Evaluation Report on the second year of Bringing Child and Adolescent Mental Health Services to rural communities 1998-1999

A Rural Health Support, Education and Training Program (RHSET) funded Project

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Executive Summary

This is the second annual evaluation report of the Rural Health Support, Education and Training Program (RHSET) Telehealth Project being undertaken from 1998-2000 by the Division of Mental Health, Child and Adolescent Health Services (CAMHS) at the Women's and Children's Hospital (WCH), Adelaide, South Australia. This report focuses on events and developments in 1999.

The title of the project is “Bringing Child and Adolescent Mental Health Services to rural communities”. The project involves the provision of professional development, support and training, for mental health staff in rural and remote sites such as Darwin, Alice Springs, Roxby Downs and Coober Pedy. The three aims of the project are to improve accessibility to services, to establish telehealth networks and to evaluate the effectiveness of telehealth. These services are delivered using telehealth technologies: videoconferencing in particular, as well as the Internet, printed materials and videotapes.

Figure one shows the locations involved in the project.

Figure 1: Map of Project Sites
Evaluation Methodology

The objectives of the evaluation necessitated the use of both quantitative and qualitative techniques. Hence, four approaches were used to collect data: a review of the literature, interviews, the development of case studies and an analysis of logs.

Major Findings

A review of the literature provides two major findings. Firstly, the CAMHS RHSET Telehealth project complements previous uses of technology to provide professional development to mental health staff in rural settings in Australia. Secondly, the second literature review shows that the CAMHS RHSET Telehealth project extends previous uses of technology to provide professional development to mental health staff in rural settings, in three main ways:

- the network is particularly complex: the network stretches across a State/Territory border, involves two different health departments and the distances between sites—e.g. 3,000km from Adelaide to Darwin—are extreme.

- sub-networks involve the provision of professional development from one regional town (Port Pirie) to a remote mining town (Coober Pedy) and from a metropolitan office of CAMHS (the Western Office) to another mining town (Roxby Downs)

- the network has always used other media such as print, videotapes and the World Wide Web to complement its videoconferencing sessions.

Level of activity

The 1999 Telehealth Diary recorded the essential details for each telehealth session such as the date, duration and content of the session, together with a record of who was present at each location. An analysis of the diary indicates that a total of 14 major sessions were held, ranging from 45 to 70 minutes (average length of 58 minutes), involving a total of 98 different participants.

Topics for the main telehealth sessions included: Interview Techniques; Interviewing Adolescents; Grief and loss; Disruptive Behaviour Disorders; Adolescent Mental Health and Review; School Refusal; Young People and Psychosis; Young People and Depression; Management of Suicidal Young People; Psycho-pharmacology; Working with Adolescent Males - A Narrative Approach; Discussion of Case Work Issues and Review of Previous Topics; Working with Indigenous Families.

There were fewer main sessions in 1999 compared with 1998, although 17% of the sessions conducted in 1998 were for administrative purposes. The reduction in the number of main sessions was a result of regular sessions between Port Pirie—Coober Pedy and Port Adelaide—Roxby Downs, that were not recorded in the main diary of sessions. There were significant increases in 1999 in terms of the total number of participants (an increase of 51); the average number of participants at the
‘far end’ rose from 3.1 to 12.6; and the total number of different participants at the far site rose from 21 to 70. Coober Pedy was by far the most frequent far end location (attended 100% of sessions) followed by Darwin (79%) and Alice Springs (64%).

Interviews

From October-December 1999, interviews were conducted with a sample of seven key participants in the project from the following locations: Darwin, Alice Springs, Roxby Downs, Coober Pedy, Port Pirie and from CAMHS offices in Adelaide and Port Adelaide. The participants were selected because of their major roles in the project. Additionally, the Project Officer was interviewed on two occasions.

The interviews demonstrate that the telehealth project resulted in the effective development of both formal and informal networks between CAMHS and remote site practitioners. The telehealth project encouraged additional collaboration between health professionals from different disciplines, within each site. The project also succeeded in helping remote-site practitioners to access CAMHS resources and in a number of cases new services have emerged, such as the direct provision of support from a rural office of CAMHS to an isolated community.

Roxby Downs case study

Roxby Downs was established in the 1980s and is one of Australia’s fastest growing population centres, due to the huge mining activities in the district. This rapid growth stretches the available community resources and can affect mental health in the community. During their visit in May 1999, CAMHS staff conducted a mental health needs assessment in conjunction with Roxby Downs Area School staff and senior students.

During 1999, the Western Office of CAMHS, at Port Adelaide, used the telehealth videoconferencing facilities on at least a monthly basis to link to the remote mining town of Roxby Downs. Additionally, two CAMHS staff members visited Roxby Downs in May 1999, for face-to-face discussions.

The school counsellor at Roxby Downs Area School has been the same person throughout 1998-99, although the community school nurse has changed. She values the professional network provided by the CAMHS RHSET project, particularly the ability to talk directly with the CAMHS Western Office staff, including the School Liaison Officer. She particularly appreciated the opportunity to talk about a case involving grief and loss with mental health professionals within CAMHS staff.

Coober Pedy

Coober Pedy is a remote opal mining town, 860km north of Adelaide in the far north of South Australia, on the edge of the Simpson Desert. Despite this isolation, the staff at Coober Pedy were the most frequent participants in the RHSET CAMHS Telehealth project in 1999.
Mental health issues that are common in the Coober Pedy area include youth depression, attention deficit disorder, family disharmony, early psychosis and substance abuse issues. Many of these issues were addressed in seminars provided in the 1999 RHSET CAMHS Telehealth project in 1999. CAMHS also provided videoconferencing links from the Port Pirie office. These two features of the 1999 professional development program may explain the very strong support for the network by the Coober Pedy health staff.

Issues for further investigation

The evaluation of activities in 1999 shows that, if the professional development network is to flourish, there is an ongoing need for research and development, particularly as the technologies involved in telehealth continue to change and improve and as users become more confident. Many of the initiatives taken in 1999 have only started to be addressed, so any ongoing funding could wisely be directed at the completion of initiatives taken to date.

Ongoing funding is required for project management, transmission costs, the costs of bridging, the implementation of new web-based technologies and the costs of supplying videotapes and printed materials. Ideally, funds would also be available for presenters to travel at least once per year to the sites receiving the professional development sessions.

Concluding comment

The evaluation of the first year’s activities in 1998 provided evidence of the effectiveness of the professional development model used in the project. The model involves the provision of professional development services using a combination of technologies: videoconferencing, videotapes, printed materials and a web site. Additionally, participants in remote and rural locations are surveyed to assess their professional development interests and needs. Other aspects of the model are the annual face-to-face visit by the CAMHS staff to the remote sites, to establish rapport and the encouragement for participants to network with the other personnel involved in the professional development activities.

The evaluation of the 1999 activities confirms the potential of this telehealth professional development model for use on both a State-wide and a national basis. The 1999 report also highlights the effectiveness of regular telehealth links between CAMHS office at Port Pirie and the mining town of Coober Pedy and between the CAMHS office at Port Adelaide and the mining town of Roxby Downs.

