DISCUSSION PAPER:

Child and Youth Mental Health Services in Queensland

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1.0 INTRODUCTION

The National Mental Health Strategy (1992*)* set the agenda for mental health reform across Australia. The *Queensland Mental Health Plan (1994)* followed by the *Ten Year Mental Health Strategy for Queensland (1996)* set the strategic direction for reform in Queensland, and identified a number of priority groups, including child and youth, which required their own policy statement.

The Future Directions for Child and Youth Mental Health Services policy statement (1996) recognised the needs of children and young people as a priority to ensure equitable access to appropriate mental health services. Children and young people present different patterns and types of mental health problems and disorders, therefore clinicians need to be skilled in providing a range of therapeutic interventions which take account of developmental stages, legal status, family, school and social context. Services are targeted at those who have, or are at risk of developing, mental health problems.

Since the endorsement of the policy statement, there have been two additional documents which influence service direction, namely *The National Standards for Mental Health Services (1997),* and the *Second National Mental Health Plan (1998)*. *The National Standards for Mental Health Services* provide a framework to ensure appropriate structures, processes and quality control measures are implemented within mental health services, and incorporate mechanisms which ensure the rights of consumers and carers to be involved at all stages of service development.

The *Second National Mental Health Plan* highlights the increasing burden of disease related to mental health and the increasing evidence that mental health promotion and prevention activities are effective in preventing mental health problems and reducing the impact of mental illness. Childhood and adolescence are recognised as optimal developmental stages to implement a full range of interventions. Therefore, the key platforms of the *Second National Mental Health Plan*, Mental Health Promotion and Prevention, Quality and Effectiveness and Partnerships are used as the framework in this document. The adaptation of the organisational structure as recommended in the *Ten Year Mental Health Strategy for Queensland,* as well as the development of a skilled workforce to ensure that services provided are of a high quality, are also highlighted in this document.

The platform of Quality and Effectiveness examines aspects of clinical treatment, from intake and referral processes through to clinical treatment programs. The use of evidence based practice contributes to quality improvement in service delivery and ensures consistency of implementation throughout Queensland. It is also noted that services to indigenous people need to be delivered in culturally appropriate ways.

The spectrum of clinical interventions cannot be delivered by specialist mental health services alone. It is widely recognised that the primary health care sector and some community organisations are better placed to provide a range of activities, particularly in the area of mental health promotion and prevention. In addition, clinical interventions for children and young people need to take into account the context of their lives, which includes family, school and social context. Therefore, effective treatment involves the development of partnerships with key agencies in service delivery. Partnerships in treatment should also be sought between the clinician, the child or young person and their family.

2.0 PURPOSE OF THIS DOCUMENT

This document aims to outline a number of issues relevant to the day-to-day delivery of mental health services by Child and Youth Mental Health Services (CYMHS) in Queensland and to set the direction for a two-day statewide CYMHS meeting to be held in Brisbane on 6-7 June 2002.

This discussion paper outlines issues for consideration regarding accessibility, coordination and efficiency of Queensland Child and Youth Mental Health Services. Additionally the paper outlines key issues that need to be explored at the meeting, to ensure consistent implementation of child and youth mental health policy at a service delivery level. The paper also provides some initial discussion points to consider, which will be explored along with other issues at the Statewide meeting.

Objectives for the 2-Day Meeting:

The objectives for the 6-7 June 2002 meeting are:

- To discuss key issues for the ongoing service development of CYMHS across the State in a strategic and productive approach with this discussion paper setting the main agenda items for the meeting.
- To provide a statewide forum for CYMHS to meet and develop practical strategies for the ongoing development of child and youth mental health services in a consistent, cohesive, and cooperative manner across the State.
- To document current CYMHS service delivery models in Queensland that are consistent with policy that acknowledges innovation and variety due to Metropolitan, Regional, Rural and Remote issues of the State.
- To document specific issues that require further policy development and Corporate Office support in a meaningful and proactive fashion.

3.0 OTHER RELEVANT DOCUMENTS

The following is a list of documents that were consulted during the development of this discussion paper:

- A Population Health Model for the Provision of Mental Health Care (Raphael, 2000)
- Framework for the Development of the Future Mental Health Workforce in Queensland (July, 2000)
- Future Directions for Child and Youth Mental Health Services (Queensland Mental Health Policy Statement, 1996)
- Future Directions for CYMHS Implementation Framework (August 2000) – unpublished
- Mental Health Services: Optimal Staffing Profiles and Recurrent Costs for Selected Inpatient Units and Community Health Services (Hospital Redevelopment Project, July 1997)
- National Mental Health Policy (1992)
- National Standards for Mental Health Services (1997)
- Promoting the Mental Health and Wellbeing of Children and Young People Discussion Paper: Key Principles and Directions (Raphael, October 2000)
- Queensland Mental Health Plan (1994)
- Queensland Mental Health Policy (1993)
- Queensland Mental Health Policy Statement for Aboriginal and Torres Strait Islander People (1996)
- RCH&HSD CYMHS Discussion Paper: The accessibility, coordination and efficiency of CYMHS (March 2000) - unpublished
- Second National Mental Health Plan (1998)
- Ten Year Mental Health Strategy for Queensland (1996)
- Victoria's Mental Health Service The Framework for Service Delivery: Child and Adolescent Services (Victorian Mental Health Branch, May 1998)

4.0 VISION AND PRINCIPLES FOR SERVICE DELIVERY IN CHILD AND YOUTH MENTAL HEALTH SERVICES IN QLD

VISION

To promote, maintain and improve the mental health and well being of the children and youth of Queensland

PRINCIPLES FOR SERVICE DELIVERY IN CYMHS

The Future Directions for Child and Youth Mental Health Services policy statement lists the following principles for guiding service delivery in CYMHS:

1. Each child or young person displaying serious level of disturbance, or who is at risk of developing a serious disturbance, should have timely access to high quality mental health services, which take into account family and social circumstances and cultural and language differences.
2. Service provision should include the development of strategies for identification and early intervention targeting those with known risk factors.
3. Mental health services for children and young people must be flexible and individually tailored, taking into account individual development and a person's social context as well as clinical need.
4. Children and young people need to be able to make informed decisions and be involved in the processes affecting them.
5. Services should be developed, delivered and evaluated with the involvement of consumers and parents or guardians.
6. Mental health services for children and young people will be coordinated between adult mental health, general health, welfare and education services in ways that ensure children and young people have access to the particular mix of services they require.
7. The service approach will maximise the support given to the child and young person's caring network, including parents, and build on existing strengths and opportunities within their environment

DISCUSSION POINT: Vision & Principles

Please comment on how your CYMHS has incorporated these principles in the delivery of child and youth mental health services.

