

Case Study Scenarios

To the Queensland Health
Community Health Review

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QC●SS

queensland council of social service inc

WORKING FOR A FAIR QUEENSLAND

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Introduction and project scope

QCOSS has recently signed a service agreement with the Department of Health (QH) to deliver a multi-stage research and consultation project in relation to a number of health issues and processes including:

- Informing the Queensland Health Community Health review
- Informing the connecting health care in communities (CHIC) program
- An issues paper identifying the impacts of co-payments and out of pocket expenses on Queenslanders' access to timely health services
- A discussion paper on local government health care partnerships
- Assistance to enhance participation in QH consultations and forums
- A discussion paper and recommendations on effectively targeting population health interventions for low socio-economic populations

This report responds to the following activity outlined in the service agreement:

Development of a scenario paper outlining at least three scenarios of client experiences in the current community health environment from metropolitan, regional and rural/remote perspectives (the target population to be low income or otherwise disadvantaged consumers, ideally including scenarios for children and older people or adults with chronic conditions). Scenarios to identify issues and barriers encountered, range of services accessed and any innovative solutions applied. The paper will be used to inform the QH Community Health Review.

Methodology

As this comprehensive project has only recently been agreed, QCOSS is currently in the process of engaging staff. In this context and by agreement with QH, we engaged a consultant to assist us with collecting the initial case studies outlined below.

QCOSS with assistance from the consultant engaged with QCOSS members and other key stakeholders to identify possible case studies in each of the three target areas.

A number of contacts were made and the consultant made initial approaches to further assess the relevance of the case study to the project brief.

As the project effectively took place over three weeks, we were confined to those case studies that emerged quickly and could be accessed. The consultant travelled where necessary to undertake face to face interviews and on one occasion completed an interview over the phone.

An interview tool was developed and is included in the appendix. The consultant also developed and utilised a simple consent form to ensure that the purpose of the project and how the information will be used is completely transparent to participants. This is also available in the appendix.

Some issues were encountered in this process:

- As time was short, we were confined to those contacts that were easy to make and establish by the project deadline. Case studies involving people with significant barriers to access who were perhaps less well connected to the service system would have taken longer to find yet may have yielded more relevant and useful information. We anticipate that with ongoing staffing of the project these types of connections will be made and consolidated to the benefit of later project milestones
- It was difficult to always focus people on the "community health" aspects of this project. In reality the case studies reveal a number of related issues including access to community health services. In some instances we have documented the cases more broadly to reflect that people need community health services often in the context of other considerable challenges such as poverty, child care needs and employment constraints.
- As the project consultant reflected after gathering the case studies: *"I think it's hard for health consumers to reveal the issues really as their understanding of the system can be so limited and the people who really miss out don't even know they are missing out"*

Metropolitan: Sandra

Sandra is 20 and lives with her mother, Debbie and young brother Craig in Brisbane's urban fringe. Her father died some years ago. Her older sister has been treated for schizophrenia for several years and is trying for the second time to live back in the community with support. Sandra has also been diagnosed with schizophrenia and is managing the condition fairly well with regular medication. However, the recent past was not so positive.

When Sandra was 14, Debbie noticed some significant changes in her personality and other symptoms very similar to those her eldest daughter had experienced with the onset of schizophrenia. Debbie hoped that early intervention would help prevent deterioration in Sandra's mental health. They consulted the family doctor and were referred to a Child and Youth Mental Health Service psychologist.

"...I would have walked away from that appointment and never returned because I was made to feel that the behaviours were our fault."

"At that point," Debbie said, "If I didn't already have an awareness of mental illness, I would have walked away from that appointment and never returned because I was made to feel that the behaviours were our fault. I already felt bad just because we needed professional help."

