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Shifting the focus of child and youth wellbeing programs from crisis to prevention: a mixed methods study of the role of First Nations' community-controlled organisations

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Abstract

Background Australian governments and the First Nations Coalition of Peaks, through the Closing the Gap reforms, have committed to build the Aboriginal and Torres Strait Islander community-controlled sector and increase decision making by community-controlled services. This paper describes a First Nations-led place-based research program with community-controlled health and youth service partners in Far North Queensland to understand and map the regional child and youth wellbeing service system and co-design strategies to improve service provision.

Methods This mixed-method research was conducted through a First Nations-led approach that is both place-based and systems focused. Following research planning workshops with community-controlled health and youth service partners, 47 staff members from 27 Cairns and Yarrabah intersectoral child and youth-wellbeing organisations were interviewed in 2021-22 to map the characteristics of their services. Their responses were coded using a modified version of the internationally validated Description and Evaluation of Services and DirectoriEs for Long Term Care (DESDE-LTC) mapping tool to determine the characteristics of whole system intersectoral services. Forty-four participants then attended co-design workshops in each place to discuss the results and identify further priorities.

Results A high 68% of the main types of care were crisis-related services (focused on child protection, youth justice, mental illness, homelessness, illness/injury, and disengagement from education), with just a third (32%) focused on prevention/early intervention. Despite clear leadership from community-controlled services, only 23% of the main types of care were delivered by community-controlled organisations, with 51% delivered by mainstream non-government organisations, and 26% by government departments. Funding agreements drove the characteristics of services, with community-controlled organisations providing a higher proportion of the more complex crisis-oriented services, whilst non-government organisations received funding for preventive programs. Service providers prioritised a need for greater investment in prevention and early intervention, with community control of decision making considered critical to improving the appropriateness of care.

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Conclusions These findings speak to the recent national commitment to increase decision making by Aboriginal and/or Torres Strait Islander community-controlled services. The recommendations of north Queensland regional service providers can inform improvements in the Closing the Gap reforms, and hence in the systems that support the wellbeing of First Nations children, youth and families.

Keywords Service system, Prevention, Health promotion, Policy, Aboriginal and Torres Strait Islander, Indigenous

Background

Australia's Closing the Gap Strategy targets will not be achieved without improvement in the wellbeing of First Nations children (up to 12 years) and young people (12 to 19 years), who comprise more than two fifths (42.9%) of the First Nations population [1]. The Strategy aims to reduce the entrenched gaps in health and life expectancy between Aboriginal and Torres Strait Islander peoples (hereafter termed First Nations) and non-Indigenous Australians by 2030 [2]. Current progress towards the 19 Closing the Gap targets is not promising - of the 15 targets for which national data are available, only four are on track [3]. The cost of failing to close the gaps is reified in life circumstances that seriously challenge the social and emotional wellbeing (SEWB) of many First Nations children and young people and limit their capacity to fulfill their life potential. This paper focuses on wellbeing-related services for First Nations children and youth (5–18 years). It describes a First Nations-driven place-based research program with community-controlled health and youth service partners in two locations in Far North Queensland to understand the focus of current service delivery systems and co-design service system improvements.

The Closing the Gap Strategy as it pertains to children and youth encompasses an intersectoral approach to support the First Nations children and youth who are most disadvantaged [4]. The six child and/or youth-specific targets focus on peri-natal health, early thriving, early childhood and subsequent education; youth justice and child protection. A crisis-oriented approach is understandable since, for example, First Nations children and youth are placed in supervised detention at 16 times, and out of home care at eight times the non-Indigenous rates [5–7]. However, despite a recognised need for crisis care for some First Nations children and youth, First Nations service providers are concerned that a continued focus on crisis only perpetuates current problems and that children are landing in crisis-oriented services because there are insufficient or inappropriate preventive and early intervention services in place for averting crisis [8]. Providers and clients of services to First Nations children and youth also experience the challenges of a service system that is complex and difficult to navigate, often inflexible, having a range of access issues, requiring enhanced information sharing, and experiencing workforce challenges [9]. As well, additional complexities arise with respect to the cultural appropriateness of care in ways that both address intergenerational trauma arising from the effects of Australia's colonisation and that do not perpetuate discrimination or racism [10].

Aboriginal and/or Torres Strait Islander community-controlled organisations are incorporated Aboriginal and/or Torres Strait Islander organisations initiated by and based in a local Aboriginal or Torres Strait Islander community [11]. They propose a strengths-based and holistic SEWB approach to support "a multidimensional concept of health that includes mental health, but which also encompasses domains of health and wellbeing such as connection to land or 'country', culture, spirituality, ancestry, family, and community" [12]. The First Nations' concept of SEWB is inherently place-based, and aligns well with a continuum approach to mental health and wellbeing whereby children and youth are not dualistically defined as being well or unwell, but are located across a continuum, from wellness, coping, struggling, to unwellness [13]. Such a continuum highlights opportunities to create more holistic and kinship models of care across the spectrum of care, both by promoting improved wellbeing and early intervention, and by supporting social and educational functioning for children and youth with a diagnosed mental illness [13].

However, little empirical evidence exists to guide the development of holistic SEWB practice for First Nations children and youth by primary healthcare, youth or other sectoral service organisations [14–16]. There is evidence that whole systems perspectives are useful for informing improvement efforts in mental health systems [17], and there are many reports of programs that help young First Nations people build their strength and resilience by discovering their creativity, capability, leadership potential and achievement [16]. There are also international examples of successful efforts to shift child and youth wellbeing services from crisis to prevention through family-centred models (e.g. [18, 19]). But recent reviews of First Nations Australian SEWB and mental health programs found limited or no understandings of the quality of service provision in First Nations child and youth wellbeing, evidence-based prevention or early intervention approaches for First Nations children and adolescents, or how organisations can shift their own service systems from crisis to a prevention/early intervention focus [14, 16, 20].