Has your CYMHS adopted any additional complementary principles for the delivery of services within CYMHS?

O Yes – Please comment O No

Other Comments

5.0 CHILD AND YOUTH MENTAL HEALTH SERVICES' TARGET POPULATION

5.1 AGE

The CYMHS target population is defined at 0-18 years of age or under 19 years of age. Adult mental health services' target population is described as over 15 years of age in the Ten Year Mental Health Strategy for Queensland. As research findings become available there is an emerging picture of special need for the 14 – 25 age range. It is in this age bracket that the onset of mental illness is often experienced for the first time. The developmentally oriented approach to treatment, which incorporates the individual and their social context, is thought by some to produce better outcomes for this age group. The World Health Organisation promotes this view by arguing that people in their early twenties are still concerned with developmental issues, and often still dependant upon their parents.

5.2 MENTAL HEALTH CONDITIONS

The Future Directions for Child and Youth Mental Health Services policy statement outlines that as a specialist service CYMHS will "target direct service delivery to that portion of the population whose disorders are severe and complex, or at risk of becoming so, and whose needs cannot be met by other services" (page 4). It also states that "suicidal, psychotic, severely disturbed and traumatised children and young people whose behaviour is causing risk of harm to themselves or others will be given urgent priority" (page 5). It also details examples of high risk groups including:

- Children and youth living with family members who have mental illness
- Children and youth in care or in contact with the law
- Those with early onset mental disorders (eg. conduct disorder, psychosis)
- Those suffering abuse, neglect or other traumas
- Children and youth with chronic illness or disability
- Youth engaging in substance abuse

"Serious psychiatric disturbance" applies to the diagnosable psychiatric conditions (ICD10)/DSMIV) adversely affecting psychosocial development of children and young people which contributes to major interactional difficulties in their social environment. Some diagnosis categories clearly delineate the presence or absence of a disorder (eg. psychosis), whereas others (eg. anxiety) are more dimensional and require a clinical decision to determine severity. Hence, access to the specialist service (ie CYMHS) is to be determined by a clinical decision that takes into account the psychiatric nature of the disorder, the severity of disturbance, the complexity of the condition, the extent of functional impairment and distress.

DISCUSSION POINT: CYMHS Target Population

Please comment on how you envisage Services (including CYMHS and Adult Mental Health Services) could work in partnership to deliver services to the 14-25 year old age range.

The following are some special client populations that often require mental health input in combination with other services. Please tick those that you believe are appropriate for CYMHS to provide mental health input along with comments to support your choices.

O Children of parents with drug abuse issues

O Children of parents with a mental illness

O Children with intellectual and developmental disabilities and learning disorders (can include: ADHD, brain injury, challenging behaviours, autism, Asperger's Disorder)

O Co-morbidity with acute and chronic illness and physical disability

O Distressed infants

O Homeless youth

O Self-harming youth

O Socially disadvantaged youth (including those in care or in contact with the law)

O Special cultural groups (eg. Indigenous, Non-English Speaking, Refugees)

O Substance abusing youth

O Suicidal youth

O Trauma victims (including abuse and neglect)

O Other (please specify)

Comments

6.0 STAFF PLANNING GUIDELINES

The staff planning guidelines for Child and Youth Mental Health Services are outlined in the Ten Year Mental Health Strategy for Queensland (1996-2006) and the Mental Health Services: Optimal Staffing Profiles and Recurrent Costs for Selected Inpatient Units and Community Health Services (Hospital Redevelopment Project, July 1997) as follows: -

Inpatient Child (0-13yrs) beds

- 7 beds per 100,000 population of 0-13 year olds.

It is anticipated that in 2006, Queensland's population of 0-13 year olds will be 830, 000 thus requiring 64 beds across the State. There are currently 24 child beds, which are located in the Brisbane and Gold Coast areas.

Inpatient Adolescent (14-18yrs) beds

- 15 beds per 100,000 population of 14-18 year olds.

It is anticipated that in 2006, Queensland's population of 14-18 year olds will be 280,000 thus requiring 48 beds across the State. There are currently 46 youth beds, which are located in the Brisbane, Logan, West Moreton, and Gold Coast areas.

CYMHS Community Clinical Staff

- 25 Full-time equivalents (FTE) per 100,000 population of 0-18 year olds.

This 25 FTE is made up of 21.3FTE for Nursing/Allied Health + 3.7FTE for Medical (which is 1.2 psychiatrists to every 2.5 psychiatric registrars). It is anticipated that in 2006, that would result in 289FTE CYMHS community staff.

Indigenous CYMHS Community Clinical Staff

- 5FTE per 10,000 indigenous population of 1-18 year olds.

It is anticipated that in 2006, that would result in 24FTE for the State.

CYMHS Administrative Support Staff – Community and Inpatient

- 5FTE per 100,000 population of 0-18 year olds in the community and 1FTE per 10 inpatient beds for child and youth mental health services' inpatient units.

DISCUSSION POINT: Staff Planning Guidelines

Do you consider the current planning guidelines appropriate beyond 2006 for: -
a) Inpatient Child Beds

O Yes O No – Please outline reasons and suggest an alternative model:

b) Inpatient Adolescent Beds

O Yes O No – Please outline reasons and suggest an alternative model:

c) CYMHS Community Clinical Staff

O Yes O No – Please outline reasons and suggest an alternative model:

d) Indigenous CYMHS Community Clinical Staff

O Yes O No – Please outline reasons and suggest an alternative model:

e) CYMHS Administrative Support Staff – Community

O Yes O No – Please outline reasons and suggest an alternative model:

f) CYMHS Administrative Support Staff – Inpatient

O Yes O No – Please outline reasons and suggest an alternative model:

Are there any other resources that you believe are required in CYMHS? Please tick categories and specify what numbers and location for the resource.

