CONFIDENTIAL REPORT TO THE STEERING COMMITTEE

REVIEW OF QUEENSLAND COMMUNITY MENTAL HEALTH SERVICES TO CHILDREN AND YOUNG PEOPLE.

JANUARY, 1995

REVIEW TEAM
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"If you scrapheap people, they will scrapheap your society"
Peter Garrett, Midnight Oil, "60 minutes", 1992.

data is not necessarily information,
information is not necessarily knowledge,
knowledge is not necessarily wisdom,
none of the above is action.

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INTRODUCTION

This review and internal report was commissioned by the Mental Health Branch, Queensland Health, to advise and assist in the development of policy for mental health services to children and young people.

The Review Team members were:
Dr.Graham Martin, Director and Chief Child Psychiatrist, Southern Child and Adolescent Mental Health Services, Adelaide, South Australia;
Ms. Sue Behan, Senior Policy Officer, Mental Health Policy Unit, Mental Health Branch, Queensland Health;
Ms. Erica Lee, Director, Greenslopes Child Guidance Clinic, Brisbane South.
Site visits were carried out in August and September, 1994.

The process of the review was guided by the Terms of Reference (see page 13.) and by preliminary discussions with the Steering Committee chaired by:
Dr. Bernard Hughson, Acting Director of Mental Health, Queensland Health.
Other members of the Steering Committee were:
Ms. Mary Abbott, Brisbane South Regional Health Authority;
Ms. Sharon Caddy, State Public Services Federation of Queensland;
Mr. Ross Coghill, Human Resource Management, Queensland Health;
Mr. Roy Drabble, Queensland Nurses Union;
Ms. Anne Harrison, Brisbane Youth Service;
Ms. Erica Lee, Director, Greenslopes Child Guidance Clinic, Brisbane South;
Dr. Trevor Sadler, Director, Barrett Adolescent Centre;
Ms. Elisabeth Wilson-Evered, Psychologist, Adolescent Forensic Unit.

The report was due for presentation to the Steering Committee by the end of November 1994 but went through several drafts; the final report was completed in January 1995 and presented to:
Dr. Harvey Whiteford, Director of Mental Health, Queensland Health.

Before providing an Executive Summary (page 16.) this report attempts to provide a summary of implications from both national and state policy to provide some benchmarks against which the Terms of Reference may be compared.
Key Findings from the review are on page 16. as part of the Executive Summary.

In providing a report it needs to be made clear that;

- mental illness, particularly in children and young people, is not easy to

define – **but** some time honoured assessment tools and processes exist and some diagnostic categories are reliable;

- there is as yet little national or international consensus on "best practice" in management of mental disorder in children and young people, and this makes it difficult to set benchmarks against which the success of interventions can be measured – **but** there are a range of interventions we know work with many conditions;
- the specialised role of mental health services to children and young people, and how these should be coordinated, is not easy to define when there is so much overlap in responsibility for interventions between multiple and equally important service systems – **but** there is an obligation to define what we do;
- it is not easy to prioritise services from a low resource and low workforce base – **but** the demand for clinical services and the dictates from evolving policy force us to consider priorities.

These complex issues are considered below, and further developed under *Preamble to the Main Report* (page 22.).

Mental Health for Children and Young People

Mental Health Problems and Disorders in childhood, adolescence and young adulthood are expressed through emotional symptoms, behavioural disorders and/or social difficulties. These are often accompanied by, or underpinned by, cognitive difficulties, speech and language problems and disorders, and psychomotor difficulties. Certain developmental life transitions, physical and intellectual disability, and a range of medical disorders are known to be associated with mental health problems.

The clinician who specialises in the area of Mental Health for Children and Young People seeks to assess, manage or intervene through counselling or therapy with *all* such disorders which:

- cause problems in living in the here and now;
- can reasonably be predicted to cause problems in living in the future;
- are known to be (or where there is a high index of suspicion that they are) symptoms of, or precursors to, mild, moderate or severe mental disorder;
- where there is a fear in the young person, their parents, other professionals or the community that they may be symptoms of, or precursors to mild, moderate or severe mental disorder.

Mental Health Problems and Disorders are less likely to be complained of by the child who is more likely to be brought by, or sent by, others – parents,

teachers, doctors, family service workers, residential care workers, police or courts. The child may not agree there is a problem or may be unable to express what the nature of the problem is. Because the child is in the process of development, the overall presentation may be diffuse or not quite fit the full blown picture of a clear–cut mental disorder; symptomatic presentations, descriptions of emotion, behaviour, and social behaviours, all differ with age and stage. Because the child lives in a family the symptoms may be underpinned by, the direct result of, distorted by, or perpetuated by, the family dynamics.

Professional workers in Community Mental Health Services for Children and Young People must:

- understand mental health problems and disorders;
- understand child development;
- understand the child's inner world and be capable of working with the child;
- understand family dynamics and be able to work with the child's family;
- take a broad bio–psycho–socio–cultural view of any symptom, problem or disorder presented to them;
- be able to liaise with, or intervene in, the wider system in which the child is involved;
- be trained in a wide range of assessment techniques and therapeutic interventions, or they must have ready access to that expertise.

This complexity accounts for why the most functional services are fully multidisciplinary with child psychiatrists, clinical or educational psychologists, social workers, psychiatric nurses, occupational therapists and speech pathologists all working together in the same clinic. A comprehensive service can be offered to the young patient and their family in the one place. However, with increasing competition for scarce resources, particularly in the public sector, Community Mental Health Services for Children and Young People are being asked to be clear about what they do, prioritise their services and provide benchmarks for evaluation of services. We all have to work smarter and know where we can be the most effective, manage better and do more with less; aiming to be holistic or comprehensive has to be balanced with an efficient use of the available resources.

The Context of Reform

Major reform is occurring in Mental Health Services throughout Australia. However, at this time there is no national or state policy or plan written

specifically for the mental health of children and adolescents. Inferences on what is thought by the community to be important have to be drawn from the National Mental Health Policy (1992) and Plan (1993), The Queensland Mental Health Policy (1993) and Plan (1994), National Goals, Targets and Strategies for improving Mental Health (Feb, 1994), the Health Goals and Targets for Australian Children and Youth (1992) and the Health of Young Australians (1994).

The **National Mental Health Policy** (1992) states explicitly that:

> .... *priority in the allocation of resources should be given to people with severe mental health problems or mental disorders who, because of the nature of their condition, require ongoing and, at times, intensive treatment.*

The implication for Mental Health Services for Children and Young People is that we should seek to deal predominantly with those disorders which may be clearly defined as *severe* and *in need of long term care.* Such conditions are often *complex, difficult to diagnose in their earliest presentations* but more likely to have ultimately a clear cut *psychiatric diagnosis* (see **Preamble to the Main Report** under **core business)**

In contrast the National Mental Health Policy also states:

> *the policy also recognises the impact of mental health problems more generally on individuals, their families and the community...*

This statement fits well with Mental Health Services for Children and Young People where a broad bio-psycho-socio-cultural view is routinely taken to understand both the aetiology and perpetuation of disorder.

The National Mental Health Policy adds:

> *The development of effective mental health promotion, prevention and early intervention strategies and the enhancement of training and support for primary care service providers, is fundamental to the achievement of these objectives.*

There are two issues here which are crucial to the further development of Mental Health for Children and Young People. First, the general area of prevention; both primary and secondary prevention of mental health problems are feasible. In addition good quality clinical work during, and relapse prevention after, an early episode of mental disorder may well lead to fewer

and less serious episodes later in life. The second issue is psychoeducation as one form of mental health promotion which, if applied consistently and early, can be shown to change the long term course of mental disorder.

The **Queensland Mental Health Plan** (1994) sets out specific objectives and strategies for the implementation of mental health service reform (p.7.):

- establishing mainstreamed integrated services to promote continuity of care across service components;
- providing locally available care through more equitable distribution of mental health resources;
- involving consumers in the planning, operation and evaluation of services;
- prioritising services to those most in need and ensuring services respond appropriately to the needs of priority groups;
- progressing the reform of psychiatric hospitals;
- establishing and maintaining links with Primary Health Care Services;
- implementing quality management systems including the Minimum Service Standards;
- improving intersectoral links, particularly with housing and disability support agencies.

Each of these is as relevant to the Mental Health of Children and Young People as to adult mental health. It is noted (p.10) that "significant additional resources are required to implement the *Queensland Mental Health Plan*", and that this "has begun to be addressed through the Commonwealth and State budgetary processes." Several Key Initiatives are directly relevant to Mental Health Services for Children and Young People (p.10):

- enhancement of Regional mental health services including extended hours services and mobile intensive treatment teams;
- enhancement of Capital Works infrastructure for community based mental health services;
- enhancement of mental health services to children and young people;
- policy and subsequent service development to address the needs of priority groups including Aboriginal and Torres Strait Islander people, people from non-English speaking backgrounds, women, and children and young people.

In the draft of the **National Goals, Targets and Strategies for improving Mental Health** (Feb, 1994) five areas were "chosen to focus attention", areas which met the following criteria (p.3.):

- high public health impact of the disorder including cost and distress both to people experiencing mental ill health and their carers;
- achievability – the availability of demonstrably effective strategies/ interventions to engender change;
- the capacity to measure and monitor change;
- the ability to engage consumer support; and
- the ability to engage community support.

These criteria challenge our thinking in the area of Mental Health for Children and Young People. Historically we have not been good at monitoring our activities and we have not been active in engaging consumer or community support. Further, the symptomatology which appears in childhood or adolescence and which underpins the development of serious mental disorder has not been totally elucidated and we have not universally heeded the policy imperative to prioritise those conditions which have a high public health impact. Finally, we have not prioritised those conditions for which a demonstrably effective strategy is available; rather community clinics have tended to accept all referrals from whatever source.

Five specific areas were prioritised:

- community attitudes to mental health (p.3.);
  (It was noted that activities in this area would be informed in part by work currently underway such as the National Consumer Advisory Group (NCAG) media projects. The 'ARAFMI school project' was noted).
- Child and Adolescent Mental Health (p.4.);
  (*"It is clearly demonstrated in the literature that mental health problems and mental disorders experienced early in life place individuals at greater risk for the development of mental health problems later in life...*
  Within this goal specific targets have been set to address suicide, depression, and behaviour disorders").
- Suicide;
- Depression;
- People living with mental disorders.

As far as the Mental Health of Children and Young People is concerned the specific Indicators, Targets and Strategies to address the Goal: *"reduce the prevalence of mental health problems and mental disorders in children and adolescents"* are detailed further in the draft report (pp. 22–26).

Two other reports are worthy of mention here. First, the **Health Goals and Targets for Australian Children and Youth** (1992) defines several goals which have implications for Mental Health Services for Children and Young People:

Goal 1.2 *Reduce the frequency of Adolescent Suicide by at least a third by the year 2000* (to 18/100,000 for males and 2/100,000 for females, p.17.);

Goal 2. *Reduce the impact of disability.*
While the emotional, behavioural and social impacts of physical disability (p.29.), chronic illness (p.31.) and intellectual disability (p.32.) on children and young people are not detailed, they are often referred at some time for mental health assessment and counselling;

Goal 4.2 *Reduce the morbidity in adolescence and adulthood associated with alcohol and tobacco use* (p.44.).
Both of these and other drug use/abuse are more common in young people with mental health problems and mental disorder.

Goal 5. *Enhance Family and Social Functioning* (p.52.).
The impact of family break-up and/or alternate care are well known to mental health services specialising in children and young people.

The draft policy paper **The Health of Young Australians** (1994) takes note inter alia of these goals and targets and develops seven *Key action areas* (pp 16–23.):

- Putting people first;
  To promote and enhance the health and well being of young Australians through adequate resourcing of their health care and their increased participation in decisions about their health care at all levels.
- A balanced approach;
  To improve health outcomes for young Australians through an integrated and comprehensive approach to health planning and service delivery
- Addressing inequities;
  To ensure that all young Australians are able to achieve optimal health through provision of a full range of health care services appropriate to their needs, with a focus on those most at risk of poor health.

- Coordination and collaboration;
  To develop cooperative, targeted and cost–effective health strategies for both children and young people.
- Information;
  To promote well informed and skilled consumers, workers, managers involved in the provision of health care.
- Research, data and monitoring;
  To develop a clear focus in research, data collection and monitoring on the health needs of children and young people as a major group within the Australian population and on the health needs of special sub–groups within that group.
- Training;
  To equip health professionals to work effectively in the maintenance and enhancement of the health of children and young people.

None of these documents focuses in detail on the overall field of Mental Health for Children and Young People, nor do they provide a comprehensive list of the priorities that a mental health service should address. However, they do inform our thinking, and provide a basis for a process toward the development of specific mental health goals and targets for Children and Adolescents.

Conclusions

The conclusions that may be drawn at this stage are that Mental Health Services for Children and Young People should:

- be comprehensive with a continuum of care from the community through to intensive inpatient care;
- be mainstreamed;
- be available in all regions with an equitable distribution which reaches those in most need;
- be responsive to consumer needs;
- have strong links with primary health care as well as good intersectoral links;
- have good quality data from a clear monitoring process and regular evaluation of services;
- address the most serious mental disorders (those disorders which are complex, severe, more psychiatric, and likely to have the greatest impact subsequently on the community);
- be able to respond to mental illness and its precursors (predisposing factors) as they present in the Child, Adolescent and Young Adult

population in a timely, effective and appropriate manner;
- have clear early detection and early intervention programs for serious mental disorders and mental health problems;
- have programs for psychoeducation and mental health promotion for patients, carers and the community;
- be well staffed according to population base;
- have staff who are experienced, competent, well trained and well supported.

We should at least be able to focus on those specific disorders already agreed on by the community, in the Health Goals and Targets documentation, as of national importance. At this stage the list contains:
- depression;
- suicide;
- drug and alcohol problems;
- the effect of all forms of abuse;
- the impact of chronic illness and disability;
- the sequelae from parental separation and alternate care.

Clearly this list is inadequate from the point of view of a worker in the field of Mental Health for Children and Young People, since there has been as yet no process of broad national discussion on what should be targeted for this field. There is a need for a national effort to define Health Goals and Targets for the Mental Health of Children and Young People based on the combined experience of mental health workers in this specialised area of children and young people; presumably this would greatly expand the above list of targets.

The Review of Queensland Community Mental Health Services for Children and Young People was developed in the light of these major national and state reforms. The review team had a limited time frame and finite resources and was unable to visit every region or team. However, in addition to broad assessment of policy and planning documentation, statewide data, and a review of previous discussions and recommendations on Queensland Mental Health for Children and Young People, the Review Team visited Brisbane North (representatives from all 6 teams), Brisbane South (representatives from all 4 teams), Barrett Adolescent Centre, and 4 other community Teams (see appendix)where we met with carers and representatives of referring agencies in addition to staff. We are grateful for the openness and warmth with which we were accepted. Finally, discussions were held with a number of individuals and we also received 26 written submissions.
We have attempted to avoid criticism of particular units and/or individuals.

Without exception, those individuals who spoke with us showed a dedication to the central tasks of Mental Health for Children and Young People, despite being overwhelmed by the quantity and quality of the case work *or* the amount of bureaucratic and administrative work (which had to be done in the relative absence of administrative staff) which cut into the amount of time available for clinical work.

We were asked to review community Mental Health Services for Children and Young People statewide, acknowledge tensions, raise dilemmas and make judgments about the appropriateness, adequacy and overall quality of those services. We were specifically asked not to recommend specific solutions. As a result, this report may appear to be a long list of complaints or criticisms without solutions. However, we understand that the report will be used as the basis for a broad and open process of statewide consultation which will lead both to clear policy and focused solutions.