Multiple barriers to such efforts have consistently been identified. These include significant under-resourcing and short-term funding cycles and problems of mismatch between funding accountability indicators and the SEWB model [14, 21]. Funding sources available to Aboriginal and/or Torres Strait Islander community-controlled organisations are complex and not equally available to all community-controlled services. Health services, for example, rely on a mix of funding from eight different sources – including from Commonwealth government (Indigenous Australian's Health Programme; Primary Health Networks; the Medicare Benefits Schedule, Practice Incentive Program and Pharmaceutical Benefits Scheme; and other sources), State and Territory governments, local governments; business funding; and impact investing sources [22]. Community-controlled youth services are funded by sources including fee-for-service contracts from government departments, grants, and philanthropic support. There is also a need for SEWB services to have the flexibility to adapt to emerging issues; a lack of access to data, research and evidence; and the difficulty of accounting for intervention impact in such complex contexts [23]. Services therefore struggle to determine where or how to most appropriately invest their efforts to engage, promote SEWB or avert risk for First Nations children and youth.

There is now increased recognition of the importance of, and opportunity for Aboriginal and/or Torres Strait Islander community-controlled services to influence decision making and investment decisions in health. Underpinning the national Closing the Gap strategy, Australian governments and the First Nations Coalition of Peaks agreed in 2020 that achievement of the targets was contingent on the operationalising of four reform areas (or political determinants): (1) formal partnerships and shared decision making between First Nations communities and governments; (2) building the community-controlled sector; (3) transforming government organisations; and (4) shared access to data and information [3]. These reform areas promise greater decision making in First Nations hands, and an opportunity to examine the feasibility of reinvesting funds in or reallocating funds to preventive services. However, the first review of the national agreement showed that it was unclear how much funding is allocated to community-controlled organisations, as the Australian government and most State and territory governments had either not undertaken or not published the expenditure reviews that they had agreed to undertake to identify opportunities to prioritise community-controlled organisations. Instead, the Productivity Commission found persistent barriers to government progress on implementing systems changes, with no systematic approach to power sharing for joint decision-making, failure of governments to acknowledge and act on the reality that Aboriginal and Torres Strait Islander people know what is best for their communities, and limited progress in determining what strategies needed to be implemented to disrupt the business-as-usual of governments [24]. The research question for this study is: What are the characteristics of the whole service system of First Nations child and youth wellbeing services in Far North Queensland, and what priority improvements are identified by First Nations service providers?

Methods

This paper was written by three First Nations managers from the community-controlled health and youth services (MN, ME, LW), three First Nations researchers (RF, VS, SC) and two non-Indigenous researchers (JM, AvB) from the Cairns-based Jawun Research Institute of Central Queensland University and two non-Indigenous researchers (MAF and LSC) from the University of Canberra. Responding to the priorities of a community-controlled youth service in Cairns and a community-controlled primary healthcare service in Yarrabah, a five-year program of youth wellbeing systems research was implemented from 2019 [25]. First Nations youth wellbeing service systems were considered to encompass the spectrum of services from prevention, early intervention, to treatment and recovery across six sectors: primary healthcare, mental health, education, youth service, child protection and youth justice. A collective impact approach was used to instigate place-based community-driven systemic change aiming to inform and shift decision-making and investment across partners/local organisations [26–28].

Settings and partners

Cairns

Cairns is a regional city in Far North Queensland with 26,935 First Nations people (10.6% of total population), and an average age of 24 years [29]. The Traditional Owners are the Gimuy Walubara Yidinji and Yirrkanji peoples. Cairns-based partner organisation, Deadly Inspiring Youth Doing Good (DIYDG) is a community-controlled youth organisation that was developed from a small collective of young (18–22 years) past participants of the Indigenous Leaders of Tomorrow (ILT) Program delivered by the Queensland Department of Education [30]. They met on a weekly basis from 2013 to volunteer and give back to the ILT program and community more generally. In October 2016 these young people agreed to form the Indigenous Corporation DIYDG as a youth-led non-profit organisation to inspire, equip, and empower young people to take action and make a change. DIYDG now provides services across the prevention to crisis spectrum through eleven programs [30]. Across its range

of programs, DIYDG implements a kinship structure that reflects the organisation's First Nations cultural values, connection to spirit and purpose for being. The seven programs at the prevention end of the spectrum include:

- *Good Vibrations*: a peer-to-peer engagement and support program;
- *Lived Leadership*: a program to develop leadership skills primarily amongst Aboriginal and Torres Strait Islander school students and young adults;
- *Kunjar Men's Collective*: created to support men and youth, specifically focusing on suicide prevention;
- *Naytive mentorship*: provides hip-hop music classes, supporting young people to write and record songs and learn the business management of being a solo artist; includes *No Shame in My Game* which provides vocal training;
- *Deadly Drivers Program*: delivers driver training and road safety education;
- *You Do You*: young people are supported in a range of projects that they devise through the compliance structures offered by DIYDG; and
- *Wanna Know: a* research program to support young people to provide feedback for a range of issues.

The two DIYDG programs at the crisis end of the spectrum are:

- *Pamle Pamle* which provides individual tailored supports to children and youth in the child protection system through one-on-one mentoring, accommodation supports, outreach and engagement, and case coordination management; and
- *Level Up* which provides alternative learning for youth referred from the youth justice system with the intent of empowering them to return to mainstream education providers.

Yarrabah

Yarrabah is located 55 km southeast of central Cairns and is Australia's largest discrete Aboriginal community. The Traditional Owners are the Gungandji and Yidinji peoples. Yarrabah's population includes 2505 First Nations people with an average age of 25 years [31]. Because of family links and geographical proximity to Cairns, Yarrabah people regularly access its services, employment, education and relational connections, and Cairns-based First Nations people often have kinship links in Yarrabah. Partner organisation, Gurriny Yealamucka Health Service is Yarrabah's Aboriginal community-controlled health organisation (ACCHO) and sole provider of primary healthcare services in the community. The Gurriny Yealamucka Youth Wellbeing Program started in 2016; a Yarrabah youth hub building was constructed in 2019 [10]. The youth program is currently staffed by a Youth Service Manager, Youth Program Coordinator, a Senior Case Worker and four part-time trainee Youth Workers. Programs at the youth hub are structured according to age groups, with wellbeing promotion programs provided for diverse groups of youth. These include teaching beautician and pampering skills; cooking; family tree connections; weightlifting; and "just educating the youth". Cultural mentoring is an important aspect of all programs. Youth hub staff also coordinate the mentoring of young people, to teach skills needed for employment such as driving lessons and completion of employment applications. The Youth Wellbeing Team takes a whole of community approach, considering whole of community engagement to be critical.