The professional assessment was that parent-child conflict was causing the difficulties. Meanwhile, Debbie was finding it hard to cope at home with Sandra. She was in trouble at school. She had periods of anger and at other times was very closed off and was using marijuana and sniffing paint regularly, or "self-medicating with paint" as Sandra said. Debbie asked the family doctor and Department of Communities to help her obtain mental health assistance for Sandra but this had no impact.

Sandra's health and well being was spiralling downwards. She was expelled from school, began self-harming and was increasingly in trouble with the police. Debbie knocked on many service and advocacy doors appealing for help. Sandra was given medication for five months and Debbie could see a marked improvement, but for some reason this was stopped and the downward slide continued.

"Sandra's life was at risk every day and we had to live not knowing if she would survive the day. She was hearing voices. She cut her wrists so badly she needed surgery. She has cut her throat three times, on one occasion needing over 70 stitches. Now she has more than a hundred scars on her body. Sometimes we would have to call the police two or three times a day to help us."

Over four years, Debbie estimates that Sandra has had 200 assessments, and in only one of those was her parental understanding of Sandra's situation requested.

Over four years, Debbie estimates that Sandra has had 200 assessments, and in only one of those was her parental understanding of Sandra's situation requested. Debbie feels that successive health workers accepted the initial assessment of parent-child conflict, which prevented Sandra from receiving the help she needed. The children's welfare agency that provided supported accommodation to Sandra agreed. They too struggled to cope with Sandra's illness and similarly failed in their effort to get help for her illness. Even when referred by the local Child and Youth Mental Health Service for hospitalisation in the adolescent psychiatric ward of the neighbouring district hospital, Sandra would be observed for a night or two then discharged when staff concluded that there was no mental illness or problem. It seemed to Debbie that patients referred in from another district community health service to the ward were given less priority. It seemed like the ultimate revolving door between community services and hospitals and Sandra's confidence in the services was diminished each time it happened.

It seemed like the ultimate revolving door between community services and hospitals

Sandra was jailed on her 18th birthday. Eventually, on one of Sandra's court appearances when the media reported her sorry tale, the magistrate ordered a mental health assessment which took place outside the district. For the first time, a psychiatrist asked Debbie to provide information. There was a diagnosis of schizophrenia, treatment, 12 months in hospital then discharge with regular, ongoing visits to Community Mental Health and Debbie is now confident that Sandra's symptoms are being treated.

Apart from occasional incidents, Sandra's life is now much less traumatic, although her daily life is very limited. Mental illness has been very socially isolating for Sandra and her family. Because of her criminal record, Sandra cannot enrol to complete secondary school. She has no friends and has very little confidence. She is unemployed. Occasionally the children's welfare agency who provided supported accommodation arranges to take her out socially. From Debbie's point of view, the damage she hoped to prevent with her first visit to Child and Youth Mental Health has happened.

"...there has been a huge personal cost for Sandra and her family, but thousands of worker hours have been needlessly used ... an enormous waste."

Debbie says, "Not only has there been a huge personal cost for Sandra and her family, but thousands of worker hours have been needlessly used by staff from the Queensland Police Service, Community Health Services, the Department of Communities, the courts, juvenile detention, prisons, hospitals, and community children's welfare agencies – an enormous waste."

Debbie's unrelenting resolve to get help for her daughter continues. Debbie says, "It's really hard for a young person to say to a health professional '*I'm hearing voices*'. It's hard for anyone. She told them, but they didn't take notice or enough care to understand. The cruelty of the system is a hundred times worse than the illness itself."

Issues for the consumer are:

Continuum of care

- * Health service reluctant to collaborate with other services

Access

- * Repeated failure to diagnose or treat the mental illness
- * Failure to provide early intervention
- * Loss of consumer confidence that health providers could help

Client-centred service

- * Lack of empathy – felt judged and blamed by health workers
- * Assessments excluded consumer's significant relationships
- * Failure of community health and hospital to achieve consumer outcomes

Equity

- * Alarming waste of public resources

Metropolitan: Kylie

Kylie is a 23 year old Indigenous woman and mother of four with three of the children under three years old. One child is only in her care four days a week and Kylie's main goal is to regain full custody.