Finally, may I take this opportunity to thank my colleagues Sue Behan and Erica Lee for their patience, support and stamina during the review process and for their detailed, careful and thoughtful comments on successive drafts of this report.

Graham Martin
Adelaide, January 6th, 1995.

TERMS OF REFERENCE

1. To review child guidance clinics (otherwise known as youth, welfare and guidance; child, adolescent and family community mental health services; child and youth mental health services) in Queensland within the context of national and state mental health policy.

2. To examine the availability, quality and appropriateness of these services.

3. To identify operational issues relating to staff mix, levels, resource allocation, location and access to inpatient services.

4. To determine access to child guidance clinics and service utilization by young people over 14.

5. To determine the extent to which children and young people with special needs including those who are of Aboriginal or Islander or Non-English speaking background, homeless, dual disability or within the care and protection of juvenile justice systems, have access to child guidance services.

6. To provide a draft report to the Director of Mental Health by November 1994.

EXECUTIVE SUMMARY

1. The major recommendation from this review is that a Queensland Policy and Plan be developed for Mental Health Services for Children and Young People, taking into account all the issues raised by this report.

2. The review shows that current services overall are not able to meet the prerogatives in either national or current state policies concerning mental health.

3. The review shows that current services overall are not able to meet the demand for comprehensive and responsive mental health services for children and young people.

In particular the following Key Findings should be noted:

- Only 2 regions have adequate community coverage in terms of clinics;
- Only 2 services exist in Queensland's 20 top growth areas;
- There are inadequate numbers of staff to meet the defined need;
- There is inadequate statewide training and supervision for all professions employed;
- There is inadequate statewide leadership;
- There is inadequate statewide academic activity;
- There is no comprehensive system of community and inpatient services in any region;
- There are insufficient acute care inpatient services, particularly for seriously disturbed young people over the age of 14 years;
- Overall, community services are not serving the seriously disturbed;
- Overall, community services are not serving young people over the age of 14 years;
- Services to special needs groups are inadequate;
- There is poor integration with other systems of care for children and young people;
- There are inefficiencies in existing clinical processes;
- There is no statewide mental health promotion program for children, young people and their families;
- The services are unable to develop prevention programs and there is little statewide prevention activity;
- Statewide activity and other statistical data is not available;
- The services have limited resources to implement quality management systems;
- There is concern about existing workforce morale and retention of skilled staff.

TERM OF REFERENCE 1.

To review child guidance clinics (otherwise known as youth, welfare and guidance; child, adolescent and family community mental health services; child and youth mental health services) in Queensland within the context of national and state mental health policy.

Overall, Queensland mental health services for children and young people have a variable and sometimes limited capacity to provide services consistent with National and State Mental Health Policy. This capacity is severely limited when considering young people over 14 years, crisis response, severe mental disorder and priority groups.

TERM OF REFERENCE 2.

To examine the availability, quality and appropriateness of these services.

AVAILABILITY

Queensland is seriously under-resourced in terms of funding, community mental health clinics for children and young people, and staffing.

Community teams are readily available to those who live in the Brisbane regions. In contrast, community teams and services are not readily available further away from Brisbane, further north, in rural or isolated areas, *or* in areas of recent population increase.

Under-resourcing as an issue was brought forcibly to the Review Team's attention by referrers and carers, in all regions visited, by the level of anger and distress at the inability to gain access to relevant services.

QUALITY AND APPROPRIATENESS

The Review Team had no doubt that *where services are available,* the level of commitment of staff has led to as good quality and appropriate direct clinical services as can be expected within current resourcing.

While services may have evolved in different ways depending on the local demands or the professional interests of individuals, or the particular staff mix, it is clear that teams have struggled with the complexity of the task and made hard decisions in order to prioritise referrals and cope with immense demand for services. Despite this, waiting lists are very long (up to 9 months for non urgent cases), with the exception of one clinic which has severely limited the range of disorders seen.

All clinics have clear intake procedures, use the case conference method as central to clinical management and offer thorough and careful assessment.

Despite this, there is little commonality between clinics. With some exceptions, therapy appears to be based on longer term, centre-based therapies; brief methods of individual therapy and systems based methods are not universal.

TERM OF REFERENCE 3.

To identify operational issues relating to staff mix, levels, resource allocation, location and access to inpatient services.

Both National and State policies on Mental Health note that mental health service delivery is specialised, with an emphasis on secondary and tertiary care. There is therefore a demand that staff in services have adequate qualifications and training to the task, a range of skills and a high level competence. In addition there is a need for ongoing supervision and training. The policies have implications for the type of professions who should be employed *and* the level at which clinicians should be employed.

Because of the complexity of the task, it is impossible for all of the skills necessary to reside in one profession. Traditionally, therefore, multidisciplinary teams have evolved to ensure that the skills at least reside within the team.

STAFF MIX

The Review Team was unable to find an agreed on Queensland comprehensive model; all teams differed and seemed to have developed in response to local need or special interest. One model of clinic composition is presented in the main report; this differs somewhat from the Bashir Report (1994).

In addition to the core members of the mental health clinic for children and young people, two historical professional anomalies exist. The role of the medical officer needs to be reviewed as child psychiatrists are employed in increasing numbers in clinics. Further, the role of the child guidance therapist needs to be reviewed in the light of all professions gaining generic child therapy skills.

Discussion is needed on the role of the speech pathologist, the occupational therapist and the physiotherapist in regional clinics. A number of other professionals are employed in small numbers (a paediatrician (1FTE), a consultant neurologist (0.1 FTE), a dietitian (0.1 FTE)). The role of these professions should be reviewed.

STAFF LEVELS

In general the Review Team considers there are problems in levels of appointment. There is a fine line between cost containment in employment (ie

employing the cheapest staff possible) and creating a service which cannot function (because of relative lack of skill, experience, confidence and competence with resultant loss of effectiveness and efficiency).
In general, at the PO2 level staff are likely to be still orienting to Mental Health Services for Children and Young People, gaining clinical skill and relatively inexperienced. The PO3 level has an expectation that staff will have gained basic and some advanced skill and be somewhat experienced. However, both of these levels are in need of ongoing supervision and training.
The Review Team formed the opinion that nearly one third of staff were untrained new graduates or inexperienced in specialised mental health, and there are insufficient seniors at the PO4 level in community mental health teams specialising in children and young people to ensure either supervision or ongoing training at the level required to achieve a standard of excellence in services at the level of best practice.

RESOURCE ALLOCATION

In general, the historical level of poor funding to mental health services for children and young people shows up most clearly in the poor quality of clinic environments, the lack of general and technical equipment and the occupational health and safety issues which arise.
The main issue with resource allocation is how to increase the overall amount of budget allocation to mental health services for children and young people. The Review Team understands that it is unlikely that the necessary funds will readily be made available in the near future.
A question which may be raised therefore relates to whether current resources can be spread more thinly to allow for service development in regions where there are no clinic services and very limited visiting services. In the view of the Review Team this is an unrealistic consideration. While it *appears* that the Brisbane regions are well resourced (see the Solomon report on this issue, and Appendix 2. Table 1.), in fact they are well resourced only by comparison to the rest of the State's regions. There is 'little fat in the system' and all clinics are under immense referral pressure.

LOCATION OF SERVICES

Historically, at least in Brisbane regions, considerable thought has gone into the placement of clinics to provide easy access. In contrast, with population movements and growth in other areas, some clinics are now a distance from new population developments and relatively inaccessible or isolated.
The principle of *access* needs to be taken into consideration as a key component in the further development of both metropolitan and rural services. Even though stand alone clinics can be shown to be an efficient use of

resources, co-location is now expected to be considered, but it is important to maintain the identity of Mental Health Services for Children and Young People as *health* services.

ACCESS TO INPATIENT UNITS

There are few inpatient resources allocated to young people, and serious difficulties in trying to get young people with mental disorder admitted to hospital; this is especially true for those 14 years and over, and those in regions other than Brisbane South and North.

TERM OF REFERENCE 4.

To determine access to child guidance clinics and service utilization by young people over 14.

Overall, the review team found it difficult to gain a complete picture of this issue given that central statistics are not available. It appears there is little use of Mental Health Services for Children and Young People by those over the age of 14 years.

TERM OF REFERENCE 5.

To determine the extent to which children and young people with special needs including those who are of Aboriginal or Islander or Non-English speaking background, homeless, dual disability or within the care and protection of juvenile justice systems, have access to child guidance services.

The Review Team found it difficult to gain a true picture of access by special groups because of the paucity of statewide statistics

There appears to be very little usage of child guidance services by Aboriginal and Islander peoples, non-English speaking people, homeless young people, young people in custody or the juvenile justice system, or those young people with a dual disability.

The review team could not find any evidence of coordinated programs of consultation and liaison between Mental Health Services for Children and Young People and services providing care to these groups. There is no overall statewide mental health plan to ensure adequate availability of services to young people in any of these situations.

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PREAMBLE AND MAIN REPORT

PREAMBLE TO THE MAIN REPORT

Visibility

Mental Health for Children and Young People (Child and Adolescent Mental Health, Child and Adolescent Psychiatry; Child Guidance; Child, Adolescent and Family Mental Health; Child and Youth Mental Health;Youth Welfare and Guidance; Family, Adolescent and Child Therapy; Under 18 Mental Health) is not a flashy endeavour. It is only rarely dramatic or newsworthy, does not use radically new technologies or vastly expensive diagnostic and therapeutic equipment, uses few resources in terms of inpatient beds and the infrastructure necessary to support them, and uses only a limited range of medications in a sparing way.

The core work of Mental Health Services for Children and Young People is assessment of emotional, behavioural or mental disorder, the development of a management plan in association with relevant others and, where appropriate, therapy or counselling. These are essentially private and confidential processes which are difficult to monitor or measure. In addition they are discussed infrequently in the media or by the press compared with the often dramatic cures from surgical intervention, or the poignant medical cures for childhood cancer or leukaemia. Mental Ill Health still carries a marked stigma in the community, and ethical mental health professionals do not discuss their work publicly.

These two issues – the lack of flashiness and the privacy of the processes – make Mental Health for Children and Young People relatively invisible to governments and other funding bodies.

On Core Business (also see Introduction)

Mental Health Services for Children and Young People must be able to respond to mental illness and its precursors (predisposing factors) as they present in the Child, Adolescent and Young Adult population in a timely, effective and appropriate manner. This task is beset by complexity. It is therefore difficult for those outside the field to gain a true sense of just what a mental health worker grapples with every day.

Complexity: The Developing Child in the Family and Community Context.

Traditionally, Mental Health Services for Children and Young People have dealt with the mental health of all children and adolescents from birth to aged 18 years. In practice, clinics vary in the clients they see as a result of the context in which the clinic is placed, the interests and expertise of the particular staff employed, the professional relationships forged with professionals in other services, the identified needs of the area or region, and imperatives from local

and statewide politics and policy.

Two critical issues underscore all practice in this area. First, the child is in the process of development, with each stage (however defined) drawing on more or less successful completion of the previous stage. Secondly the child is not autonomous – that is they are dependent on, and in dynamic equilibrium with, the family and social context into which they are born. In western society, the tasks of autonomy have been completed later and later and are often now not achieved until early adulthood.

In practice we can note that the majority of young people seen in community mental health services are between the ages of 5 and 14 years. An argument can be mounted that child health workers and paediatricians (from their training, experience and daily focus) are more suited to look after the under 5s and here there is considerable overlap between child health and child mental health. However, we know from the considerable and expanding work in the field of infant psychiatry/infant mental health that the first three years of life *and* the earliest child-parent relationships are critical for personality development.

Prevention as a Focus

The policy imperative is to deal with the most serious mental health problems and/or frank mental illness, but only few cases in infancy and early childhood show absolutely obvious evidence of these. The dilemma is that if we believe in the developmental perspective then a strong argument can be made that, given adequate staffing, professional workers in the child and adolescent area should be involved with younger children who show even the slightest hint of mental health problems or developmental problems known to underpin later mental health problems; this is good secondary prevention. In fact it is the professional mental health workers who work in the area of children and young people who are most likely to have the training in emotional, moral, behavioural and social development, the depth of understanding of the parent-child relationship and the range of individual and systemic therapeutic skills necessary to work with young families from this perspective. They rarely develop prevention programs as such because of the time taken up by the pressure from referrals of older children who are more obvious cases of disorder or illness, but in ignoring the sometimes subtle needs of the younger child, the more obvious cases are later created – which perpetuates a vicious cycle.

Adolescents

At the other end of the age range is a slightly different problem; in practice mental health professionals in community clinics oriented to children and young people see relatively few older adolescents. This is odd because the

policy imperative is to deal with the most serious mental health problems and/or frank mental illness, and there is clear international evidence that serious disorders have their peak onset at about 16 years. Two explanations may be offered.
First, the current services/clinics may be unsuitable for adolescents and youth; names which contain the word "mental" may put young people off, the environments may be more geared to the younger child and their family. A more cogent argument relates to the fact that these young people are more likely to have a distinct diagnosable disorder. When this is the case, a psychiatrist is more likely to be needed as a consultant or primary therapist. In a service where there are very few child psychiatrists, where there are no dedicated acute admission units for young people, cases will drift toward adult services which do have psychiatrists and facilities. This creates a serious dilemma. Staff in adult services are rarely trained in development issues to the degree necessary; specifically they find adolescents and young people very hard to deal with. Further, adult services are unlikely to take much cognisance of the system – that is the family, school and social context issues; but these are the very areas in which child psychiatrists and other professionals working with young people excel because of their training, experience and focus. Until a young person reaches autonomy from their context (and it is recognised that in some cases this may now be up to and including the age of 24 years) an argument exists that *only* these professionals are trained to deal with the complexity of the issues. Lip service is paid to this complexity in the multi-axial classifications of DSM-IV and ICD-10, but even where adult psychiatric services are highly trained in family and community work, the referral pressure to manage seriously ill people is against comprehensive systemic work in the medium or long term.

What conditions should be treated ?
Mental Health professionals in Services specialising in children and young people are expected to have knowledge and experience of, and deal with, the full range of recognised mental disorders seen in adulthood. They may not see them in their most florid or chronic presentation but they can be expected to deal with several of the initial presenting episodes given that, as previously noted, the Epidemiological Catchment Area (ECA) study has shown that the most serious disorders have a peak onset at mean age 16 years.
Axis I
Within Axis I of DSM-IV this means Schizophrenia and Other Psychotic Disorders (295 et seq.), Mood Disorders (296 et seq.), Anxiety Disorders (300 et seq.), Somatoform Disorders, Factitious Disorders, Dissociative Disorders, Sexual Identity Disorders (302 et seq.), Eating Disorders (307 et seq.), Sleep

Disorders (307.42 et seq.), Adjustment Disorders (309 et seq), Impulse Control Disorders (312 et seq).

Axis II

Under Axis II, although Personality is generally accepted as not fully developed until mid adolescence, mental health professionals in services specialising in children and young people are expected to have knowledge and experience of, and deal with, the full range of recognised personality disorders, particularly where these are closely connected with the presenting problems. A particular issue here relates to Borderline Personality Disorder. This diagnostic label is often used rather freely to describe people who act out. The dilemma is that young people as a group tend to act out their problems with substance abuse, or self harming behaviours; they are likely to gain an inappropriate label very quickly within an adult mental health system where contextual or development issues are not taken into account. In addition, and increasingly where special services are poorly funded and devolving toward generic services, mental health professionals in services specialising in children and young people can be expected to have knowledge and experience of, and deal with, all aspects of Mental Retardation (317 et seq.) and Pervasive Developmental Disorders (299.00 et seq) and the complex implications for family life.