The report shows that this unique telehealth model of professional development is meeting the needs of staff based in rural and remote communities, it deserves ongoing funding support and it warrants continued evaluation. The model for professional development is attracting international attention, evidenced by the acceptance of an article for publication in the refereed Journal of Telemedicine and Telecare: ‘An evaluation of a network for professional development in child and adolescent mental health in rural and remote communities’ (Mitchell, et al, 2000).
Chapter 1: Project and Evaluation Methodology

The Rural Health Support, Education and Training Program (RHSET) Telehealth Project being undertaken from 1998-2000 by Child and Adolescent Health Services (CAMHS) at the Division of Mental Health, Women's and Children's Hospital (WCH) involves the provision of professional development for mental health staff in rural and remote sites such as Darwin, Alice Springs, Roxby Downs and Coober Pedy. The project is called, “Bringing child and adolescent mental health services to rural communities.” The three aims of the project are to improve accessibility to services, to establish telehealth networks and to evaluate the effectiveness of telehealth. These services are delivered using telehealth technologies: videoconferencing in particular, as well as the Internet, printed materials and videotapes.

The project is financed by RHSET, the South Australian Department of Human Services, Territory Health Services and Coober Pedy Suicide Prevention Project and the sites involved in the project are Port Augusta, Whyalla, Port Lincoln, Roxby Downs, Coober Pedy, Alice Springs and Darwin.

Context

Historically, rural and remote communities have had limited access to mental health services and service delivery has generally been provided through isolated general practitioners and other primary health care service providers supported by infrequent visiting specialist services. The Report into the National Inquiry into the Human Rights of People with Mental Illness (1993) noted that training and support for mental health, health and other professionals involved in working with children and adolescents with mental health problems, in rural and remote areas, was totally inadequate.

The Women’s and Children’s Hospital, Division of Mental Health (CAMHS) has been working to address these issues and has established permanent child and adolescent mental health services in Whyalla, Port Lincoln, Port Augusta and Port Pirie. The Division has also established a Northern Country Advisory Committee to facilitate the development of these services.

The WCH Division of Mental Health is a leader in South Australia in the development of innovative information technology strategies to further improve service delivery to rural and remote communities who have difficulty in accessing support and services from these established centres. Feedback from CAMHS staff in rural South Australia has indicated that one of the principal reasons that they will
work in rural areas is due to the extensive support mechanisms that have been set up by the Division.

**Project objectives**

The three objectives of the project are:

1. to improve the accessibility of rural and remote health and other service providers in remote areas of Australia to specialist child and adolescent mental health consultation and support, and ongoing training and education through the use of telehealth technology

2. to establish telehealth networks between service providers in rural and remote communities (e.g., rural and remote areas of South Australia, Darwin and Alice Springs)

3. to evaluate the effectiveness of telehealth as a strategy for providing a broad range of services, related to child and adolescent mental health, to rural and remote areas.

These objectives formed the basis of the evaluation of the first evaluation of the project (Mitchell, 1999) and also provide the focus for this second evaluation report.

**Evaluation Methodology**

The wide-ranging objectives of the evaluation necessitated the use of both quantitative and qualitative techniques. Four distinct sources of data were used:

1. Structured Interviews

A structured interview was constructed in order to widen the perspective of the analysis possible from the survey data. The interview comprised 16 open questions that sequentially addressed the three objectives of the project. A total of 7 interviews were conducted during October-December 1999. Staff from the eight main locations (Alice Springs, Darwin, Roxby Downs, Coober Pedy, Port Adelaide, Port Pirie, Elizabeth and Adelaide) were represented. The questions for CAMHS staff were modified slightly from the set of questions put to non-CAMHS staff.

2. Case Studies

Two major case studies — of Coober Pedy and Roxby Downs — were prepared, involving dialogue over an extended period with relevant CAMHS staff and staff based in the two remote sites.

3. The RHSET Telehealth Diaries

Two separate logs were maintained during 1999. Firstly, a log was maintained by the Project Officer that recorded details for each telehealth session such as the date,
duration and content of the session, together with a list of the participants present at each end. A total of 14 different sessions were recorded in this RHSET Telehealth Diary. Secondly, a log was maintained by the CAMHS manager from Port Pirie, noting the 6 sessions conducted between Port Pirie and Coober Pedy.

4. Monitoring of Project Management

The evaluator attended the majority of the project management team meetings during 1999-2000 to observe and take notes. On several occasions, the participation was via teleconferencing. In addition to informal contact, the evaluator also formally interviewed the project manager on two occasions.

**Project Management Structure**

The Project has been managed using a two-tiered structure: a Project Management Group and a Project Advisory Committee. The Project Management Group consists of the Project Manager, Phil Robinson, Project Officer, Chris Seiboth (replaced by Kathryn Robinson in September 1999), and senior members of CAMHS. The group met bi-monthly during 1999 and addressed the following topics at each meeting:

- arrangements at each of the main sites, Darwin, Alice Springs, Roxby Downs and Coober Pedy
- responses to the regular telehealth sessions, particularly the Seminar program and the distribution of videotapes
- project documentation, including conference papers, preparation of a journal article, and the web site
- evaluation
- training
- budgetary matters.

Additionally, a Project Advisory Committee was formed with representatives from all sites, members of the project team and invited members from State and Territory Health Services. During 1999, the Committee met on an occasional basis to provide overall direction for the project. Robinson et al (1999) report that the Project Advisory Committee has provided ongoing advice, contributed to project planning, provided comment on the evaluative processes, participated in the development of further initiatives and ensured the project objectives are met.

**Technological platforms**

Professional development was provided using four main technological platforms: videoconferencing, printed materials, videotapes and the Internet.
Videoconferencing equipment is installed at all sites involved in the network. All sites have PictureTel equipment, except for Coober Pedy which has a small, portable ERIS unit. The CAMHS sites have PictureTel SwiftSites, a small, portable and economy-priced unit that sits on top of a monitor. Darwin uses a larger System 4000 room unit and Alice Springs uses a SwiftSite.

All the videoconferencing sessions used Integrated Services Digital Network (ISDN) at the low bandwidth of 128kbps, the equivalent to two lines. The costs of such links are as follows: 54 cents per minute for calls from 165-745km (e.g. Adelaide to Roxby Downs) and 62 cents per minute for calls over 745km (e.g. Adelaide to Alice Springs). Many of the videoconferencing sessions conducted in 1999 used a bridge, to enable more than two sites to attend. Bridging costs are typically around $50 per site per hour.

Printed materials were issued to support some of the videoconferencing sessions. The main fourteen seminars conducted in 1999 were videotaped and the tapes were then circulated to sites requesting copies. The tapes were particularly popular with personnel who missed the live videoconferencing session.

A portion of the Women's and Children's website is dedicated to this project at <www.wch.sa.gov.au/dmh/projects/rhset.html>.

CAMHS staff are exploring the potential of putting the videoconferencing sessions onto CD ROM, for easier handling and distribution than videotapes. Investigations have revealed that videostreaming is not yet an affordable or reliable means to make available the video material to staff in rural and remote locations.
Chapter 2: Comparisons with other networks

A review of the international literature relevant to the CAMHS RHSET Telehealth Project, in relation to Telehealth potential and protocols, remote professional development and educational delivery, was provided in the first evaluation. Set out below is an additional review of the literature, pertinent to the focus of the second stage of the project. This second literature review identifies where the CAMHS RHSET Telehealth Project complemented and extended the use of telehealth for remote professional development and networking in Australia.