O Secure Beds - Please Comment_____

_____

Location?_____Numbers?_____

O Day Patient Programs - Please Comment_____

_____

Location?_____Numbers?_____

O Other - Please Comment_____

_____

Location?_____Numbers?_____

Other Comments

7.0 QUALITY AND EFFECTIVENESS

Quality and effectiveness relates not only to the range of treatment services provided but also to the organisation and sustainability of mental health services, skills of the clinical teams, appropriate access to service components, and access to research and evaluation to ensure that services are responsive to the latest research evidence.

Treatment should be individually designed to address the nature of the presenting problem and the needs of the client. A range of therapeutic modalities can be utilised, taking into account the developmental stage, context of the problem, and the goals of the child/youth and their family. Clinical interventions should be evidence-based and effectiveness measured in accordance with the goals and objectives of the contracted treatment plan and the satisfaction of clients/families with services.

The standards of care across all components of the mental health care system, community treatment, acute inpatient, extended treatment, need to comply with the National Standards for Mental Health Services ensuring that services are of the highest quality and based on good evidence.

7.1 ORGANISATIONAL STRUCTURE

The Ten Year Mental Health Strategy for Queensland identifies an integrated structure for specialist mental health services, which includes community treatment programs, acute and extended inpatient services, for an identified catchment area. CYMHS is incorporated within the integrated team structure.

In recognition that only a few of the thirty-nine Health Service Districts have sufficient populations to warrant the full range of mental health clinical services, the Ten Year Mental Health Strategy outlines the concept of a network of services, where a number of Satellite Districts are linked to a Principal Service Centre. The network ensures access to the full range of mental health services, from community treatment to acute inpatient services. Principal Service Centres may carry additional responsibility for psychiatric consultation, professional and clinical supervision, and staff training and development.

This arrangement appears effective for adult mental health services where all regional centres, which are also Principal Service Centres, have acute inpatient units. However, many of the CYMHS teams are relatively small and provide support to smaller satellite sites of one or two staff, who are often new graduates. Consequently, there may be limited access to the multi-disciplinary team, including child psychiatry, and supervision, with no capacity for acute inpatient treatment, particularly for adolescents. Additionally, outside the Principal Service Centres, CYMHS staff are generally part of an integrated mental health team, managed together with adult mental health or managed through a community health service. Consequently, mechanisms need to be identified for operational structures and processes for CYMHS within and across the three zones to sustain the child and youth mental health specialty and promote recruitment and retention.

The Ten Year Mental Health Strategy for Queensland states that a Principal Service Centre is “responsible for providing acute inpatient services, community treatment, outreach and clinical and professional support services to satellite services within its own and other Districts in the network” p.39. A Satellite Mental Health Service is said to “provide intake and assessment, continuing treatment and case management, and consultation and liaison from a small number of mental health professionals based in rural or non-provincial centres. These services are supported clinically and professionally by outreach mental health services from provincial and metropolitan mental health services (from within the District or from another District)” p.39.

PRINCIPLES

Structure and processes within CYMHS

- In satellite centres, finding alternatives to the appointment of stand-alone clinicians for child and youth mental health is preferable. For instance, appointing a CYMHS clinician in combination with adult mental health service staff or basing them in a larger network centre with outreach services to the satellite centre is an option.
- Services with sufficient team size (as per planning guidelines in the Ten Year Mental Health Strategy) will be organised as multi-disciplinary teams drawn from a range of disciplines including psychology, social work, nursing, psychiatry, occupational therapy and indigenous health. A team leader would also be appointed from an identified professional group.
- All team members will provide both case management and discipline-specific specialist functions
- Team members will collaborate in treatment planning

Structure and processes within the District Mental Health Service and Network

- Service directions for child and youth mental health must be consistent with State and National directions for reform and responsive to the identified needs of the local community
- The team leader of CYMHS will be an active participant in the management of District Mental Health Service (DMHS) and will have responsibility or input into the CYMHS budget and outputs
- The team leader will be responsible for the daily coordination of the clinical team
- The child psychiatrist at the principal service centre, through the established reporting mechanisms identified for each network, is clinically responsible for service delivery across the network. Note that clinical responsibility is not the same as medico-legal responsibility. Queensland Health legal advice on this issue stated that “Except in circumstances where a child psychiatrist directs a staff member to undertake certain care/actions for a patient/client, he/she is not responsible in a medico-legal sense for the actions of other professionals in the multi-disciplinary team of CYMHS.”
- The child psychiatrist will collaborate with the team leader and discipline seniors and be accountable to the Director/Manager of the DMHS (or equivalent depending of the DMHS structure) for the delivery of quality clinical services
- Provides outreach and clinical and professional support services to satellite services within the network.

Structure and processes at Satellite Centres

- Where CYMHS staff are appointed as members of a combined adult and child and youth team, equal consideration should be given to a person with experience in CYMHS to apply for the team leader position
- Clinical direction, and clinical accountability for the child and youth component is set in collaboration with CYMHS at the principal service centre
- Supported clinically and professionally by outreach mental health services from the principal service centre within the network.

Structure across the Queensland Health Zones

- Mechanisms will be sought to develop consistent approaches to service delivery within each of the Zones
- CYMHS will participate in the planning of services across the zones.
- Consideration will be given to the coordination of CYMHS at the zonal level. Elements of this structure will include:
  - Clearly defined professional and supervisory responsibilities in each zone
  - Child psychiatrists who will be available for consultation across the zone
  - Access to a full multi-disciplinary team across the zone

DISCUSSION POINT: Organisational Structure

For each of the following items please comment on:

- How your CYMHS incorporates the principles by providing some examples
- What difficulties your CYMHS has encountered in incorporating the principles and some suggested solutions for these difficulties

a) Structure and processes within CYMHS

b) Structure and processes within the District Mental Health Service and Network

c) Structure and processes at Satellite Centres

d) Structure across the Queensland Health Zones

Other Comments

7.2 ACCESS TO THE FULL RANGE OF SERVICES FOR A SPECIALIST CHILD AND YOUTH MENTAL HEALTH SERVICE

Population mental health (Raphael, 2000) offers a conceptual framework that brings together:

- A developmental approach that recognises the specific needs of the various stages through childhood and adolescence
- The concept of working with whole populations, groups at risk and individuals
- A full range of interventions including health promotion, prevention, early intervention, treatment, rehabilitation and long-term care
- All levels of care, including primary care (general practitioners, school counsellors, community health centres, etc), secondary (specialist) care, and tertiary care (for the most complex, rare and severe problems).