Axis III

In special services such as inpatient units, mental health professionals in services specialising in children and young people are expected to have knowledge and experience of medical conditions (Axis III) which may be adversely affected by psychological factors (316 et seq.) and conversely (particularly in the 90's) they must be conversant with the effect of prescribed medications (332 et seq. and 995.2) and other substances which can induce psychological problems or frank mental disorder (291.00 et seq. and 303.90/305.00).

Axis IV

As previously noted mental health professionals in services specialising in children and young people have special expertise to address Relational Problems (V61) born of their knowledge and experience of the applications of systems theory. Of special note they work closely with systems external to the clinic such as the school environment, on the grounds that a child spends a considerable part of their life at school. Wide experience of services throughout Australia suggests that this wider systems thinking (Axis IV) is almost universal for professionals who work with children, adolescents and young adults.

Special Issues

Furthermore, many disorders are recognised as specific to infancy, childhood or adolescence – Learning Disorders, Motor Skills Disorders, Communication Disorders, Attention Deficit Disorders (314), Disruptive Behaviour Disorders (312 et seq.), Eating Disorders of Early Childhood, Tic Disorders, Elimination

Disorders, Separation Anxiety, Elective Mutism. Of particular note, Post Traumatic Stress Disorder (309.81) can easily be provoked in young people, as the result of a range of environmental insults. Problems related to Child Abuse and Neglect (V61.2) are the special province of Mental Health services for children and young people.

Finally it must be emphasised that the most serious disorders – major depression, schizophrenia, Obsessive Compulsive Disorder, Eating Disorders – do not occur in large numbers, but if untreated or poorly treated are likely to develop into chronic conditions which lead to serious social impairment. The ECA study shows us that the peak onset for these conditions is around 16, but they begin to appear from around 14 years. It is imperative that mental health services for children and young people have the resources to manage these serious disorders and actively target the mid to late adolescent young person more likely to develop more serious disorder.

It must be stressed again here that the child and adolescent professional worker always assesses, manages and treats mental disorder in the context of individual development as well as the family and community context. This ability to deal with such complexity is a special attribute found in those who elect to go on and train in the special area of Mental Health for Children and Young People.

A Specialty Within a Specialty

Because professionals work with children, adolescents and their families they are often seen (or parodied) as less than or more juvenile than other workers in mental health. This is a myth.

All of the professions involved in the area of mental health for children and young people undertake the standard training for their professions; this is usually directly geared to adult work although there is often a component of developmental work. These professionals then elect to train further so that they can work in the child area which takes special ability, maturity and patience. The process is perhaps best exemplified by the training for Child Psychiatrists who are first subjected to the rigours of four years of adult psychiatry training. Having completed the adult examination they then go on to two further years of intensive training in child psychiatry to gain acceptance by the Faculty of Child Psychiatry, RANZCP. The length, intensity and focus of this training is designed to provide very special knowledge, skill and experience to fit the psychiatrist for working with children; it often comes as a serious shock that children are not just little adults. Child Psychiatrists are therefore qualified to treat *both* adult and child patients; adult psychiatrists are not. This

is also true of other professionals; their origins in adult work and subsequent training make them capable of treating both adults and children where their counterparts in adult services can not.

Treatment Approaches

A wide range of treatment approaches is used to address the particular mental disorder or mental health problem in the particular child in the particular context.

As previously noted, medication tends to be used sparingly. However, as in adult mental health it is used accurately and effectively with specified mental disorders. Psychoeducational and Parent Training approaches often form the basis of child guidance work. Individual Child Psychotherapy may be short term or long term and can be based on a number of sound psychodynamic theories; practitioners often seek lengthy extra training and supervision to fit them for the role. Cognitive Behavioural Approaches have been the mainstay of therapy with anxiety disorders and conduct disorders for over 25 years. Family Therapy approaches, deriving from a number of clear schools of thought (Structural, Strategic, Systemic and Solution-focused) have proved efficient and effective with a wide range of mental health problems and disorders. More recently Narrative Approaches to both the individual and the family have been shown to be brief and effective with a range of conditions. Group work programs (social skills, parent education, adolescence focused groups) are effective for many disorders. Most workers have gained expertise in almost all of these approaches, and have the facility to apply the appropriate therapy to a specific problem.

The Multidisciplinary Approach

The best services have adopted a multidisciplinary approach. This permeates management as well as clinical process.

Twenty years ago, services specialising in the mental health of children and young people used the range of professional disciplines in an interdisciplinary discipline-specific way; social workers worked with parents, psychologists tested children for intelligence and skills, psychiatrists assessed the presence or absence of mental disorder, psychiatric nurses acted as child therapists. The more modern multidisciplinary approach as in Figure 1. has acknowledged that there is overlap in clinical function between professions and a blurred area where all professions may do the same work in the same way. This has provided more richness of professional interaction and a higher level of clinic skill, an increase in efficiency (more therapists to do the therapy) while retaining the discipline-specific skills for when these are specifically necessary.

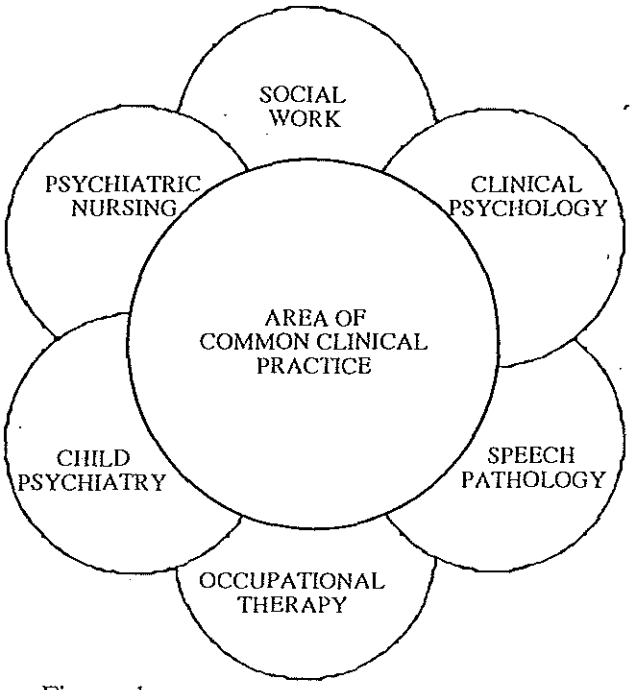

Figure 1.

The Assessment and Treatment Process

Historically, and based on the influence of the medical model, treatment has always followed comprehensive and thorough assessment of the problem in the person in the family in the context (what has been called the bio-psycho-socio-cultural model). In classical practice this has meant that services follow a clear process of assessment. The case is allocated on triage information and the family is seen for an initial interview. Decisions are taken about whether specific professional assessments are necessary (eg full psychological testing) and the child is then seen for two interviews (one formal in which a number of assessment procedures are followed; one informal in which the child is allowed to play freely under close observation by the primary or designated therapist. Following this and any specific assessments, the family is reinterviewed and a management plan is discussed and agreed on. At some point the team and/or the medical director are involved in discussion of the the case to ensure that correct diagnosis has been reached and management/treatment have been correctly planned. Therapy then begins.

The good part about this sort of process is that it ensures a thorough assessment is performed and in particular ensures that nothing is missed. This is very important for the child and family as it may be the first time that such a process has been completed, it is very important for the peace of mind of a medical director who has to oversee many more cases than can be directly seen, it is very important for the administrator who fears legal sanction if a

problem is missed, there is an important heuristic function especially for junior staff, and there is generally a satisfaction in having a comprehensive set of clinic notes.

There are many problems with this approach:

- it is difficult to complete thoroughly when the presenting problem is a crisis (medical, personal or family);
- it is lengthy. Most evaluations of child services suggest that clients only attend an average of three (3) sessions. In practice this means that many families drop out before completion of the assessment process, let alone the completion of the therapy program. This may in part account for the very high DNA (did not attend) dropout rates of around 25-30% found in most services;
- it does not acknowledge the reality that many families seek help for mental health problems which may be dealt with by brief methods of intervention (advice to, or education of, the parents; brief focused intervention; solution focused intervention);
- it does not acknowledge the reality that in most clinics there is not the availability of medical officers and child psychiatrists to drive a medical model;
- it does not acknowledge that therapy starts with the very first contact to the clinic.

Newer models exist, usually based on brief intervention using the care and authority of the parents or the power of the family system to effect relevant change. In services where these methods are adopted as the primary intervention, waiting lists and times have been reduced and evaluation suggests that not only is the service more efficient, it is more effective and meets the stated needs of the client population. The more comprehensive process may still be adopted alongside the therapeutic process or to follow two or three sessions of focused therapy for more serious disorder or as new or more complex problems emerge. However, not all mental health problems require a comprehensive assessment; flexibility of approach leads to efficiency without losing effectiveness.

On Tools of the Trade

Mental Health Services for Children and Young People depend for their success on the quality, skill, health and commitment of their staff; the essential therapeutic tool is the self.

- If staffing is inadequate in numbers then the pressure of new referrals to the service often leads to abuse of commitment followed rapidly by burnout and high staff turnover. This is particularly true for staff working in isolation or in isolated country areas.

- If training or experience are insufficient – either because specialist training is not available or because staff are employed at levels too low in the professional scale – then the needs of the clients overwhelm the skills of staff leading to professional anxiety, lowered self esteem, limited effectiveness and an inefficient therapeutic process.
- If regular supervision is unavailable (either peer or hierarchical, within discipline or cross-discipline) then error correction cannot occur and effectiveness and efficiency suffer.
- If easy access to educational update resources (books and journals relevant to the field, regular seminars focused toward current Mental Health dilemmas, in – state or interstate conferences) is not available then newer methods of assessment and intervention cannot be explored and best practice becomes an unfulfilled dream.
- If administrative structures (formal structures and informal links), policies and procedures are not clear, and do not support staff in the service, then unrealistic demands can be made from outside the service, by other staff in the service or from within the self.
- If there is no overall vision for the service or unifying leadership then staff do not know what the limits of the task are nor are they able to define the level to which they can aspire.
- If the physical environment is not safe, comfortable and adequate, then neither staff nor clients are able to focus on the task in hand.

On the Wider Implications

When Child Guidance Clinics are under immense pressure from referrals, it becomes almost impossible to consider other aspects of the work; the critical fact of professional life becomes to get through the cases for the day or for the week. However, focusing on the direct and indirect clinical needs of this population ignores several other realities:

- Mental Health workers in the in the specialist area of children and young people predominantly work with both the child and with the wider system (the family, the school and the community). Interventions therefore have an impact on many more people than just the identified client.
- It is now well established that there are continuities between child and adolescent mental health and adult mental health. Anxiety in childhood underpins Anxiety, Panic Disorder and Obsessive Compulsive states in adulthood; abuse in childhood is linked to the development of Borderline states in adulthood; conduct disorder in young adolescents is a precursor of later delinquency and criminality. These adult mental health problems and disorders cost the state an immense amount of money. Mental Health Services for Children and Young People must have adequate resources to do effective preventive work at the earliest opportunity.

- It has been demonstrated that the peak age of onset for adult psychosis is 16 years (ECA study). Burdekin estimates (reference) that 0.5% of the population by the age of 17 will have had an episode of severe psychosis. We know that early detection and intervention with comprehensive programs at the start of an illness reduces the later emotional, educational, family and social impact and therefore the cost to the state of psychotic illness. Mental Health Services for Children and Young People must have adequate resources for Early Detection.
- An immense amount of research work is yet to be done to clarify child and adolescent psychiatric disorders and their implications. Mental Health workers are often partly trained and skilled at this research work and are keen to address research questions which derive from their clinical work as well as evaluate their own programs. Little funding is ever built into calculations for the development of services, so research questions remain largely unanswered; evaluation of programs and clinical interventions rarely occurs.
- Mental Health workers in the specialist area of children and young people have a wealth of knowledge and experience which is of value both to other workers (general practitioners, teachers, school counsellors, family services workers, residential care workers etc) and to students of a wide range of professional backgrounds. Pressure of direct clinical service, and too few people to do the basic task, often precludes the sharing of this resource.

In conclusion it must be said that for most Mental Health workers in services for children and young people, the response to the needs for direct and indirect clinical service are paramount. Little time is planned to be set aside for Mental Health Education, Mental Health Promotion, Early Detection, Early Intervention, Evaluation, Research or Teaching (let alone personal professional development), despite the fact that any or all of these activities enrich clinical practice, lead to efficiencies and cost–effectiveness in clinical programs and, finally, provide variety for the clinician – one clear way to avoid clinical burnout.

TERM OF REFERENCE 1.

To review child guidance clinics (otherwise known as youth, welfare and guidance; child, adolescent and family community mental health services; child and youth mental health services) in Queensland within the context of national and state mental health policy.

POLICY CONTEXT

This review follows a number of previous reviews of parts of the Mental Health Services for Children and Young People; the report takes these into account. The Review Team considered the community services in the context of the agenda for reform of mental health services set by a number of key national and state initiatives. These include the National Mental Health Policy (1992) and Plan (1993), The Queensland Mental Health Policy (1993) and Plan (1994), National Goals, Targets and Strategies for improving Mental Health (Feb, 1994), the Health Goals and Targets for Australian Children and Youth (1992) and the Health of Young Australians (1994)

1.1. National Mental Health Policy Context

1.1.1. *Priority in the allocation of resources*

All clinics attempt to respond to the pressure from carers and referring agencies (expressed or perceived need). Overall, there is a limited ability to respond to the severly ill/disturbed; in only one clinic is there a policy which defines core business as managing *severe, complex, serious and treatable mental disorders.* Serious difficulties exist in gaining access to inpatient facilities for mentally disordered young people or those with serious mental health problems, either at times of crisis for intensive treatment, or for ongoing treatment.

1.1.2. *The impact of mental health problems more generally on individuals, their families and the community.*

Historically, community teams have been immersed in the bio-psycho-socio-cultural model and therefore take families and the community into account during assessment and treatment. However, with pressure on limited resources the tendency to limit assessment and intervention to the designated client and/or the immediate family is increased.

1.1.3. *Effective mental health promotion, prevention and early intervention strategies...*

There is little evidence of coordinated statewide or regional mental health promotion or early intervention programs. A program for suicide prevention has recently been funded for four regions and is being managed through the

Program Development Branch of Queensland Health.

1.1.4. *...and the enhancement of training and support for primary care service providers*

There is emerging consultation and liaison with schools and developmental paediatric services. We found generally poor liaison with general practitioners. There is little opportunity for consistent training and support of others whose work overlaps with mental health services given the pressure of referrals.

1.2. Queensland Mental Health Policy Context

1.2.1 *mainstreamed integrated services...*

The majority of clinics are located in small houses in the suburbs, both geographically and operationally isolated from hospital and community paediatric and developmental assessment services, youth health services, community health or adult mental health services. Two of the services visited are organised to operate within the regional integrated mental health program and these links have helped with protection of the budget, access to psychiatrists, inpatient beds, and a service focus on severity.

1.2.2. *...to promote continuity of care across service components*

According to the reports we were given there are very poor links between inpatient/outpatient services in hospitals and community clinics. Acute admission to hospital is difficult for under 14's, especially outside the Brisbane area. There is no acute admission unit for adolescents between ages 14 and 18 and complex local arrangements have to be made. There is a lengthy waiting list for the medium term adolescent inpatient unit (Barrett Adolescent Centre, Wolston Park Hospital). There is no interchange of, or sharing of, clinicians. The complaints aired by numerous community staff suggest very poor communication as well as immense frustration in gaining admission of, and then maintaining contact with, seriously disturbed adolescents.