Design

This mixed methods study used an iterative approach designed to promote co-design. Community-controlled, non-government and government service providers were engaged throughout the entire research process, from identifying the research issues, engagement in data collection and translation, ensuring a focus on building collaborative relationships to create strategies that addressed the needs of First Nations children and youth. First, qualitative planning workshops were run with community partners to test the acceptability and feasibility of a quantitative service mapping method based on the internationally validated Description and Evaluation of Services and DirectoriEs for Long Term Care (DESDE-LTC) mapping tool [32]. Second, interviews with service providers were held using a modified version of the DESDE-LTC instrument [33] (See Supplementary file), and data coded to determine the characteristics of whole system intersectoral services in Cairns and Yarrabah. Third, community partner-led co-designed workshops were held in each place, with the same service providers invited to feed back results and identify improvement priorities (see Fig. 1).

The initial research planning workshop was held in Cairns to inform community partners about the DESDE-LTC service mapping approach and reach consensus about its acceptability and the feasibility of using the tool to map First Nations SEWB services. Ten people (six First Nations) participated from the two community partner organisations and two university research teams. The workshop facilitators (MF and LSC) explained how the DESDE-LTC tool simplifies the characteristics of complex service systems by classifying and coding services according to: (1) target population age group and other demographic characteristics; (2) diagnosis or reason for service access; (3) main type of care (classified by using one or more of six codes for type of care delivered i.e. residential, day, consultation, accessibility, information

Fig. 1 Iterative research method including purpose of each phase and number of participants and services involved

or self-help/voluntary care) and intensity; and (4) qualifiers to denote service characteristics relevant to local conditions [34, 35]. The tool had not previously been used in First Nations contexts, and decisions were made by partners at the workshop about modifications needed to tailor the tool and method of administration for context. The DESDE-LTC tool and method of administration were modified by adding relevant questions from a First Nations perspective (e.g. including community-control as a form of governance), including the initial training session for community partners and translating the complex data into meaningful narratives for community service providers [32].

Services were included in the study if they:

- Targeted children, adolescents, or young adults (5–18 years) or their families/carers;
- Supported the SEWB of First Nations children and/or youth;
- Provided direct care or support;
- Were located within the Cairns or Yarrabah regions; and
- Were universally accessible: i.e. without significant out-of-pocket expenses and not operating under a fully privatised insurance scheme.

Eighteen Cairns service organisations and ten Yarrabah service organisations met the inclusion criteria and all but one (Cairns school) agreed to participate in interviews ($n = 17$ services) (Fig. 1). Twenty-seven Cairns staff members and twenty Yarrabah staff members from these organisations were interviewed following written consent for interview and recording ($n = 47$ participants; 21 First Nations and 26 non-Indigenous). Interviews followed the adapted DESDE-LTC protocol and elicited information about: team name; location and area of coverage; governance; main type of care provided, target population, acuity, mobility and intensity of service provision; workforce in full time equivalents (including First Nations); and links with other services. All interviews were recorded and securely stored electronically according to CQU data management protocols. Participants were sent summaries of the interview for their confirmation of accuracy. In the spirit of data sovereignty, an Atlas of the DESDE-LTC data for each community was provided back to the community partner [33, 34].

The two community-controlled partner organisations (DIYDG and Gurriny Yealamucka), then facilitated community co-designed workshops in each place (Cairns and Yarrabah). Workshop participants discussed results of the DESDE-LTC mapping and identified service gaps, provided contextual meaning to the results and prioritised future steps. Forty-four workshop participants (23 First Nations, 21 non-Indigenous) attended from 12 of the participating service organisations in Cairns and seven in Yarrabah. With consent, these workshops were also recorded. Four topics were discussed at each community workshop using a world café method [35] to create a space where everyone felt heard and could contribute meaningfully to collaborative conversations, voicing diverse perspectives, and enabling participants to share knowledge and insights through multiple rounds of small group discussions. The topics were: (1) the availability of services including duplication and gaps; (2) the provision of services by Aboriginal and/or Torres Strait Islander Community-Controlled Organisations; (3) the balance of preventive care compared to crisis care; and (4) the extent of Indigenous youth leadership and guidance of service delivery. Discussions were structured with four questions guiding each topic: (1) How are we going

Table 1 Summary of service availability and types – Cairns and Yarrabah[a]

	Service providers	Care teams	Main types of care (MTC) – all ages	Child/youth specific MTC
Cairns	17	43	48	43
Yarrabah	10	23	24	18
Total	27	66	72	61

[a]Complete analyses of service characteristics have been described previously [33, 34]

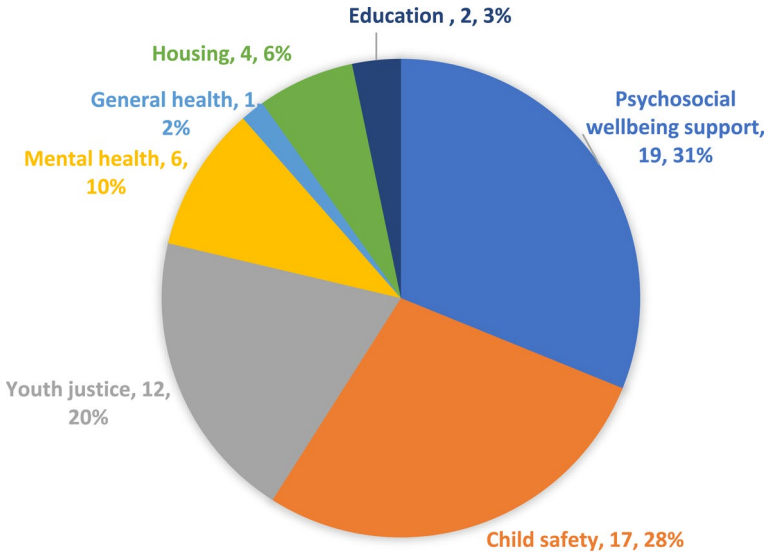

Fig. 2 Purpose of services for First Nations children/youth in Cairns and Yarrabah

as a community? (2) What is working? (3) What is not working so well? (4) What can be done to make things better?