Violence features large in Kylie's memories of growing up and when her grandmother died she left home at 14 to live on the streets. She had her first child at 17 and moved to Queensland when she was 20.

Kylie feels things have looked up for her in Brisbane where her home now is a community housing rental property where she feels very secure. Importantly for Kylie, she feels strongly encouraged by workers from an Indigenous health service and a homelessness service. They have urged her to move from street survival thinking towards being confident about her abilities and strengths and to make the most of them. "It makes a big difference. I feel like I'm finally growing up now in the last two years." The services also offer invaluable support and Kylie knows she can ask for help with any problem at all.

Without a doubt, Kylie believes the one-stop-shop, face to face services of the Indigenous health service make a huge difference in her life. She thinks it is the ideal model for community health services for every community, and not just for Indigenous people.

Kylie believes the one-stop-shop, face to face services of the Indigenous health service make a huge difference in her life.

Kylie says that at the health service there are clinics for diabetes, child health, mental health, antenatal care, eyes, dental, immunisation, welfare and more. "It's really good. I'm telling you it works!"

"There's a bus stop near my house here but several times they have pulled up and told me I can't fit on with the pram, even when it looks roomy to me. So I'm just left on the footpath. But the health service provides transport for me and the children to safely get there. Not only that, but they send reminder notices about appointments and ring me up at times. They also do home visits for the first few months when you have a baby – fantastic.

"You have to have face to face information – phone advice is hopeless."

"People at the Indigenous health service are really

friendly. They've got time to say hello and you don't have to wait for hours to be seen. You have to have face to face information – phone advice is hopeless. If you need a referral elsewhere, they check to see if you need support for the appointment.

"What is also really important is confidentiality. A couple of times things leaked out about me not coping and it got really bad. You just shouldn't talk about people without permission. I stopped going there so much because of that."

Kylie feels like she plays her part as well when it comes to knowing how to access services – "I ask a lot of questions. I ask services to tell me exactly what they do. You have to get up and make an effort to find out about everything yourself."

"I ask services to tell me exactly what they do. You have to get up and make an effort to find out about everything yourself."

Kylie's links with health services haven't always been so good. In one Brisbane hospital Kylie felt like she was treated like a 'head case', was talked about behind the screen as if she wasn't there and her children's files were lost. Things went from bad to worse, Kylie got angry, and four security guards were called to keep her in a cubicle.

These days, Kylie can see that things are improving and she can see a time when employment will be her goal. She'd like to work helping families, like the homeless service workers she knows.

Issues for the consumer are:

Access

- ✓ Several services co-located
- ✓ Transport to clinics provided
- ✓ Referral *plus* support to use other services
- ✓ Face to face information, rather than telephone
- ✓ Culturally appropriate
- ✓ Appointment reminders
- ✓ Confident to ask about any problem

Client-centred service

- ✓ Felt respected
- ✓ Felt encouraged
- ✓ Felt service workers gave enough time and were interested

Confidentiality

- ✗ Breaches eroded trust

Metropolitan: Leigh

Leigh is 37 years old and lives in Brisbane in a two-bedroom rental house managed by a community housing provider. He has been diagnosed with schizophrenia and has an amphetamine addiction. Leigh has a nine year old daughter, Molly, who lives in north Queensland. He currently has no access time with her.

In 2005 Leigh left a South Australian hospital-based mental health unit and travelled to Queensland to try to improve his situation. He worked for a relative for six months, although this was challenging because he was homeless and living rough at the time.

Though some work colleagues were very welcoming and supportive, he developed a speed habit and his life quickly unravelled. Leigh says the speed habit “controls my life, even though my usage has decreased a lot. It is a very demanding drug.”

