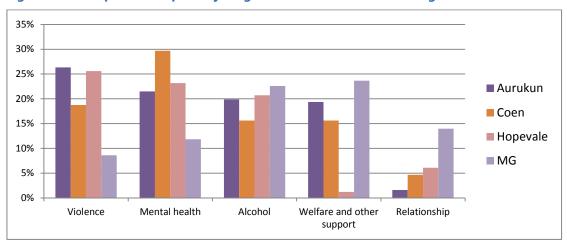


Figure 3.5: Comparison of primary diagnosed assessment issue categories between WBCs

Figure 3.6 presents on a proportionate basis the top reasons for all client presentations and compares this to FRC referred clients (note one client can have multiple reasons for presentation) from inception to 30 June 2013. The data illustrates that: addiction to alcohol/other drugs/gambling (20%), violence (11%) relationships (10%), welfare support (12%), stress (8%) and legal (7%) together make up 68% of the reasons for presentation. Note the term "addiction" relates to clients presenting with problems associated with alcohol and/or other drug use and gambling, including problems of heavy episodic use, rather than those formally diagnosed as being alcohol or other drug dependent.

The data shows there are a higher percentage of FRC clients presenting with addiction problems (30% of FRC clients compared to 20% of all clients). While the reasons for presentation are of similar proportion in 2013/14 to that since inception for most categories, the proportion of welfare support activity has increased from 9% since inception to 23% in 2013/14 which has been driven by all WBCs.

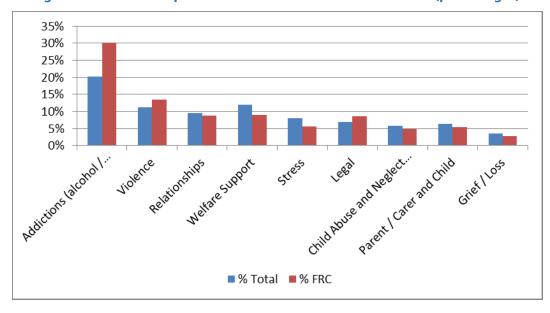


Figure 3.6: Reason for presentation all clients versus FRC clients (percentages)

Note (1): Data is since inception to 31 March 2014.

Note (2): The database does not allow for an accurate breakdown of the 'addiction' reason for presentation, but it is primarily for alcohol and other drugs.

Note (3): Addictions relate to clients presenting with problems associated with alcohol and/or other drug use, including problems of heavy episodic use, rather than those formally diagnosed as being alcohol or other drug dependent. Note (4): One contact can have multiple reasons for presentation.



A comparison between WBCs of the reason for presentation for the 2012/13 and 2013/14 years combined (Figure 3.7) demonstrates that Aurukun has the highest proportion of presentations for addictions and violence, Mossman Gorge for welfare support and Hopevale for child abuse and neglect.

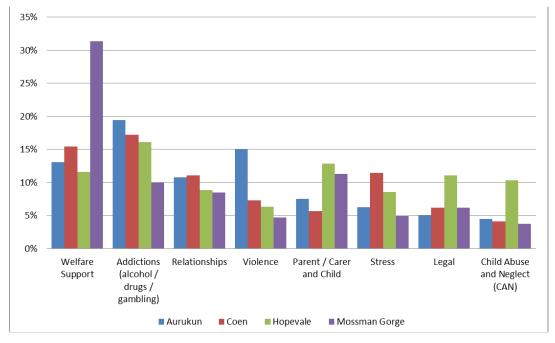


Figure 3.7: Reasons for presentation – WBC comparison

Note (1): Relates to period 2012/13 and July 13 to March 2014.

For males, addictions and prison related matters make up a significantly greater percentage of the reasons for presentation than females. For females, welfare support, relationships and parent/carer and child support makes up a greater proportion of reasons for presentation than males.

As noted above, the growth in attendances for welfare support across all WBCs (but particularly at Mossman Gorge) is a vexed issue. The positive aspects of this include an increasing trust in the WBC as a service that can provide a holistic and integrated range of SEWB services (including welfare support) to the community. Additionally, the provision of assistance with matters of welfare has been an important way of addressing the overall level of stress in a community and it has proven to be an important tool for facilitating the first engagement with a client that very often leads to more in-depth counselling. In this respect it is regarded as an invaluable tool in promoting the WBC service and engaging with all members of the community. However, it might also be reasonably argued that a range of other services in the community have been funded to provide primary welfare support and hence care needs to be taken that this does not become a disproportionate amount of the work undertaken by the WBCs, particularly given there hasn't been commensurate funding for this work. Alternatively it may be considered that in the design and delivery of wellbeing services in the longer term, a more efficient and client/family centred approach is to incorporate relevant existing 'welfare and support funding' sources into the wellbeing services funding pool and deliver a more integrated service. This should be considered on a community by community basis and the relative strengths and weaknesses of such an approach balanced.

It is proposed that opportunities for formally integrating welfare and support services into social and emotional wellbeing services including appropriate funding be considered on a community by community basis.



3.5 Service model implementation

This section examines what is happening on the ground in the context of the practical service expectations highlighted in Section 3.1 and addresses the evaluation question has the service model as agreed been implemented?

Each WBC is addressing the range of service expectations identified from the service model relatively well. While each area is discussed separately, a strength and uniqueness of the model is the level of integration between the areas of activity with a client often participating in multiple types of activity, often with a joint approach by service providers.

3.5.1 KEY POINT OF CONTACT AND REFERRAL

Each WBC is providing a key point of contact and referral for the community. The data indicates that since inception 77% of clients (103% of FRC clients) were recorded as completing the intake process, 46% the holistic assessment (62% of FRC clients) and 40% the engagement social education session streaming (54% of FRC clients). Data capture in this area has strengthened since the earlier years.

Of the clients interviewed in relation to their experience of the referral process and first contact with the WBC, most answered the question (41 clients or 96%, n=43) as either 'no worries' with the process or found it to be 'really smooth and clear'. Only two clients found it slow or confusing. Ninety four percent of clients interviewed (44 clients, n=47) felt comfortable with their initial contact with the WBC and 91% of clients (43 clients, n=47) felt the whole process was satisfactorily explained.

There was no significant difference reported between those mandatorily referred and those who attended voluntarily. Of the FRC referrals, one client expressed being angry about the referral and another felt shame at first, but both still described the WBC entry process as being good.

Partners also considered that the WBC was a key point of contact with community and that appropriate referrals were being made to and by their respective organisations, often informally.

3.5.2 USE AS A DROP-IN CENTRE

Aligned with being a key contact point, one of the most significant roles the WBCs are playing is that as a point of pressure relief. Clients (or in fact general community members) who are highly stressed/distressed often as a result of heightened tension and confrontation in the home or community, come to the WBC to talk, be listened to, have a cup of tea, and simply get time out. Clients and community members also utilise an available telephone to help manage administrative matters. This drop-in aspect is highly valued by the client group, the community more generally and many of the partner agencies.

Whilst the use of the WBC as a stress relief point was observed in each community, this was more substantial in Aurukun. There was a significant amount of 'drop in' occurring for a range of issues and correspondingly crisis management. Whilst acknowledging the importance of a drop-in service, the RFDS have recognised the need to ensure this does not overwhelm the therapeutic service particularly at Aurukun and they have implemented management changes to support an appropriate service balance being implemented and maintained.

At the time of reporting, data for the level of drop-in activity was not systematically recorded but it can be substantial. A recent 3 day audit showed that 73% of all visits in that period were not recorded and advice was that these visits related primarily to drop-in and other informal activities (refer to Appendix 15). This was certainly observed to be the case by the evaluators who have spent of 3-5 days in the WBCs on four separate occasions.

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It was clear however, that through the provision of this 'drop in' service at each of the WBCs, opportunities are opened up for community members to receive brief intervention and engage as clients (where they are not already clients) for longer term follow up and therapeutic intervention through counselling and groups. Staff noted however, that this transition from utilisation as a drop-in service, to use as a service for ongoing intervention is a slow process.

There is no data available in relation to the number of clients who originally attended as a 'drop-in', but overall 29% of clients were self-referred (23% Aurukun, 31% Hopevale and 31% Mossman Gorge) since inception and it is likely a proportion of these originally attended as a drop-in. Of the clients we interviewed who were self-referred (n= 22), 50% indicated they highly valued drop-in services. Overall 32% of all clients interviewed and 88% of clients who had used the WBC as a 'drop-in' stated that these services had contributed to the changes they had made. Additionally 46% and 28% of community members interviewed felt that drop-in services and being a safe place respectively were most helpful components of the service model.

Where the person is willing to engage further, the WBC is able to provide significant assistance, support and therapeutic intervention that can and does assist with the immediate problem and some underlying problems.

As noted, many partners also highlighted both the importance of the drop-in service and a designated facility where this could be facilitated comfortably. Many consider this service to be critical to averting crisis for individuals and de-escalating conflict and confrontation between family and community members. Both the justice group and the police in Coen provided examples of how community members known to them had taken themselves to the WBC prior to or in response to confrontation, (rather than reacting) knowing that this would allow them time to calm down and prevent them taking action they would regret.

These presentations to the WBCs to assist in the management of high levels of stress and distress align with the Australian Indigenous Psychological Association description of what constitutes poor SEWB for Indigenous people.³⁷

3.5.3 CLINICAL AND GENERAL COUNSELLING BOTH AT INDIVIDUAL AND FAMILY LEVEL THAT MEETS THE ASSESSED NEED OF THE CLIENT

The WBC has offered clinical and general counselling at both individual and family level to varying levels since inception. Service activity and reasons for presentation are reported on in Section 3.4 and Appendix 15.

As reported previously, over time the RFDS has moved to strengthen the therapeutic aspect of the service in line with stakeholder feedback. While there is no data available WBC team leaders advise that greater than 50% of clients involve the family in some capacity.

The profile and number of contacts varies widely. Sixteen percent of total WBC contacts occurred within the first two months of first contact, 33% of total contacts occur by the end of six months and 49% of contacts occur by the end of 12 months. The profile is almost identical for FRC referred WBC clients. Forty eight percent of all clients have had a total of 1 to 10 contacts to date (29% for FRC clients) and 44% of all clients had between 11 and 50 contacts (57% for FRC).

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Kelly, K., Dudgeon, P., Gee, G. & Glaskin, B. 2009, Living on the Edge: Social and Emotional Wellbeing and Risk and Protective Factors for Serious Psychological Distress among Aboriginal and Torres Strait Islander People, Discussion Paper No. 10, Cooperative Research Centre for Aboriginal Health, Darwin.

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Overall 89% of all clients we interviewed and 100% of clients who had had received 1:1 counselling stated that these services had contributed to the changes they had made. Of these clients, 48% specifically mentioned the listening aspects of counselling as being helpful.

There is no one mandated approach being used and it is left largely to the discretion of the clinician as to the most appropriate approach for a particular client and their individual preference (consistent with many other health services). It also means that it is not possible to determine whether any one particular or specific approach is better than another. Staff reported the most common counselling/intervention approaches used with individuals and by extension those considered most effective included:

- General counselling
- Motivational interviewing
- Narrative therapy
- Cognitive behavioural therapy
- Strengths based approach
- Psycho-social education
- Group work
- Advocacy.

In most cases a combination of approaches is used. Recent changes to the information system will capture this information systematically in future.

As presented in Table 3.1 the most commonly selected psychosocial module was the 'drug and alcohol misuse module', undertaken by 26% of all clients and 47% of FRC clients. The judicial module was the least common.

Table 3.1: Number and proportion of all clients and FRC clients completing selective module streams

Module	No. of clients	No. of FRC clients	% of All clients	% of FRC clients
Drug and Alcohol Misuse	277	180	26%	47%
Domestic Violence	179	97	17%	25%
Relationships/Parenting and Family	171	71	16%	18%
Mental Health Modules	95	30	9%	8%
Judicial Modules	7	3	1%	1%

Note (1): Period is since inception to June 2013.

Approximately 88% of actual contacts were either not recorded as being undertaken in the context of a specific modules or the treatment was not provided within the context of those modules. This reflects a need to articulate more clearly in the revised model of care, the purpose and use of the modules.



3.5.4 CONDUCT REGULAR GROUP ACTIVITIES TARGETED AT PARTICULAR AGE GROUPS OR GENDER FOCUSING ON RELEVANT ISSUES AND RESPONDING TO COMMUNITY NEED

All WBCs provide or are involved in various group activities either as the lead agency or in collaboration with other agencies. These groups are used to convey key messages consistent with the WBC mandate. Regular Men's and Women's groups are common in each of the WBCs although they have waxed and waned over time. Groups for children and adolescents were less common initially, although these have developed significantly since the Phase One Evaluation Report (April 2013) with active groups in all WBCs. This direction is strongly supported by partners. One key success is the long standing weekly cooking classes for primary aged school children run by Apunipima in Coen, held in the WBC and supported by their staff. One night each is allocated to boys and girls and a few parents (a number of who are WBC clients) also attend. These are held in the WBC and supported by WBC staff. This has been sustained for a couple of years.

Another success is the twice weekly homework groups in Mossman Gorge which are now being supplemented by an educator. In Hopevale a number of activities have been implemented and/or supported by the WBC: an inter-agency working group has been established with the WBC playing a lead role; supporting a program that is working with a small number of boys who are creating challenges at the Cooktown school; and leading with visiting mental health clinicians a personal development and protection program for young girls that culminated in a camp and now ongoing group activities. Most significantly, these latter two programs have been facilitated by the local community development consultants.

The number and type of groups has changed over time and a more detailed level of activity is presented in Appendix 15. Overall 28% or 13 of all clients we interviewed and 50% of clients who had participated in groups stated that these services had contributed to the changes they had made.

Fifty per cent of relevant community members interviewed (50%, 175 people) indicated they found groups a most useful service.

Each of the WBCs are providing on-country activities (group cultural activities, camps, health/mental health checks, outreach visits) to varying degrees and these are highly regarded by clients/community. Additionally, the WBCs offer community 'events' or support partners in these activities. Stakeholders generally believed there may be opportunity to expand on these initiatives in response to identified community need.

3.5.5 LEAD OR PARTICIPATE IN COMMUNITY WIDE CAMPAIGNS TO ADDRESS RELEVANT KEY SOCIAL ISSUES AND PROVIDE LEADERSHIP AT A COMMUNITY LEVEL IN RELATION TO RESPONDING TO RELEVANT SOCIAL ISSUES

HOI reported during earlier evaluation activity of an apparent lack of leadership and coordination at the local level for agencies to identify issues and develop strategies for particular families or community wide addressing relevant social issues. There is more recent evidence of the WBC, community's and local agencies coming together to address particular prioritised community needs (e.g. focus on youth in Hopevale, difficult to manage younger people in Aurukun, and petrol sniffing and provision of after-school and holiday activities in Mossman Gorge) and this should continue to be encouraged.