1.2.3. *locally available care/equitable distribution of resources*

Solomon and several other reports have already pointed out the lack of resources in certain regions and the non-equitable distribution for some rapidly growing populations. This serious problem is further explored by the review team (see pages 40 (item 2.2.), 68 (item 3.29), and Appendix 2., Tables 1-3.).

1.2.4. *involving consumers*

We found little evidence of the involvement of consumers in the planning,

operation and evaluation of services.

1.2.5. *ensuring services respond to priority groups*

Only in one clinic was there evidence of a sustained effort to provide access for Aboriginal or Torres Strait Islanders; this initiative used existing adult resources. We found no evidence of comprehensive and sustained efforts to access non-English speaking groups.

There is little availability of mental health services to homeless young people.

There is little availability of mental health services to young people in the care and protection of the juvenile justice system.

The availability of mental health services to abused young people is a complex matter because other services (Family Services and SCAN teams) are involved in the assessment process. Even though many service providers spoke of the increasing severity, complexity and duration of the sexual and emotional abuse seen in children, the timing of and access to treatment is of concern.

As already noted, one other clinic has a specific policy on responding to the most serious cases of mental disorder or mental health problems *as a priority*.

1.2.6. *progressing the reform of psychiatric hospitals*

This *is* an issue for mental health services for children and young people in that not enough beds are available for children and adolescents, and the ones that are available are most accessible from Brisbane South and North. Acute facilities are not available, particularly for the older adolescent. There are very few flexible arrangements existing with psychiatric hospitals, general hospitals or paediatric units in the regions to provide for acute admission or secure care within the young person's region of origin.

1.2.7. *establishing/maintaining links with Primary Health Care Services*

There is evidence of some local arrangements being in place, but these are not part of a coherent statewide plan.

1.2.8. *implementing quality management systems...*

There is no statewide reporting of mental health statistics for children and young people; this made it impossible for the review team to comment on efficiency, or draw comparisons between regions. At a local level, clinics on the whole did not have the equipment, the expertise or the training to develop quality management systems. Routine evaluation of therapeutic processes and programs is available in only a limited way. There are no staff personal appraisal systems in place. Adequate and regular supervision has been difficult to provide given the pressure for clinical work on the available senior staff. Management planning is good in some clinics but almost unavailable in others.

With no overall state policy or plan for the mental health of children and young people, benchmarks for best practice are unavailable.

1.2.9. *including the Minimum Service Standards*
Most staff were aware of and discussed Minimum Service Standards. However, how these are applied to mental health services for children and young people needs to be explored and enhanced.

1.2.10. *improving intersectoral links*
With no overall central planning group for the mental health of children and young people this has been difficult at the most senior level; it is also a challenge at the regional and local level. Overall there appeared to be generally poor and ad hoc communication with Government departments such as Family Services, Education, The Police and other predominantly case-based sectors.

From *Key Initiatives*, **Queensland Mental Health Plan**, (p.10):

1.2.11. *enhancement of Regional mental health services...*
This clearly applies to the mental health of children and young people given our comments in 2.2., (page 40), 3.2.9. (page 68) and Appendix 2., Tables 1-3.

1.2.12. *...including extended hours services...*
Only minimal attempts in some clinics have been made to address this issue, including establishing links with adult integrated mental health service extended hours teams.

1.2.13. *and mobile intensive treatment teams.*
This has been planned for *one* region only as part of integration with the adult integrated mental health service.

A number of other international, national and state initiatives were considered as informing practice in the mental health care of children, young people and their families:

The **United Nations Charter of the Rights of the Child (1990)** and the Commonwealth and State responses:

- National Youth Health policy:Draft
- Draft National Suicide Prevention Strategy
- National Health Goals and Targets: Draft

- National Prevention Strategy for Child Abuse and Neglect, 1994
- Queensland Youth Policy and Draft Youth Health Policy

The underlying principles set by the above include:

- the need to treat children in the context of their family and community settings
- the duty to support families and parents to meet their responsibilities to their children
- inherent rights to appropriate and high quality health care
- the child's and the young person's inherent right to protection
- the child's and the young person's inherent right to be heard

The **United Nations Resolution on the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1992)**, and responses:

- Mental Health Statement of Rights and Responsibilities (1991) – including statements on children's rights to treatment

- National Mental Health Policy (1992) and Plan – with emphasis on:
  - **specialisation** of mental health service delivery to ensure that there is a dedicated health system to serve the needs of those with mental disorder and severe mental health problems;
  - **co-location** of mental health services with general health services to reduce stigma and improve access;
  - **integration** of inpatient and community mental health services to improve continuity of care;
  - development of **close interagency networks** to ensure that people have equal access to generic services as well as continuity of care.

- Queensland Mental Health Policy (1993) and Plan (1994) – with emphasis on:
  - a **consumer focused service** – ensuring that services meet the needs of the individual (not programs into which the child and young person must fit);
  - **regional self sufficiency** – providing services as close as possible to where children and young people live; promoting **rural and remote outreach** and **emergency response**.

- Queensland Health Primary Health Policy and Implementation Plan – principles closely aligned with national and state mental health policy and

plan:

- development of community based services;
- more equitable distribution of services;
- multidisciplinary approach to health;
- community participation;
- intersectoral collaboration;
- service coordination and needs based service planning at a local level;
- emphasis on health promotion and prevention.

- Other Queensland policies/documents:
  - Draft Child Protection Act (and policy paper) – with an emphasis on not only judicial processes for investigation but also a policy stating commitment to adequate levels of support and therapeutic services;
  - Domestic Violence Legislation;
  - Queensland Government Response to Burdekin (being developed; has major points about children, young people and the needs of families to be supported.

TERM OF REFERENCE 2.

To examine the availability, quality and appropriateness of these services.

AVAILABILITY

Introduction

Community child adolescent and family mental health services were begun in Brisbane in 1959 and a network of clinics in Queensland has evolved "which reflects historical context, demographic factors and financial constraints of the past 10 years" (Child and Adolescent Mental Health Service Policy: Discussion Paper, September, 1992, p. 7.).

This evolution has been in response to demand based on perceived need. A number of individual psychiatrists have been seminal in the development of the service, but no statewide needs assessment has been completed.

Service Gaps Already Identified

The Discussion Paper (ibid., p. 7.) states: "Queensland lacks adequate levels of community child and adolescent mental health clinics, an extensive consultation liaison program, intensive day treatment centres, acute inpatient services, adequate levels of medium term services and supra-regional forensic assessment and treatment services".

The lack of sufficient clinics is to a certain extent detailed in the Solomon Report (Shane Solomon and Associates, 1993, p.56. See Appendix 2, Table 1.: **Current and Proposed Mental Health Services for Children and Young People.**).

However, it must be noted that Solomon based their predictions on the age range 5 – 19. At this stage the commitment of Mental Health Services for Children and Young People is to the complete child and adolescent range – that is to 0 – 19 years age group. In subsequent Tables and calculations this is taken into account.

2.1. Funding

In 1992-93 Mental Health Services for Children and Young People consumed $5,720,000 ($5.72m.). This includes both community and inpatient/outpatient hospital services. This is a tiny 4% of the total budget for Mental Health ($143m.) and 0.27% of the total Health budget for Queensland. In contrast, the services are charged with the mental health of all children and adolescents aged 0 to 18 years inclusive (28% of the Queensland population).

Queensland ranks sixth overall (third last) for the per capita estimated real expenditure on specialised mental health services at $47 (behind Victoria with $73) compared with a national average of $57 (First National Mental Health Report, 1993 (p. 23.)). Further, Queensland ranked last in the estimated per

capita expenditure on community based mental health services at **$10** behind ACT with $21 per capita (national average **$14**, First National Mental Health Report, 1993 (p. 29.)).

2.1.1. Recent Service Increases

There have been service increases since 1993 which are not covered in Solomon or elsewhere. The lack of statewide statistical reporting services makes it complex to gain a complete picture of these. However, New Initiative State growth funding has been allocated as follows for child and youth mental health services:

- 93/94: $500,000 allocated
- 94/95: $2m. allocated

A further state government initiative occurs in the 1994/95 Budget: $1.5m. has been allocated for 1994/95 for a 3 year project: *Young People at Risk: access prevention action*. This is a primary health community development strategy to address the issue of Youth Suicide (Queensland currently has the highest rate of youth suicide in Australia at 18.5 per 100,000 aged 15 - 19. Australia has the highest rate of youth suicide in the world at 16.5 per 100,000). This pilot funding is to 4 regions (West Moreton, Sunshine Coast, Brisbane South and South West) and is linked with further allocations from the mental health budget to improve youth mental health clinical services.
As a final note, there is currently a capital works commitment to the Adolescent inpatient unit at Brisbane North, and to include mental health services for children and young people in the 10 year Capital Works Plan.

Despite these initiatives, and given the population served, insufficient funding is available to Mental Health Services for Children and Young People, both as a percentage of the mental health budget or the general health budget, or by comparison with other states of Australia.
The Review Team estimates that by 2001, the overall budget for staff alone in a statewide comprehensive service needs to be close to $15 m.

2.2. Regional Community Services

A total **16** community mental health clinics for children and young people exist at this time.
Brisbane North is well served with 6 community clinics; the projected fall in population by 2001 for this region should be taken into account when planning services for this region.
Brisbane South is adequately served at this time. For patients in both Brisbane North and South, access to local, well staffed clinics and inpatient services is

easier than for patients in any other region.
Three of the 13 regions (Mackay, Central/Central West and Wide Bay) do not have regional mental health community clinics for children and young people(Solomon, 1993; see Appendix 2., Table 1.) even though there are now mental health workers in all regions except Central which is currently advertising for mental health workers for children and young people. On grounds of access and equity, the absence of adequate services needs to be corrected.
Both Sunshine Coast and South Coast are rapidly growing areas (see Appendix 2., Table 1.). On population figures neither has adequate resources in terms of teams at this time, and by 2001, the situation will be serious.
The Review Team estimates that by the year 2001, based on figures from the Queensland Mental Health Plan, at least a further 10 community teams will be needed to meet the current projections in population growth for the age group 0 to 19 years (see Appendix 2., Table 3.).

2.3. Staffing
A total **112.02 FTE** clinicians work in community mental health services for children and young people (Mental Health Branch, November 1994); an additional **4.4 FTE** clinicians are employed by youth mental health services. These are supported by **17 FTE** administrative staff and **4 FTE** other staff.
In contrast, **51.61 FTE** clinicians are employed in inpatient or outpatient hospital services supported by **2 FTE** administrative staff; an additional **22.19 FTE** clinicians are employed by youth mental health services.

2.3.1. Staff–Patient Ratio
A conservative **10%** of young people in Queensland are likely to be suffering from emotional, behavioural or mental disorder at any one time (more than **96,700** children and adolescents by the year 2001) and an estimated 2-3% of young people are likely to present for clinical services per annum (between **19,350 – 29,000** children and adolescents by the year 2001).
A reasonable expectation is that clinicians can manage an average 75 new cases per annum (range 50 – 100, depending on experience and training, and the type of case). At this time an estimate of total presentations to the service is between **14,000 and 21,000** patients per annum. This suggests that **the service is attempting to deal with between 85 and 128 new referrals per clinician per annum, an average of 107** at this time (based on 164 clinicians for the inpatient, outpatient and community service).

2.3.2. Determination of Appropriate Level of Services
Solomon, (ibid, p. 57.) noted that "further work is needed to determine the

'appropriate level of child and adolescent services", but went on to detail the development of 11 major community Mental Health Services for Children and Young People, "six of these having 20 clinical staff (two in Brisbane North, two in Brisbane South, one in Sunshine Coast, one in South Coast), and the remainder about half this level (of staff). Solomon did not detail how they reached the levels of staffing except to comment that concerns had "been expressed about the size of traditional child guidance clinics."

Three methods may be considered for determining levels of staffing and therefore funding:

2.3.3. Simple Method

This method is based on clinical experience in systems in other states which suggests that in a fully functional team, each clinician is capable of assessing, managing and treating between 50 and 100 new clients per annum, depending on the complexity and seriousness of the cases and the experience of the clinician.

If we consider that **by 2001 there are estimated to be 967,612 young people aged 0 to 19 years in Queensland** and assume that only a conservative 2% will need referral to Mental Health Services for Children and Young People for emotional, behavioural or mental disorder then **19,350 will be referred** in that year. By calculation, based on an average 75 new cases per clinician, some **258 clinicians** will be necessary, plus support administrative and secretarial services. The calculation does not take into account the burden of serious chronic cases, but it does take into account a range of other activities associated with team development and maintenance as well as personal professional development. It is to be stressed that these calculations are conservative and do not take into account acute or chronic inpatient services.

2.3.4. Nominal area population

This method has been used successfully in South Australia (see Submission to the Select Committee on Health Administration, 1993, Proposal for Comprehensive Country Services in the southern region of South Australia, 1994) to provide comprehensive Mental Health Services for Children and Young People. It is both pragmatic and reasonably accurate. The calculation is based on a nominal area population of 30,000 children and adolescents, with one child guidance team being placed in each nominal area. Each team consists notionally of a Regional Director or Team Leader, 2FTE psychiatric nurses, 2FTE social workers, 2FTE clinical psychologists, 1FTE child psychiatrist, 1FTE other profession (occupational therapist or speech pathologist) plus 1 - 2FTE administrative support (TOTAL 10 - 11FTE per team).

Working to this model would suggest that Queensland needs a total of **32** Mental Health **clinics** for children and young people, appropriately placed according to regional need. The projected total number of **staff** (including both professional and administrative support staff) is **361**. (See Appendix 2., Table 2: **Projected Needs 2001: Numbers of Community Mental Health Staff for Children and Young People (clinical plus administrative support) according to the Nominal area population method (Southern CAMHS, S. AUST).**
This method suggests that the annual **staffing** costs of a comprehensive community mental health service for children and young people might need to be in excess of $18m by 2001.

It is to be noted that the Queensland Mental Health Plan (Appendix 1., p. 93.) quotes a similar but more conservative rate of staffing:

- 10 clinical staff per 40,000 population under 20 for child and youth community services;

Working to this model would suggest that Queensland needs a total of **26** Mental Health **clinics** for children and young people, appropriately placed according to regional need. The projected total number of staff (including both professional and administrative support staff) is **296**. (See Appendix 2., Table 3: **Projected Needs 2001: Numbers of Community Mental Health Staff (clinical plus administrative support) in services for children and young people according to the Nominal area population method (Queensland).**
This calculation suggests that the annual **staffing** costs of a comprehensive community mental health service for children and young people might need to be close to $15m by 2001.

It is to be stressed that these calculations do not take into account specialist units of a tertiary nature which Solomon suggests are necessary and which logically might be placed in Brisbane North or South, or possibly in North Queensland at either Townsville or Cairns, nor do they take into account the need for integration with inpatient units:

- Currently acute mental health beds are only available for children under 14 at the Child and Family Therapy Unit, Royal Children's Hospital);
- The Mater Children's Hospital has approximately 3 beds for psychiatric admissions;
- Barrett Adolescent Centre operates as a medium term non-acute inpatient unit;
- Acute Adolescent beds are planned in the Capital Works Program at Royal Brisbane Hospital;
- Dedicated beds are planned to extend inpatient adult mental health services in Gold Coast, Peninsula and Logan

Further, our calculations on community Mental Health Services for Children and Young People do not take into account the rebuilding program recommended in Solomon, nor annual infrastructure or goods and services support.