He was employed again this year by a brother in NSW, and found that the demands of work, the total acceptance of his brother and nephew, having an income and eating well meant he could reduce his drug use. He feels more stable, but sees that he still has a long way to go.

Back in Brisbane, Leigh hit bottom as he faced up to the fact that he could have no access with his daughter while he had no home, no job, a drug habit and mental illness. He was also driven to seek help for his increasingly paranoid mental state.

Leigh decided to try to see a private psychiatrist on the assumption that as a fee paying patient, he would receive a quality service. His confidence in the public mental health system was very low, after seeing a variety of psychiatrists over several years and receiving conflicting diagnoses, including “nothing wrong”. He had found only one psychiatrist who offered respect, clear information and advice.

Leigh approached a number of welfare services to help pay for a private psychiatrist appointment. He made a number of appointments and in a limited way, shopped around to find someone he felt could help him. One of the agencies who paid for a psychiatric consultation was an inner Brisbane homelessness service. The homelessness agency offers direct services to homeless people within a consortium of other agencies, working together under a Memorandum of Understanding to offer a variety of responses.

Recognising that Leigh was very unwell and would be unable to afford to continue to see private psychiatrists, the homelessness worker offered to call a homelessness health outreach service which has mental health as well as drug and alcohol workers who actively support people with dual diagnoses.

“The homeless service worker really listened to me, understood what I had been through ...”

Due to his condition, Leigh was reluctant to trust anybody. But he says “the homeless service

worker really listened to me, understood what I had been through and what hadn’t worked in the past, and so tried something new. They pay attention in the right areas and they spend a bit more time. They succeed with nearly everybody – a lot of people.”

On several occasions the homelessness worker phoned the health outreach service to ask for a worker to immediately visit their offices to meet Leigh. This immediacy was a major factor in Leigh beginning to trust the health outreach workers (social worker, psychiatrist, counsellor). The fact that he didn’t have to wait weeks for an appointment, “and fall into a hole” while he waited and the fact that he could meet the same workers several times meant that Leigh was able to start, and maintain, a course of medication. Building trust and a relationship with the health worker is very important to Leigh, particularly because of his paranoia.

The fact that he didn’t have to wait weeks for an appointment, “and fall into a hole” while he waited ...meant that Leigh was able to start, and maintain, a course of medication.

A non-government organisation case worker is also assisting Leigh and will accompany him to a self help group meeting to help reduce his anxiety about speaking in this sort of group. The non-government organisation worker is also helping him with Centrelink paperwork and his search for part-time work that will not jeopardise Centrelink payments.

Leigh has found that word-of-mouth is virtually the only way to find out about health and welfare services. "You have to be lucky."

Although Leigh has no literacy problems, he has found that word-of-mouth is virtually the only way to find out about health and

welfare services. "You have to be lucky." He assumes that services are not widely advertised because of the extent of demand. Leigh knows of so many needy people who are not receiving help, he concludes that community health services would be unable to cope if more people knew about them.

Through the advocacy of the homelessness and health outreach services, Leigh was able to move into secure accommodation where he has prepared a room for his daughter in anticipation of being re-united with her. Now that he is not homeless, the health outreach service has offered to refer Leigh to a general north-side mental health service for ongoing support. The planned referral was very concerning to Leigh who explained how important a relationship of trust is to him. Leigh feels that he has been listened to respectfully and is pleased that the referral process will now be gradual. He says the health outreach service has taken into account "the client's unique situation".

While he did not use the term 'over-assessment', he clearly expressed exhaustion from "telling his story". At times, just the thought of having to repeat his story was enough to deter him from trying to access services.

Leigh lives in his own house three or four nights each week, but

...just the thought of having to repeat his story was enough to deter him from trying to access services.

finds waking up alone is difficult. His only friend also uses drugs and although he has been counselled about the risks of this friend's influence, he highly values having a companion to talk to. Leigh's goal is to have a supervised access visit with his daughter in two months and start working again.