There does not appear to be any cross agency social service/primary health group that formally interacts with community leaders to oversee this process. This is something that needs to be developed within the context of each community and is further discussed in Section 3.7.5 Ultimately the role played by the WBC will vary depending on the type of issue and the community.



3.5.6 A FOCUS ON DRUG AND ALCOHOL PROBLEMS (AS WELL A WIDE RANGE OF OTHER SEWB ISSUES)

In relation to ATODS services the WBCs provide assessment, counselling, information and education, support and case management. They do not provide withdrawal management, residential rehabilitation or pharmacotherapy. Clients requiring these services and willing to participate are currently referred to an appropriate service out of community.

The diagnosed assessment issue and reason for presentation are set out in Section 3.4.2 and demonstrate that the WBCs have clients with a wide range of presenting problems including alcohol and other drugs which comprised 20% of primary diagnosis issues. In addition an examination of underlying issues for all clients since inception indicates that 53% of clients had at least one presentation where alcohol or other drugs was an underlying issue.

3.5.7 A FOCUS ON MENTAL HEALTH ISSUES (AS WELL A WIDE RANGE OF OTHER SEWB ISSUES)

The diagnosed assessment issue and reason for presentation are set out in Section 3.4.2 and demonstrate that the WBCs have clients with a wide range of presenting problems including mental health which comprised 21% of primary diagnosis issues. In addition an examination of underlying issues for all clients since inception indicates that 43% of clients had at least one presentation where mental health was an underlying issue - this is not necessarily based on a formal diagnosis but rather an underlying issue identified by the staff member at the time of that presentation.

WBCs receive referrals from general practitioners working at the health clinics. As general practitioners are not funded on the basis of developing formal mental health care plans, such plans are not completed. Rather a simple referral is made to the WBC. The WBC will undertake its own assessment and refer back to, and work with the GP as required. The shared care arrangements are not formalised. The Department of Health have advised that all clients should have been under the management of the GP care plan. Where clients are also clients of CYHHS Mental Health close working relationships are developed between front line service providers. As identified elsewhere in this report there is opportunity to strengthen the formalised relationships and operational protocols with CYHHS Mental Health.

In Aurukun most community members who are clients of CYHHS Mental Health are also clients of the Personal Helpers and Mentors program. Any support provided by staff based in Aurukun relating to these clients is attached to that program.

For mental health clients WBCs are providing clinical counselling, general counselling and psychosocial support to the client, family support, access to group activities and a drop-in facility if required. While they do not administer drugs they facilitate locating the client and monitoring the effects.

3.5.8 PRIMARY HEALTH CARE INTEGRATION

The WBCs were established to deliver an integrated, community based and culturally appropriate social health service with a focus on alcohol and other drugs, gambling, family violence, mental health and general counselling in each of the four sites. In the early years of operation the WBCs focus was on the provision of these services and as previously discussed included iterative development of the service model to best respond to community need, taking account of existing service provision and collaborating with a range of other service providers. This included working with the predominant primary health care (PHC) providers, that is, local CYHHS clinics and Apunipima.

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As the WBCs became further established, the existing relationship with local PHC service providers, an obvious client benefit, the establishment of the Single Desk Officer Trial (3.16) and feedback from funders highlighted the opportunity to collaborate further and integrate where possible non-SEWB primary health care (e.g. physical health) for the client group in line with source program funding and international best practice with the aim of enhancing client outcomes.³⁸

The WBCs have responded and enhanced the provision of PHC services by:

- Reallocating funding to support primary health care registered nurses regularly attending WBCs
- Building capacity and resilience of younger people (upper primary school and early high school)
 including disengaged youth through a range of group activities and working closely with partners
 covering areas including life skills, activities of daily living, interpersonal skills, hygiene, sexual
 health, budgeting
- As part of this process identify younger people still requiring vaccinations and for high school children conducting vaccinations
- Working with woman's community groups to provide information around issues such as diabetes, foot care, menopause mental health issues
- Building capacity of staff (particularly community development consultants) to facilitate and cofacilitate these groups and identify the need for and refer clients for physical health related issues
- Trying to conduct or refer clients for annual health checks (noting this can be challenging when clients present with issues causing a high level of psychological distress)
- Building primary health care preventative messages into the range of regular group activities
- Working closely with Apunipima and the health service/hospital at the local level. For example at Mossman Gorge: regular meetings with the clinic, housing the clinic while it was undertaking renovations, healthy eating program (12 times in 2014), men's group 6 times in 2014, healthy lifestyle prevention program 6 times in 2014). At Coen: planning for the Quit smoking program (since commenced), Apunipima GP uses WBC for women's health clinic, regular meetings with lead staff and planning around particular clients and the long running healthy eating program which has been held within the WBC; hosting the young mum's and babies group which has a focus on the physically healthy child. At Aurukun involved in men's group and positive pathways and have set up sexual health clinics and smoking cessation programmes in the WBC.

The outcome of this collaboration between the WBCs and the PHC services has been a more holistic and integrated mental, social and physical health service for the clients. Additionally, the feedback from partner agencies has been that this has been instrumental in enhancing their service delivery to community members who may not routinely attend the clinic unless they had an acute issue they wanted addressed.

It is proposed that the RFDS continue to focus effort on integrating non-SEWB primary health care into its service. The RFDS should continue to work in conjunction with Apunipima and the local clinic in WBC communities to further integrate SEWB and Non-SEWB services (in the case of Apunipima as part of that organisations strategy to embed a SEWB approach across their family and community centred primary health care model).

Whilst not suggesting the current level of integration is as developed as it could be, the experience to date in relation to the integration of SEWB and PHC services suggests that more formalised integration

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³⁸ World Health Organisation and World Organisation of Family Doctors. Integrating mental health into primary care: the global perspective. World Health Organisation, Department of Mental Health And Substance Abuse, Geneva. (2008).

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between the two service types is feasible as a future model of service delivery. The issue of integration with primary health care is further discussed in Chapter 5.

3.6 PARTNERSHIPS

This section examines partnership effectiveness and presents opportunities for strengthening partnerships.

3.6.1 PARTNERSHIP EFFECTIVENESS

The need for the WBCs to develop strong effective partnerships is identified in the service model as being essential for their effective operation. Equally, the need for effective partnerships was highlighted in the evaluation framework due to the complex nature of the range of factors that contribute to improving the SEWB of the community.

Most partners at both the local and regional level appear to have a solid understanding of the role of the WBCs with most having a good understanding and a strong collaborative relationship working in partnership to enhance outcomes for clients.

In a number of cases partners specifically mentioned that the WBC, by being in community five days per week and having appropriate expertise, was assisting their own agency to be more effective, and/or enabling them to concentrate on their core business.

Having said this there are also significant opportunities for strengthening partnerships which are discussed below.

Queensland Health (CYHHS - Mental Health) feel strongly (and RFDS agree) that there is a need to further strengthen the relationship by developing a service agreement between CYHHS and the RFDS. This will strengthen the service model by clarifying the service interface in relation to roles and responsibilities for joint client management, how information is shared and conducting joint case reviews. Aligned with this is the need for more transparency in relation to how the WBCs manage their clients. This would build on the service flowchart that has been developed.

The effectiveness of the partnership with the FRC has steadily improved over time from a relatively poor starting point due to some lack in clarity of WBC role and differing service expectation. While there have been significant improvements due to service expectations being clarified, the service model being further developed, and RFDS staff and management changes and stability, there is still opportunity to strengthen the partnership by enhancing service transparency and working more closely with the FRC at the local level. The FRC report having received limited details on the programs and their structure. In addition, in some cases they would like more information on how their clients are engaging and progressing, in addition to the agreed summary that is currently provided.

The need to strengthen relationships and provision of information at the local level has been recognised by the RFDS and the FRC. The current strategy being trialled at Aurukun includes: the development of a memorandum of understanding; providing the FRC access to the WBC client information system; the WBC staff attending FRC case conferences; provision of a regular client summary report including more feedback in relation to a client's progress and engagement issues; and using a shared data system to track client progress.

On a very positive note, the partnership between Child Safety Services and the WBCs has proven to be very successful in contributing to improved outcomes for children and families.

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Key review finding #5 Of significance, regular meetings and collaboration between child safety services and WBC staff to discuss common clients and support case management has contributed to preventing separations and/or facilitating reunifications child safety services advise have not previously been achieved. This is a very significant achievement and therefore it is proposed that any future SEWB service model should include extensive collaboration with Child Safety.

Examples of other positive partnerships are highlighted below:

- All clients interviewed where service coordination was relevant to their WBC attendances (i.e. they
 were involved with other services), believed the services were well coordinated. Where relevant,
 90% (33 clients, n=36) thought that the service providers were talking to each other while the
 remaining three clients were not sure.
- At Aurukun, Mossman Gorge and Coen, WBCs meet with the local Queensland Health (QH) or Apunipima clinic (daily/weekly/fortnightly) to discuss specific clients and relationships. At Hopevale discussion of clients occurs at officer level. There are plans to strengthen the formal relationship with the clinic at Hopevale as a result of recent management changes.
- Probation and Parole and Justice Group clients are being mandatorily referred to the WBC.
 Accordingly there is joint planning based on the individuals' conditions and the partners report
 that the WBCs are integral to supporting and ensuring clients meet their conditions. The
 partnership also facilitates discussion of barriers that may be experienced in relation to an
 individual meeting their conditions. The police also reported that they are recommending the WBC
 to community members where they consider this would be beneficial, and that 'everyone' knows
 of the WBC.
- At Mossman Gorge: with Apunipima for a nutrition project; CYP for parenting program; PCYC for children's activities; with schools regarding challenging children/families and developing homework clubs and holiday activity classes; with a range of stakeholders for fortnightly case coordination meeting for younger people; fortnightly meetings with the ATODS team leader.
- At Aurukun: with Western Cape College and others to strategise how to deal with younger difficult clients; Cape York Academy a life skills program with year seven students to help prepare them for boarding school; Cape York Academy/FRC/Police/CYP/Queensland Health –currently implementing a 10 week Intensive Youth Support Program for 14 very difficult children (5 to 12 year age range) to increase school attendance; assisting with provision of holiday activities for adolescents returning from boarding school.
- At Hopevale: working with a range of agencies to support the men's group, women's group and the parenting program; the visiting mental health service in support of a young women's group; the high school in relation to disengaged youth by providing support and activities in Hopevale; the community centre in relation to domestic and family violence services.
- At Coen: supporting early childhood services in the delivery of a young mothers group; Apunipima
 to deliver nutrition programs to both school boys and girls; and the Justice Group to support
 offenders to manage particular issues and on occasion avoid incarceration.

In a number of cases partners specifically mentioned that the WBC, by being in community five days per week and having appropriate expertise, was assisting their own agency to be more effective, and/or to enable them to concentrate on their core business.

3.6.2 KEY ELEMENTS FOR SUCCESS

Partnerships in any context are affected by a range of factors including: stage of development (developing or mature); understanding of the partner's role; expectations of the partner; the value a partner can add; priorities; and not the least personalities.

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The best successes were noted where WBC team leaders and management demonstrated both a strong commitment to develop a particular relationship, possessed good communication skills and of course had a willing partner. This is usually enhanced where the team leader/management of the WBC has been in their position for a reasonable period of time.

3.6.3 REFERRALS BETWEEN PARTNERS

One indicator of a healthy partnership is the level of formal referral from relevant organisations to the WBC. Table 3.2 sets out where WBC clients were referred from. The FRC (34%) and self-referrals (31%) have been the main original referral source for the WBC accounting for over two thirds of all referrals. We are also aware that FRC and other agencies have prompted clients to attend the WBCs of their own accord (i.e. self-refer) and hence some of the self-referrals may have originated from a partner agency but is not reflected as such in the referral data.

It should be noted that the referral source for many clients who are re-referred have not been recorded until April 2014. For example the CYHHS clinic at Aurukun advised they refer a significant numbers of clients to the WBCs on an informal basis and regular basis. These referrals will not be included in the data presented in this table as they were already recorded as WBC clients.

Table 3.2: Original referral sources

Referral Source	Aurukun	Coen	Hope Vale	Mossman Gorge	Total	Proportion %
Family Responsibilities Commission (FRC)	238	32	110	51	431	34%
	49%	16%	28%	28%		
Self	116	80	129	67	392	31%
	24%	39%	32%	37%	392	
Other	49	17	41	20	127	10%
	10%	8%	10%	11%	127	10%
Child safety	24	4	26	2	56	4%
	5%	2%	7%	1%	50	4%
Correctional Service	11	5	28	7	51	4%
	2%	2%	7%	4%		
Family member/friend	8	7	29	11	55	4%
	2%	3%	7%	6%		
Hospital	21	14	10	3	48	4%
	4%	7%	3%	2%		
Mental health care service	11	14	10	2	27	20/
	2%	7%	3%	1%	37	3%
Alcohol and other drug treatment service	5	10	5	1	21	2%
	1%	5%	1%	1%		
Police, diversion, community justice	6	12	6	3	27	20/
	1%	2%	1%	1%	27	2%
Apunipima				15	15	1%
				8%	15	
Medical practitioner	1	9	4		14	1%
	0%	4%	1%	0%		
Grand Total	490	204	398	182	1274	100%

Note (1): Data in table relates to the number of clients since inception to 31 March 2014.

Note (2): Includes clients with status never attended and refused services.

Note (3) Data reflects original referral source. Clients can shift from being, for example, FRC referred to self-referred and this is not reflected in the data above...



As noted above, formal referrals to the WBC have predominantly come from the FRC. This is to be expected given the WBCs were in part established to support community people facing difficulties who have come to the attention of the FRC. Figure 3.8 presents the number of referrals by quarter from the FRC based on FRC reports. Overall the number of FRC referrals has decreased since the 12 months to March 2010 period, but increased since the December 12 quarter. This increase is attributed to the FRC having an increased confidence in the WBC service during this period rather than increased need. It is understood from the FRC that where possible they aim to encourage clients to attend the WBC voluntarily, rather than being mandatorily referred. This also reflects the views of the FRC that we have noted both from direct consultation and their reporting) that the WBCs have been an important referral source for the FRC (albeit not without some difficulties at times as discussed in this report) and in that respect continuation of the FRC would need to take account of the SEWB services that would be available into the future for their clients under any revision to the existing model.

