The Royal Australian & New Zealand College of Psychiatrists

Queensland Branch

10th March 2016

Honourable Margaret Wilson QC,
Commissioner,
Barrett Adolescent Centre Commission of Inquiry

Dear Commissioner Wilson,

Re: Barrett Adolescent Centre Commission of Inquiry:
Supplementary Information and Key Points.

Adolescent Mental Illness in Queensland

An estimate of the prevalence of mental illness in Queensland adolescents can be made using data from:

- The Mental Health of Children and Adolescents: Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing, 2015[1].
- Queensland Government population projections, 2013 edition[2].

This data leads to an estimate of 51,408 adolescents living with a mental disorder.

The researchers further classified the severity of mental illness, based on impact on functioning (impact score), which leads to the following breakdown:

Severe	Moderate	Mild
A positive diagnosis plus an impact score greater than or equal to 1.75 and/or a history of suicide attempt in the 12 months prior to interview.	A positive diagnosis plus an impact score greater than or equal to 0.95 or a history of suicide plans in the 12 months prior to interview	All other cases with a positive diagnosis.
11,875 (23.1%)	16,861 (32.8%)	22,671 (44.1%)

The population of adolescents that are admitted to sub-acute services such as Barrett Adolescent Centre and the Walker Centre are a sub-group of those classified as severe. As noted in the terms of reference this group have 'severe and complex mental illness'. As previous witnesses have testified, characteristics of this group include severe symptoms that are treatment resistant and are associated with severe functional impairment and/or a high level of risk to self (and sometimes to others). This group are more likely to have backgrounds that include psychosocial adversity, childhood abuse and neglect and problems in family functioning. I am not able to give an estimate of the numbers but would expect they would form less than 1% of the severe group.

It is important to note that there are some limitations of this research, of particular note for the inquiry is that the researchers assessed for disorders that were common and had the greatest impact on children and adolescents: anxiety disorders, major depressive disorder, ADHD and conduct disorder. Psychosis is a low-prevalence disorder in this age group and was not assessed for, therefore is not included in the figures above.

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Service Provision for Adolescents with Mental Illness

From following the inquiry, I have noted discussion regarding levels of care and how the lack of a universally accepted nomenclature has made understanding recommendations and service provision more difficult. Therefore, I am providing an overview of the continuum of care for adolescents and explaining how the ECRG recommendations relate to this:

UNIVERSAL/PRIMARY SERVICES	**SECONDARY SERVICES**	**TERTIARY SERVICES**
Eg: GP; MindMatters, School Guidance Officers and School Based Youth Health Nurses; NGO based parenting and family support programs, parent education programs, Headspace Promotion and prevention for all adolescents. Early intervention for distress (e.g. reactions to bullying). Promptly identify and refer to secondary or tertiary services	*Eg: GP, School Guidance Officers and Youth Health Nurses, Community based NGO programs such as Relationships Australia, Centacare, private allied health practitioners, Headspace* Deliver interventions for problems of mild to moderate severity. Identify and refer more serious and complex cases to tertiary services.	*Child and Adolescent Psychiatrists, Child and Youth Mental Health Services, Clinical Psychologists and other allied health with a high level of expertise.* Deliver specialist treatment for chronic, complex and comorbid and/or severe and high risk patients. Provide consultancy and education to universal, primary and secondary services.

Where an adolescent is treated depends on:

1. Illness factors such as type and severity of symptoms, response to treatment.
2. Adolescent factors such as level of maturity (noting pseudo-maturity: adolescents who have had to become independent due to parental neglect, mental illness or substance abuse but lack many psychological skills and are vulnerable including to mental illness), intellect and capacity (including to understand medical information and make informed consent decisions), and resilience (derived in part from biological factors such as temperament and from early life experiences especially the quality of relationship with primary caregivers).
3. Family factors including relationships between the adolescent, their parents and other family members; and the overall functioning and stress of the family. For example, a family where the parents are healthy and are well-resourced with support from extended family and friends, stable housing and employment, etc. will be better able to engage with service systems and focus on the adolescents' needs than a family where the parents are suffering with illness or substance abuse and/or struggling with unemployment, poverty, unstable housing and/or other stressors. The relationship

between family functioning, relationships and adolescent mental illness is complex. Problems in family functioning can contribute to the onset of mental illness, or problems can develop in response to a living with severe mental illness. The capacity of a parent to provide ongoing support may be more fragile if there are pre-existing vulnerabilities such as a childhood history of trauma for the parent. Problems in family functioning, whether arising before or after the adolescents' illness, can continue to act to perpetuate the adolescent's difficulties. Family therapy has a proven evidence base in the treatment of mental illness, with demonstrated improvements in both the mental health of the identified patient and the physical and mental health of carers of people with mental illness.