This type of service model is illustrated in Table A-1 or alternatively as in Figure A-1 (See Appendix A). A population approach to mental health would improve the quality of mental health for a large percentage of the population. However, the incidence of mental health problems and mental disorders will not be eradicated completely. Research has indicated that optimum mental health care is more effectively achieved by providing the full range of interventions (mental health promotion, prevention and treatment) in a flexible combination, which can be adjusted in response to community needs. Therefore, it is recognised that specialist treatment services will always be an essential element within this type of service model or strategic framework.

The CYMHS specialist service (depending on its location) needs to have access to a number of the following mental health service components from their zone:

- Community Teams
- Consultation Liaison
- Day Treatment Programs
- Forensic Service
- Inpatient Child beds
- Inpatient Adolescent beds
- Links to all Universities
- Links to Training and Development in Brisbane
- Outreach to Rural areas
- Research
- Rural Health Training Units
- Supervision

Based on bed planning guidelines, many of the networks do no have sufficient population to warrant dedicated inpatient units. Consequently, if there is demand for acute adolescent admissions, creative solutions will need to be sought. Acute admission may sometimes require transfer away from local Districts, which does not result in providing care in the local environment. Admission to adult inpatient units is sometimes used, but is not always a suitable alternative. Partnerships with paediatric inpatient units in local general hospitals can be also be explored as an option. Both options of admissions to paediatric units or adult units needs to involve appropriate child and youth mental health training and support being provided to the inpatient staff.

DISCUSSION POINT: Full Range of Services for CYMHS

Please comment on the advantages and disadvantages in adopting a population health approach to the delivery of mental health services.

With reference to the mental health service components outlined on page 14, please comment on:

- How your CYMHS has negotiated access to the relevant mental health service components
- What difficulties your CYMHS has encountered in obtaining access to relevant mental health service components and some suggested solutions for these difficulties

Other Comments

7.3 SERVICE DELIVERY

Child and Youth Mental Health Service (CYMHS) staff need to be able to undertake a systematic comprehensive diagnostic evaluation, formulate a biopsychosocial diagnosis, design a goal-directed treatment plan, and negotiate the diagnostic formulation / treatment plan with the family in such a way as to cement a treatment alliance.

The sequential clinical processes undertaken by mental health clinicians are as follows:
1. Referral
2. Intake
3. Diagnostic evaluation
4. Diagnostic formulation
5. Treatment planning (including discharge planning)
6. Negotiation of the diagnostic formulation and treatment plan with the client and family
7. Implementation of treatment (including evaluation of treatment outcomes)
8. Discharge with referral back to referring agent or other service as appropriate

Statewide standardisation of some of these clinical processes will be necessary to ensure the ability to validly benchmark data from different CYMHS across the State.

REFERRAL, INTAKE AND ASSESSMENT PROCESSES

This section corresponds to the access and entry standards of the National Standards for Mental Health Services. It requires services to demonstrate their ability to be available for the client. For smaller service sites, this requires some creative thinking and collaboration with other services (ie adult mental health service, local hospital for emergencies etc.).

The first point of contact is also viewed as the first point of intervention that can influence future interventions, therefore the intake process should be provided by clinicians skilled in mental health triage. In rural and remote areas where specialist child and youth mental health services are not readily available, health professionals must have the knowledge base to ensure appropriate referral and to seek crisis intervention should that be necessary.

<u>Emergency Response</u>
People who develop mental health problems often present in a crisis or urgent situation, where lives of individuals may be at risk. The current size of child and youth mental health services limits the capacity for all services to provide the full range of services including urgent and crisis response, which include:
- extended-hours
- 24-hour crisis response
- urgent response capacity in community clinics
- acute and mobile intensive treatments
- short term acute inpatient treatment

It will not be within the capacity of all services to provide these components. However, services linked across the networks and zones should cooperate to provide the full range of responses. All health sites should identify the strategies within their networks and zones and articulate clear statements to their communities about the responses they provide. These include arrangements for extended hours or crisis response that may be combined with adult mental health services and emergency departments of local hospitals.

Referral

Referral processes need to be clear so that at intake a decision can be made to:

- give priority to the most seriously disturbed children and young people and those most at risk for developing severe disturbance and to
- manage less severe levels of disturbance by providing consultation, education, training and support to others in direct contact with the child or young person.

The Future Directions for Child and Youth Mental Health Services policy states that "in most cases it is preferable that clients access the service through a referring agent such as a general practitioner, guidance officer or youth worker. However, in situations of acute need, service responsiveness requires that families or individual youth can directly access the service" (page 5).

Intake

At intake, the clinician elicits from the referring agent, the client/carer and other relevant sources, data regarding the following issues:

- Identifying information
- Referral agent details
- Reason for referral
- Duration of problem
- Severity of problem
- Acuity of problem/imminent risk
- Family structure/supportiveness/protectiveness
- Previous mental health/medical/educational evaluations or treatment

At intake one of the following triage decisions is made:

1. *If the reason for referral does not reflect a mental health problem* (eg., the child is referred for a mild behavioural issue), the case will be referred to the relevant community agency (eg., to the local Community Child Health Clinic for completion of a Triple P Program).
2. *If the mental health problem is not severe* (see Table 1), the case may be referred, for example, to a general practitioner, school guidance counsellor, Community Child Health Clinic, or Non-Government Organisation (NGO).
3. *If the mental health problem is severe*, the case will be accepted for evaluation. *High-acuity cases* (see Table 2) need to be evaluated at once (within 24-48 hours) with regard to disposition. Some acute cases will require *immediate hospitalisation*. Others will require intensive (eg., daily) *community crisis management,* in some instances with *respite* for the family other than hospitalisation.
4. *If the case is severe but not acute* (see Tables 1 and 2), it will be accepted for diagnostic evaluation. Generally speaking, an appointment will be made as soon as possible (within 10-15 working days). Where practicable, the clinician that has undertaken the intake/triage assessment will proceed to complete the diagnostic assessment/evaluation.