Results

Findings from service mapping using DESDE LTC method

As shown in Table 1, in Cairns, the 17 service providers mapped incorporated 43 care teams (i.e. teams of professionals that provide a basic stable unit of input of care). The 43 care teams provided 48 main types of care delivered to children and young people (5–18 years). Five of the 48 main types of care were provided to support people of all ages, and 43 were provided to support only children and/or young people. In Yarrabah, 10 service providers included 23 care teams. These 23 care teams delivered 24 main types of care. Six main types of care were provided to support people of all ages, and 18 were provided specifically to support children or young people. The following findings are based on analysis of the total 61 main types of care available specifically for children and/or youth across the two places. Results for 43 services in Cairns and 18 in Yarrabah are aggregated, with cross-site differences noted.

Service provider participants identified three overarching priorities from the DESDE-LTC results for implementing improvements to wellbeing supports for Indigenous youth. These were: youth empowerment and leadership; shifting services from crisis to prevention; and (in Yarrabah only) workforce training in trauma-informed care. This paper focuses on the second priority – shifting the service system from a crisis orientation to a whole system model that provides a balance of care that is locally and culturally appropriate, including the extent to which services are delivered by Aboriginal and/or Torres Strait Islander community-controlled organisations. It describes the current service balance and efforts of community-controlled health and youth services to make improvements. The key enabler for service system improvement was determined to be a reform of funding systems and associated accountability requirements to better match First Nations models of SEWB service provision.

Improvement strategy 1: rebalancing to a holistic rather than crisis-oriented service system

A third (32%) of the 61 main types of care provided by the 27 Cairns- and Yarrabah-based child and/or youth-specific wellbeing service providers were at the prevention/early intervention end of the prevention-crisis spectrum (Fig. 2). The proportions of prevention/early intervention compared to crisis-oriented services was similar in both Cairns and Yarrabah at 31% and 33% respectively, and the most common reason for engagement was unspecified psychosocial/wellbeing support. The remainder of

the available main types of care (68%) were crisis-related services (child protection, youth justice, mental illness, homelessness, illness/injury, and disengagement from education).

This led youth wellbeing service providers at the Cairns co-design meeting to agree: "*There is lots of focus on kids in crisis, not enough for kids out of crisis….Young people are popping up in crisis due to the gaps*" (Service provider, Cairns community workshop). Overwhelmingly, service providers at the workshops in Cairns and Yarrabah said that there was a need to prioritise funding for more preventive and early intervention services. A Cairns service provider commented: "*We can't get psychological referrals, there's a longer than six months wait - We wait until things are at tipping point*". Cairns service providers also stated concerns about the lack of availability of mental health services for children aged from 8 years to 12 years. One said: *"Services don't see kids under 11 years to service the prevention end. There are gaps in primary aged kids – young kids require attention but services are not delivered to kids… younger than high school age*". Another said: *"We want to get to youth before they are in crisis"*.

Participants advocated for more investment in prevention and early intervention such as services that advocate with families, ongoing therapeutic services for vulnerable children and youth, 'on-Country' programs, and primary health care. School-based interventions were supported, including the provision of supports in schools, more organisations around promotion and prevention, development and training after school and after hours, transition-out-of-school programs and re-engagement with school leavers. Cairns service providers aspired to: *"a systematic approach from government and [the] sector that caters to young people who are doing okay"*.

Service providers acknowledged that gaps also existed at the crisis care end of the child and youth wellbeing service spectrum. "*We are going poorly. Not well, poorly. There is no weekend or nighttime support. Residential care – there are no houses available. There is nowhere to refer clients regarding high or complex mental health needs. We struggle to find services to link with clients*" (Service provider, Cairns community workshop). In Yarrabah, a participant said: "*There's no youth crisis care – Queensland Health, for example, is funded for two days a fortnight, but only one day a fortnight guaranteed attendance in Yarrabah – referrals are required from a clinician*". Another said: "*We have the same conversations again and again, but youth are still in crisis*".

Improvement strategy 2: strengthening community-controlled models of service delivery

Despite clear leadership from community-controlled services, only 23% of the main types of child and youth wellbeing care provided by the 26 services were delivered by Aboriginal and/or Torres Strait Islander community-controlled organisations (ACCOs) (Fig. 3). Mainstream non-government organisations (NGOs) delivered 51% and government departments delivered 26% (10% by the QLD Department of Children, Youth Justice and Multicultural Affairs (DCYJMA) Child Protection, 8% by Queensland Health (QH), 5% by the QLD DCYJMA, and 3% by the Queensland Department of Education (QDE). Whilst 26% of services in urban Cairns were delivered by community-controlled organisations, paradoxically in

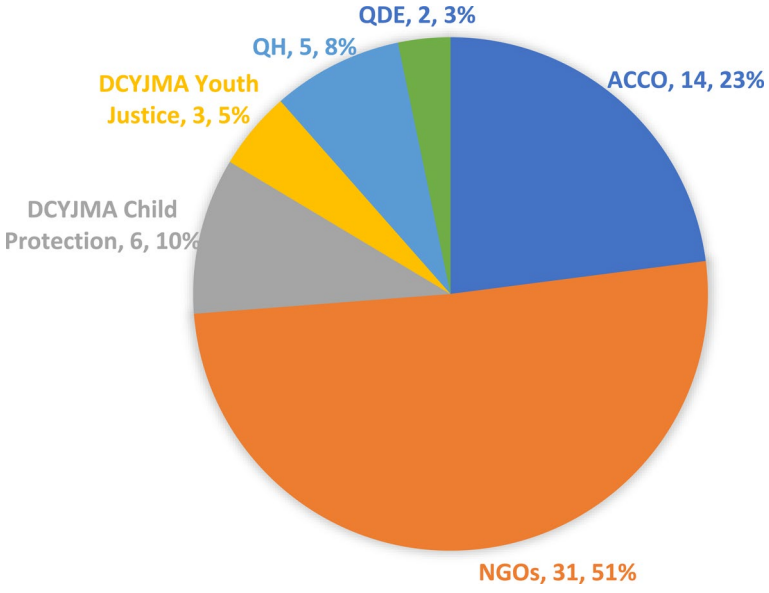

Fig. 3 Governance of child/youth wellbeing services in Cairns and Yarrabah

the discrete First Nations community of Yarrabah, only 17% of services were community-controlled.