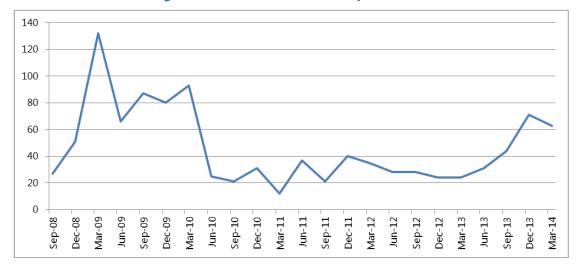


Figure 3.8: FRC referrals to WBC per the FRC

Note (1): Source- FRC quarterly reports.

3.7 COMMUNITY ENGAGEMENT

This section examines whether the WBCs are effectively engaging the community and opportunities for enhancement. It analyses the key strategies and approaches used to engage the community and assesses the extent of community engagement.

3.7.1 STRATEGIES AND APPROACHES USED TO ENGAGE THE COMMUNITY

This sub-section sets out and analyses the effectiveness of the key strategies and approaches used to engage the community which are:

- The employment of local staff as community development consultants
- The provision of appropriate programs and services
- Effective communication and relationship building with key partners and groups in the community such as mayors, counsellors, family representatives and the leaders of community led groups and organisations
- The establishment of Local Advisory Groups (LAGs).

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3.7.2 STAFFING

LOCAL STAFF

Local Indigenous staff employed as community development consultant's (CDCs) amounted to 7 FTE (23% of the FTE) as at 31 December 2013. Their primary purpose is to facilitate appropriate community engagement through: Being a credible local person; Vouching for the credibility of non-local staff and the service in the community; Assisting in orienting new staff to the cultural expectations of that specific community; Assisting other team members with relevant and appropriate information concerning the community members and clients, and Facilitating or supporting the delivery of the range of WBC programs.

They also have opportunity for ongoing professional advancement, thus in the longer term potentially contributing to service sustainability and increasing the number of professional SEWB workers. Their employment also demonstrates a commitment by funders to the importance of local employment and to some degree self-determination and community control.

Based on interviews with management and staff, feedback from partners in the evaluation has found that CDCs have largely fulfilled their role as outlined above. However, as has been recognised it is now time that they take a more active and central role in facilitating and delivering relevant programs or parts of programs which some CDCs now do.

In summary local staff have fulfilled their role and strengthened community engagement. They are an important component of the WBC model however as has been recognised they now need to take a more active role in appropriate front line service delivery. This is discussed in more detail Section 3.10.

NON-LOCAL STAFF

It is self-evident to propose that a community will only engage with a service where they have trust in and have developed a relationship with local and non-local staff. For the WBCs this means that non-local staff have to be culturally competent, demonstrate a willingness to participate in community 'events', be approachable and flexible (within the parameters of the program) and of course give the client confidence of their technical skills (counselling, advocacy, community programs).

It is our experience from working in and with communities, that community members will make a judgement about a visiting professional's interest in their job and the benefits arising and whether this includes a commitment to the community. Understandably this influences the level of engagement with the service.

The evaluation has concluded that the RFDS is demonstrating a strong commitment in implementing strategies that aim to recruit the right staff for the role on offer and adequately supporting them and developing their skills and that the service model and service approach is culturally appropriate and sensitive to Aboriginal needs.

However, it is worth noting here from feedback provided and our observations while in the WBCs, that staff are highly regarded and hence the community has engaged. It is also noted that for new staff it takes time to develop trust and rapport with clients and the community and this is understood by the RFDS. A number of staff extend themselves beyond the 'expected role' to participate in the community.

Further to this, the extent to which non-local staff engage with, and are seen as being part of, the community, influences community members and partners definition of a fly in/fly out (FIFO) service. Feedback was that the service wasn't considered FIFO. This definition tends to be associated with services that visited for 1-2 days, once a month. WBCs are generally considered to be non-FIFO.

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The above commentary is not to say that there wasn't a view that the preference of some stakeholders was for non-local staff to reside in community or be in attendance 5 days a week, more so it was acknowledgement that it was considered to be a full 5-day a week service.

In summary the WBC is recruiting non local staff that are able to, and have, effectively engaged the community. They are also providing an appropriate framework for this to occur.

3.7.3 APPROPRIATE PROGRAMS AND SERVICES

A community will only engage with a service if it provides a range of programs or services that are of relevance to that community. The range of individual services clinical and general counselling services and group activities are highlighted in Section 3.5.

The key aspects of the program and services that have caused community members to engage include:

- WBCs are established as a welcoming and culturally safe place where people can come and simply have a cup of tea and a chat
- Being a safe place where people can obtain refuge from stressful or violent situations
- Tailoring activities and groups to community (and cultural) needs consulting with lags, Women's groups and Men's groups regarding their needs and program preferences
- Offering a range of programs (e.g. Alcohol and other drugs, relationships, family violence, mental health) in a variety of settings (e.g. WBC, in-home, in other agencies, community based groups, on-country)
- Partnering with other service providers.

The importance of offering culturally appropriate programs and services that will engage the community cannot be overstated.

In summary programs and services are offered in a way that are effective in engaging the community.

3.7.4 COMMUNITY RELATIONSHIPS

It was evident from our observations and feedback through the consultation process that WBC staff are generally committed to communicating and building relationships with key community personnel and groups to ensure effective community engagement. This is not only with partners (discussed in Section 0) but also with key community people such as mayors, counsellors, family representatives and the leaders of community led groups and organisations.

It is important that these key community people are engaged effectively when the WBC and other agencies are working together to address particular prioritised community needs. As reported in Section 3.7.5 there does not appear to be any cross agency social service/primary health group that formally interacts with community leaders to oversee this process. This is something that needs to be developed within the context of each community. Ultimately the role played by the WBC will vary depending on the type of issue and the community.

3.7.5 LOCAL ADVISORY GROUPS AND COMMUNITY INPUT

This sub-section examines the Local Advisory Groups (LAGs) which were established as the key 'formal mechanism' for community engagement. Key evaluation questions in relation to the LAGs include:

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- Is the LAG effectively contributing to WBC service delivery?
- Are suitable LAG members appointed?
- Is the LAG strengthening its role and taking on additional duties over time?

It also discusses the issue of transition to community control and how best to proceed with obtaining effective community input.

OPERATION OF THE LAGS

LAGs were established to be a key voice in and for the community, to provide a local perspective into community needs and priorities and potentially assist with transition to community control.

The RFDS has devoted significant resources to supporting the operation of the LAGS, with the project officer(s) based in Cairns. For the three years ended June 2014 there was one LAG project officer except for a six month period where there were two project officers. The cost of these staff over that period was approximately \$250,000. In addition there are significant travel related costs, for example in the previous 12 months there were 6 trips to Aurukun, 12 trips to Coen, 12 trips to Hopevale and 36 trips to Mossman Gorge.

The principal role for LAGs to date have included: having input into the content of annual action plans; developing LAG action plans; providing feedback on services delivered: interviewing preferred candidates for WBC positions; and providing a local perspective into community needs and priorities. The LAG roles are articulated in their terms of reference.

There is some cross membership between LAGs, Apunipima Health Action Teams (HATs) and in at least one instance an FRC Commissioner. This cross membership, where it exists, is reported to have assisted in improving communication and coordination.

The extent to which the LAGs have been effective has been influenced by a range of factors that include: the capacity of people recruited; gender imbalance (mostly females); local clan/family issues; the level of attendance of some members; the frequency of meetings; the amount of sorry business; the level of community violence that can occur from time to time; the ability of the team leader to link in with the LAG; the voluntary nature of the positions; the fact that the key support positions have been based in Cairns; and the fact that the LAG role is advisory.

The effectiveness of the LAGs has differed between communities and varied over time within communities, largely determined by one or more of the above factors. We reported previously and it is still the case that based on stakeholder feedback and our observations during community visits, HOI considers that LAGs are struggling to fulfil their role. Having said this, we consider that they are currently more functional at Mossman Gorge and Hopevale.

Team leaders have been questioning the value of the LAGs as a conduit to the community for some time (because meetings can be infrequent and attendance is generally poor). They have found it more beneficial to seek feedback from say men's and women's groups and community leaders with whom they have been able to develop a relationship.

The RFDS developed and tried to implement a new community engagement strategy which included establishing a Community Reference Network with membership from local LAGs and key regional stakeholders. Whilst there was one meeting, implementation of the strategy proved problematic and it was not continued with.

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In summary the LAGS have only been partially effective and in some cases ineffective in providing a structure for formal community input. The LAGs are not currently in a position to be a vehicle for management responsibility and ultimate community control.

Notwithstanding considerable effort and resources, capacity building efforts have not been effective to date in underpinning a longer term intention of community control. The issue of community control is discussed further in Section 5.2.2.

Strengthening formal community input is discussed below.

FORMAL COMMUNITY INPUT

Through the evaluation it has been noted that:

- There tends to be no structured approach for formal multiple agency input in addressing community issues in the social services/primary health care area (interagency meetings include a large number of agencies and they are not designed to identify relevant issues, design appropriate responses and monitor the result at the level of detail required)
- Multiple agencies need an effective vehicle for community input
- Informal input through clients and team leader/manager relationships with community members, while invaluable, is not sufficient
- Mechanisms set up by other organisations to obtain 'more formal' community input where they
 exist tend be struggling e.g. HATS
- There are a limited number of people in the community with the skills, time and interest to participate
- Paid participation is likely to attract higher quality input and more commitment (e.g. FRC Commissioners)
- The model for successful structured community input is likely to be different in each community.

In light of the above **it is proposed** that a joint agency/community approach to obtaining more structured community input into social services/primary health care that is unique to each community be established.

It is proposed that the interagency meetings in each community be the vehicle for 'kick-starting' this process. In establishing a joint approach the following principles should apply:

- Community members should be paid appropriately for their participation
- Membership should be clear and determined locally
- The chairman of the group should be determined locally but joint chairs (one agency, one community member) would be ideal.
- The role of the group should focus on:
 - needs identification
 - developing appropriate responses
 - monitoring results
 - providing feedback on service performance.
- The group should have a clear (funded) support structure

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- The group should have clear reporting and accountability lines
- Meetings should not be too frequent, for example bimonthly initially then quarterly
- Funders will need to accept that this approach is suitable in the context of governance requirements for specific programs.

3.7.6 THE EXTENT OF COMMUNITY ENGAGEMENT

Ultimately, the real test of the effectiveness of the community engagement strategies and approaches is the extent to which community members are aware of and use the service and are satisfied with the service received. This sub-section presents data and analysis on service utilisation and who is using and not using the WBC.

Forty eight per cent (average) of all community members have been a client of the WBC and 57% of the adult community. In the year ended 30 June 2013, 24% of the entire community were clients of the WBCs and this will increase in the 2013/14 year based on data to March 2014. There have been substantial increases in the number of clients on a per annum basis in all communities since inception and at Mossman Gorge and Aurukun the number of clients in the current year (2013/14) has already exceeded all prior years with the introduction of new management in both WBCs. This indicates a good level of community engagement. Appendix 17 presents more detailed information.

In terms of ongoing client engagement, there were eight contacts per client in 2012/13 for all clients and 7.2 for FRC clients. Since inception 48% of all clients have had a total of 1 to 10 contacts to date (29% for FRC clients) and 44% of all clients had between 11 and 50 contacts (57% for FRC). This indicates a significant number of clients are engaged to at least a reasonable extent.

WHO IS USING THE WBC

The number of female and male clients is broadly reflective of the broader population and while the number of clients aged between 19 and 25 years is consistent with the community age profile, clients aged 0 to 18 years are underrepresented (refer to Appendix 17 for additional information). The need to engage younger people has been raised previously in multiple forums and the WBCs have made significant effort in this regard with the particular focus being group related activity. While this increase in activity will not be directly reflected in individual client numbers as group participants are not necessarily recorded as clients, there will be some impact on the historical underrepresentation of younger people as WBC clients.

One key measure of how the community view the WBC is whether it is being used, by whom and how that changes over time and in particular the level of self-referrals. Since inception 29% of initial referrals have been-self referred and 4% referred by family or friends. While there has been a steady increase in the number of self-referrals by quarter, this has been driven by Aurukun. At Hopevale, Coen and Mossman Gorge the new referral trend is relatively static with significant quarterly fluctuations. Note that this trend is likely to be understated as the system does not take account of where a referral changes from say a mandatory referral to self-referral. This has been addressed by the recent information system upgrade. Detailed self-referral data is presented at Appendix 17.

In summary the WBC is engaging a reasonable representation of the community based on age and sex, particularly when taking account of their recent focus on, and initiatives for younger people.

3.7.7 COMMUNITY PERCEPTION AND UNDERSTANDING OF WBCs

Community perception of the WBC is a key indicator for the effectiveness of community engagement by the WBC.

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Overall, 91% of community members (319 people, n=351) considered the WBC to be for 'all people' not just those that were 'mental' or 'bad'. Eighty five percent (including the small number who had never attended) believe or understand the WBC to be 'welcoming' and 'helpful'.

The level of community understanding of the WBC role and function is another key indicator of successful community engagement.

Figure 3.9 presents the extent to which the community understands the role and function of the WBC. This is based on how community members responded when asked what they understood the WBC does. Fifty nine per cent provided a clear and correct interpretation of the WBC role with some variation between WBCs (63% at Hopevale, 66% at Mossman Gorge, 49% at Aurukun and 74% at Coen) and 30% provided a description that was 'roughly okay. Only 11% of community members (38 people, n=351) could not at least broadly describe the role of the WBC. This was consistent across WBCs except at Coen where 100% of respondents could describe the role of the WBC.

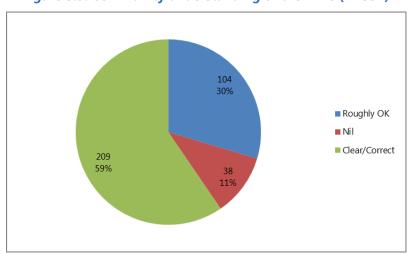


Figure 3.9: Community understanding of the WBC (n=351)

Most but not all partners felt that the WBC was effectively engaging the community. The FRC has reported that in their view some difficult to engage clients are not being sufficiently pursued by the WBC to encourage their engagement. They believe that the WBC should make persistent effort and be more proactive over time to help engage the client, using whatever approach works for that particular client.

In summary community members appear to have a reasonable or good understanding of what the WBC does and they believe the WBC is 'welcoming' and 'helpful.

3.8 CULTURAL APPROPRIATENESS AND SENSITIVITY

Common themes for effective cultural adaptation of services have been identified as:

- "Therapists must practice flexibly
- Services must be meaningful within the cultural context that they are delivered
- Assessments should be conducted prior to implementing treatment
- Therapists must remain open to what clients bring to therapy
- Traditional treatments should not be dismissed rather used as existing resources
- Therapists must communicate empathy with clients in a culturally appropriate manner



Therapists should not interpret cultural differences as deficits".