Major findings

This literature review provides two major findings. Firstly, this second literature review shows that the CAMHS RHSET Telehealth project complements previous uses of technology to provide professional development to mental health staff in rural settings in Australia. Secondly, this second literature review shows that the CAMHS RHSET Telehealth project extends previous uses of technology to provide professional development to mental health staff in rural settings in Australia, in four main ways:

- the network is particularly complex: the network stretches across a State/Territory border, involves two different health departments and the distances between sites — e.g. 3,000km from Adelaide to Darwin — are extreme.
- sub-networks involve the provision of professional development from one regional town (Port Pirie) to a remote mining town (Coober Pedy) and from a metropolitan office of CAMHS (the Western Office) to another mining town (Roxby Downs)
- the network has always used other media such as print, videotapes and the World Wide Web to complement its videoconferencing sessions
- the provision of this professional development service is now part of the normal fabric of the CAMHS operation and is achieved on a modest budget with high user satisfaction levels.

Telepsychiatry networks

During the 1990s, Australia has been among the leaders in the world in the use of videoconferencing to deliver clinical psychiatry by videoconferencing, particularly in South Australia (e.g. Hawker et al, 1998) and Queensland (e.g. Yellowlees & Kennedy, 1996). For instance, Yellowlees and Kennedy (1996, pp.207-208) report
that an integrated mental health service at the Royal Brisbane Hospital provided the platform for the provision by videoconferencing of a range of internal services such as clinical consultations, nursing handovers and hospital grand rounds. External services provided by the videoconferencing network included clinical supervision, interviewing, meetings and teaching. With regard to teaching:

A variety of teaching activities, both into our system and out from our system, took place. These involved Queensland and other parts of Australia. The Department of Psychiatry began modifying its post-graduate educational programme to incorporate distance learning via telemedicine.

((Yellowlees and Kennedy, 1996, p.208)

**Victorian network**

Gelber & Alexander (1999) report on the use of videoconferencing equipment by the Child and Adolescent Mental Health Service in Victoria since April 1995, the first regular service of its kind for child and adolescent mental health in Australia. This operation is part of the Royal Children’s Hospital mental health service which provides inpatient, outpatient and consultation services for children, adolescents and their families. As a tertiary service it has responsibility for providing a range of mental health services to the western half of Victoria, which has a population of 230,000 people under 19 years of age. Gelber & Alexander report that many respondents to their survey

identified the importance of videoconferencing to their professional practice. Respondents were able to distinguish between individual access to professionals (which would improve their professional practice) and reduction of social isolation (which would make them not feel so alienated). (1999, p.22

In contrast to the South Australian CAMHS network, Gelber & Alexander (1999, p.22) report that the survey of staff ‘reported relatively little use of the technology for teaching and training’, although the Victorian CAMHS has since developed ‘a method of using videoconferencing technology for education and training and feedback has been positive’ (p.22). The Victorian CAMHS focus is on consultation, clinical work and case supervision, while the South Australian CAMHS RHSET network is focused on professional development. The SA CAMHS RHSET network has always used other media such as print, videotapes and the World Wide Web to complement its videoconferencing sessions.

**Proposed Victorian-Tasmanian network**

A primary focus on providing professional development for health care workers in rural settings, similar to the CAMHS project, is paralleled by one proposed project (Crowe and McDonald, 1998). The aim of the Victorian-Tasmanian project is similar to the CAMHS network in aiming to reduce disparities in access to high-quality continuing medical education (CME) for health professionals in rural and remote areas, as compared with metropolitan areas. Crowe & McDonald (1998) explain:

At present, for example, major teaching hospitals hold weekly grand rounds and regular seminars on
developments in nursing and medicine given by local and overseas experts. The best that rural and remote nurses can expect are occasional visits to city hospitals and possible attendance at annual meetings. (p.240)

The Victorian-Tasmanian project differs from the CAMHS network in that it does not specifically address mental health professionals. Crowe and McDonald report that the target group for their project will be rural and remote directors of nursing in Victoria and Tasmania and that two methods of educational delivery have been selected for comparison:

The first method is one-hour weekly videoconferencing sessions of CME to staff at 32 rural centres in the State of Victoria. The second method involves the conversion of these sessions to a WWW-based format for distribution on compact disk (CD) to 20 sites in Tasmania with appropriated PCs. (1998, p.241)

This approach differs slightly from the CAMHS network which has found videotapes, not the World Wide Web, are of most value to complement the live videoconferencing networks. The CAMHS network has also found that four to five sites are about the maximum number that can be involved in a conference, if regular interaction is desired. The proposed Victorian-Tasmanian delivery to 32 sites would suggest a ‘broadcast’ approach, with a dominant presenter and minimal interaction. The research undertaken by the CAMHS network also shows that the provision of stored video via the World Wide Web, while an interesting option, introduces a number of technical and financial obstacles for users, such as the need for high powered PCs at all sites and the costs of establishing and maintaining a stored video service.

South Australian telepsychiatry network

D’Souza (2000) reports that the South Australian telepsychiatry network set up a pilot educational programme to meet the educational, training and professional development needs of rural mental health practitioners. The reasons for this initiative are similar to the motivation for the SA CAMHS RHSET network:

There has been a long-standing difficulty with attracting health-care providers, including psychiatrists and general practitioners (GPs), to rural areas of Australia. Factors inhibiting professionals from moving into rural and remote regions include professional isolation, difficulty in maintaining professional knowledge, difficulty in maintaining a career path, poor peer consultation and having to travel long distances. (D’Souza, 2000, p.187)

D’Souza (2000) then established a series of educational and clinical modules incorporating current research and clinical information, targeted for rural and remote mental health practitioners. Modules were developed on the following topics:

1. depression and suicidal ideation in psychosis;
2. the discontinuation syndrome with selective serotonin reuptake inhibitors - identifying and managing it;
3. management of schizophrenia;
4. the management of first psychosis;
5. crossing over from typical to atypical antipsychotics;
6. cognitive-behaviour therapy applied to psychiatric disorders;
7. overview of obsessive-compulsive disorder;
8. managing the borderline personality disorder. (D’Souza, 2000, p.188)

In total, forty-six community mental health workers from nine rural areas and twenty GPs from five rural areas participated in the sessions. D’Souza concludes that:

There were high satisfaction scores with the service fulfilling their professional and academic needs with regard to mental health. The service helped improve confidence and competence in managing mental illness...The results of the evaluation suggest that telemedicine can play an important role in the process of attracting and retaining health professionals in rural areas. (2000, pp. 188-189)

Child and adolescent psychiatric service in rural New South Wales

Dossetter et al (1999) examine the feasibility of a child and adolescent psychiatric service in rural New South Wales, using telemedicine, based on trials conducted in 1996-97. The study found that telepsychiatry proves access to a flexible, effective tertiary service for those with special, complex needs, including the disadvantaged or isolated. (p.525) Bridging technology for multipoint conferences was not available for the trial, lessening the impact of the network’s services on a range of staff.