Surprisingly, most of the types of care provided by the Aboriginal and/or Torres Strait Islander community-controlled sector in Cairns and Yarrabah were mapped as being at the crisis end of the service spectrum. The types of reasons for accessing care provided by Aboriginal and/or Torres Strait Islander community-controlled organisations (in order of frequency) were youth justice (9.8%), child protection (4.9%), wellbeing/psychosocial (4.9%), and (re-engagement into) education (3.3%). In comparison, non-government organisations provided more diverse types of care, with most care being focused at the preventive end of the service spectrum. The drivers for accessing non-government organisations' care (in order of frequency) were wellbeing/psychosocial (19.7%), child protection (13.1%), mental health (4.9%), housing (4.9%), youth justice (3.3%), education (1.6%), alcohol and other drugs (1.6%), gender/sexual orientation-related (1.6%).

Community control of decision making was seen to be critical to improving the appropriateness of care. A Cairns service provider at the co-design workshop noted that what was needed was: "*To be able to work the way we want or need to work (culturally)*". Community-controlled service providers spoke of their relational approaches with families. For example, a Cairns First Nations service provider said: "*We are best placed to make decisions around what happens to us, and we must lead the conversations around what works in our own communities. Evidence shows that mainstream services continue the cycles of colonisation and systemic racism that continue to perpetuate the issues they seek to solve*". Service providers considered that capacity for community-controlled decision making was also growing. A Cairns service provider reflected that this increase in community-controlled services and programs meant that: "*People and groups with vision are emerging … and having decision making power*".

Current models of community-controlled youth wellbeing support included promising approaches for shifting crisis services to preventive services. In Yarrabah, Gurriny Yealamucka Health Service was designed to provide services for First Nations children and youth who were considered to be at high risk, for example, those at risk of offending, those caught up in domestic violence, and *"those whose behaviour is really anti-social by this community standard, let alone any other community standard"*. However, Yarrabah service providers considered a universal approach to child and youth wellbeing to be most appropriate in their community because *"we found that everyone's sort of at risk when you talk about the social determinants, so we didn't really target.... It was everyone that was a youth was at risk and everyone needed to have some something to do"*. In Cairns, DIYDG implemented a family-centred approach to working with young people in crisis: "*Our Youth Worker knows the families of all these children, so she's best placed to facilitate it [Pamle Pamle program]. … The Youth Workers we have across the board come from the areas in which these young people we're servicing live in. And that's the point of difference that we have*".

From the outset, models of youth wellbeing implemented in Cairns by DIYDG and in Yarrabah by Gurriny, were informed to a large degree by the aspirations and preferences of First Nations young people. A Yarrabah youth wellbeing worker recalled: "*The first thing was to create a forum … and from the forum we ask two questions. What makes a better Yarrabah? And … how can we, as service provider, make it better for you? So from that they gave us a lot of ideas and information … a lot of our programs actually came from that.... This is why the [Yarrabah Youth Hub] building is here. Because they spoke about a building as well*".

Both partner services noted the importance of having a dedicated building space for child and youth wellbeing. A Gurriny manager reflected: *"this space has gotten very big and very busy in a very short amount of time"*. Another youth wellbeing manager explained: "*so during the day, because we want people to go to school and not let it be the reason they're not going to school, it's 18 to 25. Unless you obviously are school leaver … And we tried to target young mums and … utilising, laundry and showers and that.... somebody is coming for the food, like for lunch, also cater for that as well … like a drop-in center.... 12 to 17, when they come through after school, we only got an hour and a half with them before they have to leave, so that's three to 4:30. So basically on the video games. Playing on the computers and doing the drawings. So they're definitely just there for the recreational. They have their feed*". The youth hub takes a whole of community approach, considering whole of community engagement to be critical. The youth wellbeing worker noted: "*We talked to obviously the elders as well.... You know, just letting the community know what we're doing because they're gonna go back and tell their kids…*".

Key enabler: funding and accountability

Funding and accountability were considered as enabling conditions. Foundational enablers include the skills, capabilities and resources that need to be in place to achieve a system change. Service providers considered that the focus of service provision was largely driven by the availability of funding. For much of the research period, key Aboriginal and/or Torres Strait Islander community controlled organisations struggled to attain even basic operational funding. A Cairns service provider considered: "*It's government designed services really. And we try to rely on what the community need is, against what funding we get. Sometimes it doesn't always match too*

Table 2 Key findings from the service mapping and co-design workshop

	Service mapping data	Service provider priorities
Crisis – prevention continuum	68% of Cairns and Yarrabah wellbeing services for First Nations children and youth were provided at the crisis end of the spectrum (in child protection, youth justice, mental illness, or educational disengagement)	Service providers advocated for more investment in prevention and early intervention, ongoing therapeutic services, 'on-Country' programs, primary health care, and support for children moving from primary to secondary school and other transitional support.
Delivery by community-controlled organisations	Only 23% services were delivered by community-controlled organisations, with 51% provided by mainstream non-government organisations and the remainder by government departments	Community control of decision making was seen to be critical to improving the appropriateness of care.
Funding as a driver	Current funding agreements drove the provision of services, with community-controlled organisations compelled to provide a higher proportion of the more complex crisis-oriented services whilst non-government organisations received a higher proportion of funding for (less complex) preventive programs	The focus of service provision was largely driven by the availability of funding and nature of accountability requirements.

well". For example: *"the challenge that we face. … the individual placement support (I.P.S.) contracts under Child Safety … We're not like a funded service so it's like literally well 'you get this to do this little slither of the pie to do this work'".*

A challenge for the cultural safety of services was that accountability requirements to funding bodies did not match the needs of children and youth. A Cairns service provider explained: "*The target goals that are determined by the C-S-O [Child Safety Officer]… happens to have no relationship with the child, so if this young person's on the streets and the C-S-O's expecting them to go to school, there's a whole lot of work in between that needs to be done and it's sometimes we're really highlighting 'hey your current care plan is pointless' because you're focusing heavy on enrolments and this young person can't even get food tonight".* Service providers in Yarrabah agreed. One Yarrabah service provider noted: "*that's part of what the government contractors say we need, [but] not necessarily what we need.… having a case management load … is that what we really need? Is that what the young people want? … There's one thing the Indigenous community-controlled health sector is always doing, is constantly juggling four or five pools of funding, to try - and hoping to get what you really want to do out of it*". Another Yarrabah service provider commented that many non-government organisations working in Yarrabah lacked accountability to the community: "*External bodies are getting the funding but not delivering outcomes. There's no consultation with community prior to an organisation getting funding – no accountability to community, no power to community. There is not enough transparency in program outcomes/requirements; especially in the NGO sector*".