The service model and the approach adopted by WBC staff is very reflective of providing a culturally appropriate and sensitive service in line with the above principles. It fully recognises the challenges facing Aboriginal people and the importance of community input and control and self-determination. The RFDS places a high priority on cultural capability demonstrated by the RFDS Queensland Cultural Capability Framework and the Aboriginal and Torres Strait Islander Employment Strategy which were launched in June/July 2013.

Cultural capability training for staff has three layers, namely online introductory training, face-to-face training (tailored for more depth and practical application), and in community orientation and support. When the internal project officer position is vacant external support is obtained.

Local staff are employed and well supported (refer to Section 3.10).

In response to the client question, 'Have staff working with you understood and been able to respond to your Aboriginal culture?' 81% of clients we interviewed agreed that the WBC staff did understand and respond to their Aboriginal culture a lot. Only five clients thought the WBC only responded a little and no one thought it did not respond at all. This is illustrated in Figure 3.10 below.

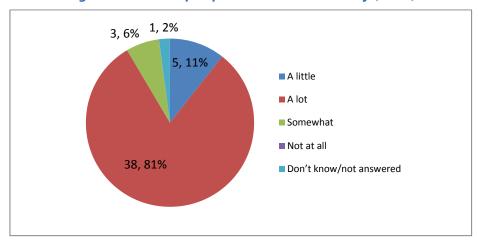


Figure 3.10: Client perspective on cultural safety (n=47)

While some community members interviewed identified the need for more on country and cultural activities to be conducted, very few people indicated that services were not been provided in a culturally respectful manner.

While not the best group to make this judgement, most staff (13 staff or 93% of survey respondents, n=14) believe the service model is culturally appropriate and sensitive and most (12 staff, or 86% of survey respondents, n=14) also believe that services are being provided in way that is culturally appropriate.

Based on our observations of the practices and approaches we noted during community visits HOI considers the service model is culturally appropriate and sensitive and that services are offered and provided in way that is culturally appropriate.

In conclusion the service model and service approach is culturally appropriate and sensitive to Aboriginal needs but there is a need to continue to develop on country and cultural activities.

³⁹ Smith TB et al. Culture. Journal of Clinical Psychology: In Session 2011; 67(2):166-175 2011.



3.9 FLEXIBILITY AND RESPONSIVENESS

Key elements for ensuring flexibility and responsiveness include obtaining input from the LAG and other groups, and working closely with partners to respond to particular issues at client or the community level.

Partners reported the WBC model and approach as being flexible and responsive as required with the exception being the FRC. The strategy to strengthen the partnership with the FRC is presented in Section 0.

Most staff (13 staff or 93% of survey respondents, n=22) believe the service model is flexible and responsive to community needs and partners agreed.

At Mossman Gorge concerns were expressed by partners early in the evaluation that the WBC was not as flexible and responsive to community need as it should be. In response the RFDS restructured the management arrangements and partners now report (and HOI observed) that the WBC is flexible and responsive to community need.

It is our conclusion that the service model and approach is flexible and responsive to the in the context of a documented service model.

3.10 STAFFING (INCLUDING CAPACITY BUILDING)

This section analyses the staff structure and success of capacity building with local staff.

3.10.1 STAFF STRUCTURE

Staffing by category for the WBCs is set out in Table 3.3. Eighty three per cent of staff are based in community, approximately 39% of staff are Indigenous (12.8 FTE) with the majority of these (7) being CDCs. The majority of the CDCs are female (71%). There was one indigenous clinical counsellor and two Indigenous community counsellors and development officers.

Table 3.3: WBC's staff by category ¹

Staff category	Total FTE	Filled FTE	Vacant FTE (excl. casual)	% of Total FTE
Cairns-based Manager/Clinician	1	1	0	3%
Cairns-based Staff Support	5	5	0	17%
Team Leader	4	4	0	14%
Clinical Counsellor	12	9	3	31%
Community Counsellor and Development Officer	3	3	0	10%
Community Development Consultant	7	6.6	0.4	23%
Community-based Administration Officer	0	0	0	0%
Total	32	28.6	3.4	100%

Note (1): As at 31 December 2013 per WBC Activity Report July to December 2013. Excludes casual cleaners.

Based on the requirements of the service agreement and in the context of the provision of a SEWB service the WBC staff structure is sound and suited to the delivery of WBC services. No concerns were raised by the RFDS, partners, clients or community members with respect to the structural aspects of

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staffing. The mix of males and females is reasonable and there has been focus on the need for, and recruiting of, Indigenous staff wherever possible. The small number of Indigenous clinical staff members is a factor of availability and remote location and not the structure or culture of the WBC itself.

Local Indigenous staff were reported as providing an invaluable role in ensuring close links with and knowledge of community in respect of both day-to-day issues and cultural aspects and sensitivities in the community. They enhance the ability of clinical staff to be effective.

Approximately 52% of time of staff based in community is spent on one-to-one therapy and support, 20% on associated clinical support activities and 28% on group activities. While there is no specific benchmark this would appear reasonable in the context of the WBC service model.

Staff are clear about their broad role, function and scope of practice but this needs to be reinforced in the context of the service model. Consistent with previous findings staff were confident in providing the relevant WBC services and felt they had the skills and experience and appropriate qualifications to provide those services.

RFDS have made a substantial commitment and investment in the training and development of all staff. This is highly valued by staff. Overall staff are supported, skilled and developed to address the ongoing requirements of the WBC service model.

The Queensland Aboriginal and Islander Health Council (QAIHC) has responsibility for rolling out the national SEWB workforce strategy in far North Queensland including identification of training needs and facilitation of appropriate training strategies. Engagement with the RFDS has been problematic to date as the infrastructure and activity of the RFDS has allowed the RFDS to develop the workforce without the assistance of QAIHC. Indeed, the workforce development carried out by the RFDS has been substantial. However, ongoing dialogue is now occurring between the RFDS and QAIHC and it is anticipated that this will result in more collaborative approaches to workforce development.

3.10.2 CAPACITY BUILDING OF LOCAL STAFF

Local Indigenous staff who are employed as CDCs comprised 7 FTE (23% of the FTE) as at 31 December 2013. Their primary purpose is to facilitate appropriate community engagement through:

- Being a credible local person
- Vouching for the credibility of non-local staff and the service in the community
- Assisting in orienting new staff to the cultural expectations of that specific community
- Assisting other team members with relevant and appropriate information concerning the community members and clients
- Facilitating or supporting the delivery of the range of WBC programs.

The need to enhance local staff to become more proactive and lead community development and some group activities, undertake some more formal counselling and participate in planned health checks has been recognised by the RFDS and there is evidence that this is being achieved particularly in Coen, Hopevale, and Mossman Gorge where there is more long standing local staff and greater readiness for further responsibility.

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Partly in recognition of this, CDCs have been trained to facilitate Aboriginal Mental Health First Aid (AMHFA) and are expected to facilitate up to three community based courses per annum depending on demand, capacity and time. ⁴⁰ To date 10 CDCs have undertaken this training and of these, three have commenced facilitating courses as the lead trainer and three have participated in running courses. Table 3.4 highlights additional information regarding indigenous staff activity in the July to December 2013 period.

Table 3.4: Indigenous staff activity

Item	Number
Number of workshops/programmes lead by indigenous staff	161 (3 Aurukun, 95 Coen, 25 hope Vale, 38 Mossman Gorge)
Number of workshops programs co-facilitated by indigenous staff	102 (4 Aurukun, 48 Coen, 33 Hopevale, 17 Mossman Gorge)
Community worker diploma attained or enrolled	5 FTEs CDCs out of 7 FTE
Number of CDCs who have undertaken AMHFA training and facilitated the program	10 undertaken training
	3 commenced facilitating
	3 assistant facilitators

Note (1): Source Cape York WBC's Six Monthly Report July – December 2013).

Based on interviews with management and staff and feedback from partners, HOI consider that CDCs have largely fulfilled their role as outlined above. However, as has been recognised it is important they take a more active and central role in facilitating and delivering relevant programs or parts of programs. In addition in some cases there is capacity for staff to assume leadership roles.

RFDS management have reported the employment and capacity development of local indigenous staff, who in some cases are now excellent role models for other community members, has been a key success for the WBCs. This will be further enhanced as they move to adopt a leadership role as per discussion in Chapter 5.

Key support strategies for local staff include:

- Team leader identifies and arranges support for local staff
- Flexibility (for cultural purposes) in interpreting HR policies and procedures in relation to local staff although this can create potential and/or real tensions with more formal HR policies
- RFDS employ senior Indigenous staff who are available to provide support, as local workers are not likely to use the employee assistance scheme
- Commitment to staff development
- Development of the Strength Within Program (run in its various forms since 2006), a SEWB workforce development program which both provides a formal qualification (currently a Certificate IV in Mental Health and in Community Services Work) and excellent support and mentoring

⁴⁰ RFDS Capacity Building and Workforce Development. Project Four. DoHA Six Monthly Report January – June 2013.

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- Development of a capacity building and workforce development activity plan to provide ongoing assistance and opportunities to further study and develop career options
- CDCs have also completed three training blocks focused on community groups and forums, client case management and the applied suicide intervention skills training program (Assist), in addition to Mental Health First Aid Training
- Development and support to assist and support other health professionals in the delivery of a holistic primary health care
- Some team leaders have allocated one of the clinical staff to informally support/mentor a local staff member on an ongoing basis
- Support from other local staff across the WBC network (e.g. at annual RFDS indigenous staff workshop). The next workshop is due to be held in 2014.

From a structural perspective there is a pathway and support available for local staff to develop their career provided they have the capacity to enhance their qualifications. To date no one has taken this option which is consistent with the general experience elsewhere.

3.11 SYSTEMS AND PROCESSES

This section briefly examines whether the key systems and processes of financial management, quality and promotional materials are supporting the delivery of effective WBC services.

3.11.1 FINANCIAL MANAGEMENT

The WBC budget is managed globally from RFDS Cairns Base which allows strategic reallocations to occur as required in line with prioritised need and in the context of the overall budget. Within that global budget management there are local delegations at WBC team leader level. The RFDS maintains a structured approach to expenditure approvals within the context of their risk management system. The RFDS strengthened its overall budgeting during 2012/13.

There was a surplus of 3% of available funds in 2012/13 which is a significant improvement on earlier years (i.e. previous years had significantly larger surpluses) except for 2011/12.

Overall the system of financial management supports effective operation of the WBCs within the context of the RFDS risk management approach.

3.11.2 QUALITY

The majority of staff (8 staff, or 71% of survey respondents, n=14) believe the WBCs have an effective approach to quality improvement (only one staff member disagreed) and this was an improvement from earlier in the evaluation.

The WBC model of care highlights the importance of culturally appropriate quality improvement activities to inform effective future service delivery. Previously a key structural component of quality improvement were the actual or proposed six monthly WBC team quality improvements workshops that 'provided the teams with the opportunity to reflect on achievements to date and identify areas for improvements'. These workshops were not continued and the focus for quality improvement is around clinical governance and the ongoing development and implementation of activity plans.

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At a more strategic level the RFDS has been committed to improving quality. Examples include strengthening of the model of care, upgrading the client information system, and developing a more rigorous approach to client assessment. The RFDS is International Organisation for Standardisation (ISO) 9001 Quality Management Systems accredited, which is used by DoH for contractual requirements.

From the perspective of the WBC there is evidence that the RFDS has a commitment to effective quality improvement. However we believe there is opportunity to strengthen quality particularly building on information to be generated from the recently upgraded client information system. For example there would be significant merit in analysing which clinician is using particular therapeutic approaches and establishing discussion groups to analyse experiences and results achieved with particular therapies and approaches.

It is proposed that the WBC establish therapeutic discussion groups to analyse and discuss experiences and results achieved with particular therapies and approaches.

3.11.3 PROMOTIONAL MATERIALS

There are a wide range of promotional materials that are used by the WBCs. Some of these materials are generic health focused material developed and distributed by relevant organisations, for example, *beyondblue*. Some have been specifically developed for use in Indigenous communities and others developed by the WBCs themselves.

In addition the RFDS commenced circulating newsletters late in 2012 and currently they are being issued bimonthly. A number of key partners reported not being aware of the newsletter and the WBC should circulate the newsletter more widely.

While almost all staff survey respondents believe partners and clients were provided with appropriate educational and advertising materials, feedback received during site visits suggested that specific materials promoting the WBC service would be highly regarded by partners.

For the duration of this program there has been a lack of regular communication with stakeholders and community through newsletters, the internet and other means. Considerable resources were provided for the LAGs to produce community plans but these were never really utilised in the context of communication with the community.

It is proposed that the WBC develop specific materials promoting the WBC service. This could be done after the service model is updated.

3.11.4 DATA SYSTEMS

The WBCs utilise an information system developed in-house (YOTEM). The data set incorporated the National Drug and Alcohol Minimum Data Set requirements. The system was established and fully implemented prior to the commencement of the evaluation but was not in place from the inception of the program and correspondingly a full and comprehensive data set is not available. Determining what the outcome measures would be for the program was also not established from the outset and hence a comprehensive set of outcomes data is not available. However, the data that is available has been used to inform progress reporting to the Department and the evaluation.

The RFDS progressively recognised deficiencies in the system, both in capturing information required for service and outcome analysis, but also in supporting clinicians implementing effective work practices. Funding was approved in the 2013 financial year (~\$75,000) to upgrade YOTEM as part of

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the Single Desk Officer Trial utilising savings across a number of programs. Funding was also approved (approximately \$170,000) to purchase and upgrade MMeX to capture client level outcome data.

Enhancements to YOTEM included adaptability of the system to a wide range of 'Smart' devices, expansion of the data that is collected, a range of tools designed specifically for the workflow of clinicians in remote settings and a further range of tools to enhance clinical governance. These enhancements took effect from April 2014. Any additional data was not available to the evaluation. However the changes will allow the RFDS to undertake more detailed analysis and present a complete picture of activity in future periods.

Whilst early signs are that the YOTEM enhancements are adding value, the MMeX system has been costly for limited benefit. It is understood the RFDS is planning to move outcome data capture to YOTEM.

General data collection has improved over time. As is common in many services, data quality improves the more it is seen to be utilised for both management and clinical purposes and this has been the case for the WBCs. As reported elsewhere, drop-in activity has not been effectively captured and this should change with the YOTEM enhancements and indeed is critical to ongoing monitoring and evaluation of the service.

3.12 INFRASTRUCTURE

Over the course of the project, a total of \$7.3 million was allocated for building, staff housing and associated establishment costs.