Professional development was a secondary feature of the network, with primary attention given to clinical assessments and management of severe, complex, mental and neuropsychiatric disorders. However, the authors concluded that telepsychiatry ‘makes a valuable, economic contribution to supporting and educating rural health professionals, thereby enriching rural mental health services’. (p.525)

Summary

In summary, Australia is a world-leader in the provision of telepsychiatry, led by initiatives in South Australia and Queensland. Much of the literature on the use of telehealth technology for mental health purposes relates to the delivery of psychiatric consultations and assessments. There is little focus on the specific area of child and adolescent mental health, except for the work of Gelber (Gelber & Alexander, 1999), Mitchell (1999) and Robinson et al (1999). The only other examples of a targeted focus on the professional development of mental health workers in rural areas, using telehealth technologies, are Crowe & Mcdonald (1998), who report on a proposed project, and D’Souza (2000) who reports on a service for the full range of mental health workers in five rural areas of South Australia.
Research reported in the remaining chapters of this study will identify the differences between the SA CAMHS RHSET Telehealth network and the proposed Victorian-Tasmanian project (Crowe & McDonald, 1998) and the work of D'Souza (2000). These differences will include the unique development of the CAMHS RHSET professional development network across a State/ Territory border and the development of sub-networks from one regional town to a remote mining town and from a metropolitan office of CAMHS to a second mining town. The development of these sub-networks demonstrate that the availability of videoconferencing and other technologies enables professionals in remote locations to easily access appropriate expertise in other centres. The SA CAMHS Network has also used a range of technologies to provide professional development, beyond those proposed by Crowe & McDonald (1998).
Chapter 3: Analysis of RHSET 1999 Telehealth Diary

This chapter provides an analysis of the RHSET Telehealth Diary maintained by the two Project Officers in 1999. The diary recorded the major sessions involving most sites in the network. In addition to these major sessions, a number of sessions were conducted between sub-networks such as Port Pirie—Coober Pedy and between CAMHS Western Office, Port Adelaide—Roxby Downs.

Numbers of participants

The 1999 Telehealth Diary recorded the essential details for each telehealth session such as the date, duration and content of the session, together with a record of who was present at each location. An analysis of the diary indicates that a total of 14 major sessions were held, ranging from 45 to 70 minutes (average length of 58 minutes), involving a total of 98 different participants.

The following table breaks these statistics down into the ‘near end’ (normally WCH in Adelaide) and ‘far end’ categories (i.e., Darwin, Alice Springs, Coober Pedy, Roxby Downs, Port Augusta, Port Pirie, Port Lincoln). The table also provides a comparison of 1998 and 1999 figures.

Table 3.1 Details of telehealth sessions, 1999 vs 1998

<table>
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<tr>
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<tbody>
<tr>
<td>Total number of session participants</td>
<td>68</td>
<td>53</td>
<td>111</td>
<td>177</td>
<td>Total: 179</td>
<td>Total: 230</td>
</tr>
<tr>
<td>Average number of participants in each session</td>
<td>1.9</td>
<td>3.8</td>
<td>3.1</td>
<td>12.6</td>
<td>Average: 5</td>
<td>Average: 16.4</td>
</tr>
<tr>
<td>Total Number of different participants</td>
<td>24</td>
<td>28</td>
<td>21</td>
<td>70</td>
<td>Total: 45</td>
<td>Total: 98</td>
</tr>
</tbody>
</table>

Figures in Table 3.1 show that there were fewer main sessions in 1999 compared with 1998, although 17% of the sessions conducted in 1998 were for administrative
purposes. The reduction in the number of main sessions was a result of regular sessions between Port Pirie—Coober Pedy and Port Adelaide—Roxby Downs, that were not recorded in the main diary of sessions.

Table 3.1 shows that there were significant increases in 1999 in terms of the total number of participants (an increase of 51); the average number of participants at the ‘far end’ rose from 3.1 to 12.6; and the total number of different participants at the far site rose from 21 to 70.

Session Topics

The topics for the fourteen sessions in 1999 were as follows:

1. Interview techniques
2. Interviewing adolescents
3. Grief and loss
4. Disruptive Behaviour Disorders Part 1
5. Disruptive Behaviour Disorders Part 11
6. Adolescent Mental Health and Review
7. School Refusal
8. Young People and Psychosis
9. Young People and Depression
10. Management of Suicidal Young People
11. Psycho-pharmacology
12. Working with Adolescent Males - A Narrative Approach
13. Discussion of Case Work Issues and Review of Previous Topics

Range of disciplines represented

It was also of interest to analyse who was using the Telehealth system in 1999. The 98 participants came from 8 different disciplines. An analysis of who used the Telehealth system is presented in the following table (which includes a near end/ far end distinction).
In comparison with 1998, there were higher percentages of psychiatrists and nurses involved in 1999.
Participation by locations

Using the data contained in the 1999 Telehealth Diary, the extent to which each far end location used the Telehealth system was assessed. The results indicate that Coober Pedy was by far the most frequent far end location (attended 100% of sessions) followed by Darwin (79%) and Alice Springs (64%). Given the remoteness of Coober Pedy, this is an important finding. The case study of Coober Pedy will be discussed in a later chapter, revealing that it also participated in a number of other sessions with Port Pirie.

Figure 3.2: Percentage of sessions attended by each ‘far end’ location

* Launceston is not part of the normal network and only participated for trial purposes in one session.

Summary

While the number of major sessions in 1999 was less than in 1998, more people attended sessions, including more nurses and psychiatrists, from more locations, than in 1998. The major findings were the 34% increase in the overall numbers of participants from 1998 to 1999, and the high level of participation by the remote sites of Coober Pedy, Darwin and Alice Springs. Chapters 5 and 6 will show that much more emphasis was placed in 1999 on direct videoconferencing links between the Port Pirie office of CAMHS and Coober Pedy and the Western Office of CAMHS in suburban Port Adelaide and Roxby Downs.
Chapter 4: Analysis of Interviews with Participants

From October-December 1999, interviews were conducted with a sample of seven key participants in the project from the following locations: Darwin, Alice Springs, Roxby Downs, Coober Pedy, Port Pirie and from CAMHS offices in Adelaide and Port Adelaide. The participants were selected because of their major role in the project. Additionally, the Project Officer was interviewed on two occasions.

The interview questions are set out below in italics, with a summary of the answers following. As far as possible, the identities of the participants have been disguised.

For brevity, answers that were similar are not reproduced below; nor is material referred to in the subsequent chapters on Roxby Downs and Coober Pedy.

Summary

The interviews demonstrate that the telehealth project resulted in the effective development of both formal and informal networks between CAMHS and remote site practitioners. The telehealth project encouraged additional collaboration between health professionals from different disciplines, within each site. The project also succeeded in helping remote-site practitioners to access CAMHS resources and in a number of cases new services have emerged, such as the direct provision of support from a rural office of CAMHS to an isolated community.

Background Questions

1. How have you personally been involved with the Telehealth project?

All of the interviewees in 1999 were extensively involved in the Telehealth project, in roles such as presenter, local contact person or active participant.

2. How has your group been involved with the project?

Involvement in the project by the interviewees’ colleagues included presentation of professional development seminars; participation in seminars; links between specific sites, such as Port Pirie and Coober Pedy; and visits between sites, e.g. CAMHS personnel visited Roxby Downs and Coober Pedy.

One benefit of the project is that it often brought together a multi-disciplinary team of health professionals working in the one location, to focus specifically on child and adolescent mental health. For example, the Darwin group participating in the project included a child psychiatrist, a psychologist, a family therapist and three clinical nurse consultants. Other Darwin staff involved included registrars from the
Darwin hospital, school counsellors and a school nurse. The telehealth sessions encouraged this multi-disciplinary group to bring their range of expertise to the case or issue being discussed at the Telehealth session.

From the CAMHS point of view, the development of closer associations with remote sites has led to the inclusion of a wide range of CAMHS personnel in the project. For instance, the close contact between CAMHS Western Division and Roxby Downs led to the involvement in the project of the school support staff within CAMHS. Also, as a result of discussions raised by the seminar sessions, a CAMHS staff member who is expert in the assessment of children was put in contact with one of the participants at a remote site. The project also enabled CAMHS staff at country locations such as Port Lincoln, Whyalla, Port Augusta and Port Pirie to participate in the professional development sessions.

3. What are the major challenges facing your group in terms of providing a range of services, related to child and adolescent mental health, in your area?