The Queensland Mental health Plan quotes (Appendix 1., p. 93.):

- 20 beds per 100,000 population 15-19 for acute inpatient services targeted to the needs of young people;
- 7 beds per 100,000 population under 13 for acute inpatient services targeted to the needs of children.

The issue of inpatient services will not be examined further as it is not the subject of this review, nor is it within the terms of reference of the steering committee.

2.3.5. System of Care

The Review Team also took the opportunity to examine community services in the light of comprehensive international models of *best practice* care. One such demonstrated model is termed "System of Care".

The system is based on the United States NIMH Child and Adolescent Service System Program (CASSP). This provides a continuum of care with the "attempt to implement a full array of services" for children and adolescents with serious mental illness (a demonstration program for North Carolina, Behar et al., 1993, p. 285.). This *best practice* program is particularly attractive because it has developed new program strategies to stabilize disturbed children in their homes and therefore avoid hospitalization and the associated costs. Despite this it must be stressed that a full range of comprehensive services is made available including regional hospital and day service centres.

One Service Block services 180-200 children and families per year and the cost per client is estimated to be $5,671. Working on 2% referrals per annum to such a service gives an estimate of total cost over $80m for Queensland as a whole. This cost however includes inpatient units, infrastructure costs and all other costs with nothing hidden.

2.3.6. Overall Availability

It is clear from the above summary of previous reports, and the calculations of projected needs for staff, that Queensland is seriously under-resourced in terms of funding, availability of community clinics and staffing.

In particular it is of note that several regions do not have any service although the population of 0-19 year olds in each warrants an accessible regional mental health team for children and young people. Sunshine Coast and South Coast are both already seriously under-resourced both in terms of services and professional staff.

There are major geographical issues of accessibility which will need to be addressed:

- the major population growth has been in coastal metropolitan cities. This has not been reflected in the historical placement of services;
- major centres inland – eg Mt Isa, Longreach, Charleville – will not be able to support full or even half teams if a simple calculation is made according to the size of the population. However, a strategy will need to be developed to deal with this issue on social justice and equity grounds. (see Appendix 3.:Rural Strategy);
- outreach to sparse population in rural and remote regions also provides a challenge.

2.4. Country Services

Three community mental health teams specialising in children and young people have arrangements to provide visiting services to country areas. Staff are drawn from existing team members. A number of private child psychiatrists visit country and northern country areas to provide a consultative service.

The Review Team understands that a Professor of Psychiatry from New South Wales provides a regular visiting Child and Adolescent Psychiatry service to a mid north region.

There is no overall statewide plan to ensure adequate resident or visiting services to country areas.

2.5. Non-English Speaking Services

The Review Team did not find any evidence of comprehensive targeted services to non-english speaking clients. There did not appear to have been a statewide assessment of the need for special services and it was not clear to the Review Team how much negotiation, liaison and consultation has occurred with specific communities.

There is no overall statewide mental health plan to ensure adequate availability of services to non-english speaking children, young people and their families.

2.6. Aboriginal and Torres Strait Islanders

In one region a local arrangement with a psychiatrist specialising in the area has led to a relevant visiting service to far north communities. The Review Team could not gain other evidence of services being targeted to Aboriginal and Torres Strait Islander children, young people and their families. It is not clear how much negotiation, liaison and consultation has occurred with communities, community health workers and relevant elders to clarify the need for services, as well as the way in which services should be delivered. It does not appear

that Aboriginal and Islander mental health workers are employed as such in the specialised area of children and young people.
There is no overall statewide mental health plan to ensure adequate availability of services to Aboriginal and Torres Strait Islander children, young people and their families.

2.7. Other Essential Community Services

The Review Team also found evidence of a gross lack of other essential community services – particularly in the areas of Developmental Paediatric Services (eg in one clinic there was a wait of up to 18 months to see a psychologist in Child Health), Sexual Abuse, Youth Health, Support and Respite Services. This varied from region to region, but was the subject of some heated discussion with both professional staff, staff from other services who refer to mental health clinics, and consumers. It was unclear to the review team how needs are defined for these other services, how liaison occurs at a senior level and what overarching structures ensure their availability. What was clear from our discussions was that when these services are not available, they place an additional burden on Mental Health Services for Children and Young People.

2.8. Child and Adolescent Psychiatrists

As an issue of availability, in every clinic and service visited, the lack of Child and Adolescent Psychiatrist in full time public service was mentioned as a very serious problem.
There are 6.08 FTE child psychiatrist or visiting consultant positions for the community service (8.53 FTE for the total service – inpatient, outpatient and community). Only one of these positions is filled by a full time child psychiatrist.
The current number represents a serious shortfall which is:

- inadequate to deal with the cases of serious mental disorder in children and adolescents;
- inadequate to supervise trainees in Child Psychiatry;
- inadequate to supervise registrars rotating from adult services for their college – mandated training in developmental psychiatry;
- inadequate to provide teaching and training to undergraduates, postgraduates, primary health care workers;
- inadequate to support other professions in community teams.

Private child psychiatry services can be accessed for some urgent psychiatric assessments and many adult psychiatrists have been willing to provide a little assistance. However, the lack of a vigorous comprehensive statewide training program, and the inability to attract to and retain child psychiatrists in Public

Service in Queensland is a potential disaster likely to have an impact for many years. Not only does it seriously disadvantage children and young people with mental disorder and serious mental health problems, but it generally withdraws the influence, supervision and training that should be available for other professional groups. Finally it is likely to cripple the adult psychiatry training program if registrars cannot gain adequate (or in fact any) supervision from qualified child psychiatrists during their RANZCP mandated 6 months of training in developmental issues.

The Review Team estimates that by the year 2001, there should be at least 24 FTE child psychiatrists in public service.

Under-resourcing as an issue was brought forcibly to the Review Team's attention by referrers and carers in all regions visited. The level of anger and distress at the inability to gain access to relevant services was particularly prominent in our meeting with more than 40 community members from the Sunshine Coast.

'QUALITY AND APPROPRIATENESS

2.9. Absence of Corporate Mission

There is no clear statewide mission statement.

2.9.1. Absence of Statewide Identity

As a corollary, there does not appear to be a sense of statewide identity, and clinics varied widely in their clinical process. This is important both for staff working in the service and consumers seeking to access the service. There is no clear and consistent name for services, which are variously known as Child and Adolescent Psychiatry; Child Guidance; Child, Adolescent and Family Mental Health; Child and Youth Mental Health;Youth Welfare and Guidance; Family, Adolescent and Child Therapy; Under 18 Mental Health. One implication of this is that the consumer cannot find an appropriate service in the phone book. If they move between regions they have to begin the search again.

Within regions where more than one clinic exists (Brisbane North and Brisbane South), clinics communicate, share clinical expertise, discuss casework, management ideas and future directions even though there is evidence that personnel find it difficult to move between clinics. There is little such communication and sharing between regions, and a sense of defensiveness bordering on siege exists; we were told that it was "as if barbed wire exists around each region".

For regions this lack of statewide mission, identity and commitment may lead to argument that the protected mental health funding in the region should be utilised solely for a regional focus. Where inpatient or special units have developed originally to serve the statewide population, they now find themselves in one region (eg Barrett Adolescent Unit); resentment has begun to surface that one region's funding is serving other regions' needs.

For clinics differing arrangements are beginning to emerge locally. These are often creative responses to ensure survival, and while not inherently wrong, dilemmas are created For instance one clinic may relate well to (or even co–locate with) a regional adult mental health service; this provides for good continuity particularly where adolescents with mental disorder need access to ongoing adult services. Elsewhere, clinics may co–locate with child health services; this may improve mental health services for the younger child, or perhaps provide a service for youngsters with intellectually disability. However, as overall there are not enough resources to go round, one special relationship or development creates inequity for another group. If an overall vision and plan existed for the State, then care could be taken to ensure that services met the needs of all special groups.

For individual staff, while they may have a clear commitment to and

knowledge of their region, there is little sense of belonging to Queensland Mental Health Services for Children and Young People. The level of knowledge about what occurs in other regions is poor and there are no formal communication processes to change this. As a result, solutions found in other regions to particular problems are not shared or adapted and this may retard the development or adoption of best practice models.

2.9.2. Absence of Statewide Plan

There is no statewide plan for Mental Health Services for Children and Young People. This means that there are:

- no agreed on targets and goals for services;
- no agreed on priorities for community teams to work on;
- no generally agreed benchmarks by which staff can measure the effectiveness of their work.

2.9.3. Uneven Service Development

As a further result of the absence of a statewide mission, policy and plan, the development of services has been uneven and is likely to be increasingly so if some regions have a commitment to mental health services for children and young people and others do not. Where strong leadership exists in a region, competition for scant resources may be successful, with development of high quality service and innovative programs. Community services where no such leadership exists (or worse where no service currently exists) cannot compete for funds against high profile, high tech, hospital based services. On grounds of equity and access this seriously disadvantages those in the community who live in regions where little or no service exists at present.

The Review Team had no doubt that where services are available, the level of commitment of staff has led to high quality of direct clinical service. While services may have evolved in different ways depending on the local demands or the professional interests of individuals or the particular historical staff mix, it was clear that teams had struggled with the complexity of the task and made hard decisions in order to cope with the sheer weight of referrals. Some services had aligned themselves with child health and had developed a focus on developmental issues, others had focused on more serious mental disorder or older children and adolescents. Some services had been forced to block all but the most serious new referrals in an effort to deal with waiting lists up to eight (8) months. At least two clinics had not limited their service in a planned and coordinated way and staff, both individually and as a team, were showing the signs of burnout; this is a serious matter of occupational health and safety for professional staff in this field.

The truth is that with adequate resources and fully staffed and functional clinics,

arguments about alignment of services are largely academic; Mental Health Services for Children and Young People *should* be dealing with developmental issues from birth through to late adolescence, they *should* be coping with the most serious of mental disorder in young people and there *should* be adequate time and resources set aside for educational, promotional and preventative programs. With adequate resources, Mental Health Services for Children and Young People should be able to maintain their own integrity and autonomy while relating appropriately to education, child health, welfare, adult mental health, and other non-government services.

2.10. Referrals

The Review Team found some evidence that the most serious cases of mental disorder are not referred to community clinics. This may be to do with difficulties of access, the reputation of any given clinic, the experience, training or lack of availability of particular therapists (for instance child and adolescent psychiatrists to diagnose disorder, admit, or prescribe medication), or the need for crisis or after hours service which are not available. Where a clinic has made a specific attempt to prioritise serious mental disorder, there is evidence that the age of referrals steadily increases and serious disorders are increasingly referred.

What is critical is that referring agencies know of the priorities and entry criteria of any given clinic, and that trust has been built up to the point where both the referrer and the intake clinician know that this is an appropriate referral of sufficient urgency. Overall arrangements for intake of urgent referrals were complex and varied significantly between clinics. Some clinics did not have the ability to respond to urgent referrals within 2 to 3 weeks.

The clinical process appears to be similar from clinic to clinic and centres around the weekly case conference. Most clinics accept primary referrals (direct from a parent or family member) and secondary referrals (from a general practitioner, paediatrician, community health worker, étc.). Tertiary referrals are more common in metropolitan services or to the inpatient or specialist services.

In most clinics client referrals are accepted and details taken by telephone either by a clinic nurse or by a member of the therapy staff on a roster basis. The use of a full time clinic nurse for this process is time honoured and may well provide a good quality first contact with the clinic. However, discussion should occur about whether this is an efficient use of a professional position when so few staff are available for therapy.

2.11. Allocation

Allocation of cases occurs at the weekly case conference which appears to be a universal clinic process. Discussion of cases with some monitoring by clinic

directors and senior staff provides appropriate checks on which cases are taken by junior staff. The case conference is time consuming and, in involving all staff, may not be an efficient process for those staff not able to take cases at that time or staff who provide specific or highly specialized assessment processes. Other methods of allocation exist which may be more efficient. For instance, allocation of primary referred cases may be on a roster basis; that is to the next available time slot no matter what the professional background. This process is appropriate where staff are generally highly skilled and experienced and expected to be autonomous. It is consistent with systems based thinking for emotional and behavioural disorders evolving in the family context. It is not appropriate for cases of potential serious mental disorder and there are risks that difficult or complex cases may be allocated to relatively inexperienced therapists or experienced therapists may not have their skills used appropriately. At this stage of development of Queensland services, the general case conference may provide the safest method of allocation and it has an heuristic function in promoting clinic culture.

2.12. Assessment

There is evidence that thorough and lengthy assessment occurs at all clinics. Several forms of this exist. In one form, the therapist assesses the family at initial interview and follows this with assessment sessions for the child. A feedback session is followed by the development of a clear management plan and the start of appropriate therapy sessions. In a second form a number of therapists assess the situation from a variety of viewpoints. The family and/or parents are assessed by social workers, the child by a psychologist and/or a psychiatrist and/or medical practitioner. Further assessments may then be arranged with speech pathologists or occupational therapists as appropriate. Local variations on these processes exist.

Two problems may occur with this approach. First, many families attend with relatively simple or minor problems for which they do not require nor need such thorough process. They seek accurate identification of the issues and appropriate interventions by the end of the first or second session. Second, families who DNA (do not attend - ie fail to turn up subsequently) often do so within the first 2 – 4 sessions. With a thorough approach they may not actually reach the feedback session let alone the therapy program. Newer approaches exist and have been trialled in some clinics; they are particularly suitable for more experienced and senior therapists. The more thorough assessment approaches provide excellent training and grounding for newer therapists. Clearly there is a tension between efficiency and thoroughness. Services interstate and internationally, however, have acknowledged that many problems as presented by the patient and family can be solved effectively *and*

efficiently without such comprehensive assessment processes. Given that no evidence exists at this time that the thorough approach is any better than brief therapy approaches for the client and their presented problems, these matters deserve further exploration and discussion, particularly for cases where no mental disorder as such exists.

2.13. Therapy

There was evidence in all services that a range of therapies was applied appropriately according to the case and the skills and training of the therapists. There is a long tradition in Queensland of individual child and adolescent therapy accompanied by parental counselling. Over the last 20 years family therapy methods have been adopted and a strong family movement exists. More recently there has been an introduction of cognitive behavioural methods. There was variability between clinics in the usage of these therapies, and the review team could not ascertain the level of skill and experience of therapists in the short time available. The patchy use of specific therapies suggested there has been no statewide approach to training.

Concerns must be raised about the length of therapeutic contact for clients. In some services about 10% of cases had had between 50 and 80 sessions in the year. It was not clear how this was reviewed. Review processes were described by most services, but it was not often clear what criteria were applied and in some cases it was not clear who had authority to apply them.

There was no consistent focus on efficiency of therapy. This is a complex matter in a multidisciplinary field with so many differing forms of therapy applied and a very tiny body of research evidence in the field of mental health for children and young people to show whether therapy works, how therapy works and which therapy works best for what condition. However, effectiveness and efficiency are key issues in a service which is seriously under-resourced, and should be the matter of enthusiastic debate. Staff in all clinics should be contributing both to the debate and to further research to clarify the issues.

2.14. Crisis Management

Without a clear continuum between community and hospital services and with major gaps in service, particularly for the adolescent and more serious mental disorder, there are serious problems in the response to crisis situations. Community services seem to operate in isolation even when aligned with mental health or child health. There seems to be a tenuous set of links to hospital services, and very poor communication between the various parts of the service. Further, there are major gaps in services, particularly for the adolescent and more serious mental disorder, and this means that there is no

sense of a continuum across a holistic Mental Health Service for Children and Young People . As a result of this, there are serious problems in the response to crisis situations. It is difficult to seek help across regions, and it is difficult to admit young people without the sense of all staff being involved in a statewide service with common aims.