A purpose built WBC was constructed in each of the four communities. They comprise of a reception area (which can get very crowded), an open area for staff offices (which can be very busy and noisy), counselling rooms, a larger meeting room, a small kitchen, a covered outside 'meeting area' which is used frequently by community members, and a relatively large amenities area.

In addition, staff housing was constructed (four staff houses in Aurukun, with a total of nine bedrooms, three staff houses in Coen with a total of seven bedrooms and three staff houses in Hope Vale, with seven bedrooms.

The WBCs are located adjacent to the health clinics/hospitals and in the general vicinity of other government services except at Hopevale. They are embedded into the community infrastructure.

The WBC buildings have a 'clinical layout and feel about them', WBCs have tried to ensure the buildings are functionally utilised and have tried to make the centres welcoming and practical (e.g. local names, musicians playing on the veranda) within the constraints of the actual buildings. This was confirmed in community consultations.

The building does not incorporate an effective purpose built space for client and community drop-in which is a key part of the service model.

It is proposed that any new SEWB including a drop-in component, incorporate an effective design that enhances client flow and the service experience.



3.13 SERVICE AVAILABILITY

In discussing the issue of service availability the context for the WBCs needs to be considered. In 'hand out to hand up', WBCs were envisaged as being community run village hubs designed to address the key support needs (e.g. mental health, alcohol and other drugs counselling) seen as essential for rebuilding social norms. They were not seen as comprehensive 24/7 services. Indeed the CYWR Trial was trying to avoid further dependence on additional services or establishing passive service delivery.

In reviewing service availability, key elements are seen to include opening times, a capacity for some appropriate level of after-hours response/service and staff availability.

The WBCs are primarily a weekday service 9am to 5pm (4.30 at Mossman Gorge) with no structured after hours emergency response. The intention of the service model is that emergency responses will be addressed by local health clinics. As above, there is also the concern that the more services are offered, the more the risk of dependency on the staff and service. That is, WBC programs should be building capacity and not have clients seeking assistance on every occasion an issue arises.

Non-local staff in the communities (excluding Mossman Gorge) are generally working flexible working hours (3 days x 9.5 hours in community, one day in base, and one day off) which provides essential flexibility while in community. This allows for example, after-hours activities to be undertaken (e.g. groups) and 'quiet time' for clinical notes. RFDS staff and key Queensland Health staff also strongly believe this is contributing to longevity of staff in their roles and reducing potential 'burnout'. Some staff members who have been in their roles for two or more years are clear that this flexibility will enhance the likelihood of them remaining in this role for a more extended period of time.

Throughout the consultation process with clients and community members, none interviewed identified lack of service availability as being an issue.

Partners generally reported no issues with service availability except that one or two partners thought there should be an emergency response after hours and that on occasions the centres had been closed at critical times when needed by the community, for example during a funeral or when there were significant periods of unrest. Further investigation revealed that these were isolated and/or explainable incidents or associated with safety and risk management.

In conclusion, service availability is appropriate to the intended role and function of the WBCs and is not any different to the majority of ambulatory mental health and drug and alcohol services found across Australia.

3.14 FUNDING AND COSTS

Since inception in July 2008 to June 2014 a total of \$24.6 million has been made available to operate the WBCs with \$7.3 million provided for capital works.

Table 3.5 presents funding sources for the operation of the WBCs for the period we were able to source data. Funds have come from multiple programs and organisations with the Australian Government funding 78% and Queensland Government 22%. Since July 2012 funding has been managed under the single desk officer trial (refer Section 3.16). As illustrated a significant proportion of funds were mental health and drug and alcohol program funding.



Table 3.5: Funding sources 2012/13 to 2013/14

Source	Program	2012/13	2013/14	Total	%
		\$	\$	\$	
Department of Health	Aboriginal Torres Strait Islander Health - Substance Abuse	1,253,453	1,274,761	2,528,214	25%
Department of Health	NGOTGP	1,674,750	1,674,750	3,349,500	33%
Department of Health	Mental Health Services in Rural and Remote Areas - Stage Two	714,385	723,500	1,437,885	14%
Queensland Health	Alcohol Reform Contribution	1,102,280	1,102,280	2,204,560	22%
Medicare Local	Rural Primary Health Services (Hopevale)	92,441	92,441	184,882	2%
FaHCSIA/Department Social Services/ Department of Health	Cape York Welfare Reform CDEP replacement measure/Indigenous Employment Initiative	182,562	163,583	346,145	3%
Total		5,019,871	5,031,315	10,051,186	100%

Note (1): Figures unaudited.

Table 3.6 presents an estimate of unit costs of the WBC from a number of perspectives based on 2012/13 costs and recorded activity and estimates for 2013/14. The indicative cost per contact in 2013/14 was \$516 and the cost per face to face contact was \$796. The cost per group participant was \$116 per participant. The indicative cost per client for individual services was \$4,745 and the cost per community member was \$1,708. 2013/14 unit cost estimates are less than 2012/13 due to increases in activity. There is no comparative data available, although based on this data the cost of the service is very resource intensive.

Table 3.6: WBC operating costs and unit costs

Item	2012/13 actual	2013/14 estimate
Total cost of WBC ³	\$5,089,087	\$4,812,000
Share 1:1 and clinical support services	71%	71%
Share for group activities/events	29%	29%
Total cost individual services ⁴	\$3,613,252	\$3,416,520
Total cost group related activities/events ⁴	\$1,475,835	\$1,395,480
Cost per contact	\$669	\$516
Cost per face to face contact	\$1,079	\$796
Cost per group participant	\$367	\$116
Cost per client (individual services)	\$5,353	\$4,745
Cost per community member ⁵	\$1,806	\$1,708

Note (1): Relevant information is not available to allow unit costs to be calculated for previous years.

Note (2): In 2012/13 the number of participants and groups/events has been estimated by doubling the number of participants for the January to June 2013 period.

Note (3): Costs represent the 2012/13 audited expenditure figures.

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Note (4): Total costs associated with individual 1:1 services and group related activities/event are estimated based on an apportionment of time of WBCs staff who are based in community. These apportionments are estimates only. Accordingly unit costs should be considered indicative only.

Note (5): Cost per community member is based on the 2011 ABS census population numbers.

Note (6): Unit costs will be overstated as they exclude uncaptured activity.

Note (7): 2013/14 figures are estimated based on six months data to December 2013.

Figure 3.11 presents the expenditure by cost category for the period July 2008 to June 2013. There is no benchmark data available to undertake a comparison at this level. Clearly the fly in fly out model of staff is costly and fixed wing aircraft cost recovery accounts for approximately 11% of total expenditure.

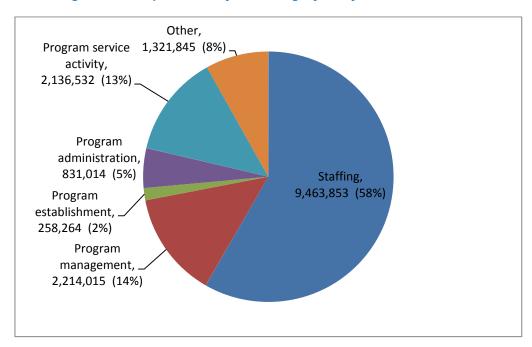


Figure 3.11: Expenditure by cost category - July 2008 to June 2013

Note (1): **Program administration** incorporates insurances, computing expenses, printing and stationery, telecommunications communications costs and utilities.

Program service activity incorporates air-wing cost recovery charges (~75%), vehicle related costs, lease payments and specific program activity.

Other incorporates cleaning, rent, repairs and maintenance, airfares and accommodation and meals allowance for duty travel and airfares and food allowances associated with training.

3.15 Service access and profile comparison

This section considers the question, has the service model resulted in better access to services than in other comparable communities and how does the service profile and service approach compare. A more detailed analysis is presented in Appendix 16.

Based on analysis undertaken in relation to available activity and staffing information service, access is greatly enhanced in WBC communities. Specifically the:

• Population per FTE for WBC communities (ranging from 74 at Coen to 196 at Aurukun) is much greater than non WBC communities (ranging from 238 at Laura to 644 at Kowanyama. That is there are more staff available to service the community

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- Following on from the previous point, the percentage of population that is a client of the RFDS operated WBC or SEWB service is significantly greater in the WBC communities (20% at Aurukun to 34% at Coen) compared to other communities (ranging from 2% at Napranum to 7% at Kowanyama)
- The number of contacts per client per annum is greater in WBC communities than in other communities receiving SEWB services
- The WBCs are a five day a week service with service staff and local community development
 consultants whose sole focus is the clients and people of that community. The WBC has a clear
 mandate and resourcing to provide programs/campaigns at the individual, group and community
 level and they are fully embedded into the community
- Their presence in the community and diverse range of programs facilitates the capacity to engage a wider range of community members on a regular basis, both as clients and potential clients. They also work closely with, support and assist other partners, for example child safety, probation and parole, the school, in supporting their clients.

3.16 SINGLE DESK OFFICER TRIAL

The WBCs are one of four RFDS activities that have been incorporated into the Single Desk Officer Trial (SDOT) covering the three-year period ended June 2015. The SDOT is of relevance to this evaluation in that it was identified as a potential enabler to strengthen management and administration and improve service outcomes.

The aim of the trial from the RFDS perspective was to improve grant administration efficiencies and improve service outcomes. The trial combined funding from multiple programs (in the case of the WBC six funding programs - refer to Section 3.14).

The RFDS is conducting a separate evaluation of the SDOT from its perspective. Benefits from the SDOT identified to date include: 41

- Helping to highlight and reinforce the line of sight from what services are being delivered to
 funding program requirements and provide a mechanism to help ensure services meet the
 requirements or are reoriented and reported accordingly. Examples include the need to strengthen
 non-SEWB primary health care in the WBCs and the need to strengthen reporting to highlight the
 extent of alcohol and other drug related services at the WBC given the level of funding from drug
 and alcohol related programs
- A general service wide reorientation into achieving program outcomes and not just inputs and outputs (all Activities), although in the case of the WBC Activity, the evaluation has significantly contributed to this focus
- Greater combined capacity to implement clinical governance and reporting systems, evident, for example, in the recent implementation of improved clinical tools, introduction and reporting of mental health outcome measures and the recently enhanced capability of the client information management system implemented in April 2014
- Specification and development of processes and systems to strengthen recording of outputs and actions

⁴¹ DoH Activity Five. Single Desk Officer Trial Six Monthly Report. June – December 2013. RFDS Queensland.

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- The Single Relationship Manager has streamlined departmental contact and resulted in increased administrative efficiencies, including more responsive, consistent and co-ordinated communication to and from the DoH
- Facilitated a breakdown of the silo effect both at the RFDS and from the RFDS perspective at DoH
- Associated with this is a less fragmented and more responsive service approach, including significantly enhanced team cohesion across programs and better utilisation of staff and skill mix to meet community needs (demonstrated, for example, in the ability to more flexibly and rapidly respond to a recent major suicide incident; and more specific tailoring of staff skill mix to client needs)
- Facilitating the aggregation of what can be small amounts of unused funding within various components of an Activity, or across Activities, to create a quantum of funds that can be utilised more productively to deliver a program, either within or across Activities.
- Overall across all Activities there have been substantial reductions in management/team leader salary cost profile and support and administration salary cost profile since commencement of the Trial and as a consequence the proportion of salary expenditure being spent on direct service provision has increased substantially from 59% at 30 June 2012 to 72% at 31 December 2013. The overall spend on non-service provision salary related costs is decreasing which means that funds will be able to be released for expenditure on program related activity.

In conclusion from the RDFS perspective the SDOT has improved the RFDS grant administration efficiencies as it relates to relevant Activities by amongst other things reducing multiple points of departmental contact, and reducing duplicative contract deliverables. Reporting requirements are significantly more comprehensive and analytical although as a consequence more time consuming to compile.

The SDOT has improved service outcomes indirectly, and significantly enhanced service responsiveness and service integration, while from the RFDS perspective at least, maintaining integrity of existing relevant program and financial accountability requirements.

HOI is aware of Commonwealth Machinery of Government changes that will impact upon the source of funding streams for the WBC. From the WBC perspective **it is proposed** that the SDOT continue to June 2015 as per the agreement.

3.17 SUMMARY OF FINDINGS

Key review finding #6 The WBCs are providing a new and unique approach to the provision of SEWB services. Overall each WBC is addressing the range of service expectations of the community and other stakeholders relatively well. What is unique about the WBC is that it allows for SEWB services (including mental health and drug and alcohol services) to be provided in combination seamlessly.

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Key review finding #7 Service access to SEWB services is greatly enhanced in WBC communities when contrasted to other communities in Cape York. Overall, 48% of the entire community, 57% of the adult community (>19 years) and 26% of the population <20 years are currently, or have been, WBC clients.

Violence (21%), mental health (21%), alcohol (20%) and welfare/other support (16%) together make up 78% of the diagnosed assessment issue categories (the primary issue for the client). Many clients have multiple issues.

SERVICE MODEL

The service model provides a new and unique approach to the provision of SEWB services. What is unique about the WBC is that it allows for SEWB services (including mental health and drug and alcohol services) to be provided in combination seamlessly. The model is very resource intensive.

The service model has undergone significant development since the commencement of WBC services. It was last revised in September 2012 and the RFDS plan to review and update the service model in 2014. The most recent service model included a more systematic and consistent approach in assessment and outcome measurement.

In addition the RFDS strengthened 'clinical service provision and standards' and adopted a purposeful strategy to employ people with psychology qualifications or strong MH backgrounds. The sense at the time was that the early focus had been on the provision of a broad SEWB service and that 'clinical' work (1:1 counselling/therapy) was not being afforded a sufficient priority and there were questions concerning the relevant skills and experience of WBC staff to provide these services.

The service model documented and implemented aligns with the key service elements and has been implemented as agreed. It is in alignment with the program theory. While staff understand the service model there is opportunity to strengthen understanding of it by promoting the service model more actively during the induction process.

One key area of difference is in the provision of non SEWB primary health care brief interventions which until more recently have not been built into the WBC activities in any structured way. However the WBC has recognised this issue and has commenced implementing relevant strategies as part of its Activity Plan for 2012 -2014.

The service model discusses the relevance of, but does not mandate, particular approaches or therapies (e.g. cognitive behaviour therapy, motivational interviewing, and narrative therapy). This is left to the counsellors to determine based on the particular needs of the client.

SERVICE MODEL IMPLEMENTATION

Overall each WBC is addressing the range of service expectations of the communities and other stakeholders relatively.

In most cases clients, partners and staff seem to have a clear and reasonable understanding of the service model. Most partners have a clearer view of the service model and/or or the role and function of the WBC and significantly more so than in mid-2012. This likely relates to the consultation on and documentation of a clearer service model; more interaction over time that facilitates a clearer understanding; and stability of management staff.