Service providers suggested that there could be more collaboration between funding bodies and community services prior to funding decisions being made. One said: "*There should be planning around funding requirements before allocation; for example, mental health delivery data or information to feed into funding at contact development stage. A co-design phase of funding to take into account that not one-size-fits-all; reflective of what Yarrabah needs*".

Results summary

The findings from the service mapping using the DESDE-LTC instrument reflected the concerns of place-based service providers that the service system was not doing well at meeting the wellbeing needs of First Nations children's and youth wellbeing. The data provided evidence for identifying improvement priorities and for advocacy to improve the service system. Table 2 summarises the key findings from the service mapping compared to the identified priorities of service providers.

Discussion and conclusions

This paper examined the current context, local improvement strategies and key enablers for improving First Nations child and youth wellbeing services in Far North Queensland. The uniqueness of this research is that it was conducted through a First Nations-led approach that is both place-based, and systems focused. It speaks to the central role played by community-controlled organisations, and the connection to Country/relationships with place that are embedded within their service delivery. The "bottom up" information collected in this way provided a unique picture and characterisation of the support systems currently provided in Cairns and Yarrabah for First Nations child and youth wellbeing, and service providers' perspectives of the cross-sectoral system of service delivery.

Sustained and coordinated action by governments and non-government organisations are essential for incrementally amending the current crisis-oriented mental healthcare models that perpetuate inadequate care provision for First Nations children and youth [36]. These findings are timely given the recent commitment of the Australian governments and the First Nations Coalition of Peaks, through the Closing the Gap reforms, to build the community-controlled sector and increase decision making by Aboriginal and/or Torres Strait Islander

community-controlled services [3]. Investment in prevention and early intervention for children and young people experiencing initial onset depression or anxiety has been shown to provide a return on investment of $7.90, and early intervention for individuals experiencing their first episode of psychosis to return $10.50 for every $1 spent [37]. However, only 2% of national health expenditure is currently spent on preventive care [23]. There is a clear need to understand how governments can effectively devolve funding investments to community-controlled organisations and how First Nations leaders can strategically plan and coordinate preventive cultural, social and political conditions that strengthen the health and wellbeing of First Nations children and youth at a place-based level. Enablers of systems change towards prevention include: appropriate governance mechanisms; increased investment in prevention; credible and reliable health information; embedding prevention in primary health care; health literacy; consumer engagement; enhanced public health workforce planning; and monitoring, and evaluation and reporting [38].

Given the extremely high financial cost of care at the crisis end of the service continuum (where crisis care in child protection, youth detention, and mental health hospital wards costs $2200-$2550 per child per day; nationally $7billion +and increasing), service improvements could be made for the same or reduced cost by shifting a small proportion of the current investment from crisis to prevention [5, 7, 18, 39]. There are international examples of the successful reinvestment of funding from crisis-oriented services towards preventive services, with positive results. For example, in Erie County, USA, a fiscal crisis prompted efforts to reduce costly residential treatment bed days by reallocating savings to appropriate and effective community-based services, with at-risk youth and their families pro-actively linked to these services. Outcomes included significantly improved functioning of the youth who were discharged from residential services to family care, with sustained results over a three-year period [18].

A key strategy for improving systems of care for First Nations child and youth wellbeing lies in providing enhanced support for local solutions and decision making by local community-controlled organisations. These include relational First Nations ways of connecting with young people, families and community, building partnerships to increase opportunities for success, supporting participation in community and cultural activities, empowering ownership of places and spaces, and offering early intervention programs to reduce systems involvement [29]. Community-controlled health and youth organisations recognise the importance of the social, structural, economic and cultural conditions that underpin health, and the value of First Nations holistic approaches to wellbeing (understood as encompassing physical, social, emotional, cultural, spiritual and ecological wellbeing for both the individual and the community). In response, they have developed creative ways to provide healthy environments to support holistic programs across the prevention-crisis spectrum. There is evidence that such holistic family/kinship-centred, preventive, culturally safe, community-controlled approaches work [40, 41]. For example, in a recent study involving 639 Aboriginal people from Central Australia, participants reported that the domains of SEWB (high community cohesion, high individual agency in community, having an Aboriginal language as a first language, speaking an Aboriginal language a lot, high exposure to cultural practice and knowledge, and multigenerational or extended family households) were correlated with high/very high family functioning [42].

In this research, creating meaningful data for community partners supported ongoing community efforts and advocacy to align services with holistic approaches to children's and youth wellbeing and also opened dialogue at the cross-cultural interface of service funding and delivery. The two Atlases that documented the data for each community are now owned by the two community partners [33, 43]. Creating meaningful data and Indigenous data sovereignty requires valid and appropriate tools. There are emerging ecosystems methods and validated tools, such as DESDE-LTC, available for researching the effects of whole of systems approaches to SEWB and/or mental health improvement, but these are likely to require modification for First Nations contexts [17]. For example, the REfinement MApping Services Tool (REMAST) shows promise for evaluating the current and post-improvement SEWB service systems for First Nations children and youth by analysing the availability of main types of care; care placement capacity; workforce capacity; and geographical accessibility to services [43, 44].