4. Systemic factors such as the availability, accessibility and acceptability of services that are needed by the adolescent and the family and the coordination of care and working relationships between services. Where there are complex family problems and the presence of a need for systemic working, this predisposes towards care in public mental health services.

The Expert Clinical Reference Group (ECRG) identified service model elements to meet the needs of adolescents requiring extended mental health treatment and rehabilitation. All the service elements proposed by the ECRG are either components of tertiary services (above) or would need close working relationships and strong clinical governance and/or input from tertiary CYMHS (2b, the residential services).

Tertiary Child and Youth Mental Health Services			
Tier 1	Tier 2a	Tier 2b	Tier 3
Public Community Child and Youth Mental Health Services	Adolescent Day Program Services	Adolescent Community Residential Services	State-wide Adolescent Inpatient Extended Treatment and Rehabilitation

Acute Child and Youth Mental Health Service (CYMHS) in-patient units interact with and support care provided throughout the continuum of care provided by outpatient and sub-acute tertiary level services.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP), including Queensland Faculty of Child and Adolescent Psychiatry (QFCAP) members, strongly support the view expressed in the ECRG document that '*young people are treated in the least restrictive environment possible, and one which recognises the need for safety and cultural sensitivity, with the minimum possible disruption to family, educational, social and community networks'*.

There are some general principles regarding the treatment of children and adolescents that are agreed and should guide service provision:

1. Adolescents particularly those who are in early adolescence and in families that are not neglectful or abusive should be treated as part of a family unit. This includes provision of care from community CYMHS clinics and outreach services. Improved access to family therapy across Queensland would be a useful augmentation of available services. The role for existing and new outreach services (such as AMYOS) is strongly supported.

2. Treating adolescents in outpatient settings where they can remain engaged or be re-engaged with family, peer networks, education and other community connection is preferable to inpatient treatment.

3. Engaging with the community and working systemically is important for the welfare of our patients. The NGO sector is an important component of this. There are challenges and opportunities in the intersection between public psychiatry (CYMHS), other government agencies (such as child safety services, youth justice and education) and the NGO support and residential sector. Barriers to best practice include governance issues, level of expertise and professional development, case mix and it's management, level of structure and containment offered, resourcing etc.)

As outlined in the submission to the Inquiry, overall the RANZCP supports consideration of a medium term in-patient unit that provides extended treatment and rehabilitation. However, there are concerns about the risks inherent in such models e.g. from institutionalisation; and that such units may divert attention and resources from models of care that are community based. As the commission has heard, it is essential that there is: a clearly defined model of care, clinical governance, supervision and monitoring to ensure adherence to the model, careful patient selection, strong emphasis on involving family and maintaining links with community, and a focus on minimising duration of stay while maximising therapeutic gains (generally cited at 3 to 6 months as a maximum). There is concern that longer lengths of stay carry risks of deinstitutionalisation and iatrogenic increase in disability. Evaluation of this is difficult, as long lengths of stay are likely to be associated with the most severe illness. Careful follow-up studies are required to elucidate the risks and benefits, including relationships between illness severity, duration of admission and outcome.

Numbers of patients meeting criteria for a subacute in-patient service are small. Further, some of the patients previously referred or considered for referral needed specific aspects of what BAC offered, such as safe, therapeutic accommodation or specialist schooling that could accommodate the impact of major mental illness such as psychosis. Even considering the group that have benefitted, in the light of the current practice and evidence base, I wonder if more intensive community services could have met their needs. It is probable that the development and provision of other intensive services such as AMYOS, supported education settings and residential settings with the requisite expertise, can reduce and perhaps remove the need for sub-acute in-patient services. Patient groups most likely to require sub-acute care are those with treatment resistant psychosis. A subset of patients with intractable suicidality may also derive benefit, with careful selection and a focus on return to the community and community care.

Development and implementation of intensive models of community care (supported by acute in-patient units) is an important component of contemporary care that has the potential to reduce the need for sub-acute services. Such services include the Assertive Mobile Youth Outreach Service (AMYOS) and Evolve Therapeutic Services (ETS). ETS has demonstrated efficacy in improving outcomes for children in out of home care, including adolescents, with severe mental illness, emotional and behavioural problems. AMYOS is a new model, developed from a solid theoretical base. The commission has heard evidence for and against such community models. The evidence base for effectiveness is small but developing. The position of RANZCP is that such services are an important and potentially highly effective model of care; and evaluation and expansion of knowledge is needed and encouraged.