The service model and the approach adopted by WBC staff is reflective of providing a culturally appropriate and sensitive service. Eighty two percent of clients interviewed agreed that the WBC staff did understand and respond to their Aboriginal culture a lot and very few community members raised

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cultural awareness as a concern. However, there is a need to continue to develop and integrate on country and cultural activities within the service offerings.

The WBC staff structure is sound and well suited to the delivery of WBC services based on the current service model. The mix of males and females is reasonable and there has been focus on the need for, and recruiting of, Indigenous staff wherever possible. The small number of Indigenous clinical staff members is a factor of availability and remote location and not the structure or culture of the WBC itself.

Consistent with previous findings staff were confident in providing the relevant WBC services and felt they had the skills and experience and appropriate qualifications to provide those services.

RFDS have made a substantial commitment and investment in the training and development of all staff and in particular local Indigenous staff. This is highly valued by staff. Overall staff are supported, skilled and developed to address the ongoing requirements of the WBC service model.

For the duration of this program there has been a lack of regular communication with stakeholders and community through newsletters, the internet and other means.

Violence (21%), mental health (21%), alcohol (20%) and welfare and other support (16%) together make up 78% of the diagnosed assessment issue categories (primary issue for client). For males, problems with alcohol/other drugs and prison related matters make up a greater percentage of the reasons for presentation than females. For females, welfare support makes up a greater proportion of reason for presentation.

The total HoNOS scores for all WBC clients is similar to the national profile of mental health ambulatory clients (8.69 compared to 9.1). On a subscale basis, the behaviour score is significantly greater than the national profile (2.25 to 1.6) particularly given that WBC data incudes clients who are not mentally ill, and is what might be expected in the reform communities. The non-FRC and FRC client profile is similar.

The K10 score for all WBC clients is similar to the national profile of mental health ambulatory clients Proportionally, WBC clients at high or very high distress levels is marginally greater than the general Indigenous population (33% compared to around 27% to 30%).

Overall WBC clients fell in the risky or hazardous level of drinking category on initial AUDIT screening. FRC clients were in the same category. There is no benchmark data to facilitate comparison.

Based on the SDS 36% of client's demonstrated dependence on cannabis with significant variations between WBCs. Mossman Gorge and Aurukun had the highest percentage of clients recorded as being dependent upon cannabis and consequently the highest average score. Correspondingly, it has been noted that since inception 53% of clients had at least one presentation where alcohol or other drugs was an underlying issue and the alcohol and other drug psycho-social module has been the most extensively used of all modules (undertaken by 26% of all clients and 47% of FRC clients).

PARTNERSHIPS

Overall the WBCs have been successful in developing effective partnerships. Most partners at both the local and regional level appear to have a solid understanding of the role of the WBCs with most having a good understanding and a strong collaborative relationship working in partnership to enhance outcomes for clients.

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In a number of cases partners specifically mentioned that the WBC, by being in community five days per week and having appropriate expertise, was assisting their own agency to be more effective, and/or to enable them to concentrate on their core business.

Queensland Health (CYHHS - Mental Health) feel strongly (and RFDS agree) that there is a need to further strengthen the relationship by developing a service agreement between CYHHS and the RFDS. This will strengthen the service model by clarifying the service interface in relation to roles and responsibilities for joint client management, how information is shared and conducting joint case reviews. Aligned with this is the need for more transparency in relation to how the WBCs manage their clients. This would build on the service flowchart that has been developed.

The effectiveness of the partnership with the FRC was discussed in detail in the Phase One Evaluation Report. While there have been significant improvements since the initial years of WBC operation due to service expectations being clarified, the service model being further developed, and RFDS staff and management changes and stability, there is still opportunity to strengthen the partnership by enhancing service transparency and working more closely with the FRC at the local level. To date they report having received limited details on programs and their structure. In addition, in some cases they would like more information on how their clients are engaging and progressing, in addition to the agreed summary that is currently provided.

The need to strengthen relationships and provision of information at the local level has been recognised by the RFDS and the FRC. The current strategy being trialled at Aurukun includes: the development of a memorandum of understanding; providing the FRC access to the RFDS client information system; the RFDS to attend FRC case conferences; the RFDS regular summary report including more feedback in relation to a client's progress and engagement issues (above what has been agreed previously); and using a shared data system to track client progress.

It is proposed that the RFDS develop a service agreement with CYHHS - Mental Health and a memorandum of understanding with FRC, which provides an appropriate level of detail as to how the organisations will work in partnership to strengthen the management of clients and enhance the effectiveness of both services.

In the case of the FRC this will build on the learnings from the current trial in Aurukun and for CYHHS Mental Health it will build on the current service flowchart.

COMMUNITY ENGAGEMENT

Overall WBCs have effectively engaged the community.

Local staff have fulfilled their role and strengthened community engagement. They are an important component of the WBC model however as has been recognised and achieved to some degree, they now need to take a more active role in appropriate front line service delivery.

Programs and services are offered in a way that are effective in engaging the community WBC staff are generally committed to communicating and building relationships with key community personnel and groups to ensure effective community engagement.

There does not appear to be any cross agency social service/primary health group that formally interacts with community leaders to address issues of common concern. This is something that needs to be developed within the context of each community. Ultimately the role played by the WBC will vary depending on the type of issue and the community.

LAGS have only been partially effective and in some cases ineffective in providing a structure for formal community input. The LAGs are not currently in a position to be a vehicle for management

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responsibility and ultimate community control. Notwithstanding considerable effort and resources, capacity building efforts have not been effective to date in underpinning a longer term intention of community control.

The WBC is engaging a reasonable representation of the community based on age and sex, particularly when taking account of their recent focus on and initiatives for younger people. Community members appear to have a reasonable or good understanding of what the WBC does and they believe the WBC is 'welcoming' and 'helpful.

Key opportunities for strengthening community engagement include:

- Developing an effective vehicle for more structured community input
- Ensuring the FRC is informed of all efforts to engage hard to engage clients. This should be addressed as part of the development of a memorandum of understanding referred to previously.

It is proposed that a joint agency/community approach to obtaining more structured community input into social services/primary health care that is unique to each community be established.

It is proposed that the interagency meetings in each community be the vehicle for 'kick-starting' this process. In establishing a joint approach a number of principles have been proposed in Section 3.7.5

SERVICE ACCESS

Based on analysis undertaken of available activity and staffing information, service access is greatly enhanced in WBC communities. Overall, 48% of the entire community, 57% of the adult community (>19 years) and 26% of the population <20 years are currently, or have been, WBC clients.

Specifically, the population per full-time equivalent (FTE) staff for WBC communities is much
greater than non-WBC communities (i.e. more staff available to service the community) and
following on from this, the percentage of the population that is a client of the RFDS operated WBC
or SEWB service is significantly greater in the WBC communities compared to other communities
(ranging from 20% at Aurukun to 34% at Coen compared to other communities ranging from 2%
at Napranum to 7% at Kowanyama).



4

4 WHAT HAS WORKED

This chapter addresses the evaluation aim of identifying which prevention, intervention and treatment approaches are successful and the key factors (such as tools, delivery approaches governance arrangements etc.) that are contributing to this success.

The chapter also proposes opportunities for improvement made in the context of strengthening the current WBC approach as it is operated by the RFDS in the current WBC communities. Each of these proposed opportunities for improvement will need to be considered in the context of the major recommendations presented in Chapter 5.

4.1 WHAT TREATMENT APPROACH WORKS AT THE INDIVIDUAL LEVEL?

The evaluation has demonstrated some benefit for individuals. This section presents what clients, the community and staff felt had contributed most to individual change.

4.1.1 CLIENT PERSPECTIVE

The key factors clients that considered had contributed to changes they had made (sometimes in combination) included:

- 1:1 yarning/counselling. Overall 89% of all clients we interviewed and 100% of clients who had received 1:1 counselling stated that these services had contributed to the changes they had made. Of these clients, 48% specifically mentioned the listening aspects of counselling as being helpful. This is also in keeping with clients and community members using the WBC as a 'drop-in' often simply to escape their environment, seek safety, de-stress and/or 'vent'.
- **Group sessions**. Overall 28% or 13 of all clients we interviewed and 50% of clients who had had participated in groups stated that these services had contributed to the changes they had made.
- **Drop in.** Of the 47 clients interviewed who were self-referred (n= 22), 50% indicated they highly valued drop-in services. Overall 32% of all clients interviewed and 88% of clients who had used the WBC as a 'drop-in' stated that these services had contributed to the changes they had made.
- **Own determination**. Eight clients (17%) mentioned their own determination although often driven by extrinsic factors (e.g. FRC, child safety, probation and parole, risk of jail).

Other things clients listed as being the most helpful included support and advocacy with other agencies (6 clients or 13%).

Looking beyond the WBC the Cape York Welfare Reform evaluation reported that employment status and perception of strong leadership changes over the past three years were the strongest drivers of positive individual change. This was followed by whether the person had followed up on talks with the



FRC, or used the WBC. Members of households with 5–10 people and those with higher levels of education also had a high prevalence of positive individual change.⁴²

4.1.2 COMMUNITY PERSPECTIVE

Relevant community members were asked what part of the service they found most helpful (note respondents could provide more than one response) and the responses are presented in Figure 4.1 and Figure 4.2. Counselling/listening/yarning was the most common response (72%, 252 respondents), followed by drop in and safe place (74% combined), then groups (50%). Other services mentioned included: help with Centrelink and telephone availability, advice, advocacy and support in relation to court matters.

The results were relatively consistent between WBCs. Of note is the smaller percentage of Hopevale respondents who rated 'drop-in' as a most useful service aspect reflecting that this centre is not used as frequently for this type of service, and the relatively high percentage of respondents at Coen rating groups as a most useful service likely reflecting the maturity and consistency of some of groups in that location (refer to Figure 4.2).

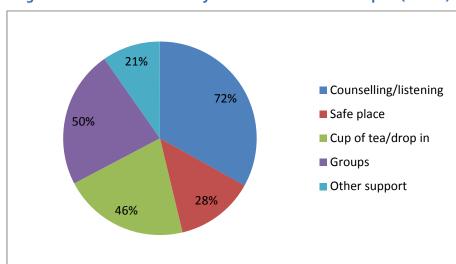
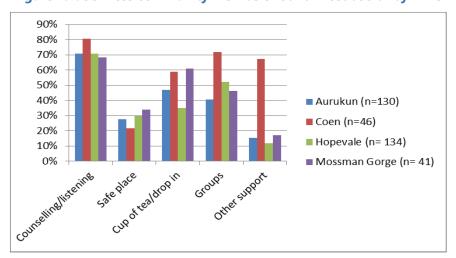


Figure 4.1: Services community members found must helpful (n=351)





⁴² Ibid. Cape York Welfare Reform Evaluation, p 133



4.1.3 SUMMARY

The benefit to individuals is derived from various service components (either separately or in combination) which is different for different clients. Table 4.1 sets out a comparison of what clients, community and staff consider contribute to making change. Counselling is ranked the most highly in terms of helping people, followed by the safe place/drop in role with groups being third most important. Whilst ranking and differentiating between service types, it was very evident from our consultations with all stakeholders that the combination of components is what makes the WBC unique and beneficial.

Table 4.1: Comparison of what works

Service	Clients ¹	Community	Staff ²
		(n=351)	
Counselling	100%	72%	First
Safe place/drop in	88%	74%	Second
Groups	50%	50%	Third

Note (1): Percentage relates to the number of clients who rated this service as a contributing to changes they had made where they received that service.

Note (2): Staff is a priority ranking of what they see as most valuable in assisting clients.

The most effective counselling/intervention approaches are considered to include: General counselling; Motivational interviewing; Narrative therapy; Cognitive behavioural therapy; Strengths based approach; Psycho-social education; Group work, and Advocacy. In most cases a combination of these approaches is used and they can change over time as the client develops and staff change.

A regression and univariate analysis was undertaken across a range of input and assessment issue parameters against achievement in outcome measures. No significant correlations were noted. The wide range of counselling therapies and approaches, and their use in various combinations in a wide variety of client circumstances means that it is not possible to determine whether any one particular approach is better than another.

What is unique about the WBC is that it allows these services and others to be provided in combination seamlessly. It is the availability, integration and combination of services, that is, individual counselling, group, drop-in, advocacy plus referral to other agencies that facilitates client engagement and assists the client to make change.

4.2 KEY SUCCESS FACTORS AND CHALLENGES

This section summarises the key success factors of the service model that has been implemented and the key challenges confronted. More detailed analysis is provided in the relevant sections in Chapter 3.

4.2.1 KEY SUCCESS FACTORS

The key success factors include:

• Level of integration between the areas of activity. This is a key strength and uniqueness of the service model. The model allows for the seamless provision of individual counselling and treatment, a capacity for drop-in and a safe place and provision of a wide range of group activities in a variety of settings. This often includes a joint approach with partner service providers. A client will often participate in multiple types of activity at the same time or progress through various activities at different times.

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- Capacity to work with clients across a wide range of issues that impact upon SEWB. WBC staff provide services relating to issues such as mental health, alcohol and other drugs, welfare support, family violence, relationships, parenting, child safety, advocacy and probation and parole support. As part of this, clinical services are provided in the context of assessment, treatment, case review and appropriate clinical supervision i.e. with a degree of rigour in the very unstructured service environment that exists.
- **Drop-in element**. Aligned with being a key contact point, one of the most significant roles the WBCs are playing in each community is that as a point of pressure relief. Clients (or in fact general community members) who are highly stressed/distressed often as a result of heightened tension and confrontation in the home or community, come to the WBC to talk, be listened to, have a cup of tea, and simply get time out. This has included perpetrators of violence who recognise thay may be 'losing control' of their emotions. Clients and community members also utilise an available telephone to help manage various income and social matters that often are a source of major emotional concern. This drop-in aspect is highly valued by the client group, the community more generally and many of the partner agencies.

This is percieived as being valuable for stress release and provides opportunity for community members to receive brief intervention and engage as clients (where they are not already clients) for longer term follow up and therapeutic intervention through counselling. Many consider this service to be critical to averting crisis for individuals and de-escalating conflict and confrontation between family and community members groups.

A component of this is the availability of the WBC as a safe place. While not utilised for this purpose as frequently as for general stress relief, this is still a valued element of the centres.