This research focused on understanding the characteristics of the service system and potential priority improvements for First Nations child and youth wellbeing services in two Far North Queensland locations. The strengths of this approach include active participation from local service providers to identify tailored strategies that fit the unique contexts that they worked in. The intersectoral focus enhanced consideration of the interconnectedness of services, allowing for a comprehensive analysis of complex issues and potential buy-in for improvement strategies. Limitations of the study include the difficulty in generalising place-based findings to other areas due to unique local conditions and characteristics, and challenges in attributing cause and effect due to the complex interactions between multiple interconnected factors at play. Childhood is a critical time for service intervention to influence an individual's lifelong

wellbeing, and in adolescence, early intervention can minimise the impacts of developing severe conditions, thus preventing ongoing harm [36, 45]. Prevention efforts can also provide opportunities to redress health inequalities [23]. Of the six Closing the Gap targets that are directly focused on child and youth outcomes, only two are currently on track to be met [3]. The recommendations of local service providers such as those reported in this paper can inform improvement in these targets, and hence in the systems that support the wellbeing of First Nations children, youth and families.

Supplementary Information

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Supplementary Material 1.

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

Authors'contributions
MN, ME and LW identified and informed the issue. JM, RF, AvB, VS and SC analyzed and interpreted the qualitative participant data regarding the service system focus on crisis versus prevention, and the extent to which services were being delivered by community controlled organsiations. MF and LSC guided and performed the analysis of the DESDE-LTC data. JM compared the qualitative data with the DESDE data and was a major contributor in writing the manuscript. All authors read and approved the final manuscript.

Authors information
MN, ME, LW, RF, SC are First Nations Australians. JM, AvB, MF and LSC are non-Indigenous Australians.

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Data availability
The datasets generated and/or analysed during the current study are not publicly available due to the qualitative nature of the data, multiple data sources, and small sample size from a discrete (potentially re-identifiable participant group) but are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate
Research was conducted in accordance with the National Health and Medical Research Council's guidelines for research with Aboriginal and Torres Strait Islander peoples and communities. The project also adhered to the World Medical Association's Declaration of Helsinki. The Ethics applications were approved as per the following: Central Queensland University Human Research Ethics Committee (0000021644); Queensland Department of Education acceptance through Queensland Education Research Inventory appraisal system (550/27/2319); and Queensland Health, Cairns Hinterland Hospital Health Service Human Research Ethics Committee (1557/04458-2021). The Queensland Department of Children, Youth Justice and Multicultural Affairs provided approval to conduct the research project involving departmental staff (Child Safety 04458-2021; Youth Justice 02361-2021). Informed consent to participate was obtained from all of the participants in the study.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

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References

1. Australian Bureau of Statistics. Estimates and projections, Australian Aboriginal and Torres Strait Islander population methodology. (2011 to 2031). https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/estimates-and-projections-australian-aboriginal-and-torres-strait-islander-population/2011-2031.
2. Lowitja Institute. Transforming power: voices for generational change close the gap campaign report 2022. Melbourne: Lowitja Institute; 2022.
3. Commonwealth of Australia. Closing the Gap. In: Department of the Prime Minister and Cabinet, editor. Canberra; 2022. https://www.closingthegap.gov.au.
4. Commonwealth of Australia. Safe and supported: Aboriginal and Torres Strait Islander First Action Plan 2023–2026. In: Services CsSDoS, editor. 2022. https://www.dss.gov.au/system/files/resources/final_aboriginal_and_torres_strait_islander_first_action_plan.pdf.
5. Productivity Commission. Report on Government Services 2022 Part F, Sect. 16, Child protection services. In: Productivity Commission, editor. Canberra; 2022. https://www.pc.gov.au/ongoing/report-on-government-services/2022/data-downloads.
6. Australian Institute of Health and Welfare. Community safety for First Nations people: Aboriginal and Torres Strait Islander people In: AIHW, editor. Canberra; 2023. https://www.aihw.gov.au/reports/australias-welfare/indigenous-community-safety.
7. Productivity Commission. Report on Government Services Part F, Sect. 17: Youth justice services. In: Productivity Commission, editor. Canberra; 2022. https://www.pc.gov.au/ongoing/report-on-government-services/2022/data-downloads.
8. The Lowitja Institute. Journeys to healing and strong wellbeing final report. Melbourne: The Lowitja Institute; 2018.
9. Northern Queensland Primary Health Network. Mental health stepped care redesign: stakeholder summary report. Cairns: NQPHN; 2023.
10. McCalman J, McDonald T, Fagan R, Jose S, Neal P, Caelli N, et al. The availability, appropriateness, and integration of services to promote Indigenous Australian youth mental health and wellbeing: Indigenous youth and service provider perspectives. Child Youth Serv Rev. 2022;20(1):375. https://doi.org/10.3390/ijerph20010375.
11. NSW Health. Aboriginal Community Controlled Health Services. 2017. https://www.health.nsw.gov.au/aboriginal/Pages/contact.aspx.
12. Gee G, Dudgeon P, Schultz C, Hart A, Kelly K. Aboriginal and Torres Strait Islander social and emotional wellbeing. In: Dudgeon P HMRW, editor. Working together: aboriginal and Torres Strait Islander mental health and wellbeing principles and practice. Canberra: Commonwealth of Australia; 2014. pp. 55–68.