2.15. Evaluation

While the Review Team had no doubt from discussion that quality of clinical service was as high as might be expected taking into account local issues, it was difficult to obtain factual evidence of this.

The introduction of Minimum Service Standards has had an impact on staff looking at their services and does provide one statewide view of how services should evaluate themselves. However, it was difficult to gain evidence of how this was being applied for individuals and clinics; the impact is hidden as change in work practices is difficult to track in an essentially private and confidential process such as therapy.

While some clinics routinely conduct clinical evaluation surveys, there is no central collection of mental health statistics for children and young people. Not only does this make overall statewide planning a nightmare, it makes it hard to define which staff are seeing which kind of cases, for how many sessions and with what effect. Records are kept at a local level, but these are frequently in ledger format and staff had obviously had to put considerable effort into deriving facts and figures for the Review Team. There is little evidence of the use of computer systems to record demographic and client contact information, and no coherent statewide system exists.

Outcome criteria are not easy to develop in this complex field. However, we gained no evidence of client satisfaction surveys, referrer satisfaction surveys or coordinated follow-up evaluation.

Again ,while some services have done some work in this area (Brisbane North and South) there is no coordinated attempt to reduce the numbers of those who Do Not Attend (DNA) for the first or subsequent session or to find out what their dissatisfaction with the services might be. With the pressure of referrals, we suspect that DNAs are seen as a relief rather than as a comment on the need to change clinic processes or as a therapeutic challenge.

Such evaluative endeavours as these demand time, energy and proper resourcing. However, there is clear evidence from elsewhere that services which evaluate staff individually, as well as clinic services as a whole, create a culture of self-assessment, improvements in efficiency and development of a high level of effectiveness.

2.16. Clinical Accountability

There seems to be a problem in this area in that historically, all cases seen have been the ultimate responsibility of a doctor, usually the psychiatrist or child psychiatrist. This can create a cumbersome process when so many medical officers are part time, and while there may be safeguards for the clinics, regional management and the clients, the system overloads medical officers and does not address two realities. First, not all clinics have doctors. Second, in modern systems, all professionals are responsible for the quality of their clinical work while safeguards such as supervision, evaluation and personal appraisal are built in. The final responsibility is to the client and in most clinics clients are fully aware that they can complain about the service.

2.17. Prescribing for Attention Deficit Disorder

Many clinics seem to supply Ritalin direct to client families once a diagnosis is confirmed. There is considerable community pressure to continue to provide this free medication service because of the ongoing nature of the problem and the cost of ADD and ADHD medication. There is also considerable resentment from staff that providing this service occupies such an immense amount of medical time in re-prescribing and that preference is therefore given to one diagnostic group, rather than prioritising on the grounds of the severity of mental disorder or mental health problem. Further, a security problem may be created by holding drugs on clinic premises. A view can be put that all drugs should be held by local pharmacists and that once a diagnosis is confirmed and a plan made for long term medication, this can be prescribed by the local medical officer who can also be instructed on the monitoring of dosage, side effects and family interactions.

2.18. Indirect Clinical Service

There was wide variation in the approach to working with or through professionals from other services. Some teams appeared to be entirely clinic based with a siege mentality. While individual staff had adopted methods which entailed school visits and sometimes home visits, there is not a consistent approach to thinking about how to co-work with other professionals or use their skills and experience. Consultation Liaison, like a number of other indirect activities, is not widely fostered; this is not surprising with a service under such clinical pressure.

2.19. Interagency/Intersectoral Approach

There is no discernible statewide interagency or intersectoral (health, welfare and education) approach to the most serious problems in schools or in the community. Several reports interstate have led to efforts to combine health,

education and welfare staff to deal with particularly difficult issues – for instance seriously disruptive behaviour disorders in school, young people who do not fit into any system, or serious cases which have been failed by all systems. Such an approach needs the highest level of support to be achieved and at present, there are no structures to foster this approach.
As a further example of this, there is no statewide interagency approach with regard to cases of sexual abuse. Clinics therefore vary in the approach to abuse and the approach to other services (Family Services, SCAN teams) dealing with abuse.

2.20. Waiting Lists
Except for one clinic, waiting lists are very long in most regions, varying between 3 months and 9 months (the mode appeared to be close to 8 months). We were assured in all services that urgent problems are dealt with as soon as possible, even when services were closed to non-urgent cases. However, the demand characteristics of the disorder may be at odds with the staff perception of urgency which may be at odds with the parents' or family's view of what is urgent. This was clear from the very heated debates with referrers and carers, who were generally angry that assessment, support and therapy services were not available when they were needed. Some carers had travelled long distances or attempted to cross regional boundaries to gain services.
Most services attempted to deal with all referrals; careful triage programs culled inappropriate referrals. At least two clinics had not limited their service in a planned and coordinated way and staff, both individually and as a team, were showing the signs of burnout; this is a serious matter of occupational health and safety for professional staff in this field.
One clinic had effectively cleared the waiting list by limiting the referrals accepted to the most serious, complex, psychiatric and treatable disorders. While this is an appropriate way to deal with serious under–resourcing, referrers for this clinic bewailed the fact that a large number of young people with mental health problems could not now be referred.

2.21. Advocacy
There is no clear statewide policy on how clinic personnel should respond to requests for legal reports. There is no policy or training on how they should conduct themselves within the legal process. This is a major area of anxiety for staff and discussion should lead to a consistent approach which addresses the complexity of how a therapeutic system deals with an adversarial one.

2.22. Mental Health Promotion
The Review Team could find no evidence of substantial or coordinated

statewide Mental Health promotional activities. Given the immense level of knowledge in community services, this should be a part of a comprehensive service. Pamphlets should be easily available in all clinics for clients and should address a range of the most common conditions. Translation into relevant other languages should be considered. Clearly mental health promotional activity of this sort depends on a structure which supports its development and acknowledges that it is an integral part of service function. It also depends on adequate resourcing.

2.23. Early Detection/Early Intervention

The Review Team could find no evidence of substantial or coordinated statewide Early Detection or Early Intervention programs. This is not surprising given that clinics have had to focus on clinical work resulting from the referral pressure. However, there is now evidence from interstate that early detection of several conditions (psychosis, depression and suicide) is possible and useful and Early Detection and Early Intervention should be strongly encouraged as an efficient preventative way of dealing with serious disorder.

2.24. Statewide Academic Leadership in Child Psychiatry

There is no academic leadership in child psychiatry in Queensland. Such a position might contribute to:

2.24.1. development and maintenance of the overall vision for Mental Health for Children and Young People in Queensland;

2.24.2. maintenance of the statewide Mental Health planning group for Children and Young People ;

2.24.3. implementation of the Statewide Mental Health Policy and Plan for Children and Young People;

2.24.4. a Statewide Interagency process;

2.24.5. advice to Mental Health Branch on Mental Health matters for children and young people;

2.24.6. development of ongoing training programs for Child and Adolescent Mental Health multidisciplinary staff in all regions;

2.24.7. interpretation of analysed activity data for regional teams;

2.24.8. evaluation of Mental Health programs for children and young people in all regions;

2.24.9. teaching about Mental Health for Children and Young People to undergraduate and postgraduate university students from a variety of relevant backgrounds;

2.24.10. Statewide and regional needs analyses and advice on how these

needs might be met;

2.24.11. an informed community through discussion papers and the judicious use of media;

2.24.12. international knowledge in the area of Mental Health for Children and Young People through publication of research findings and informed opinion.

2.24.13. advocacy for the Mental Health of Children and Young People.

2.25. Statewide Academic Activity

While the Review Team was able to identify a number of small innovative programs, there is:

- no statewide planning to train specialist staff skills for work with children, adolescents and young adults and their families;
- no substantial contribution to undergraduate or postgraduate programs about mental health for children and young people;
- no community research into mental health for children and young people;
- no record of sustained record of publication (and therefore no contribution to the national and international literature).

2.26. Professional Training

The Review Team was surprised to hear of the relative lack of ongoing discipline specific training programs. Several staff admitted that they sought supervision and training outside of their clinics and paid for this privilege.

TERM OF REFERENCE 3.

To identify operational issues relating to staff mix, levels, resource allocation, location and access to inpatient services.

STAFF MIX

Clearly, this is a complex matter. With no statewide plan for the Mental Health for Children and Young People, the Review Team was unable to find an accepted comprehensive model. All teams differed and seemed to have developed in an ad hoc fashion in response to local need. If community teams have aligned with child health then their needs are likely to be different to those teams who have aligned more with mental health and treat more serious more identifiable psychiatric disorder.

One generic basic model of a fully functional community service servicing 40,000 young people and addressing the full range of Mental Health problems for children and young people (see **Introduction** and **Preamble to the Main Report**) can be suggested, based on interstate models. This brings together a Regional Team Director (1), Child Psychiatrist (1), Community Psychiatric Nurses (2), Social Workers (2), Clinical Psychologists (2), Occupational Therapy (0.5 FTE), Speech Pathology (0.5 FTE), Administrative and Secretarial staff (2) and such trainees from each of the professions as can be accommodated. Other staff may be added to serve special or local programs. This model differs slightly from the model suggested by Bashir (p.19.).

In addition to the core members of the mental health clinic for children and young people, two historical professional anomalies exist in Queensland. The role of the medical officer needs to be reviewed as child psychiatrists are employed in increasing numbers in clinics. Further, the role of the child guidance therapist needs to be reviewed in the light of all professions gaining generic child therapy skills.

Discussion is also needed on the role of the speech pathologist, the occupational therapist and the physiotherapist in regional clinics. A number of other professionals are employed in small numbers (a paediatrician (1FTE), a consultant neurologist (0.1 FTE), a dietitian (0.1 FTE)). The role of these professions should be reviewed.

3.1. Regional Team Director

This position is critical to the planning and day to day running of the team and may or may not be a clinician. An advantage of a non-clinician may be the formal training in management and/or financial accounting systems which

ensures accountability to the region. The advantage of the clinician may be that they already understand the clinical pressures on team members and can represent the team comfortably to other community professionals. In small teams such as the model suggested above, a shared role is possible with 0.5 FTE of the role clinical and 0.5 FTE administrative.

3.2. The Child and Adolescent Psychiatrist

Because of extensive and rigorous training and broad experience the Child and Adolescent Psychiatrist may be seen to lead the team or set the service agenda. However, the Child Psychiatrist does not need to administer the team, nor take overall professional responsibility for the other professionals; in fact this may be seen as a very expensive use of highly paid professional time. It is critical that teams have access to child psychiatric input, particularly as they begin to address the issue of serious mental disorder. For this reason alone, the lack of availability of child psychiatrists in public service is bordering on the dangerous. As previously noted, there are **6.08 FTE** child psychiatrist or visiting consultant positions for the community service (8.53 FTE for the total service – inpatient, outpatient and community). Only one of these is filled by a full time consultant; other positions are filled part time by visiting specialists whose main responsibility is their private practice; not all positions are filled. Consultant positions are supported by **1.5 FTE** senior registrar training positions and **5 FTE** junior registrar training positions in the community (3.5 FTE senior registrar and 6 FTE junior for the entire service).

On the basis of a population based estimate of need for **1 FTE** child psychiatrist per 40,000 young people, **the Review Team estimates that by the year 2001, there should be at least 24 FTE child psychiatrists.** In fact a good case can be made for there being a child psychiatrist for each planned community team (ie a **minimum 26 FTE** for the community services as projected. See Appendix 2, Table 3.).

3.3. Medical Officers

There are currently **10.17 FTE** positions for Medical Officers in the community teams. The Review Team had the opportunity to meet several and it is clear that they have played a medical leadership and often administrative role, particularly in the absence of Child Psychiatrists. In the context of a projection from the Review Team that the number of Child Psychiatrists needs to be increased, particularly as the service grapples with the issues of serious mental disorder, three dilemmas need to be raised. How can the Medical Officer's role be clarified with regard to both administrative and clinical responsibilities ? What happens to Medical Officers with extensive experience as Child Psychiatrists are trained, employed and then join community teams ? What

becomes of the Medical Officer's role if the Steering Committee agrees that prescribing of Ritalin and other medications for ADHD is more the role of the local GP/ Medical Officer, and the holding of stocks of Ritalin is more the role of the local Pharmacy.

3.4. Nurses

16 FTE Clinical Nurses are employed in community service. At this time the majority of nurses do not have formal psychiatric qualifications but have had extensive experience in the field. Many nurses play an important role with regard to triage of referrals. Two issues arise. First, what is the role of the clinic nurse if teams begin to change the triage/referral process in the light of increased resources ? How will clinic nurses survive in teams as increasing numbers of nurses *with* psychiatric qualification seek employment ?
In other states of Australia and internationally, nurses have begun to develop specialist skills. Nurses can take special responsibility for groupwork, community development, interagency work with Education and Family services, home based services, family work, and a range of other therapies. In the United Kingdom, Nurses have developed the specialist role of the Behavioural Nurse Therapist, using cognitive therapy approaches. These and many other roles may need to be explored.

3.5. Psychologists

At this time **19.92 FTE** Psychologists are known to be employed in community services, although an unknown number are also employed as Child Therapists. An issue exists for psychologists because only recently has there been a clinical masters program available in Queensland. Distinct advantages to services and to clients exist in the employment of clinicians who have received formal advanced training in the area in which they are employed. It is to be noted that experience overseas and interstate is that employment of such clinicians leads to good quality teaching and training and good quality research and publication which then enhances clinical functioning in teams. As a profession it is psychologists who have particular skills in assessment, formal testing of ability and who are most trained in formal research and evaluation methods and have the will to ensure that programs are properly evaluated. The dilemma to be addressed is how the role of psychologists will change as *clinical* psychologists (those with clinical masters) begin to fill positions.
An additional issue exists with regard to *neuro*psychologists who have received further training in addition to a masters in clinical psychology, and have special skills to assess and work with head injured and neurologically disordered young people. There is a place for a needs assessment to be completed to determine the numbers of such highly trained professionals

necessary in Queensland.

3.6. Speech Pathologists

In general throughout Australia clinical multidisciplinary staff in community clinics are drawn from the professions of nursing and psychiatric nursing, psychology and clinical psychology, social work, medicine, child psychiatry and psychiatry. Speech pathologists and occupational therapists are sometimes looked on as a luxury. This is a rather limited view.

At this time **10.2 FTE** Speech Pathologists are employed in community services. A debate has been generated about their role and place in Queensland community child guidance clinics. Given that about 60% of referrals to clinics can be shown to have speech and language problems, the demand for specialised speech pathology is likely to continue and be critical where services are more aligned to child health and development. What needs discussion is whether in the long run it is cheaper to outsource for this service or whether the considerable gain from having the Speech Pathologist as an integral part of a team outweighs considerations of cost.

3.7. Occupational Therapists

Only **0.5 FTE** Occupational Therapist is employed in Queensland services, although at least two others are employed as Child Guidance therapists.. This is surprising, given that more than 50% of referred clients have motor or psychomotor problems and that Occupational Therapists have particular skills, from their training, in preventative programs with younger children, groupwork programs to raise self esteem and confidence and special programs for psychomotor problems.

As previously noted, in a fully functional service a complete range of services should be offered from infant mental health, through early and middle childhood (when speech and language, physical ability and social skills are critical areas of the assessment of development) to adolescence.