- Recognition that it takes time for staff to establish relationships. The service model, management and staff recognise that relationships with the community members and clients are built on developing trust and reciprocity and time is allowed for this to occur.
- Key point of contact and referral. The WBCs provide a key point of contact and referral for the
 community, importantly including for community members who may not readily access other
 services.
- Capacity to work with non-voluntary referred clients. There is an expectation that the WBC will
 work with FRC referred clients (i.e. non-voluntary presentations) who may not normally access
 services until a crisis or trigger event occurs. There was evidence that many of these clients are
 able to be engaged and that some of these clients become voluntary after their tenure with the
 FRC concludes.
- **Development of effective partnerships.** As highlighted in Section 3.6, the WBC has established some very effective partnerships to support client level treatment and provision of a wider range of group activities. There are very positive examples of WBCs working with partners to enhance client outcomes. Success is predicated on there being: a clear understanding of each partner's role and expectations; the value each partner adds; clear priorities being established; and not the least the personalities of each WBC and respective partners staff.

The best successes were noted where WBC team leaders and management demonstrated both a strong commitment to develop a particular relationship, possessed good communication skills and of course had a willing partner. This is usually enhanced where the team leader/management of the WBC has been stable for a reasonable period of time.

Over the last two years, establishing effective partnerships at the regional level has also been important to developing appropriate community and local partnership responses.

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Converesely, we have also noted through the report that there have been partnerships that have not worked as successfully from time to time, both at the local and regional level. In particular we have noted the issue with the FRC. However, the improvements that have arisen in this relationship have been the result of a concerted effort by both parties and this simply reaffirms the importance of an effective partnership to good service oputcomes.

- **Effectively engaging the community.** This is fully discussed in Section 3.7. Key elements that have facilitated community engagement include:
 - the employment of local staff as community development consultants
 - being a welcoming and culturally safe place where people can come and simply have a cup of tea and a chat
 - being a safe place where people can obtain refuge from stressful or violent situations
 - tailoring activities and groups to community (and cultural) needs consulting with LAGs when they have been functioning, Women's groups and Men's groups regarding their needs and program preferences
 - offering a range of programs and services (e.g. alcohol and other drugs, relationships, family violence, mental health) in a variety of settings (e.g. WBC, in-home, in other agencies, community based groups, on-country)
 - effective communication and relationship building with groups in the community such as mayors, counsellors, family representatives and the leaders of community led groups and organisations.
- Provision of appropriate levels of training and support for local Indigenous staff. Local staff need to be a credible local person, vouch for the credibility of non-local staff and the service in the community, assist in orienting new staff to the cultural expectations of that specific community, assist other team members with relevant and appropriate information concerning the community members and clients and facilitate or support the delivery of the range of WBC programs. To achieve this there is a need to have realistic expectations of staff, and structures and strategies in place to ensure local staff are trained, supported and provided with appropriate mentoring.
- Recruiting the right non- Indigenous staff. It is critical that non-Indigenous staff are willing to connect with the community, and value the trust and respect placed in them. The staff must also be supported by high-quality cultural competence training.
- Allowing flexibility to respond to local issues and needs. The level of local flexibility is highly
 valued, however it is important that this is within the context and parameters of a clearly defined
 and documented service model.
 - One good example of a specific response to a particular SEWB need is the recently commenced Intensive Youth Support Program that is being trialled in Aurukun with 14 extremely challenging youth. Consensus of partners is that this is a critical issue for the wellbeing of the individuals, their families and also the community and it is showing early signs of promising results.

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There is a high level of correlation between the key success factors identified above and what was identified as working in a recently completed review of Indigenous early childhood, education and health intervention programs. 43

4.2.2 KEY CHALLENGES

Key challenges have included:

- Successfully obtaining structured community input on an ongoing basis, a problem shared with other agencies. This issue is fully explored in Sections 3.7.4 and 3.7.5.
- Capacity building efforts in underpinning a longer term intention of community control (which to date have not been successful). This issue is fully explored in Section 3.7.5.
- Building successful working relationships with the FRC (noting substantial improvements in the last 12 to 18 months). This issue is fully explored in Section 3.6.1.

Key review finding #8 The key success factors for the WBCs have included: the level of integration between the core areas of activity (i.e. counselling, drop-in and groups); capacity to work with clients across a wide range of issues that impact upon SEWB; drop-in element; recognition that it takes time for staff to establish relationships; ability to be a key point of contact and referral; capacity to work with non-voluntary referred clients; development of effective partnerships; employment and provision of appropriate levels of training and support for local indigenous staff; recruiting the right non-indigenous staff; and allowing flexibility to respond to local issues and needs.

Key challenges have included: successfully obtaining structured community input on an ongoing basis, a problem shared with other agencies; capacity building efforts in underpinning a longer term intention of community control (which to date have not been successful); and building successful working relationships with the FRC (noting substantial improvements in the last 12 to 18 months).

4.3 OPPORTUNITIES FOR IMPROVEMENT

This section presents proposed opportunities for improvement in the context of strengthening the current WBC approach as it is operated by the RFDS in the current WBC communities.

Each of these proposed opportunities has been developed from analysis presented in Chapter 3. While the proposed opportunities have been presented in that chapter, they are presented in this section for convenience and to provide a logical sequence to the report.

Each of these opportunities for improvement will need to be considered in the context of the major recommendations presented in Chapter 5.

1. It is proposed that the service model description be updated in the second half of 2014.

The update should incorporate the following key areas:

- the need for a clear description of the services provided by the WBCs in the mental health and ATODS service lines and the associated interface with Queensland Health
- the need for a clear description of the services provided by the WBCs in relation to FRC clients and how the WBC and FRC can work more closely together to improve outcomes for clients

⁴³ Bowes, J., Grace, R. Review of early childhood parenting, education and health intervention programs for Indigenous children and families in Australia. Issues paper number eight produced for the Closing the Clap Clearinghouse. February 2014.

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- aligned to the above points, the need to clarify how and when modules and specific topics are used and for whom
- the need to strengthen description of the approach to non SEWB primary health care services
- the need for a clear description of the skills and qualification required to work in the WBC and associated workforce development strategies.
- 2. **It is proposed** that opportunities for formally integrating welfare and support services into social and emotional wellbeing services including appropriate funding be considered on a community by community basis.
- 3. **It is proposed** that the RFDS continue to focus effort on integrating non-SEWB primary health care into its service. The RFDS should continue to work in conjunction with Apunipima and the local clinic in WBC communities to further integrate SEWB and Non-SEWB services (in the case of Apunipima as part of that organisations strategy to embed a SEWB approach across their family and community centred primary health care model).
- 4. **It is proposed** that any future SEWB service model should include extensive collaboration with Child Safety given the contribution the WBC has been able to make in relation to Child Safety preventing separations and/or facilitating reunifications not previously achieved.
- 5. **It is proposed** that the RFDS develop a service agreement with CYHHS Mental Health and a memorandum of understanding with FRC, which provides an appropriate level of detail as to how the organisations will work in partnership to strengthen the management of clients and enhance the effectiveness of both services.

In the case of CYHHS - Mental Health, this will strengthen the service model by clarifying the service interface in relation to roles and responsibilities for joint client management, how information is shared and conducting joint case reviews. Aligned with this is the need for more transparency in relation to how the WBCs manage their clients. This would build on the service flowchart that has been developed.

In the case of the FRC, the current strategy being trialled at Aurukun includes: the development of a memorandum of understanding; providing the FRC access to the RFDS client information system; the RFDS to attend FRC case conferences; the RFDS regular summary report including more feedback in relation to a client's progress and engagement issues (above what has been agreed previously); and using a shared data system to track client progress.

6. **It is proposed** that a joint agency/community approach to obtaining more structured community input into social services/primary health care specifically that is unique to each community be established.

It is proposed that the interagency meetings in each community be the vehicle for 'kick-starting' this process. In establishing a joint approach the following principles should apply:

- Community members should be paid appropriately for their participation.
- Membership should be clear and determined locally.
- The chairman of the group should be determined locally but joint chairs (one agency, one community member) would be ideal.
- The role of the group should focus on:
 - o needs identification
 - developing appropriate responses
 - monitoring results
 - providing feedback on service performance

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- The group should have a clear (funded) support structure.
- The group should have clear reporting and accountability lines.
- Meetings should not be too frequent, for example bimonthly initially then quarterly.
- Funders will need to accept that this approach is suitable in the context of governance requirements for specific programs.
- 7. **It is proposed** that the WBC develop specific materials promoting the WBC service. This could be done after the service model is updated.
- 8. **It is proposed** that the WBCs establish therapeutic discussion groups to analyse and discuss experiences and results achieved with particular therapies and approaches.

This will be facilitated by information now able to be provided by the upgraded client information system.

9. It is proposed that the SDOT continue to June 2015 as per the current agreement.

HOI is aware of the Australian Government Machinery of Government changes that will impact upon the source of funding streams for the WBC. The SDOT has improved service outcomes indirectly, and significantly enhanced service responsiveness and service integration, while from the RFDS perspective at least, maintaining integrity of existing relevant program and financial accountability requirements. Any cessation of the agreement would limit the RFDS capacity to respond to emerging or changing community needs.

10. **It is proposed** that HoNOS, K5, AUDIT C and SDS (in relation to a person's cannabis usage and associated risk factors) be utilised on an ongoing basis. It is considered this combination of tools best represents the key foci of the WBCs (i.e. mental health, SEWB and drug and alcohol).

The evaluators consider that the number of outcome indicators collected and reported systematically should be minimised to reduce the burden on clinical staff in a challenging service environment.

The HONOS has generally adequate validity and reliability. It has been thoroughly evaluated and extensively used across a range of populations (incl. Indigenous Australians and mental health clients). ⁴⁴ The AUDIT is widely used and is the preferred tool of the Australian Government for funded alcohol and other drug services. There is concern about utility in Indigenous populations and the AUDIT–C has been developed which could be used.

The K10 is widely accepted, validated and used nationally and the K5 is used in Australia for Indigenous populations by the Australian Bureau of Statistics and the Australian Institute of Health and Welfare. The SDS has generally adequate psychometrics and can be utilised for a range of substances. 45

The Indigenous Risk Impact Screen (IRIS) has a high degree of convergence with the K10 and the AUDIT and should not be required as an outcome tool.

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⁴⁴ NADA (Network of alcohol and other drug agencies). Review of Screening, Assessment and Outcome Measures for Drug and Alcohol Settings. 2009

⁴⁵ Ibid.





5 FUTURE DIRECTION

This chapter considers the evaluation aim of recommending any improvements which will enhance health outcomes and contribute to best practice service delivery. This chapter focuses more strategically on where to from here.

Proposed improvements within the context of the current service model were presented in the previous chapter.

This chapter presents a summary of the evidence to date from this evaluation and the literature, it highlights key issues in relation to rolling out a response to SEWB more broadly incorporating key success factors and ensuring potential barriers are addressed, and finally it addresses where to from here for the WBCs that were the subject of this evaluation.

5.1 WHAT HAS BEEN LEARNT FROM THE WBC EVALUATION?

This section summarises what has been learnt from the WBC evaluation in the context of ongoing sustainability.

The WBCs provided a new, unique and well-resourced approach to the provision of SEWB services that provided a high level of service access and resulted in significant levels of community engagement.

The WBC service model focusing on mental health, alcohol and other drugs and SEWB issues more broadly has been implemented as an integrated package of services, specifically counselling/support, drop-in, groups, other related activities, providing leadership in responding to community wide issues and being a key point of referral, staffed by a combination of professional staff (principally social workers, psychologists, mental health nurses and counsellors) supported by local community development consultants. Significantly the service has been housed in a separate purpose built facility and provided by a different organisation to that providing the primary health care service. The same model was rolled out to each community.

The evaluation has provided evidence that it is not a case of one size fits all. It may be that in one community the greater focus should be on individual therapeutic services with an appropriate focus depending on need e.g. a focus say family violence or alcohol, whereas in another community there may be more of a need for crisis intervention and drop-in support. This will differ by community and what other services are available, and it will likely change over time.

The findings indicate that the WBCs are having significant success in helping some individuals through immediate crises and in dealing with their immediate problems and that sustained positive behaviour change is occurring in some clients in relation to alcohol use and cannabis dependency and other social behaviours. Furthermore, there is some anecdotal evidence of individual change having a positive effect on some families within the communities. However, with the exception of Coen, individual-level improvements are not translating into sustained, consistent and clearly observable improvements in outcomes at the community level. Furthermore, unless the number of individuals making behaviour change increases substantially (including the most challenging community members), it is unlikely that sustained significant change will be observable at the community level

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unless there was another significant positive enabler of change in the communities (e.g. availability of employment).

Overall, the level of impact demonstrated over five years from the current service model, (particularly at the community level), does not appear to justify the current level of resourcing over the longer term, not-withstanding the significant contextual influence described previously.

Additionally the current service model is resource intensive and could not feasibly be replicated in the numerous Indigenous communities across Australia who might require SEWB services.

Key review finding #9: The current service model is resource intensive and therefore could not feasibly be replicated in the numerous Indigenous communities across Australia who might require SEWB services.

Key review finding #10: Based on the level of impact demonstrated over five years, the Cape York SEWB model does not appear to justify the current level of resourcing over the longer term.

5.2 WHAT ARE THE ALTERNATE APPROACHES?

This section summarises evidence in relation to alternative approaches to the implementation of SEWB services.

5.2.1 INTEGRATION

Looking more widely than the WBCs, there is a wide body of literature highlighting the link between SEWB and physical health. As highlighted in a recent literature review "the literature has highlighted the urgent need for health services to continue to work towards embedding SEWB into all aspects of primary health care, including focusing on empowerment and enhancing personal capacity the change". 46

The World Health Organisation has reported that integrating mental health services into primary care is the most viable way of closing the treatment gap and ensuring that people get the mental healthcare (and by extension SEWB services) they need. They report that primary care for mental health is affordable, and investments can bring important benefits. 47

Service integration has been demonstrated to improve physical and mental health outcomes. As evidenced for example by the success of child and maternal health services in improving outcomes for mothers and babies, with the potential for significant longer term benefit given the recognised importance of early childhood development in longer term physical, mental health and other outcomes. ⁴⁸

The approach adopted when integrating SEWB services into primary health care is one of strengthening knowledge and skills of workers in the area of SEWB, who undertake initial assessments, brief interventions and coordination and refer to appropriate experts as required. The most sustainable path to the delivery of SEWB services more widely is in the context of integration with primary health

⁴⁶ Apunipima Cape York Health Council. Background document: Embedding a social and emotional well-being approach across Apunipima's family and community centred primary health care model (2014)

⁴⁷ World Health Organisation and World Organisation of Family Doctors. Integrating mental health into primary care: the global perspective. World Health Organisation, Department of Mental Health And Substance Abuse, Geneva. (2008).

⁴⁸ Holland,C., Dudgeon,P., and Milroy,H. Supplementary paper to A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention prepared for the National Mental Health Commission (2013)

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care where SEWB is an integral part of, and embedded into primary health care services. Under this model access to relevant specialist experts remains important.