Responses to this question were many and varied, including:

- ‘dealing with psychosis of young people involved in using drugs, who need to know not to mix two types of drugs’
- ‘we are dealing with young people who are a lot more psychotic following drug usage: they use marijuana laced with acid’
- “attitudes of parents who want to ‘fix the child’ and have labeled the child as suffering from Attention Deficit Disorder”
- ‘meeting all of the local needs, as we don’t have specialist staff in all areas, such as in child abuse’.

For CAMHS staff, challenges have included:

- adjusting to the very different contexts at each of the remote sites: ‘the information has to be relevant to each site, and we have to tailor it accordingly’
- ‘coping with the frequent change of staff in some remote sites’
- ‘making solid connections with staff at remote sites’
- ‘understanding that most of the people in remote sites don’t work regularly with psychiatrists’.

4. How has the Telehealth network met the specific professional development needs of yourself and your group?

Almost all respondents listed specific topics that were addressed in one or more of the seminars as being of value to themselves and their groups. A typical response was:

The Telehealth network is good because I focus on older kids and I run parenting and behaviour
modification courses. The constant issues for me are assessing for suicide and what sort of intervention is useful and assessing depression and anxiety.

5. What have been the highlights of the project for you and your group?
Several responses included:

- ‘The project has increased my knowledge. Dr Jon Jureidini’s sessions were very useful: he explained the difference between the duty of care and the rights of children and parents’.

- ‘The support of specific staff in CAMHS has been good. They came to our school, talked to the teachers and provided resources’.

Following are the notes from one particular interview, where the highlights of the project were made very clear.

**Figure 4.1: Notes from an interview with remote-site practitioner No.1**

The main value of the Telehealth sessions for me is that I can see other clinicians express their point of view and this often confirms my point of view and my clinical approaches. It is nice to see other clinicians from England and Australia using approaches in a way that I can identify with. Our approaches are not dissimilar and I now know that we are not doing things too differently. We might have our own style but the umbrella under which we work is the same.

It was valuable to see how other people view suicide; how the other half views things. It whets the appetite to look for more information.

We have particularly enjoyed the following seminars: school refusal — it was a very good presentation, very appropriate and very relevant; depression in young people; suicide and threatened psychosis; and treatment of early psychosis.

**Objective No.1: Establishing Networks**

6. In what ways has the Telehealth project enabled you to establish new networks with the service providers involved in the project?
Several comments were:

- ‘Before the project began, I didn’t have a network. Now I find it interesting to hear about the problems and approaches in the other sites’.

- ‘I have found that many schools are used to videoconferencing and that we are able to contact a range of sites such as Woomera and Ceduna’.

One remote-site participant spoke at some length about the value of the network, the challenges faced in the workplace and changes that could be made to the telehealth program:

**Figure 4.2: Notes from an interview with remote-site practitioner No.2**
There are no formal arrangements for networking. Informally I contact the other (Telehealth project) participants who work in the same area as me. I also contact the CAMHS staff who are involved with educating youths from youth refuges, as we don’t have youth workers locally. I would like to present a telehealth session on youth shelters.

I am a sole practitioner in my field, in a difficult sub-program, and I am highly dependent on the local mental health team for support. I have spent six years in remote locations and a lot of my work involves indigenous clients, who are often in crisis.

I have more and more clients in the age group of 13-15, whose problems haven’t been caught before they are 9 years old. They are at risk from suicidal or depressive thinking; they have behavioural problems; and they have Attention Deficit Disorder. The younger patients often need behaviour modification support or their parents need parenting training. Sometimes the younger patients are adjusting to several losses in their lives.

I like the seminars and the case consultations by telehealth. I have to handle a diversity of problems, such as Aspergers Syndrome in kids. One per cent of the population have this syndrome, so it is a speciality field. I would like it addressed by the telehealth sessions. We did have one telehealth seminar on school refusal and I would like to see a session on behavioural difficulties at schools. I would like to have a telehealth seminar on ways staff from different systems (e.g. schools; youth workers; mental health workers) can collaborate on the one topic, e.g. behaviour difficulties at school.

There are so many different specialist services in CAMHS which we don’t have. We can’t use exactly, all of the ideas CAMHS staff present at the telehealth seminars, as we don’t have the staff, but we can make modifications.

7. As a result of participating in the project, what other opportunities might be available to you in the future to establish new networks with service providers involved in the project?

Comments included:

- ‘the project has raised the possibility of more links between Alice Springs and Darwin and using the link for clinical consultations’
- ‘the project has enhanced our links to the WCH; our staff now know CAMHS staff’
- ‘now I know who to contact in CAMHS, e.g. the School Support Liaison Officer in the Western Division’
- ‘we won’t be able to maintain the service without funding’
- ‘it is hard to tell, as there was not much feedback in the sessions I presented’.

8. What are both the impediments and incentives for you to establish new networks with service providers involved in the project?

Impediments cited included:
• ‘the main impediments are finance and the political factors: do we have the political will and capacity to extend the network to more rural areas’

• ‘impediments are time and getting to know who is available in CAMHS to assist us’.

Incentives identified were:

• ‘mine is not a pleasant environment: with so much social change there are social issues and harassment, so I have incentives to develop networks’

• ‘talking through of issues and passing on of ideas’

• ‘combining theory and practice: Roxby Downs has raised lots of issues and we are now very tuned to what they want’.

Objective No.2: Accessibility to CAMHS Services

9. What aspects of the training and education provided in the Telehealth project have you most appreciated and why?

• ‘I appreciate all of it. I like using the videotapes later’.

• ‘I appreciated the chance to talk to CAMHS staff about grief and loss’

• ‘I appreciated the useful sessions from psychiatrist Dr Jon Jureidini, whose ideas I have now incorporated into my work’

• ‘I valued the sessions on pharmacology and behaviour disorders’.

10. In what ways has the use of telehealth in the project changed your models of the way clinical and educational services can be provided to rural and remote sites?

• ‘I now know that services are accessible and people are prepared to assist’

• ‘The project hasn’t changed my views at all: I have always used videoconferencing, but we could use it more’

• ‘I have learnt that telehealth is a good way to provide a service from a distance, although it is good to have some face-to-face contact, particularly in the first instance’

• ‘There has been a fair bit of conversation in my team, about possibilities’

• ‘As a result of the project, Port Augusta now provides clinical services for Roxby Downs in parenting and therapeutic programs for girls who have been abused, using a combination of face-to-face and videoconferencing’.
11. What barriers have prevented you from accessing more of the specialist consultation and support services made available through this project?

- ‘If our local child psychiatrist moves, we will have more need of the service’
- ‘School timetables and holidays’
- ‘The equipment is not portable enough; it is not as easy as ringing on a telephone’.

Objective No.3: Effectiveness of Telehealth

12. What do you believe are the strengths of telehealth in providing a range of services, related to child and adolescent mental health?

- ‘You can get a lot of people at different sites and hear their points of view’
- ‘It offers an immediate network’
- ‘Once I see someone on the videoconferencing I can get on the phone immediately afterwards and talk to them’
- ‘Distance is overcome: telehealth a great reducer of distance barriers’
- ‘Once you get used to it, it is an OK lecture format. It brings into focus what is a good lecture: have a limited number of messages and reiterate them. When I was most clear in my lectures about the messages, the medium worked best. It should be an adjunct to other services. The value of the medium rises after you have met the participants in their sites, and know their context: without it you may as well make a video’.