There are models of care for adults, and developing models for adolescents, who present with chronic self-harm and suicidality, often in the context of developing personality disorder and/or on a background of childhood trauma. These models are community based, with intensive provision of care. Some such services use brief acute admissions (generally 48 to 72 hours) to support the management of suicidality in this population. Brief admissions allow for containment of risk, and a 'breather' or break for the adolescent where they are supported and are able to review and revise their coping strategies. The community team coordinates admissions, and the main focus of treatment is on community care. The adolescent returns to community, family and social settings quickly so maintains relationships, and the risks of developing dependence on in-patient care are minimised.

There are other areas where service provision to adolescents with mental illness can be improved and advanced, some suggested areas for consideration are:

- The provision of service to regional and remote areas where CYMHS are not able to resource family teams, outreach teams or day programmes but where the principles of least restrictive intervention and maintenance of family and community relationships is at least as important, if not more so, than for urban areas.

- Culturally appropriate care, for all areas and especially in regard to potential dislocation of adolescents from regional and remote areas.

- The provision of care to adolescents, including those involved with the justice system, whose mental illness is associated with high levels of aggression and/or offending behaviour.

Adolescents, young adults, transitions and "youth" mental health.

The commissioner has heard about the development of the youth mental health model (Headspace) for 12 to 25 year olds, which originated from adult mental health services and the treatment of psychosis. This model has led to improved accessibility to mental health services for adolescents and young adults with mild to moderate disorders. It has led to improved community awareness of mental illness and the needs of adolescents and reduced stigma around mental illness. However, the outcome efficacy of the headspace model has not yet been robustly demonstrated. While data showing improvement has been published[3] (31% improved, 51% no change, 13% worsened) criticism of this data is that there was no control group and other studies have found that rates of natural improvement are similar to the rates reported by Headspace. Also only 28% of clients attended for the number of sessions (6 or more) considered adequate for treatment of depression and anxiety.

In addition, the commission has heard evidence that headspace works predominantly and most effectively in early intervention and mild to moderate illness. Headspace centres can be a component of a coordinated care system for adolescents with more severe illness, working alongside tertiary mental health services and other agencies.

In Victoria, an approach to addressing the difficulty of transition at 18 and accessibility of young adults to mental health services has been to raise the upper age limit for child and adolescent mental health services (which have become child and youth mental health services). This is congruent with the developmental issues and social changes that other witnesses have identified including the advances in understanding of brain development and maturation, the impact on development of mental illness (so adolescents who have suffered

a mental illness are often developmentally immature for their chronological age) and social changes e.g. with young adults leaving home later and remaining in tertiary education.

Anecdotal evidence is that there was little change in the numbers of young people being seen by the adult services while the numbers of 18-25 year olds being seen by CYMHS grew considerably. This leads to the conclusion that these young adults were not previously receiving a service. Further personal communication with colleagues working in a region where adult services extended down to 16, is that 16 to 18 year olds are not getting effective interventions from mental health services. The exception to this is early psychosis services that have been working effectively to engage and treat adolescents with early onset psychotic disorders. I have personal experience of an early psychosis service developed in AMHS, working closely with CYMHS and with input from a Child and Adolescent Psychiatrist, and managing adolescents from 15 years of age with psychosis very well.

CYMHS are ideally suited to meeting the needs of youth as they bring expertise in mental illness, development, a focus on functional as well as symptomatic recovery, family functioning and systemic working.

Services that have made this change recognise the differing needs across the 0 to 25 age-span (a 3 year old, compared to a 13 year old, compared to a 23 year old). They have developed sub-components to meet these differing needs such as perinatal and infant services and separate inpatient units for children, adolescents and young adults. Providing these sub-components within an overarching framework and management structure allows for service provision to be flexible to the young person's development rather than fixed by their chronological age and manage transitions more smoothly for the young person and their family. In implementing these changes, a priority has been in ensuring that services for 0 to 18 year olds are not diminished by the inclusion of 18 to 25 year olds and that the services provided to all ages are of high quality. The change also included expanded linking with other government and non-government agencies such as housing and employment support, universities, and NGOs that provide support to those over 18 years of age.