In addition it should be noted that in most services there is a need for both specialist skill (profession specific training,experience and ability) and generic skill (assessment, child therapy, cognitive behavioural intervention, family therapy). No profession needs to be excluded from the attainment of generic skill. These issues are further discussed in the *Preamble to the Main Report.*

3.8. Social Workers

19.28 FTE Social Workers are employed in Queensland services, although it is not known how many are also employed as Child Guidance Therapists. These professionals play a crucial therapeutic role in community clinics; in Social Workers have particular are likely to have highly trained skills in individual

counselling, groupwork, and family/systemic therapy, wider systems interagency work, home based therapies and community development, particularly where issues of social justice, equity, and access are issues.

3.9. Trainees in Child Psychiatry

Although there are **1.5 FTE** Senior Registrar positions and **5 FTE** Registrar positions in community services, there are serious problems in attracting and maintaining trainees in Child Psychiatry.

Since regionalization, there have been special problems, at a bureaucratic level, in organization of the employment of Trainees in Child Psychiatry. This has led to trainees having to negotiate their own salaries and other work arrangements with regions as they travel from region to region to gain the requisite experience. They are obliged to transfer between regions formally which may entail interviews, problems with transfer of benefits (superannuation, holidays, conference leave). This may be one contribution to why trainees become disenchanted and seek to leave the system at the first available opportunity.

A further problem relates to the overlap of the fifth year of adult training in Psychiatry with the first year of Child Psychiatry training. Technically at the end of the fifth year a trainee becomes registerable as a specialist psychiatrist. In other circumstances they are eligible for a consultant post if one becomes available – a considerable step up in salary. However, this step up is not automatically offered in Child and Adolescent Psychiatry. Trainees therefore are disadvantaged financially by their wish to complete child psychiatric training and as a consequence, become discouraged when they see their colleagues in other areas of psychiatry doing better with less training. This too encourages them to leave the service for the high income of private practice.

A serious problem of attracting and maintaining trainees in Child Psychiatry must be overcome if Queensland is to service the young population of mentally ill.

3.10. Child Guidance Therapists

There are **19.27 FTE** Child Guidance Therapists for the community services; a range of professional backgrounds are employed in these positions which have played an important role in Queensland mental health services for children and young people. Interstate (for instance in Victoria) there are specific training programs for Child Therapists; these are based on predominantly psychoanalytic theories of Child Therapy. There is clearly a place for continuing to provide individual medium and long term therapy for a small proportion of young people within mental health services. As far as this issue is concerned the dilemma is whether this specific expertise should continue to reside in Child Guidance Therapists as a discrete profession, or whether all

professionals should be employed as per their professional background and have a range of generic therapeutic skills which include training in individual therapy.

Over the last few years, there has been considerable evolution and diversification of the child guidance therapist role to provide a broader clinical service within the team; this includes family work, parental counselling and group work. The role has remained essentially therapeutic; it is a functional role rather than discipline specific.

The Brisbane North review (Bashir 1994) has recommended reversion of CGT's to their professional discipline; the results of this have yet to be seen. A similar decision has not occurred in other regions, but this is an issue for the Steering Committee to discuss.

3.11. Physiotherapists

Two FTE positions exist for physiotherapy. Both are based in Brisbane North, but in the past have provided services to all clinics. Physiotherapists provide various assessment and treatment programs where physical issues are clearly a major part of the mental health problem (sensory integration programs for psychosomatic problems through individual, group and home based programs).

3.12. Paediatricians

One FTE position exists for paediatrics based in Brisbane North but in the past providing services to all clinics.

3.13. Consultant Neurologists

This position (0.1 FTE) has been employed to read EEG's and advise on neurological matters.

STAFF LEVELS

In general the Review Team considers there are problems in levels of appointment. There is a fine line between cost containment in employment (ie employing the cheapest staff possible) and creating a service which cannot function (because of relative lack of skill, experience, confidence and competence with resultant loss of effectiveness and efficiency). Mental Health work in the area of children and young people is complex, hard work which can be seriously draining for those who are relatively untrained or undersupervised. The risk of burnout is very high and active steps need to be taken to circumvent this.

At the PO2 level staff are likely to be still orienting to Mental Health Services for

Children and Young People, gaining clinical skill and relatively inexperienced. The PO3 level has an expectation that staff will have gained basic and some advanced skill and be somewhat experienced. However, both of these levels are in need of ongoing supervision and training.
The Review Team formed the opinion that nearly one third of staff were untrained new graduates or inexperienced in specialised mental health. The majority expressed their lack of training in specific areas of expertise (eg complex treatment for sexual abuse, eating disorders, psychosis, OCD).

3.14. Senior Staff
There are insufficient seniors at the PO4 level to ensure either supervision or ongoing training at the level required to achieve a standard of excellence in services at the level of best practice. In general, careful consideration must be given to the levels at which staff are employed in the area of Mental Health for Children and Young People, not only because policy directs it, but because this is a n extremely hard and complex area to work in. One of the major issues to be considered for mental health staff is that of staff burnout; a potentially serious Occupational Health and Safety Issue which can be avoided by employing highly trained and skilled staff, who are adequately supported and supervised, clear on their roles and particularly their limits, at levels of employment commensurate with the task and in permanent rather than temporary positions.

3.15. Country or Isolated Teams and Clinics
The employment of staff at a sufficiently senior level is particularly an issue in country or isolated areas where the employment of relatively junior or inexperienced staff without adequate supervision contributes not only to an ineffective and inefficient service, but also to therapist burnout. Experience in other states suggests that sole practitioners even when skilled and experienced have problems in maintaining both themselves and clinical standards; employment at too lowly levels doubles the jeopardy for possible occupational health and safety related problems.

3.16. Permanent versus Temporary
A great many staff interviewed by the Review Team were on short term contracts. This detracts from commitment to a team or region, promotes unnecessary anxiety about performance and job retention, and contributes to therapist burnout. It is difficult to develop and maintain team cohesion when staff cannot take a long term view of their employment.
Part of this issue may relate to the way new services are developed. Time limited grant monies are used to develop or enhance services without any

promise of permanency even if the project works well. This places immense pressure on administrators as well as employees.

RESOURCE ALLOCATION

The main issue with resource allocation is how to increase the overall amount of budget allocation to mental health services for children and young people. It is unlikely that the necessary funds will be made available in the near future. A question which may be raised therefore relates to whether current resources can be spread more thinly to allow for service development in regions where there are no clinic services and very limited visiting services.
It is the view of the Review Team that while it appears that the Brisbane regions are well resourced (see the Solomon report on this issue, and Appendix 2. Table 1.), in fact they are well resourced only by comparison. There is 'little fat in the system' and all clinics are under immense referral pressure. A further complexity relates to possible transfers of resources across regions. This may be considered in the short term, but is likely to deplete barely coping services in the longer term.

3.17. Clinic Environments

With one exception, the clinics visited were dilapidated, cramped and in varying states of disrepair. The Review Team understands that two newer clinics may be in a better state of repair, but few of the services visited provided a level of comfort and care for staff consistent with their feeling respected and cared about. Staff are housed in substandard offices where the smallest space has been utilized to provide a consultation area. In some clinics family consultation areas are the only access to another part of the clinic.

3.18. Rooms for Staff

While staff numbers are inadequate at this time, there are still not enough rooms to accommodate existing staff. Further, there are certainly not enough rooms available to accommodate students from each of the professions who, as part of their professional courses are obliged to gain experience through clinical placement. Such placements either have to be refused or they place an extra burden on existing staff conditions.

3.19. Privacy

Portable partitions are used in some services to provide 'privacy' for taking referrals, but privacy and confidentiality for the client population are both seriously compromised when working conditions are cramped, walls not

soundproofed and access is through consulting rooms.

3.20. Fire Hazard
In several clinics the buildings are in such a condition and consulting arrangements are so cramped that an issue relating to fire hazard must to be raised. Fire safety needs to be addressed as an urgent issue of occupational health and safety.

3.21. Disabled Access
In the many of the clinics visited, wheelchair and pram access is a serious problem. This is true both for access from the outside of clinics and also for movements within the clinics from room to room. There is a dilemma for older clinics to make changes consistent with more recent legislation, but the issue needs to be addressed. In particular in developing new clinics, Disabled Access is an issue be taken into consideration.

3.22. Air conditioning is not universal.
This may not seem to be an issue given that Queenslanders should be acclimatized to their own environment. However, both heat and humidity can be draining for staff and a temperate and comfortable environment is critical for good quality therapy to occur.

3.23. Equipment
Basic equipment such as chairs, desks and play equipment is on the whole ancient, uncomfortable and well used. Again this is an issue related to looking after the tools of the trade – the staff.

3.24. Travel Arrangements
Most clinics do have some cars for transport, or have the ability to use taxi vouchers. Even so, access to transport is a problem. This may limit the ability to network with other services or make home visits, and increases the reliance on clinic centred models of intervention. Making access to service cars difficult may make sense at a bureaucratic level, but causes serious inefficiencies at a local level. The Review Team were told in one clinic that staff had to walk some distance to a central car pool to gain access to cars.

3.25. Control over Budgets
In most cases written submissions have to be completed to gain replacement items – sometimes even for items under $40. Very few clinics have any control over their budgets; again this might make sense bureaucratically, but leads to daily frustration and loss of clinical time. As an example, in one clinic we were

told that for a number of years, on every occasion that stamps were required to send out urgent items, a staff member had to walk to another central clinic and ask for stamps; on each occasion that person was then reminded that the stamps were only for *emergency purposes*.

Clinics are more efficient if the Team Director has some management control over the day to day financial running of the clinic, purchase of minor capital items, books and journals, and considerable say in planning staff arrangements such as leave, conference leave etc.

3.26. Essential Technical Equipment

Mental Health Services for Children and Young People have limited technical equipment needs. All clinics need adequate dictation and transcribing equipment. An alternative to this existing in very modern services, is that all staff have access to computers and printers, are given the skills to use the equipment correctly and are expected to complete some of their own client reports themselves. In addition they may then also complete research efforts and technical reports. These two innovations lessen the pressure on administrative staff and increase productivity, particularly academic productivity.

All clinics should have at least one two-way screen for training and therapy purposes. All clinics should have video recording equipment; while there are ethical complexities to the recording of mental health interviews, there are important reasons for such action in a variety of clinical situations. Further, the training and supervision needs of staff can in part be met through the use of video.

As a final note, interstate services record statistics and activity data on computer and this is then transmitted through faxmodem to central services for collation; this provides for simplicity and efficiency in the collection of data.

3.27. Library Facilities

Mental Health Services for Children and Young People need constant professional updates through journals and access to textbooks, to maintain best practice. This facility was unavailable at most clinics, although most had developed access to more central library services; however, this is not the most efficient use of resources where the most valuable resource available to mental health services is the time of the professional staff. There was little evidence of allocation of sufficient resources to this important aspect of maintaining services at the level of best practice.

As a further note, interstate services have ready access to or have purchased equipment to provide library data searching through CD-ROM. This promotes academic thinking and work by all staff. Research is the ability to consider

questions based in clinical experience and the ability to seek to have those questions answered leading to new knowledge in the public domain.

3.28. Supervision of Young Children

A limited budget does not allow for specific staff to supervise and care for children while their parents are interviewed; this leads to inefficient use of other staff time. Clinics interstate often employ an activities supervisor to perform this function; this position can also be used to coordinate facilities (eg library), manage routine services under supervision (eg enuresis programs – use of alarms and collection of data etc) and take an active part in group programs.

LOCATION OF SERVICES

3.29. Location and Access

Historically, considerable thought has gone into the placement of clinics in the community along bus routes and providing access which is as easy as possible. In contrast, with the rapid growth of population in certain areas, a number of the clinics visited had 'got left behind' and were a distance from new population developments and are now relatively inaccessible.

In addition, poor resourcing has led to a lack of services targeted to new population developments. **For the top 20 growth areas in Queensland there are clinics available in only two areas.** This needs to be rectified.

In particular careful consideration must go into how best to provide access for country and isolated areas. Interstate models provide for either visiting teams which use existing hospital or community service facilities *or* small resident services with a minimum of two professional staff supported from major mental health clinics and housed in existing local facilities, with costs shared between rural services and the mental health service. This latter method leads to local knowledge and greater local acceptance, but staff need regular access to both other visiting professionals (eg psychologists or psychiatrists) as required, and the central clinic environment to ensure quality of service and support.

The principle of *access* needs to be taken into consideration as a key component in the further development of services.

3.30. Co-location

With regionalization issues related to co-location of services have arisen driven by pragmatism, economic rationalist thinking and the important policy issue of mainstreaming of services. It may be that stand alone clinics will not be supported in times of financial restraint, even though these can be shown to be an efficient use of current resources in some regions. Further, mental health

services are best seen as part of health services generally. Given its wide scope mental health services specialising in children and young people may appropriately be co-located with community child health clinics (especially where the focus is on the younger child) or with adult mental health services (where the focus is on more serious mental disorder or the older adolescent); examples of both of these exist already.
One of the main issues perhaps relates to the maintenance of identity as a statewide mental health service, so crucial to staff performance.
It will remain true that parents with younger children may be uncomfortable attending clinics with disturbed older adolescents; conversely adolescents are often uncomfortable attending clinics clearly set up for younger children. This has led to thinking that adolescent and youth services might be separate from child services. As noted elsewhere (see *Preamble to Main Report*), there are strong theoretical arguments for Mental Health Services for Children and Young People being maintained as one service and that in particular a critical mass of professional staff is an issue in clinic development. An alternative is therefore that consideration be given to two clearly designated parts to a service.
Interstate, examples of co-location with a range of other services (Family Services, Intellectual Handicap etc) exist; it is important to maintain the identity of Mental Health Services for Children and Young People as a *health* service.

ACCESS TO INPATIENT UNITS

There are few inpatient resources allocated to young people.

3.31. Admission

Staff in all clinics bemoaned the major difficulties of trying to get young people admitted to hospital. The problem becomes more serious:

- for young people 14 years and over;
- where there are issues of violence to the self or others;
- where the situation is in crisis;
- where the presentation is predominantly behavioural and the psychiatric diagnosis is uncertain or not yet clear;
- where the problem is an increasing distance from Brisbane

3.32. Adolescent Unit

The medium term Adolescent Unit (Barrett Adolescent Centre, Wolston Park Hospital) has a lengthy waiting list for therapeutic intervention. Further, the unit is not able or set up to take young people in acute crisis.

There is no Acute Inpatient Unit for Young Adolescents in Queensland. Psychotic, violent or suicidal young people are therefore admitted by local arrangement to adult units; this is not best practice.

3.33. Younger adolescents and children

The Review Team understands that the Child and Family Therapy Unit (CAFTU) at Brisbane Children's has been through some turmoil and is currently not well staffed in terms of senior staff. Community teams have had problems maintaining a working relationship with the Unit and with the CAFTU outpatients' clinic which is independent of community services. There is limited access for admission of younger people to the Mater Hospital. Again community staff reported difficulties in admitting young people and in maintaining working relationships.

3.34. Rural Services

There are no dedicated beds for the mental health of children and young people outside of the Brisbane Regions. Admission is to adult beds locally where these exist and by local negotiation. Alternatively, admission is to Units in the Brisbane regions where this can be arranged. Neither of these alternatives is satisfactory. Admitting young people to an adult environment can be threatening, and often staff in adult units do not have the skill to deal with adolescents or young.people. In particular there is a tendency to see the person as individual, whereas most young people need to be seen as part of their family environment. Again, transporting a young person to Brisbane breaks up the family unit and does not allow comprehensive therapy.