13. What improvements would you like to see made in the way telehealth is used?

- ‘Operators of the technology sometimes mess it up’.
- ‘I am hard to locate if there are changes to the schedule’
- ‘It would be good to have someone permanently as a ‘telehealth worker’ so I wouldn’t need to book the equipment at my site’
- ‘We need more notes with the videotapes’
- ‘We need a concise manual on how to use videoconferencing’
- ‘Telehealth sessions need to be more structured than face-to-face sessions; it needs to be clear about what we are doing in a session and where we are going’
- ‘I would like to see funding made available for GPs to link to psychiatrists’
- ‘I would like the seminar sessions to start with a grand tour, so I can meet everyone beforehand. If you knew the people better at the other sites, the medium would be amenable to many other uses’
14. What issues does telehealth raise in relation to confidentiality and protocols and how do you think these can be resolved?

- ‘I don’t see any issues: when I presented a case I changed the names and presented it in a very clinical way’
- ‘We need to stick to the guidelines produced in 1999’
- ‘I wonder about who else is connected to our airwaves’
- ‘Confidentiality is a key issue, as not all of the people attending are from the same organisation. It is difficult for us to have a case conference’
- ‘Inexperienced clinicians might need to be made aware of the new protocols and the consent form’.

15. How effective are videoconferencing, the Internet, videotapes and printed material for providing a range of services, related to child and adolescent mental health, to rural and remote areas?

- ‘Videotapes are very effective: they provide a frame of reference and can refresh people’s minds’
- ‘Videotapes are very popular, particularly when we have an overseas guest speaker’
- ‘I have never accessed the Internet’
- ‘I am very impressed with the HeadRoom website’ (URL: www.headroom.net.au)
- ‘Videoconferencing is wonderful and I need to get others involved’
- ‘Videoconferencing is very useful as an adjunct to visiting clinical services and case conferences; the Internet is of variable use in remote sites’.

16. To what extent has telehealth become a normal way of doing business for your organisation?

- ‘Videoconferencing is very good. We are very used to it now in Darwin. It is an integral part of the training and educational process in this organisation’
- ‘We are still scratching at the surface and have a long way to go to develop good systems, due to time constraints’
- ‘We are moving down that path: it has brought CAMHS and the country closer together and it meets the different needs of each site we link to’
- ‘Telehealth has provided additional resources, but I would like more’
• ‘We would like to be able to directly refer patients using the telehealth link’

• ‘It has become normal business: we all use it regularly for psychological assessments and to attend meetings’.
Chapter 5: Case Study: Roxby Downs

This chapter provides a case study of the use of the telehealth facilities to link the Western Office of CAMHS, at Port Adelaide, with the fast-growing mining town of Roxby Downs, 540 km from Adelaide.

As a result of the relationship established with the school counsellor during the RHSET CAMHS Telehealth project in 1998, a regular and structured communication was implemented in 1999. During the year, the Western Office of CAMHS, at Port Adelaide, used the telehealth videoconferencing facilities on at least a monthly basis to link to Roxby Downs. Additionally, two CAMHS staff members visited Roxby Downs in May 1999, for face-to-face discussions.

Mental health profile

Roxby Downs was established in the 1980s and is one of Australia’s fastest growing population centres, due to the huge mining activities in the district. The town has an average population age of 28 years and has the highest birthrate of any town in South Australia. This rapid growth stretches the available community resources and can affect mental health in the community. During their visit in May 1999, CAMHS staff conducted a mental health needs assessment in conjunction with Roxby Downs Area School staff and senior students. Some summary points from that needs assessment are set out in Table 5.1.

Table 5.1: Points from the mental health needs assessment of Roxby Downs, as identified by CAMHS personnel, 1999

<table>
<thead>
<tr>
<th>Feature</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Families</td>
<td>Many parents living in Roxby Downs are pursuing short term financial goals. This can effect their orientation to broader family functioning and commitment to the wider community including the school. Children in such families are effected by this focus: for example, reduced contact with parents because of work commitments or increased responsibilities such as caring for younger siblings. Many families do not have the support of extended family or long term friendship networks.</td>
</tr>
<tr>
<td>2. School</td>
<td>The school has undergone enormous growth in 1998/99 placing pressure on both physical resources such as yard space and human resources such as the development of more elaborate management structures. As in most remote locations, staff turnover is relatively high. This has implications at many levels such as the ventilation of new staff, mechanisms for continuity of school practices and culture and the integration of ‘new’ and ‘old’ staff.</td>
</tr>
</tbody>
</table>
3. Employer

The town’s existence is primarily a result of Western Mining Company’s (WMC) mining activity, hence WMC’S policies and procedures, such as shift rosters, have a huge impact on the community and the school.

The transitional nature of the people who choose to work in Roxby Downs has considerable impact on the mental health aspects of the town. For instance, many people only stay for a short time therefore friendships are difficult to maintain.

During the May 1999 visit, CAMHS staff interviewed teaching personnel at the Roxby Downs Area School, and found that the rapid growth of school and the fact that teachers only stay for an average of four years made it difficult for the school to develop traditions. It was also difficult to gain parent participation at the school, when parents worked long shifts and, in a high percentage of families, both parents worked. Some stress was created by the lack of job options locally for young people finishing school. The rapid growth of the town was also putting constant pressure on the availability of health and other community resources.

The following table provides a sample of the specific mental health issues arising in the primary and secondary school population at Roxby Downs, as identified by CAMHS and school staff.

**Table 5.2: Sample of issues impacting on mental health, as identified by CAMHS and Roxby Area School staff**

<table>
<thead>
<tr>
<th>Primary School</th>
<th>Secondary School</th>
</tr>
</thead>
<tbody>
<tr>
<td>• harassment and bullying</td>
<td>• stress of study and home work load</td>
</tr>
<tr>
<td>• dealing with change</td>
<td>• coping skills</td>
</tr>
<tr>
<td>• anger management</td>
<td>• insufficient pastoral care</td>
</tr>
<tr>
<td>• pressure to perform in upper secondary school</td>
<td>• time management for distance education</td>
</tr>
<tr>
<td>• students with special needs</td>
<td>• care issues such as parent availability</td>
</tr>
<tr>
<td>• effect of parents’ shift work: shift work/ school hours mismatch</td>
<td>• drug use</td>
</tr>
<tr>
<td>• tiredness: long days-before &amp; after school care</td>
<td>• care issues- older children minding young ones</td>
</tr>
<tr>
<td>• predominantly young families</td>
<td>• performance pressure from parents</td>
</tr>
<tr>
<td>• no available grandparents: grief and loss</td>
<td>• unemployment for a few school leavers</td>
</tr>
<tr>
<td>• older children caring for younger</td>
<td>• different school systems across Australia when children are mobile</td>
</tr>
<tr>
<td>• economic goals strong family focus</td>
<td>• play space</td>
</tr>
<tr>
<td>• proactive school planning</td>
<td></td>
</tr>
<tr>
<td>• kids with adult duties e.g. meals preparation child care</td>
<td></td>
</tr>
<tr>
<td>Challenges Faced by CAMHS Staff</td>
<td>Challenges Faced by Roxby Downs Personnel</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>confined living: e.g. caravan park</td>
<td>the advice available at CAMHS needs to be tailored to suit the Roxby Downs context</td>
</tr>
<tr>
<td>large amounts of disposable cash</td>
<td>some support staff at Roxby Downs Area School and Community Health have changed, making it difficult to develop the relationship</td>
</tr>
<tr>
<td>some suicidal thought due to hopelessness</td>
<td>the videoconferencing technology at Roxby Downs is not portable and is not easy to access</td>
</tr>
<tr>
<td>peer conflict: one school with no options</td>
<td>more funding for the videoconferencing will need to be identified, if the service is</td>
</tr>
<tr>
<td>parents' history of poor of school experience</td>
<td></td>
</tr>
</tbody>
</table>

Roxby Downs Area School is actively providing a range of programs in an attempt to meet these many challenges. These programs include: behaviour management; boys talk; boys and relationships; stop think do; reading recovery; protective behaviours; club activities; and pastoral care.