Direct referral to Adult Mental Health Service is considered particularly where first referral occurred close to the age of transition; it is developmentally appropriate for the young adult and where the diagnosis was appropriate to AMHS. Attention was paid to the transition from CYMHS to AMHS. The best 'cut-off' age for services remains an issue of debate, with some recommending 21 years and others recommending 25 years. Evidence to inform decision making in this regard is not yet available. Whatever the age, a flexible approach responsive to development rather than chronological age is recommended e.g. living with family as opposed to independent living.

In conclusion there is anecdotal evidence that expansion of CYMHS into older age groups is effective, and that extension of AMHS down (with the exception of early psychosis services) is not. Therefore, it is recommended that the possibility of expanding CYMHS to include the young adult group be further explored. In this regard, please note that the youth model has driven the use of 25 years as the upper limit; however, there is not yet consensus as to whether this or a young age (e.g. 21 years) is the best model. Additionally, further information regarding service provision and outcome data is required to inform decision making in this arena.

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Service Development and Evaluation

There is an essential requirement for robust evaluation including long-term follow-up of all services, particularly new service models and those operating with small populations. This is required both to evaluate the services that are being provided, and to build the evidence base for future service planning.

Education

The Queensland Department of Education and Training has very limited capacity to recognise or respond to impairment and disability secondary to mental illness. The current Education Adjustment Program recognises need restricted to arising from Autism Spectrum Disorder, Hearing Impairment, Intellectual Disability, Physical Impairment, Speech-Language Impairment and Vision Impairment. Many schools make great effort to meet the needs of children and adolescents with mental illness and there have been some development of alternative models including the maintenance of the Barrett School. However, the lack of formal recognition means that support is variable and may mean the adolescent having to be separated from their local school and peer group to access education.

Conclusions

Mental health services have been under resourced, at least since deinstitutionalisation, compared to the burden of disease caused by mental illnesses and in comparison to the funding of services for physical illnesses. There is a high need for adequate resourcing of mental health services across the age-span and across the continuum of care.

The resourcing of CYMHS has lagged behind that of AMHS, it is hoped that the current focus on the needs of adolescents will help redress the balance. It is also noted that the needs of infants and children should not be forgotten, whilst it is recognised that this is out of scope for this inquiry.

Mental Health Services are the most labour intensive of health services, quality services, require recruitment and retention of skilled professional staff that are supported and resourced to provide care. Public MHS have an important role in training future clinicians and should be resourced and supported to do this as part of their key business.

It is essential to provide a continuum of care that meets the needs of the community. The current emphasis on early intervention has much merit and is supported, given that early identification and intervention has been shown to improve the probability of a positive prognosis in both the short and long-term. However, for some, their mental illness will be chronic, severe and/or treatment resistant. It is important that these do not become the forgotten ones of psychiatric and social care.

Adolescents with severe and complex mental illness are not a homogenous group and a range of service models will be needed to meet their needs. Services need to be able to respond to the needs of the adolescent in context, of family, education and community supports.

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The continuum of care identified in the introduction demonstrates the different levels of service provision. Good outcomes are achieved when there is good communication, consultation and liaison and working relationships between services that result in young people and their families quickly accessing the most appropriate service for their needs.

There is anecdotal evidence that expanding CYMHS to include young adulthood results in improved service provision to 18 to 25 year olds, more developmentally appropriate service provision to older adolescents and young adults and addresses the negative impact of transition at 18 years of age. It is recommended that there is further exploration of the possible efficacy of such service provision in Queensland with a view to possible resourcing and development of expanded CYMHS services. Any expansion of population served by CYMHS must come with resources to meet that need.

Appropriate robust evaluation of services is essential and, if it provides timely, useful feedback to clinicians and those involved in service development and improvement, it is welcomed.

The determinants of onset and prognosis in mental illness are multimodal, encompassing genetic, biological, family and social factors. For those with severe illness, psychiatrists and Mental Health Services cannot achieve positive outcomes in isolation. Attention must also be paid to provision of intervention and support in education and vocational training, housing, and in wider issues such as addressing poverty. RANZCP supports attention to all the determinants of mental health in the population.

Kind regards

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[1]:https://www.health.gov.au/internet/main/publishing.nsf/Content/9DA8CA21306FE6EDCA257E2700016945/$File/child2.pdf

[2] : http://www.qgso.qld.gov.au/products/reports/qld-govt-pop-proj/qld-govt-pop-proj.pdf

[3] https://www.mja.com.au/journal/2015/202/10/changes-psychological-distress-and-psychosocial-functioning-young-people