Issues for the consumer are:

Continuum of care

✓ Services collaborated to address mental illness, homelessness, unemployment, addictions, family reconnection

Access

- ✓ Worker came to the client at another service's premises
- ✓ Trust with workers established
- ✓ No long delays for an appointment
- * Service information only through word of mouth on the street
- * Re-assessment exhaustion/aversion

Client-centred service

- ✓ Consumer felt respected, listened to
- ✓ Clear, useful treatment information eventually provided
- ✓ Workers had enough time to help

Regional: Tania

Tania Curry is an Indigenous woman living in a rural town of 3,000, half an hour by road from a regional city. She is 29 years old, a sole parent of three children aged between five months and five years. Tania rents a two bedroom home owned by a family member.

Six months ago, Tania had all her teeth removed and replaced with dentures. She is very relieved to no longer be regularly visiting a doctor with painful abscesses in her mouth.

Before this procedure, Tania had last been to a dental clinic at school when she was 13. She remembers this as a painful experience, despite being told by the dental nurse that it wouldn't be painful at all. From that point on, Tania became extremely fearful of dental treatment and avoided it for the following 16 years in spite of her obviously poor state of oral health. "You don't want to look in

"You don't want to look in the mirror. You don't want to talk to people. Bad teeth affect everything."

the mirror. You don't want to talk to people. Bad teeth affect everything," says Tania.

Over the years, people urged her to go to the dentist, but the words of advice were not enough to overcome her fear-based inertia. Finally, after yet another abscess, she summoned the courage to phone the local dental clinic. She was very articulate about her intense fear of dentists and the clinic responded in an understanding way. Sadly, her teeth were beyond repair.

For x-rays and most of the treatment, Tania had to make child care and transport arrangements to and from the nearby regional city. This was a significant logistical and financial challenge made possible through the support of her mother who lives and works nearby.

Tania wanted to make sure her children didn't develop the same fears, so she

Tania was told ... find out where the school dental van was parked in the regional city nearby and go there...

wanted to take her eldest child to a dentist for a check up before starting pre-school. Tania was told that the local clinic doesn't cater for children and that she should find out where the school dental van was parked in the regional city nearby and go there for an examination. Tania was concerned that the infrequent and expensive bus service to the regional city would not connect with one to a suburban school. She was advised to ring Queensland Health but they were unable to provide information about the mobile clinic locations.

Tania never did work out how to find the service but was pleased when her daughter had a dental examination once she was attending pre-school.

Tania never did work out how to find the service.

The issues for the consumer are:

Continuum of care

- * Local health service didn't provide information about the mobile service

Access

- * Fear of pain
- * Advice, but no assertive follow up by health workers
- * Poor transport
- * Poverty
- ✓ Family support to access services
- * Failure to provide information about mobile service locations

Client-centred service

- * Health worker didn't validate the consumer's experience of pain
- ✓ Clinic acknowledged consumer's fear

Regional: Rhonda

Rhonda Jenkins has lived for the past ten years in a small rural town which is half an hour by road from a regional city. She is 43 years old and lives in her own home with seven of her eight children, aged three to fourteen years. Rhonda currently owns a car, though made do for many years in the town without one.

She recalls a typical trip for essential health appointments and shopping in the city around 30 kilometres away.

For many of us, if we have appointments in town we have to pull our children out of school for the day and take them

“If we have appointments in town we have to pull our children out of school for the day and take them with us because it’s not possible to be home before school finishes.”

with us because it’s not possible to be home before school finishes.

There is a school bus run to the nearest town at 8.00am, so you have to get all the kids fed and ready at the bus stop by then. It’s quite a feat to make it there on time with the pram for the baby, a large bag and toddlers walking along too.

The bus fare is \$18 per adult return and once in town, a taxi fare may be needed as well as there are not a lot of bus routes. It’s not uncommon for a hospital appointment to involve a three to five hour wait – it’s a long time for kids of any age to wait, so you can imagine the noise.