**Description of services provided**

Specific cases addressed in 1999 by Roxby Downs staff and the CAMHS Telehealth Project included:

- primary school children anxious about death
- a small primary school boy suffering from gender confusion
- a boy exhibiting oppositional defiance disorder
- children affected by grief and loss, after moving from one community to another and struggling to gain acceptance in the new environment
- children from families that had moved from overseas, with no extended family in Australia
- children with Attention Deficit Disorder.
to continue.

One CAMHS staff member compared Darwin, with its almost self-contained group of mental health workers, with Roxby Downs’ limited staffing and noted that Roxby Downs has a high need for clinical consulting and support as well as professional development.

Value of the telehealth network

The school counsellor at Roxby Downs Area School has been the same person throughout 1998-99, although the community school nurse has changed. She values the professional network provided by the CAMHS RHSET project, particularly the ability to talk directly with the CAMHS Western Office staff, including the School Liaison Officer. She particularly appreciated the opportunity to talk with mental health professionals within CAMHS about a case involving grief and loss. She finds the videoconferencing facility enables her to ‘see the body language and gestures of the person at the other end’ and hence to establish good rapport. The school counsellor feels that she is unable to take full advantage of the telehealth network due to the lack of time, teaching commitments and resources.
Chapter 6: Case Study: Coober Pedy

Coober Pedy is a remote opal mining town, 860km north of Adelaide in the far north of South Australia, on the edge of the Simpson Desert. Despite this isolation, the staff at Coober Pedy were the most frequent participants in the RHSET CAMHS Telehealth project in 1999. This chapter examines their involvement in the network.

Summary

Mental health issues that are common in the Coober Pedy area include youth depression, attention deficit disorder, family disharmony, early psychosis and substance abuse issues. Many of these issues were addressed in seminars provided in the 1999 RHSET CAMHS Telehealth project in 1999. CAMHS also provided videoconferencing links from the Port Pirie office. These two features of the 1999 professional development program may explain the very strong support for the network by the Coober Pedy health staff.

Profile

While the town of Coober Pedy can swell to 4,500 at the height of the tourist season, the region serviced by the Hospital encompasses Mintabie, Marla, Oodnadatta, William Creek and surrounding pastoral stations, with a population estimated at 6,000 people. Coober Pedy is a very multicultural town comprising 48 different nationalities and an Aboriginal population of around 500. The Aboriginal population changes regularly due to the number of people travelling to and from the Pitjantjatjara lands.

Coober Pedy is now facing an ageing population, as essential services such as water, electricity and transport become available and reliable, and some older residents are electing to stay in Coober Pedy and retire.

Mental health profile

The hospital at Coober Pedy is classified as minimum volume and has 20 acute beds, an operating theatre, delivery suite and a busy casualty and X-ray facility. The Community Health Centre supports a range of activities including Community Nurses, Domiciliary Care, Women’s Health, Occupational Therapist, Aboriginal Aged Care and meals program. The Hospital is supported by only one local General practitioner. Allied health services are provided from Port Augusta (550km away) and Whyalla, and visiting specialists come from private practices based in Adelaide.
The mental health issues affecting young people in Coober Pedy have been raised at both local and statewide forums for many years. Domestic violence and substance abuse are significant concerns within the community and have a detrimental effect on family functioning and young people during their crucial developmental years. Problems identified include aggressive behaviour, problems dealing with change, safety issues, poor problem solving skills, poor self esteem, anxiety and adjustment disorders.

It is well documented that indigenous communities are at greater risk of mental health problems such as suicidal tendencies and self harm. Indigenous young people living in remote areas can experience significantly different levels and forms of stress. The social context, the place of social stresses and issues of identity impact on their mental health. Issues identified in Coober Pedy include depression, anxiety, truancy, anti-social behaviours and substance abuse problems.

The CAMHS Northern Country Services have maintained contact with Coober Pedy for at least two years. Prior to the commencement of this Project, a visit was made to Coober Pedy by staff from the Division of Mental Health. The use of telehealth facilities has extended the previous relationship. Coober Pedy’s interests were also represented on the CAMHS Northern Country Region Advisory Committee where mental health issues for young people in remote areas were made more visible. A proposal has been prepared to extend the services to Coober Pedy through the more regular visit of CAMHS staff and the continuation of the telehealth service. Challenges facing the Northern Country Division in servicing Coober Pedy include the lack of funding and the issue of how to deliver a mental health service over a vast distance.

Monica McEvoy, Regional Director of CAMHS Northern Country Services is based at Port Pirie and is the regular contact for Coober Pedy’s telehealth links. Monica emphasises that developing a telehealth service to Coober Pedy enables visiting clinicians to have videoconferencing contact with their patients in Coober Pedy in between visits, to foster an ongoing relationship. She also believes that a telehealth service would provide equity for people in a remote area, who miss out on the benefits of living in the capital city, Adelaide, or in large towns.

Monica McEvoy finds that health staff in country towns do not automatically accept innovations such as telehealth as a replacement for a face-to-face service. Some remote communities also have some disillusionment with the levels of service offered in the past and are sceptical about new offerings. Coober Pedy proved an exception to this approach in 1999, when its staff attended nineteen different videoconferences offered as part of the RHSET CAMHS Telehealth project.

**Description of services provided by RHSET Telehealth project**

Health staff at Coober Pedy participated in all the fourteen seminars provided from Adelaide during 1999, as described in Chapter 3. Staff also participated in the following six videoconferencing sessions conducted by CAMHS from Port Pirie. The
types of topics addressed in the Port Pirie sessions included sexual orientation, stealing, sibling rivalry, aggression in young children and truanting.

Table 6.1 Telehealth links from Port Pirie to Coober Pedy, 1999

<table>
<thead>
<tr>
<th>Date, length</th>
<th>Port Pirie</th>
<th>Coober Pedy</th>
<th>Professional Development Topics/Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>confidentiality</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>pro-formas</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>meeting times</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>confidentiality</td>
</tr>
<tr>
<td>4/5/99 60 mins</td>
<td>*4</td>
<td>*4</td>
<td>psychosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>sexual orientation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>stealing</td>
</tr>
<tr>
<td>11/5/99 60 mins</td>
<td>*4</td>
<td>*4</td>
<td>sibling rivalry</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>aggression in young children</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>behaviour management</td>
</tr>
<tr>
<td>10/6/99 90 mins</td>
<td>*4</td>
<td>*2</td>
<td>truanting</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>child neglect and trust</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>impact of DV on children</td>
</tr>
<tr>
<td>4/8/99 30 mins</td>
<td>*4</td>
<td>*5</td>
<td>stealing</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>no stealing contracts</td>
</tr>
</tbody>
</table>


In addition to the videoconferencing sessions, Monica McEvoy visited Coober Pedy in September 1999 with child psychiatrist Dr Jon Jureidini, for inter-agency meetings. Dr Jureidini is one of the regular presenters of professional development sessions on the telehealth network and his visit was considered very valuable by the Coober Pedy health staff. A direct result of the visit was the provision of a clinical consultation on 25 November 1999, with Monica McEvoy in Port Pirie linked to Coober Pedy, to assess a teenager from Oodnadatta.