Table 1. Indices of Severity

- The client has many symptoms that may present in multiple domains
- More than one of these symptoms are described as marked and persistent
- The symptoms are associated with marked impairment of functioning either at home, and/or in school, and/or with peers, and/or other environments (eg workplace, TAFE)
- The symptoms and impairment have been present for longer than one month
- There is limited personal/families/community resources to provide support

Table 2. Indices of Acuity

- Suicidality
- Self-injuriousness
- Aggressive behaviour
- Markedly provocative behaviour
- Marked impulsiveness or risk-taking
- Marked destructiveness (including fire-setting)
- Food or fluid restriction involving severe loss of weight, dehydration, or electrolyte imbalance
- Refusal to comply with medical treatment for a potentially lethal medical condition (eg., diabetes mellitus)
- Thought or perceptual disorder (eg., hallucinations, delusions, or disorganisation of thinking and judgment)
- Severe dysphoria, abnormal elevation of mood, panic, or psychomotor retardation
- Intoxication with alcohol or drugs or uncontrolled alcohol or substance abuse if associated with other indices
- Severe impairment of sensory or motor functioning thought to be non-organic in origin

Assessment

The historical model (based on the medical model) promoted through the Child Guidance system in Australia was that treatment commenced only after a comprehensive and thorough bio-psychosocial, development and cultural approach to assessment, which often included intellectual assessment, speech and language assessment, and physiotherapy assessment. It is now considered that this traditional form of assessment pays limited attention to the contextual issues in the client's life or its possible role in treatment. Additionally, such an assessment model is no longer appropriate for the majority of clients presenting to contemporary child and youth mental health services offered in the public health system. This is particularly evident when the presenting problem is a crisis. On the whole families who have reached the point of referring are looking for a more immediate response. This is reflected in many of the more contemporary models that combine assessment and treatment.

Most evaluations of child services suggest that clients only attend an average of three to six sessions. Hence it is important that a clinician can gather relevant information, develop a tentative formulation and an initial treatment plan in 1-2 sessions. If additional assessments were required these would occur in parallel with intervention.

The process of working with the client and the wider system should not be viewed as an optional adjunct to treatment, but as part of the therapeutic act itself. For example, involving depressed clients in the identification of key individuals who may support their treatment in the community may, in itself, result in an alleviation of symptoms and enhanced maintenance of desired change. Hence the client and family's involvement in developing the treatment plan and having an understanding of the formulation of the presenting problems is important for the consequent working therapeutic alliance and commitment to treatment interventions.

DISCUSSION POINT: Referral, Intake and Assessment Processes

How has your CYMHS implemented a secondary referral model with the flexibility of allowing young people and families to self-refer in mental health crises?

What ideas do you have for emergency response options for CYMHS in regional, rural and remote areas of Queensland?

Does Table 1 adequately capture the key indices and criteria for defining severity?

O Yes O No – Please outline reasons and suggest alternatives:

Does Table 2 adequately capture the key indices and criteria for acuity?

O Yes O No – Please outline reasons and suggest alternatives:

For each of the following items please comment on:

- How your CYMHS has implemented the triage decision and
- Any difficulties your CYMHS has encountered in implementing the triage decision along with possible solutions

a) Referring elsewhere if there is no mental health problem evident

b) If not severe, referring to other services and assisting those services by providing consultation and liaison services

c) If severe and acute, assessing in 24-48 hours

d) If severe and not acute, assessing within 10-15 working days

How has your CYMHS ensured that cases are provisionally assessed, formulated and have a draft treatment plan developed in 1-2 sessions? Discuss any difficulties your CYMHS has encountered with this along with possible solutions.

Other Comments

CONTINUING TREATMENT AND CASE MANAGEMENT SERVICES

Continuing treatment and case management follows the intake and assessment process. To deliver appropriate mental health services a CYMHS needs to:

- Take account of the different family, social and cultural contexts of patients in planning and delivery of interventions, and be flexible with regard to their place of contact.
- Provide individualised services according to the specific disturbance, developmental status, and attributes of the young person, and the strengths and limitations of their caretakers.
- Involve parents and young people in the design of treatment programs, which are provided in the least restrictive environment consistent with effective treatment and safety.
- Assure patient confidentiality without obstructing effective cooperation between professional staff providing services to children and their families.
- Be coordinated with health, welfare and education services in ways that ensure that children and young people have access to the particular mix of services they require.
- Undertake such training and staff development to enable CYMHS professionals to apply a range of therapeutic approaches, which are sensitive to the needs of young people.
- Ensure efficient and effective use of resources to provide a range of support and intervention services which are timely and achieve quality outcomes.

Community Treatment Services

Ongoing treatment needs to occur in the most appropriate and least restrictive environment. In most cases, clients would receive community based treatment services. The *Future Directions for Child and Youth Mental Health Services* Policy states that these include:

- Clinic-based services, outpatient services, domiciliary and other visiting services
- Outreach in the context of children and young people's everyday lives eg. Outreach to schools, youth services
- Specialist individualised programs for specific disorders
- A range of outcome-focussed interventions
- Intensive treatment and support using case management approach for young people with severe disturbance and mental disorders
- Outreach services to smaller communities, including rural and remote communities

Consultation and Liaison Services

Consultation and liaison services can occur in conjunction with the delivery of an intervention for a particular client or more generally to develop partnerships or progress mental health promotion, prevention and early intervention aspects of the mental health plan framework. Consequently, The *Future Directions for Child and Youth Mental Health Services* Policy states that consultation-liaison services can include:

- Consultation and liaison services provided to hospitals, general practitioners, youth services etc.
- Interagency liaison and joint case management
- Input to interagency program planning and delivery and community development activities
- CYMHS services linked with respite, supported accommodation options, and therapeutic fostering and day-relief services
- Education and training of community workers in mental health issues including understanding mental illness, detection and referral

Acute Treatment Services

The *Future Directions for Child and Youth Mental Health Services* Policy states that these include:

- Day Treatment Services – a structured day only treatment program which provides intensive treatment for brief or extended periods
- Acute inpatient services provided on a 24 hour basis – periods of hospitalisation to be kept to a minimum, age-appropriate environment either in a dedicated children's mental health inpatient unit or access to general paediatric beds for children or dedicated youth mental health unit or allocated mental health beds in adults wards for young people. Capacity to provide care and treatment for those at higher risk of harm to self or others according to the requirement of the Mental Health Act for involuntary treatment
- Partial Hospitalisation – Step down service for ongoing stabilisation after acute inpatient treatment, before receiving ongoing treatment in the less intensive continuing treatment component.