By the time we are back home around 5.30, I’m exhausted and everyone’s hungry so I ring for a take away meal and also pay for a taxi to bring it here because we’re all too exhausted to head off again pushing the pram – another \$30 or so!

The school buses to the city don’t run in the school holidays. When you don’t have your own transport many of us just don’t use health services unless we are desperate.

“When you don’t have your own transport (we) just don’t use health services unless we are desperate.”

There are no local services for hearing, eyes, speech therapy, ante-natal or maternity care. I would like to see full ante-natal, post-natal and birth services offered in town here. I don’t take the children to health services as a rule, apart from emergencies, like when my son was mauled by a dog recently. He had to be in the hospital here for five days to have dressings and antibiotics. I had my last baby at home with help from a friend who has had children herself. It was fine. The alternative was to go by ambulance to the city, give birth, be driven by ambulance back up to the local hospital here for a night or two, then go home. Who looks after the other children while all that happens?

The issues for the consumer are:

Access

- * Poor transport
- * Family support, like emergency child care
- * Long wait times for appointments
- * Services are outside the local community

Regional: Beth

Beth Myatt is the sole welfare worker at a rural outpost of a large welfare organisation. She is dismayed at the paucity of services that consistently outreach to her town from the major centre 30 minutes drive away.

"...agencies just didn't turn up for clients when they said they would"

I used to make a lot more referrals but when the agencies just didn't turn up for clients when they said

they would, my credibility suffered too. I know now exactly which services I can rely on.

A community mental health worker visits once a week to see people who are his cases but there is no long-term follow up for others who may have deteriorated or who don't acknowledge they are unwell. For those people, I have totally given up now. It is impossible to get them access to a service.

"For those people, I have totally given up now. It is impossible to get them access to a service."

Because the public transport is so poor and so many don't own cars or have relinquished licences as they've aged, I often drive people to the city for appointments and stay with them to make sure they don't give up waiting. Some older people rarely leave this town and they are extremely fearful of the city environment – they just don't happily head off to appointments in town. Sometimes I wait with them for five or six hours, almost my whole working day, but I can't find another way to make sure they get services. Sometimes they have no money to fill prescriptions after seeing a doctor – that's 'their' problem.

"I often drive people to the city for appointments and stay with them to make sure they don't give up waiting. Sometimes I wait with them for five or six hours."

A case management meeting at the hospital has started up and I have been invited to take part in that

along with some other local services. This could mean improved coordination. For example, recently an elderly diabetic man I know well was discharged from hospital late on a Friday but he had no food at home. Luckily I was able to rush off and get him some provisions.

People often come here for help with forms or for help to understand what they've been told by service providers. Dealing with the language of business or government and the time to explain things clearly is very important.

The issues are:

Continuum of care

- * Service providers are unreliable with appointments
- * Hospital-community providers case coordination

Access

- * No mental health outreach
- * Poor transport
- * Consumer anxiety about unfamiliar environments
- * Long wait times for appointments
- * Language used on government paperwork
- * Low levels of literacy
- ✓ Time to explain how services work

Remote Case Study: Edna and Carl

Edna and Carl live in a remote county town over 700 kilometres from Brisbane. Edna is 75 and doing well with help from Carl, her husband and carer, and some community health services. She has had a stroke, two lung operations and a mastectomy in recent years. She can no longer drive, doesn't have good balance but walks with a stick, is short of breath, forgets quite a bit but is very positive about her life.

After being in hospital in Brisbane for the mastectomy, Edna returned home and was visited by Joan from Home and Community Care and Margaret from the local domiciliary nursing service. Edna thinks either the hospital or the local doctor must have arranged those visits which happened very soon after her return home.

They decided they could offer help with bathing three days a week and house cleaning once a week while Carl looks after cooking, washing and driving.