13. National Mental Health Commission. The National Children's Mental Health and Wellbeing Strategy. In: National Mental Health Commission, editor. Canberra; 2023. https://www.mentalhealthcommission.gov.au/projects/childrens-strategy.
14. Bainbridge R, McCalman J, Jongen C, Kinchin I, Langham E, Campbell S, Doran C. Evidence check: improving social and emotional wellbeing for aboriginal and Torres Strait Islander people. Sydney: Sax Institute and Beyond Blue; 2018.
15. Day A, Francisco A. Social and emotional wellbeing in Indigenous Australians: identifying promising interventions. Aust N Z J Public Health. 2013;37(4):350–5.
16. Lopez-Carmen V, McCalman J, Benveniste T, Askew D, Spurling G, Langham E, Bainbridge R. Working together to improve the mental health of Indigenous children: A systematic review. Child Youth Serv Rev. 2019;104:104408.
17. Furst MA, Bagheri N, Salvador-Carulla L. An ecosystems approach to mental health services research. BJPsych Int. 2021;18(1):23–5.
18. Armstrong M, Milch H, Curtis P, Endress P. A business model for managing system change through strategic financing and performance indicators: A case study. Am J Community Psychol. 2012;49:517–25.
19. Stroul BA, Friedman RM. Issue brief: strategies for expanding the system of care approach. Washington, DC: Technical Assistance Partnership for Child and Family Mental Health; 2011.
20. Kilian A, Williamson A. What is known about pathways to mental health care for Australian aboriginal young people? A narrative review. Int J Equity Health. 2018;17(1):12. https://doi.org/10.1186/s12939-018-0727-y.
21. Australian Institute of Health and Welfare. Size and sources of the Indigenous health gap. Australia's health. Australia's health series. Canberra: AIHW; 2018. pp. 1–14.
22. Department of Health. Available funding sources and resources for the Aboriginal Community Controlled Health Services Sector. Department of Health Final Report. 2020. https://www.health.gov.au/sites/default/files/documents/2020/12/available-funding-sources-and-resources-for-the-aboriginal-community-controlled-health-services-acchs-sector.pdf.
23. Australian Government Department of Health and Aged Care. National preventive health strategy 2021–2030. In: DOHAC, editor. Canberra: DOHAC; 2021.
24. Productivity Commission. Review of the National agreement on closing the gap. Canberra: Commonwealth of Australia; 2024.
25. McCalman J, Bainbridge R, James YC, Bailie R, Tsey K, Matthews V, et al. Systems integration to promote the mental health of aboriginal and Torres Strait Islander children: protocol for a community-driven continuous quality improvement approach. BMC Public Health. 2020;20(1):1810.
26. Smart J. Collective impact: Evidence and implications for practice Australian Institute of Family Studies Child Family Community Australia. 2017. https://aifs.gov.au/resources/practice-guides/collective-impact-evidence-and-implications-practice.
27. Kania J, Kramer M. Collective impact. Stanf Social Innov Rev. 2011;9(1):36–41.
28. Kania J, Williams J, Schmitz P, Brady S, Kramer M, Juster JS. Centering equity in collective impact. Stanf Social Innov Rev. 2021;20(1):38–45.
29. Australian Bureau of Statistics. Cairns 2021 Census All persons QuickStats. In: ABS, editor. Canberra; 2023. https://abs.gov.au/census/find-census-data/quickstats/2021/306.
30. Wenitong-Schrieber L, Tranby S, Caelli N, Nona M, Jose S, Rosendale D, Ketchell S. Reclaiming our future: the establishment of a youth-led community-based Aboriginal and Torres Strait Islander empowerment organisation in Australia. Youth Voice J. 2024;2056-2969. ISSN (online). https://www.rj4allpublications.com/product/reclaiming-our-futurecommunity-based-aboriginal-torres-strait-islander-empowerment-australia/.
31. Australian Bureau of Statistics. Yarrabah 2021 census all persons quickstats. In: ABS, editor. Canberra: Commonwealth of Australia; 2022.
32. Saunders V, Fagan R, Nona M. Evaluation of the relevance, cultural appropriateness and value for community partners of an international tool (DESDE) to assess the availability and characteristics of services for the wellbeing of aboriginal and/or Torres Strait Islander youth wellbeing in Australia. Int J Cult Psychiat. In press.
33. Furst M, McDonald T, McCalman J, Fagan R, Lee Hong A, Salinas-Perez J, et al. The integrated atlas of the social and emotional wellbeing services for children and youth in Yarrabah. Cairns: Gurriny Yealamucka Health Services and CQUniversity Jawun Research Centre; 2022.
34. Furst M, McDonald T, McCalman JSJ, Nona M, Rosendale D, et al. The integrated atlas of the social and emotional wellbeing services for children and youth in Cairns. Cairns: DIYDG and CQUniversity Jawun Research Centre; 2022.
35. The World Café Community Foundation. The World cafe method. https://theworldcafe.com/wp-content/uploads/2015/07/Cafe-To-Go-Revised.pdf. Accessed 7 May 2025.
36. Cross SP, Hickie I. Transdiagnostic stepped care in mental health. Public Health Res Pract. 2017;27(2). https://doi.org/10.17061/phrp2721712.
37. Mental Health Australia and KPMG. Investing to save. The economic benefits for Australia of investment in mental health reform. Canberra: KPMG; 2018.
38. Stockton DA, Fowler C, Debono D, Travaglia J. World health organization Building blocks in rural community health services: an integrative review. Health Sci Rep. 2021;4(2):e254.
39. Australian Institute of Health and Welfare. Child protection Australia 2018–19. In: AIHW, editor. Canberra; 2020. https://www.aihw.gov.au/reports/child-protection/child-protectionaustralia-2018-19/summary.
40. Calabria B, Clifford A, Shakeshaft A, Doran C. A systematic review of family-based interventions targeting alcohol misuse and their potential to reduce alcohol-related harm in Indigenous communities. J Stud Alcohol Drug. 2012;73(3):477–88.
41. Semczuk M, Shakeshaft A, Knight A, Maple M, McKay K, Shakeshaft B. An analysis of the relationship between a community-based prevention program for young people with multiple and complex needs and the prevalence of crime. Sydney: NDARC, UNSW; 2012.
42. Wright A, Davis VN, Brinckley MM, Lovett R, Thandrayen J, Yap M, et al. Relationship of Aboriginal family wellbeing to social and cultural determinants, Central Australia: 'Waltja tjutangku nyakunytjaku'. Fam Med Community Health. 2022;10(4):e001741. https://doi.org/10.1136/fmch-2022-001741.
43. Salvador-Carulla L, Dimitrov H, Weber G, McDaid D, Venner B, Sprah L, et al. DESDE-LTC: evaluation and classification of services for long term care in Europe. Spain: Psicost and Catalunya Caixa; 2011.
44. Salvador-Carulla L, Amaddeo F, Gutiérrez-Colosía MR, Salazzari D, Gonzalez-Caballero JL, Montagni I, et al. Developing a tool for mapping adult mental health care provision in Europe: the REMAST research protocol and its contribution to better integrated care. Int J Integr Care. 2015;15:e042.
45. McGorry P, Purcell R, Hickie I, Jorm A. Investing in youth mental health is a best buy. Med J Aust. 2007;187(7). https://doi.org/10.5694/j.1326-5377.2007.tb01326.x.

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