In March 2000, a three-site videoconferencing was held, involving CAMHS’s sites in Enfield in Adelaide and at Port Augusta linked to Coober Pedy. The session focused
on developmental mental health issues for girls aged 11-13. Participants at Coober Pedy included the Community Health nurse, the school counsellor, a class teacher and a Family and Youth Services worker.

Value of the network

Monica McEvoy believes that the strengths of telehealth for health staff in towns such as Coober Pedy are as follows:

- it enables staff to access professional development and to stay in their own communities
- it saves on travel time and costs
- it increases access and equity
- it helps remote sites feel more connected to a health professionals network.

Evidence of the outcomes of the RHSET CAMHS Telehealth project is that Monica McEvoy now receives many more telephone calls from Coober Pedy than in the past. An informal but important benefit of telehealth for Monica McEvoy is that it assists with the development of an understanding of the work of health staff in remote areas:

One of the biggest advantages of telehealth is getting to know the real issues in remote towns, not just clinical issues, such as what is it like to live and work in Coober Pedy.

Health professionals from Coober Pedy who attended telehealth seminars in 1999 included a Family and Youth Services social worker, Child and Youth Health nurse, Community Health nurse, teacher and school counsellor,

Coober Pedy Community Health Nurse Tina Doulgeris has provided leadership at Coober Pedy in relation to the RHSET CAMHS Telehealth project. She is based at the Community Health Centre and focuses on Women’s Health issues. In the following interview notes, she discusses some of the highlights of the project during 1999.

Figure 5.1: Notes from an Interview Coober Pedy community health nurse Tina Doulgeris*

“Highlights of the telehealth seminars in 1999 included sessions on pharmacology, behaviour disorders and using the narrative approach working with adolescent males. A lot of us have been here for five years, and the information in the seminars allows us to be up-to-date. Telehealth provides us with training within a busy work day.

Adelaide is 9 hours drive each way. To fly to Adelaide requires a minimum absence from Coober Pedy of 2 nights; a 2.5 hour flight each way; and a cost of $500. Hence, the telehealth link to CAMHS is very useful.

Benefits of the telehealth professional development program included being able to consult with experts in the field, through practical, hands-on, question and answer sessions and the knowledge that you are getting top opinions. We gained up-to-date knowledge from the child psychiatrist as
never before.

There were spin offs from the telehealth sessions. For example, lots of health staff in Coober Pedy, Alice Springs and Darwin are sole practitioners and we developed a comradeship with them.”

* Further comments and observations from Tina Doulgeris are contained in Chapter 4.

**Concluding comment**

Coober Pedy was the outstanding site in the 1999 RHSET CAMHS Telehealth project, with staff attending all sessions provided from Adelaide and seven sessions linked to Port Pirie. The Telehealth network addressed the needs of the Coober Pedy staff, demonstrating the benefit of an audio-visual link to remote locations.
Chapter 8: Issues for Further Investigation

The first year of the RHSET CAMHS Telehealth project raised a range of themes and ideas arose that were suggested (Mitchell, 1999) as possible focal points in the second year of the RHSET CAMHS Telehealth project. The following table sets out the eleven ideas and the actions undertaken in 1999.

**Table 8.1 Actions in 1999 in response to ideas from the first year of the project**

<table>
<thead>
<tr>
<th>Ideas raised in the report on 1999</th>
<th>Actions in 1999</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. the development of protocols for videoconferencing sessions</td>
<td>A patient consent form that set out a number of protocols was developed and implemented in mid-1999.</td>
</tr>
<tr>
<td>2. the continuing exploration of alternative ways of providing professional development, using telehealth technologies</td>
<td>An initiative in 1999 was to develop extensive programs of links between the Northern Office of CAMHS at Port Pirie and Coober Pedy.</td>
</tr>
<tr>
<td>3. the use of four types of interaction during telehealth sessions: learner-content interaction; learner-instructor interaction; learner-learner interaction; learner-interface interaction</td>
<td>Presenters were particularly encouraged to facilitate interaction between participants.</td>
</tr>
<tr>
<td>4. the usefulness of telehealth for Indigenous matters</td>
<td>This topic was not addressed explicitly.</td>
</tr>
<tr>
<td>5. skill development in the use of telehealth</td>
<td>Ongoing induction and skill training was offered in 1999.</td>
</tr>
<tr>
<td>6. optimising the use of telehealth within the organisation</td>
<td>Participants at a number of sites were satisfied that the use of telehealth was achieving a high level of impact.</td>
</tr>
<tr>
<td>7. using the Internet component of telehealth effectively</td>
<td>The project web site was maintained. Trials with the use of videostreaming are planned for 2000.</td>
</tr>
<tr>
<td>8. issues concerning confidentiality</td>
<td>A number of these issues were addressed in the patient consent document.</td>
</tr>
<tr>
<td>9. ensuring the innovation is embedded in the organisation</td>
<td>In 1999, the use of telehealth became a common strategy at a number of CAMHS sites.</td>
</tr>
<tr>
<td>10. developing a more systematic staff development program which is well publicised in advance and which takes into account feedback provided by participants from the first year of seminars</td>
<td>The higher levels of attendance at the 1999 seminars show that responding to the needs of the participants was successful.</td>
</tr>
</tbody>
</table>
11. Investigating how the seminar programs could be placed on the Internet to facilitate more convenient access to material.

Investigations are continuing in 2000.

Issues for further investigation

The evaluation of activities in 1999 show that, if the professional development network is to flourish, there is an ongoing need for research and development, particularly as the technologies involved in telehealth continue to change and improve and as users become more confident. Many of the items listed in Table 8.1 have only started to be addressed, so any ongoing funding could wisely be directed at the completion of initiatives taken to date.

Ongoing funding is required for project management, transmission costs, the costs of bridging, the implementation of new web-based technologies and the costs of supplying videotapes and printed materials. Ideally, funds would also be available for presenters to travel at least once per year to the sites receiving the professional development sessions. While the focus of the RHSET project is on professional development, the technology can just as easily be applied to clinical consulting, so the use of the network for multiple applications may be one way to gain added benefits from any future expenditure incurred.

Concluding comment

The evaluation of the first year’s activities in 1998 provided evidence of the effectiveness of the professional development model used in the project. The model involves the provision of professional development services using a combination of technologies: videoconferencing, videotapes, printed materials and a web site. Additionally, participants in remote and rural locations are surveyed to assess their professional development interests and needs. Other aspects of the model are the annual face-to-face visit by the CAMHS staff to the remote sites, to establish rapport and the encouragement for participants to network with the other personnel involved in the professional development activities.

The evaluation of the 1999 activities confirms the potential of this telehealth professional development model for use on State-wide or national basis. The 1999 report also highlights the effectiveness of regular telehealth links between CAMHS office at Port Pirie and the mining town of Coober Pedy and between the CAMHS office at Port Adelaide and the mining town of Roxby Downs. The report shows that this unique telehealth model of professional development is meeting the needs of staff based in rural and remote communities, it deserves ongoing funding support and warrants continued evaluation. The model of professional development is attracting international attention, evidenced by the acceptance of an article for publication in the refereed Journal of Telemedicine and Telecare: ‘An evaluation of a network for professional development in child and adolescent mental health in rural and remote communities’ (Mitchell, et al, 2000).
Bibliography


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