Edna knows the women who run these services quite well, so if she ever needs more information or has questions, she knows who to ask.

Edna knows the women who run these services quite well, so if she ever needs more information or has questions, she knows who to ask.

Carl had to have a colostomy two years ago and he has to have regular heart checks, but doesn't need any direct services himself.

It's a town where everyone knows almost everyone else so tracking down the right person isn't too hard. It means confidentiality is very important too and Edna is very confident that her personal information is kept that way. "That's just the rule – what's said in the home stays in the home."

It's a town where everyone knows almost everyone else so tracking down the right person isn't too hard. ...Edna is very confident that her personal information is kept that way. "That's just the rule – what's said in the home stays in the home."

The key issues for these consumers are:

Continuum of care

- ✓ Hospital-GP-community health referral and communication
- ✓ Prompt commencement of services

Access

- ✓ A pre-existing relationship with the care providers

Confidentiality

- ✓ Consumer confidence that confidentiality is preserved

Appendix 1: Interview Guide

Introduce self (give a card), project, confidentiality.

Explain consent form and ask interviewee to sign it - one copy to keep and one to take.

Ask set (A) questions

Ask interviewee to tell their story in terms of need for and use of community health services. (Listen for themes of access, coordination, continuum of care, client centred delivery, transparency, confidentiality, language, equity, other)

Check if set (B) questions have been revealed.

After interview, check if I can get back in touch to clarify things or ask an extra question/s.

Thank the person on behalf of QCOSS and make voucher or gift available as appropriate.

(A)

Location	
Service Contact	
Age	
Household Characteristics (for eg. living alone, living with spouse, living with family, living with dependent children etc).	
Housing situation (tenure, security)	
Mobility	
Transport availability (private, public, frequency)	
Language	
Cultural background	
Literacy	
Other	

(B)

Condition/s (duration, multiple diagnoses)	
Service networks – who else is involved?	
Barriers (Individual)	
Barriers (Systemic)	

Key success factors	
Key factors influencing lack of access	
Social networks, affiliations	
Current level of access to available health services (type of service, frequency, follow up etc)	

For service providers

1. What did you and other stakeholders learn from the scenario?
2. What were the main challenges within the scenario? How did you meet these challenges or difficulties?
3. Did anything unexpected happen? How did you handle this?
4. What would you do the same/differently in a similar situation in the future?
5. What practice elements would you maintain/change in the future?
6. What systemic elements would you maintain/change in the future?
7. Any advice for others?
8. Examples of innovation (being implemented)
9. Innovative ideas suggested by practitioners (yet to be implemented)

Appendix 2: Consent Form



Consent Form Participation in the QCOSS Health Project

Dear

QCOSS has been funded by Queensland Health to provide information and advice about how people could better access the full range of community health services in Queensland.

Part of this project involves gathering case studies that will show the kinds of issues that people experience when trying to access health services. It is hoped that by writing down people's own stories that the issues and also the solutions can be identified.

All information provided is confidential and details such as names and addresses will be protected. These case studies, using false names, will be included in a written report provided to Queensland Health for research purposes only.

I consent to be involved in giving QCOSS information about my experience of using, or trying to use, community health services in Queensland. I understand this information will be then provided to Queensland Health.

I understand that a person who is independent of Queensland Health will interview me. I do not have to answer a question if I don't want to.

If I want to, I can have a member of my family or another person I choose to support me in the interview.

I understand the interviewer will write down my comments during the interview.

I understand that the interviewer will include information about me in a report provided to Queensland Health, but I will not be named anywhere in the report.

Neither the interviewer nor QCOSS will give my information to anyone other than Queensland Health without asking my permission first.

Signature

Date

(Participant)

Signature

Date

(Parent/Guardian) *(if required)*

Where participants are under 18 years of age, are unable to complete this form or does not understand the effect of providing consent, a parent/guardian to sign the consent form.