Inpatient services provide 24 hour acute treatment during an acute episode, in a structured environment, as part of a longer-term treatment plan. Admissions occur when the presenting behaviour cannot be safely managed in the community, or when treatment cannot be managed at a less intensive level (see Table 3 for an admission criteria for hospitalisation of a child or young person). Access to inpatient beds will only be available following assessment and referral by specialised child and youth mental health staff. This may occur as an elective admission or as a crisis assessment in emergency departments.

Inpatient services require appropriately trained staff to ensure safety and high quality acute treatment. Models of practice will incorporate the normal routine of young people wherever possible. Treatment goals will be clearly stated with appropriate strategies, responsibilities and timeframes. Discharge planning and community team involvement will be an integral part of the care plan. Day treatment may be an alternative acute treatment option where the client is well enough to sleep overnight at home but still requires more intensive daily treatment.

Extended Treatment

The need for extended inpatient treatment in child and youth mental health is not extensive. Acute treatment in community settings that support the maintenance of normal routines and functioning and minimise trauma and disruption is the treatment of choice. However, it is recognised that in a small number of cases there is a need for an extended care program. The nature of such a program requires further investigation.

Currently Queensland Health has one youth extended inpatient treatment facility (Barrett Adolescent Centre) located at Wolston Park Hospital. Young people admitted to the Unit from areas outside of Brisbane are dislocated from their families, support network and social environment which is contrary to the objectives of the *Ten Year Mental Health Strategy for Queensland*. The lack of facilities beyond the South-East corner further disadvantages rural and remote areas where no youth acute or extended inpatient facilities are available.

Table 3. Criteria for Hospitalisation

1. GENERAL CRITERIA

Each of the following criteria must apply:

1.1 The patient suffers from a psychiatric disorder, which could potentially be helped in a CYMHS inpatient unit, and which is of sufficient severity to warrant treatment at the most intensive level of care. *Excludes uncomplicated conduct disorder or adjustment disorder (unless special cited circumstances apply). Care should be taken to exclude antisocial youth whose legal counsel is seeking to use hospitalisation as a way of avoiding legal action or mitigating offences.*

1.2 Less intensive levels of appropriate care have failed following a sufficient trial, or would be clearly inadequate. *Excludes referrals where only an excessively brief or clearly inappropriate treatment trial at a less intensive level of care has occurred*.

1.3 The patient is severely dysfunctional in home, school or community to such a degree that is impossible for the parents and community to manage him or her safely. *The degree of dysfunction may be proportionately less if the level of dysfunction is being impacted upon by family or community lack of personal or professional resources.*

1.4 The patient is within the age range of 3 through 18 years, unless specially cited exceptions apply. *For example, a developmentally immature patient over 18 years of age may be more appropriate for an adolescent unit.*

2. SPECIAL CRITERIA

One or more of the following criteria must apply:

2.1 The patient is dangerous to self or others or at serious risk of physical harm to self or others or of damaging property. *Requires documentation of serious homicidal or suicidal intent in the form of acts or statements seen or heard by the clinician or a reliable observer. Requires documentation of serious risk of causing or sustaining harm or of causing damage, as a consequence of the following conditions: impaired reality testing; physically provocative behaviour (eg, behaving in a threatening manner to peers or authority); the propensity to get involved in risk-taking behaviour (eg., reckless running away from home); deliberate self-injury; self-injurious urges or ideation; the urge to harm others or damage property; hallucinations which instruct the patient to harm self or others or to damage property; fire-setting; the refusal to eat adequate food or drink sufficient fluid; or persistent self-induced vomiting.*

2.2 The patient irrationally refuses medical treatment for a potentially life-threatening condition. *Typically involves the psychologically determined refusal to comply with medical treatment for medical conditions as diabetes mellitus, epilepsy, or haemophilia.*

2.3 The patient is at risk of protracted or irreversible psychological impairment or deterioration unless he or she is under close observation and in intensive treatment in a hospital environment. *Typically associated with one or more of the following: marked psychomotor retardation; severe dysphoria (eg., depression, anger, paranoid mood); gross impairment of judgment; disorganising excitement, agitation, panic, or fear; hallucinosis; delusional thinking; or sensorimotor impairment that has no organic basis and is not purely related to substance abuse.*

2.4 Other. *This category is designed to include any condition not described above that fulfils the general criteria and which would warrant intensive observation, diagnostic evaluation, and treatment in a restrictive hospital setting. For this special criterion to apply, the particular circumstances should be cited in detail.*

DISCUSSION POINT: Continuing Treatment and Case Management Services

Does Table 3 adequately capture the key indices and criteria for hospitalisation?

O Yes O No – Please outline reasons and suggest alternatives:

Do you have any comments or examples/ideas of specific innovative approaches to delivering/accessing the services detailed under:

a) Community Treatment Services?

b) Consultation and Liaison Services?

c) Acute Treatment Services?

d) Extended Treatment?

Other Comments

CONSENT TO TREATMENT

Ideally, a service will have the consent of the parent and child/young person before proceeding with a treatment plan. The ability for a child or young person to give consent in Queensland is based on a clinical judgment of the individual's development of maturity and understanding. Clinicians must clearly identify and document the basis of these decisions in the clinical file.

In certain circumstances, the Gillick's Test should be used to determine if a child or young person of less than 16 years of age is competent to consent to medical treatment without parental knowledge. To determine whether a child or young person is "Gillick competent" to provide consent it must be shown that they are:

- Able to take in all relevant information,
- Able to weigh up the information,
- Able to make a personal decision judgement, and
- Willing to stand by their decision no matter what the consequences (taking into account emotional, physical, and spiritual/cultural consequences)

It is less clear whether a "Gillick competent" child or young person can refuse treatment. The rights of parents or guardians cannot be dismissed lightly. All decisions must be clearly documented in a manner that is defensible in a court of law.