The Northern Territory Aboriginal Medical Services Alliance of the Northern Territory identified the following rationale for integrating alcohol and other drugs and community mental health care into their Aboriginal Medical Services:

- Alcohol and other drugs and mental health issues cause a high burden of both mortality and morbidity in the Aboriginal population in the Northern Territory
- There is unmet need for services for Aboriginal people, especially in remote areas
- The most effective and efficient way to provide these services is to ensure they are community-based and operating through the existing primary health care service infrastructure. The creation of multiple service providers, especially in remote areas, is making the service system unnecessarily complex and more fragmented
- Dual diagnosis is common and generally poorly dealt with in the specialist alcohol, and other drugs and mental health sectors
- Treatment for both alcohol and other drugs and mental health issues needs to be addressed in a culturally-effective, holistic way that also addresses determinants of these problems at a community and individual level. Aboriginal communities should control theses services.
- Therapies such as Cognitive Behaviour Therapy and problem solving therapy are effective in both mental health and alcohol, tobacco and other drugs problems.
- Treatment for mental health and alcohol and other drugs problems needs to be integrated with other aspects of primary health care, including medical care and health promotion. 49

Whilst unable to identify specific evidence of success, we are advised that The Wurli-Wurlinjang Health Service in Katherine, Northern Territory is one example of a successfully run primary health care health service that has incorporated a wellbeing unit, albeit servicing a larger community than those on Cape York. Their primary health care service incorporates a SEWB team and clients have had access to a psychologist. High level clinical care for mental health clients is undertaken by their general practitioners or Territory specialist mental health services. The service mirrors much of that provided by the stand-alone WBCs including counselling, groups and education to deal with; unresolved grief and loss, domestic violence, removal from family, substance misuse, family breakdown, cultural dislocation, racism and discrimination, social disadvantage, sexual abuse, trauma and abuse, depression, poverty, drug and alcohol abuse, and intergenerational consequences of removal policies. We note that the service also operates an Alcohol and Other Drugs counselling and group program.⁵⁰

Similarly, we are also aware that the Institute for Urban Indigenous Health (IUIH) in South East Queensland has also integrated a comprehensive social and emotional wellbeing service into their primary health care services. Additionally, this model brings together four independent community controlled health services to provide for a large Indigenous population.

In determining a model for the integration of SEWB into PHC services on the Cape, there would be value in researching these service models particularly with a view to lessons learned.

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⁴⁹ Op cit, Apunipima Health Council (2014) and Aboriginal Medical Service Alliance of the Northern Territory (revised 2011). *A model for integrating alcohol and other drugs, community mental health and primary healthcare in Aboriginal Medical Services in the Northern Territory*. Unpublished.

⁵⁰ viewed at http://www.wurli.org.au/index.htm

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As discussed in Section 2.5.6 the success of any approach must be seen in the context of the enormous challenges associated with achieving both individual and community level change and that a longterm response is required. There is no evidence of a model that has been developed to address and successfully overcome the impact of compromised neurodevelopmental environments. It is now well understood that early brain development affects lifelong health and well-being of individual and that early environmental experiences significantly shape the developing brain, with many environmental factors, including smoking, alcohol, maternal nutrition and illness and stress affecting the unborn child and thus capacity for successfully achieving positive longer term outcomes.

Consistent with government priorities, as reflected by the current revision underway of the National SEWB Strategic Framework⁵¹, the evaluation is proposing the ongoing development of an integrated response to SEWB issues, albeit at different levels and utilising a variety of approaches depending on community need and input as discussed further in Section 5.3.

Based on the evidence of the evaluation to date, depending on the level of social norms operating within the community, a scaled back response to provision of integrated SEWB services would provide individuals with support to change behaviours, but is unlikely to result in sustained and noticeable improvements at the community level in isolation of a more comprehensive suite of other initiatives and the passage of time. The success of a scaled back integrated approach is unlikely to be evident at community level, at least in the short to medium term.

Key review finding #11: There is a wide body of literature highlighting the link between SEWB and physical health and the need for health services to continue to work towards embedding SEWB into all aspects of PHC. It is also reported by the World Health Organisation to be the only sustainable option in the long term.

If the integration of SEWB services is accompanied by a strengthening of the skill and knowledge of all PHC practitioners in SEWB issues, and a building of their capacity to assess, provide brief interventions, refer and coordinate (i.e. provide holistic health and wellbeing interventions), it is likely to significantly strengthen PHC delivery and enhance outcomes for clients

Key review finding #12: Integration of the existing WBC functions within a PHC setting could potentially reduce service duplication and fragmentation, improve secondary referral pathways and improve client outcomes.

5.2.2 COMMUNITY CONTROL

The RFDS was contracted as an interim auspice to operate the WBCs with a view to transitioning to a community-controlled arrangement over time, as there is evidence that effective community control enhances community outcomes 52,53,54. The LAGs were envisaged as the mechanism for shifting from a notion of community involvement and participation to potentially one of community control. As has

⁵¹ The current Social and emotional wellbeing framework: a national strategic framework for Aboriginal and Torres Strait Islander peoples' mental health and social and emotional wellbeing was intended to cover the period 2004-2009. "It is now three years since the framework's nominal end-date and the Australian Health Ministers' Conference has decided that the framework should be revised and updated to reflect the contemporary experiences of Aboriginal and Torres Strait Islander people and communities". https://www.health.gov.au/internet/main/publishing.nsf/Content/indig-sew-frame04

⁵² Close the Gap Progress and Priorities Report. Close the Gap Campaign Steering Committee for Indigenous Health Equality,

⁵³ Op cit., Holland C. (2013)

⁵⁴ Griew,R.,Tilton,E. and Cox,N. *The link between primary health care and health outcomes for Aboriginal and Torres Strait Islander* Australians. (2008)

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been discussed, the LAGs have had widely varying levels of success, however, none are envisaged as having developed to the point of assuming localised 'community control'.

Also of relevance is that the Australian Government is auspicing the Empowering Communities initiative which is examining the potential for structural shifts in power and responsibility to communities. The underlying principle being promoted by the Cape York Institute is one of 'subsidiarity', the organising principle that 'matters ought to be handled by the smallest, lowest or least centralised competent authority; and political decisions should be taken at a local level if possible, rather than by a central authority'. ⁵⁵

Accordingly when rolling out SEWB services, consideration needs to be given to the level (e.g. local, regional) at which services can be most appropriately managed and where there is a community controlled organisation with a proven capacity to deliver health related services. That is, whilst the evidence supports community control enhancing service outcomes, there needs to be an appropriate body identified to safely assume this role particularly if the four WBCs were to be transitioned to that body in one stage. Community control should be considered as the way forward, however, care needs to be taken not to overwhelm and possibly destroy an existing service simply to achieve this objective. This should be a key consideration of the proposed transition planning.

Recommendation 1: On a national basis the direction of policy and implementation should be focused on the integration of SEWB services within primary health care, ideally under community control and with the level of resourcing aligned to the level of identified community need.

5.3 ROLLING OUT SEWB SERVICES

This section sets out key factors to consider when SEWB services are rolled out to other communities, drawing on learning's from the evaluation and feedback from partners.

The key factors include:

- SEWB services should be provided in the context of integrating primary health care and SEWB services. Any introduction of SEWB services should be accompanied by a strengthening of the skill and knowledge of all primary health care practitioners in SEWB issues, building their capacity to assess, provide brief interventions, refer and coordinate.
- The overall level of need for additional SEWB services for a particular community should be assessed at a community level prior to any roll out (i.e. a needs analysis), taking into account all available services in that community.
 - It may be that in one community the focus should be on individual therapeutic services (focusing on say family violence, alcohol or grief and loss), whereas in another community there may be more of a need for crisis intervention and drop-in support. This will differ by community and what other services are available, and it will change over time.
- Solutions are likely to be different for each community.
- Consideration needs to be given to the appropriate mix of individual therapeutic counselling and support, drop-in/safe place, groups and community development and how these services may best be implemented in the context of the particular community. Regardless it is considered critical that all are available to some extent and truly integrated (not necessarily the same provider).

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⁵⁵ Lew Daly (2010-01-08). <u>"God's Economy"</u>. <u>The Financial Times</u>

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Within the context of assessed community need, a focus on counselling and therapeutic services would likely be the primary focus, albeit a place for people to drop-in appears a critical element particularly given it appears to be a predecessor to engagement in therapy. Establishing a drop-in capacity without an appropriate facility would need to be carefully considered in the context of client type, the service profile and work flow of the host facility. It may be that in some cases a new facility or extension would need to be built, however, an existing community facility may be identified and adapted appropriately. Any new SEWB service which includes a drop-in component, should incorporate an effective design that enhances client flow and the service experience.

A SEWB service should include some provision for groups and cultural activities albeit it may be in a more limited way than the current WBCs offer. To run groups that respond to community need effectively there needs to be a regular presence in the community and an appropriate location. This capacity could be added to a counselling service. The service could be provided in conjunction with or by other organisations and groups.

In summary, it is considered important that all of the service elements (counselling, drop-in, groups) be available and integrated as this is the unique and successful aspect of the WBCs

- A community must be completely committed to having additional or refocused SEWB services in its community.
- The establishment of any SEWB service should reinforce local Indigenous authority and have an agreed structure for community input. This structure should be identified in conjunction with the community. Ideally this structure or a precursor to it, could be utilised during the planning stage.
- The service delivery agent should have a proven capacity in delivering similar services in remote communities in a culturally appropriate way.
- Key service delivery partners should be consulted prior to SEWB services being established.
- Pooling of funds currently in communities who are addressing SEWB should be considered (notwithstanding the difficulty this creates for the funders).
- SEWB services would be significantly enhanced if they were supported by a local indigenous community development consultant/health worker who was capable of running appropriate programs. In the long term services should be staffed by Indigenous people who have the capacity to manage and deliver the services. Accordingly ongoing investment in long-term capacity building is an ongoing strategy requirement.
- The broad outline of the service model/approach must be clear to key stakeholders and documented but also allow for ongoing local flexibility in response to needs changing.

Key review finding #13: Prior to rolling out SEWB services in a community, a needs assessment should be undertaken to assess the appropriate mix of individual therapeutic counselling and support, drop-in/safe place, groups and community development that are required and how these services may best be 'positioned', targeted and implemented in the context of the particular community (i.e. where centred, what is already available, existing service providers, community need and community commitment).

5.4 WHERE TO FROM HERE FOR THE CAPE YORK WBCS

This section presents where to from here for the four WBCs in the context of the recommendation for SEWB and primary health care integration, the intent to transition to community control and the key finding that the current level of resourcing cannot be sustained or replicated.



5.4.1 THE NEED FOR A TRANSITION PLAN

Through the evaluation, it has been demonstrated that it is very challenging to establish and operate a broad based mental health, SEWB and drug and alcohol service and meet the wide range of stakeholder expectations. It is evident that it has taken a period of time for the RFDS to build this capacity and capability, however, it appears they are now performing much better than at any time since inception. This predominantly relates to the RFDS becoming clearer over time as to the specific priority needs of each community, the resultant service model, being clearer with partners in relation to the respective service model and thereby better managing diverse and wide ranging expectations.

In considering any transition to an alternative organisational approach, it will be critical to carefully manage the process to ensure the maintenance of appropriate capacity, capability, knowledge and accountability. This can best be achieved by the development of a transition plan.

Timing for transition planning will also be important given current funding for the WBCs ends in June 2015.

5.4.2 ASPECTS FOR CONSIDERATION IN TRANSITION PLANNING

Communities and key partners will need to be consulted during the development of the transition plan and the role of the Queensland Health clinics in Aurukun, Coen, and Hope Vale will need to be determined given a greater focus on managing emergency and acute issues.

The areas to be addressed by a transition plan include:

- Governance arrangements
- Agreeing the most appropriate strategy for initial and ongoing local community input
- Determining the priority focus for SEWB services in each community
- Identification of the mix of SEWB services to be provided in each community
- Determining the appropriate location and responsibility for each type of service
- Establishing a clear service model, service protocols supporting assessment and outcome tools and referral pathways systems
- The development of KPIs and other service reporting requirements and establishing relevant systems
- Workforce planning including finalising the role and function of each type of position and the development and implementation of a workforce development strategy
- Addressing human resource management issues (e.g. community based versus Cairns based staff, shift arrangements)
- Agreeing funding levels including ensuring funding program requirements are met
- Strategies for integrating with and supporting partner activities
- Addressing the proposed opportunities for improvement highlighted in Section 4.3 as appropriate in the context of the final timeframe developed for the transition.

5.4.3 POTENTIAL TRANSITION PHASING

When developing the transition plan, consideration could be given to:

• At Mossman Gorge, early transfer of the WBC to the Apunipima Cape York Health Council. Apunipima is the PHC provider in that community and this transition will facilitate immediate

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trialling of service integration, reduced service fragmentation and systems and processes. It is understood the community would support this.

[Note: Apunipima is already focusing on developing an integrated SEWB and primary healthcare response across is service. Early transfer will assist Apunipima in implementing its integrated approach and facilitate learnings for other communities which they service.]

- At Coen, while the transition plan is being developed, there could be an immediate move to local
 Indigenous leadership being implemented given local WBC staff have shown strong leadership
 capability. The local staff would provide the full range of SEWB services, however, be supported by
 the fly in fly out clinical professional services. This would enable all of the components of the
 service model to be delivered (general counselling, drop-in, groups and clinical interventions).
 - Under this scenario, any resources released could be allocated to communities without existing services in line with community need.
- At Aurukun and Hope Vale, while the transition plan is being developed there should be a
 continuing focus and emphasis on the recently commenced Intensive Youth Support Program that
 is being trialled in Aurukun with 14 extremely challenging youth. Consensus of partners is that this
 is a critical issue for the wellbeing of the individuals, their families and also the community and is
 showing early signs of promising results. It is a good example of a specific response to a particular
 SEWB need for that community and of the importance of a partnership approach between
 agencies.

Recommendation 2: That the WBCs no longer be funded as stand-alone services and that the WBC functions be transitioned into a comprehensive PHC service setting. To support this, a transition plan should be developed in the next six months, to facilitate implementation in 2015/16.

[Note: Communities and key partners will need to be consulted during the development of the transition plan and the role of the Queensland Health clinics in Aurukun, Coen, and Hope Vale will need to be determined given a greater focus on managing emergency and acute issues.

Key factors to be considered in transition planning and which are more fully outlined in the report include items such as governance, service mix, workforce planning, funding and phasing in different approaches for each WBC.]



The appendices to this report are contained in a separate document entitled:

Evaluation of Cape York Wellbeing Centres

Final Evaluation Report

Appendices

June 2014