TERM OF REFERENCE 4.

To determine access to child guidance clinics and service utilization by young people over 14.

Overall, the review team found it difficult to gain a complete picture of this issue given that central statistics are not available. It appears generally that there is very little use of Mental Health Services for Children and Young People by young people over the age of 14 years.

4.1. Access to child guidance clinics

Where clinics are available, staff reported that they were not being accessed young people over the age of 14 years, although technically they accept referrals from ages 0 - 18 years. The Review Team could find no evidence of active discouragement of access, but most clinics for children and young people prefer or demand family involvement in the therapeutic process. This may deter young people who are gaining, or who believe they are, autonomous. There seems to be a perception by youth that the clinics are more for children. Further, adult services will accept young people who are over 16 years, have left school and are autonomous from their families. This overlap deserves to be explored and issues clarified.

4.2. Service Utilization

As a percentage it appears that **less than 10% of referrals to clinics are for young people over 14.**

Best service utilization was seen in those clinics which had aligned themselves with adult mental health, or in those clinics which had determined a policy of seeking to treat young people with severe, complex or treatable mental disorder – which immediately increases the number of older children seen because they are the ones developing the serious mental disorder (see *Preamble to the Main Report*).

TERM OF REFERENCE 5.

To determine the extent to which children and young people with special needs including those who are of Aboriginal or Islander or Non-English speaking background, homeless, dual disability or within the care and protection of juvenile justice systems, have access to child guidance services.

The Review Team found it difficult to gain a true picture of access by special groups because of the paucity of statewide statistics

5.1. Aboriginal and Islander peoples

There is very little usage of child guidance services by Aboriginal and Islander peoples. As mentioned in the Executive Summary (2.3.), in one northern region a local arrangement with a psychiatrist specialising in the area has led to a relevant visiting service to communities. Some children are seen through the Royal Queensland Bush Children's Health Scheme. The Mater Children's Hospital has an Aboriginal Liaison Therapist for any children attending the hospital.

However, there is no overall statewide mental health plan to ensure adequate availability of services to Aboriginal and Torres Strait Islander children, young people and their families. There is no active engagement of, or employment of, Aboriginal and Islander peoples.

5.2 Non-English speaking people

The Mater Children's Hospital Department of Child Psychiatry has a a service to children of Non-English speaking background.

There is no similar special program within Mental Health Services for Children and Young People and there is no overall statewide mental health plan to ensure adequate availability of services to Non-English speaking children, young people, and their families. There is no active program of engagement of, or employment of, non-English speaking peoples.

The review Team could not find statewide evidence of documentation about mental health Services for children and young people translated into relevant languages. There is no statewide liaison and consultation with migrant services. A particular issue relates to victims who have suffered torture and trauma before arrival in Australia. These children, young people and their families deserve dedicated and specially resourced services.

5.3. Homeless young people

There is clear evidence from a number of sources that more than 60% of these young people have serious mental health problems. There is some evidence

that homeless young people prefer to attend generic community youth services and crisis accommodation services. There is no special program within Mental Health Services for Children and Young People to access these highly troubled young people, and there is no overall statewide mental health plan to ensure adequate availability of services to Homeless young people.

5.4. Young people with Dual Disability

There is clear evidence that children with physical health problems, physical disability and intellectual disability are at greater risk for mental health problems and mental disorder.

Consultation and Liaison Services exist within the Mater Children's Hospital and the Royal Children's Hospital for young people with physical health problems.

The review team could not find any evidence of coordinated programs of consultation and liaison between Mental Health Services for Children and Young People and services providing care to those with physical disability and intellectual disability. There is no overall statewide mental health plan to ensure adequate availability of services to young people with dual disability.

5.5. Young people in custody or the juvenile justice system

There is recent evidence interstate that over 60% of young people in custody have clear evidence of severe mental disorder or serious mental health problems. Until recently this population was predominantly seen as exclusively 'bad' as opposed to 'mad'; this is clearly unfounded and as a group these severely disadvantaged young people deserve much improved mental health services

In the past, a forensic service commenced at Westbrook Training Centre in the early 1960's; this has not occurred for 15 years. Some assessments occurred at Wilson Youth Centre in the past; these are now performed at the City Clinic since 1983 (now the Adolescent Forensic Unit since 1991). These assessments are not provided by Mental Health Services for Children and Young People. Adolescents are referred to private psychiatrists if therapy is warranted.

There is little consultation to or liaison with the juvenile justice system. There is no overall statewide mental health plan to ensure adequate availability of services to young people in custody or the juvenile justice system.

The level of disturbance and mental health problems in this population and current relative lack of servicing requires urgent attention in terms of adequate assessment and therapy services.

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APPENDIX 1.

List of Services Visited by the Review Team:

Yeronga Child Guidance Clinic (representatives of all 4 community teams in Brisbane South were present).

Barrett Adolescent Centre (Dr. Michael Beech)

Ashgrove Child Guidance Clinic (representatives of all 6 community teams in Brisbane North were present).

Cairns Child Guidance Clinic

Scarborough Child Guidance Clinic

Woodridge Child Guidance Clinic

Gold Coast Child Guidance Clinic

List of Individuals who met with Dr. Martin and/or members of the Review Team:

Dr. Helen Connell

Dr. Trevor Sadler, Chairperson, Faculty of Child Psychiatry, Queensland Branch

Dr. Bernard Hughson

Ms.Libby Wherrett

Dr. Diana Lange

Dr. Marion Sullivan

Dr. John Varghese

Cairns Referral Agents and Consumers

Scarborough Referral Agents and Consumers

Woodridge Referral Agents and Consumers

Gold Coast Referral Agents and Consumers

Professor Beverley Raphael

Ms.Linda Keane

Ms. Fran Keegan

Dr. William Bor

In addition, 26 written submissions were received from a number of referring agencies, other government services and carers; their comments have been acknowledged with thanks.

APPENDIX 2

Table 1.
Current and Proposed Mental Health Services for Children and Young People (after Solomon,1993)

Region	Number of Services	5-19 year old population 1991	Expenditure $ per capita (1991-2)	Projected change in number of 5-19 year olds between 1991 and 2001
Brisbane South	4	147,958	9	16,425
Brisbane North	6	96,504	23	–2,809
West Moreton	1	41,324	6	4,944
South Coast	1	70,031	4	16,186
Darling Downs/ South West	1	58,647	5	2,154
Sunshine Coast	1	72,091	4	21,757
Peninsula	1	46,222	3	6,108
Northern	1	52,581	8	1,538
Mackay		28,357	0	943
Central/ Central West		45,137	0	1,205
Wide Bay		39,376	0	3,481
TOTAL	**16**	**698,498**	**7**	**71,932**

Table 2.
Projected Needs 2001: Numbers of Community Mental Health Staff for Children and Young People (clinical plus administrative support) according to the Nominal area population method (Southern CAMHS, S. AUST)

Region	Current number of services	0-19 year old population 2001	Projected number of teams	Estimated total number of community staff
Brisbane South	4	202,007	7	75-77
Brisbane North	6	114,976	4	43-44
West Moreton	1	57,004	2	20-22
South Coast	1	111,577	4	40-44
Darling Downs/	1	67,096	2.5	27-28
South West		9,431		*
Sunshine Coast	1	104,586	3.5	39-41
Peninsula	1	67,793	2	22-24
Northern	1	75,206	2.5	28-30
Mackay		44,576	1.5	17-18
Central/		61,991	2	24-25
Central West		4,814		**
Wide Bay		46,555	1.5	17-18
TOTAL	**16**	**967,612**	**32**	**361 (range 352- 371)**

* Estimated number of staff for South West are included with Darling Downs.
** Estimated number of staff for Central West are included with Central.

Table 3.
Projected Needs 2001: Numbers of Community Mental Health Staff for Children and Young People (clinical plus administrative support) according to the Nominal area population method (Queensland Mental Health Plan)

Region	Current number of services	0-19 year old population 2001	Projected number of teams	Estimated total number of community staff
Brisbane South	4	202,007	5	60-62
Brisbane North	6	114,976	3	32-34
West Moreton	1	57,004	1.5	15-17
South Coast	1	111,577	3	32-34
Darling Downs/	1	67,096	2	23-25
South West		9,431		*
Sunshine Coast	1	104,586	2.5	29-32
Peninsula	1	67,793	2	23-25
Northern	1	75,206	2	23-26
Mackay		44,576	1	12-13
Central/		61,991	2	23-25
Central West		4,814		**
Wide Bay		46,555	1	12-13
TOTAL	16	967,612	26	290 (range 284 - 296)

* Estimated number of staff for South West are included with Darling Downs.
** Estimated number of staff for Central West are included with Central.

SUMMARY OF TOTAL STAFF LEVEL AND MIX

Queensland Child and Youth Mental Health Services
including Inpatient, Outpatient and Community
as at November 1994

CATEGORY	TOTAL F/ T EQUIVALENT
Administrative Officer	18
Child Health Assistant	1
Child Guidance Therapist*	20.27
Clinical Nurse	52
Dietician	.1
Domestic	1
General Hand	2
Manager	1
Medical Officer/VMO	11.03
Occupational Therapist	.5
Physiotherapist	2
Psychologist	21.92
Psychiatrist/VConsultants	8.53
Registrar, Senior	3.5
Registrar, Junior	6
Speech Pathologist	12.2
Social Worker	23.68
Youth Mental Health worker	2
TOTAL FTES	186.73
TOTAL CLINICAL STAFF	163.73
TOTAL CLINICAL STAFF(YOUTH)	26.59

* various allied health backgrounds

SUMMARY OF STAFF MIX AND LEVELS:
Community child and youth mental health services
(Child Guidance clinics)
as at November 1994

CATEGORY	TOTAL F/ T EQUIVALENT
Administrative Officer	17
Child Health Assistant	1
Child Guidance Therapist*	19.27
Clinical Nurse**	16
Dietician	.1
Domestic	1
General Hand	2
Manager	-
Medical Officer/VMO	10.17
Occupational Therapist	.5
Physiotherapist	2
Psychologist	19.92
Psychiatrist/VConsultants	6.08
Registrar, Senior	1.5
Registrar, Junior	5
Speech Pathologist	10.2
Social Worker	19.28
Youth Mental Health worker	2
TOTAL FTES	133.02
TOTAL CLINICAL STAFF	112.02
TOTAL YOUTH CLINICAL STAFF	4.4

* various allied health backgrounds
** 1 only with psychiatric nursing training

EXHIBIT 290

	PENINSULA	NORTHERN	MACKAY	CENTRAL	WIDE BAY	SUNSHINE COAST	
	CAIRNS	TOWNSVILLE	MACKAY	ROCKHAMPTON	BUNDABERG	MAROOCHYDORE	REDCLIFFE
PSYCHIATRIST		.1 .6 (2)			Visiting service .15 every 3 months	1	
SENIOR REGISTRAR							
JUNIOR REGISTRAR	1	1					
PSYCHOLOGIST	1	1			1	1	
MEDICAL OFFICER		1				.5	.5
SOCIAL WORKER	1				1	1.5	1
CHILD GUIDANCE THERAPIST	1	1					1
SPEECH PATHOLOGIST		1				(20 hrs) .5	1
OCCUPATIONAL THERAPIST						.5	
CLINICAL NURSE	1	1					1(psych)
MANAGER							
ADMINISTRATIVE OFFICER		1				(1 does intake) 2	1
YOUTH MENTAL HEALTH WORKERS			2				
PHYSIOTHERAPIST		.5					
TOTAL:	5 FTES	8.2 FTES	2	NIL	2	7	5.5

EXHIBIT 290

LEVEL & MIX - CHILD GUIDANCE REVIEW AS AT NOVEMBER 1994 (Cont'd)

	SOUTH COAST		DARLING DOWNS	WEST MORETON		BRISBANE SOUTH (provides visiting 1 x month service to Charleville- .15 psychologist + private psychiatrist)			
	BURLEIGH HEADS	SOUTHPORT	TOOWOOMBA	IPSWICH	BARRETT ADOLESCENT CENTRE	INALA	YERONGA	GREENSLOPES	WOODRIDGE
PSYCHIATRIST	.2	.33commence late November		-	.33		.5 (15 hrs)	.15 (6 hrs)	
SENIOR REGISTRAR	1			-	1		.5		
JUNIOR REGISTRAR	-			-	-		1		
PSYCHOLOGIST	1		1	1	1	1 .67(24hrs)	1 .5(18hrs)	1	1 .25 (9 hrs p/w)
MEDICAL OFFICER	1			.5	.86	.33 (12hrs)	.15 (6 hrs)	.33 (12 hrs) .33(12 hrs)	.33 (12 hrs)
SOCIAL WORKER	1		1	1	1	.5 1	1 .33(12hrs)	2.25	1
CHILD GUIDANCE THERAPIST	3	3 AO3 AIIPs	2	1	1	.8 (29hrs)	1	1	2
SPEECH PATHOLOGIST	.5		1	-	-	1	1		1
OCCUPATIONAL THERAPIST	-			-	-				
CLINICAL NURSE	1		1	1	17	1	1	1	1
MANAGER	-			-	-				
ADMINISTRATIVE	1		1	1	1	1	1	1	1
YOUTH MENTAL HEALTH WORKERS	-			-	-				
DIETICIAN	-			.1	-				
TOTAL:	9.7 FTE	3.33	7	5.6	23.19			30.92	

	BRISBANE NORTH							
	ASHGROVE	ENOGGERA	INDOOROOPILLY	SPRING HILL	NUNDAH	ADOLESCENT FORENSIC UNIT	REGISTRAR TRAINING	ADMINISTRATION
PSYCHIATRIST	1		.5	1	.3	.4	.7 (2)	.1
SENIOR REGISTRAR								
JUNIOR REGISTRAR				1	1			
PSYCHOLOGIST	.7	.6	2	2.2 (4)	1	1		
MEDICAL OFFICER	1.5	1.4	1	1	.3			
SOCIAL WORKER	1	.7 (2)	1	1	1	1		.4
CHILD GUIDANCE THERAPIST				1.3	1			.17
SPEECH PATHOLOGIST	1	.8	1	.4	1			1
OCCUPATIONAL THERAPIST								
CLINICAL NURSE	1	1	1	2	1			1
MANAGER								1
ADMINISTRATIVE OFFICER	1	1	1	1	1	1		
DOMESTIC				1				
YOUTH MENTAL HEALTH WORKERS								
PHYSIOTHERAPIST				.5 (2)				
GENERAL HAND						2		
CHILD HEALTH ASSISTANT						1		
TOTAL:	7.2	5.5	7.5	12.4	7.6	6.4	.7	3.67

EXHIBIT 290

LEVEL & MIX - CHILD GUIDANCE REVIEW AS AT NOVEMBER 1994 (Cont'd)

	BRISBANE NORTH
	CHILD AND FAMILY THERAPY UNIT (INPATIENT)
PSYCHIATRIST	Inpatient and outpatient staff 4 x 3 sessions (1.32 FTEs)
SENIOR REGISTRAR	1
JUNIOR REGISTRAR	1
PSYCHOLOGIST	1(2)
MEDICAL OFFICER	-
SOCIAL WORKER	3
CHILD GUIDANCE THERAPIST	-
SPEECH PATHOLOGIST	-
OCCUPATIONAL THERAPIST	-
CLINICAL NURSE	18
MANAGER	
ADMINISTRATIVE OFFICER	
YOUTH MENTAL HEALTH WORKERS	
PHYSIOTHERAPIST	1
TOTAL:	26.32