Effective treatment for young people takes into account the context of the client's life and those involved in it. The rights of parents or guardians should be suspended only where they are unwilling or unable to protect and the young person is placed at risk of harm.

There are also times when it may be necessary to utilise the provisions of the Mental Health Act 2000 to request an involuntary assessment with the view towards seeking an involuntary treatment order.

DISCUSSION POINT: Consent to Treatment

How has your CYMHS ensured staff are aware of the issues in relation to consent to treatment?

Any Comments

CHILD PROTECTION

The area of child protection is important for CYMHS. International statistics indicate that one in three girls and one in seven boys will have experienced unwanted sexual contact before puberty, 7% of females and 1.5% of males will have experienced serious sexual abuse.

As indicated in *The Future Directions for Child and Youth Mental Health Services* policy statement, mental health problems frequently manifest as disturbed behaviour. Clinicians must have a sound knowledge of the aetiology and treatment of abuse and neglect with regards to both the offending behaviour and the symptomatology that is the sequelae of abuse and neglect. Additionally, policies of managing the reporting of abuse and close links with Child Protection Services will also be important.

The Child and Youth Health Policy Unit is currently developing a policy statement and guidelines for Child Abuse and Neglect (0-18 years). The Child and Youth Health Policy Unit sits within the Corporate Office of Queensland Health and was established as part of the Health Outcomes Unit, Health Systems Strategy Branch, in April 1997. Its purpose is to improve the health outcomes of children and young people, recognised as a priority population group for health improvement.

DISCUSSION POINT: Child Protection

How has your CYMHS ensured staff are aware of the issues in relation to child protection?

How does your CYMHS respond to suspicions of child abuse/neglect?

How would your CYMHS manage child abuse/neglect?

Other Comments

SERVICES TO INDIGENOUS PEOPLE

The needs of indigenous populations are recognised as a priority group in Queensland Mental Health Policy (1993) and Plan (1994). The Aboriginal and Torres Strait Islander populations of the State are diverse and should have access to a range of mainstream and culturally informed programs.

The Queensland Mental Health Policy Statement for Aboriginal and Torres Strait Islander People, calls for programs to be culturally appropriate and for the employment of indigenous mental health professionals. Mechanisms for recruitment, training, support, supervision, continuing education and retention of indigenous child and youth mental health workers will be important.

Mental health in indigenous communities needs to be a whole-community concept, where community needs are clearly identified, and strategies to respond are developed in collaboration with the community and service providers.

DISCUSSION POINT: Services to Indigenous People

How can Child and Youth Mental Health Services be made more accessible to Indigenous people?

Do you have any specific innovative approaches or partnerships for delivering services in this area?

Other Comments

OTHER AT-RISK GROUPS

There are a number of other mental health at-risk groups which CYMHS needs to consider when providing mental health services. These include:

- Children of parents with drug abuse issues
- Children of parents with a mental illness
- Co-morbidity with acute and chronic illness, physical disability, intellectual impairment,
- Distressed infants
- Gay and lesbian youth
- Homeless youth
- Self-harming youth
- Socially disadvantaged youth (including those in care or in contact with the law such as in Detention Centres)
- Special cultural groups
- Substance Abusing Youth
- Suicidal Youth
- Trauma Victims (including abuse and neglect)

A combination of developing specific programs (which has been utilised in other States), working collaboratively with other services or other creative solutions may be required to ensure that these groups are not overlooked in receiving mental health input when appropriate.

DISCUSSION POINT: Other at-risk Groups

Do you have any specific innovative approaches or partnerships to delivering the services to these groups?

Other Comments

7.4 A SKILLED WORKFORCE

Professional Development

It is acknowledged that current undergraduate training programs do not adequately prepare the allied health disciplines for work in mental health services. It can be argued that it is not the role of undergraduate education to train students for clinical work. However it is also arguable that post-graduate training in Universities does not adequately prepare mental health clinicians. The needs of a mental health workforce are very specific. Child and Youth Mental Health Services represent a dynamic field with much innovation. Post-graduate courses can only provide a foundation.

In some professions, current undergraduate and postgraduate courses lack the critical clinical focus required to develop effective clinical practice for a small specialty such as child and youth mental health. The number of professionals recruited to the specialty of child and youth mental health are insufficient to warrant a full post-graduate program in each of the defined specialist groups.

It is widely recognised that skills and knowledge required by clinicians are not necessarily contained within universities. There is a broad range of skills and expertise available within services, both government and non-government, professional associations, independent training bodies, and within universities.

The need for comprehensive training and development is imperative. This involves standardised training in therapeutic approaches such as Cognitive Behavioural Therapy, Behavioural Management, Family Therapy, Group Therapies, Brief Therapies, and training in the kind of interventions necessary to provide effective treatment in special situations, (eg. child maltreatment, eating disorders, substance abuse, and homelessness).

The Professional Development Strategy will facilitate access to the development of appropriate training materials for child and youth mental health professionals. Wherever possible joint training programs with child psychiatrists should occur, which would result in economies of scale and foster understanding and appreciation across all disciplines.

Staff Recruitment and Retention

Child psychiatry training is well established under the mandate of the Australian and New Zealand College Psychiatry, however the number of trainees is small and ongoing problems exist in the area of recruitment and retention.

The recruitment and retention of experienced child and youth mental health clinical staff is also a serious problem outside the metropolitan area. There are limited mechanisms in place to support isolated workers and promote clinical expertise.

As well as training and recruitment issues, the challenge of staff retention and support also needs to be considered. The development of a career structure within child and youth mental health services alongside clinical and non-clinical supervision are some areas requiring expansion.

Queensland Health has developed a coordinated and strategic approach to mental health workforce planning and management to ensure that there are skilled staff to meet the requirements of the Ten Year Mental Health Strategy for Queensland 1996. This approach, detailed in the Framework for the Development of the Future Mental Health Workforce in Queensland, places an emphasis on issues of workforce leadership, capability and performance, and organisational climate. A Mental Health Workforce Steering Committee was established to guide this process and has now evolved into a Reference Group to further this development.

Supervision

The Health Advisory Unit (Allied Health) has out-sourced a project to a consortium of University Allied Health departments to undertake a research evaluation of professional supervision and mentoring of Allied Health professionals in Mental Health Services. Supervision is defined as a working alliance between two or more professional members where the intention of the interaction is to enhance the knowledge, skills and attitudes of at least one staff member. The overall aim is to increase the quality and autonomy of professional practice and to achieve the goals of the organisation in a manner in keeping with the ethical, professional and best-practice standards of both the organisation and the specific profession. In order to achieve these goals, supervision aims to bring about positive changes in clinical and administrative practices, and provides a personal support function to the employee (See "Supervision Practices in the Allied Mental Health Professions: How much do we know?" Authors: Prof Susan Spence, Assoc Prof. David Kavanagh, Prof Bruce Murdoch, Prof Jenny Strong, Dr Jill Watson, Jenny Krasny).

The aim of the project is to develop and partially implement a model of professional supervision and mentoring that is acceptable to all stakeholders. The first phase of the project:

- Identified current supervision practices in the allied health workforce in mental health services across Queensland;
- Developed a model for supervision and supervision training;
- Trialed and evaluated supervision training for supervisors and supervisees
- Developed a policy and guidelines for supervision.

The second phase of the project is continuing with evaluation of and repeat aspects of the first phase and will evaluate client and workforce outcomes. It also extends beyond allied health to the medical and nursing professionals.

DISCUSSION POINT: Skilled Workforce

What ideas do you have for improving the recruitment and retention of CYMHS staff (medical, nursing and allied health) in metropolitan, regional, rural and remote areas of Queensland?

What are the barriers to providing and accessing good supervision?

Other Comments

7.5 RESEARCH AND EVALUATION

Services are required to focus on clinical outcome, to demonstrate the effectiveness of services and interventions, and to base clinical practice on sound research evidence. Queensland Health endorses the use of evidence-based approaches for CYMHS interventions. Unfortunately the evidence for treatment efficacy in child and youth mental health is relatively poor and more work is required in this area.

Research is the tool which keeps service delivery at the cutting edge, and responsive to the needs of the community. Therefore CYMHS must also have the capacity to undertake service research within Queensland. Randomised Control Trials (RCT) are the 'gold standard' for the evaluation of specific interventions. However these are not the only type of research designs as researchers become more innovative in their use of quantitative and qualitative methods of research to more accurately replicate "real life" situations of complexity when evaluating interventions. Additionally, research can begin from the simple process of identifying a question that a clinician believes is worth exploring further. Processes for supporting clinician initiated research at the service level needs to be explored further.

The movement towards a health-outcomes focus coupled with demands that services should be accessible and responsive, and that interventions need to be timely and effective, will place additional responsibilities on services to justify their approach to service delivery. CYMHS services need to ensure ongoing review of quality management practices defined by *The National Standards for Mental Health*, in preparation for the implementation of an outcome measurement system.

In a report on consumer measurement systems for child and adolescent mental health, Bickman et al, 1999 stated: "The quality of mental health services should be evaluated not in accordance with the number of people served, but rather in terms of the effectiveness of those services. A recent survey of Australian children and adolescents (Zubrick et al., 1995) reveals that relatively few of those with mental health problems had had contact with specialized mental health services in the previous six months. This underutilisation may be partially explained by the relative paucity of existing services. Mental health services for children and adolescents are seriously under-resourced. The shortage of resources may be partially remedied by more efficiently utilizing available assets. Measurement systems have the potential to assist policy makers in the effective reallocation of existing resources. Armed with reliable data concerning service effectiveness, policy makers and administrators will be able to decide rationally how best to allocate resources for the needed expansion of services for children and adolescents. The effectiveness of services is most reliably assessed by the use of standardized measures. However, to be optimally used measurement systems should be integrated into clinical services and policy decisions" (page 1, Bickman, Nurcombe, Townsend, Belle, Schut, & Karver, 1999).

The Commonwealth has allocated funds to be used for information infrastructures as recommended in the *National Information Priorities and Strategies under the Second National Mental Health Plan.* At present, progress in the use of outcome measures in child and adolescent services varies across the states and territories, with the majority progressing slowly. A National Child and Adolescent Health Outcomes Group has been established to facilitate progress across Australia by providing high quality advice on how to implement an appropriate consumer measurement system. In addition, funding has been provided to all jurisdictions (states and territories) to commence a process of

implementation of routine collection of consumer outcome measures in child and adolescent mental health services.

Mental Health Unit (Corporate Office) will coordinate the implementation of the Queensland Health Mental Health Information Development Plan (MH-IDP), funded through the Commonwealth program. Through the MH-IDP, training will be provided to all child and youth mental health service providers in the outcome measures that will be endorsed for the national collection. The National Child and Adolescent Health Outcomes Group have recommended the Health of the Nations Outcome Scales for Children and Adolescents (HoNOSCA) to be completed by clinicians and the Strengths and Difficulties Questionnaire (SDQ) as the consumer self-report measure. The Children's Global Assessment of Functioning Scale (CGAS) will be included as a case complexity measure for the casemix classification component of the project. It is anticipated that implementation of the measures will be phased into routine clinical practice over the next financial year.

DISCUSSION POINT: Research and Evaluation

What would assist you in being able to conduct clinical research as part of regular service delivery? (Please tick and comment below)

O Identifying research ideas/questions to explore further? – please comment

O Specific resources (such as time, support)? – please comment

O Training (such as in statistics, research design)? – please comment

O Other (Specify)?

What activities (at a local or statewide level) would assist your CYMHS in the implementation of outcome measurement systems?

Other Comments

8.0 PARTNERSHIPS IN MENTAL HEALTH SERVICE DELIVERY

8.1 LINKAGES

The *Future Directions for Child and Youth Mental Health* policy statement identifies a number of community services and recommends the development of links to clarify mutual expectations and to standardise referral channels. Further developments in mental health strategic planning have expanded the principles of partnerships to include more than relationships of mutual understanding and referral processes. The concept of partnerships embraces both the treatment framework and the relationships between and amongst agencies. It promotes partnerships in treatment with the caring network, which may include general practitioners, education staff, primary health care providers, government, and non-government agencies, all of whom collaborate to promote and sustain change, and prevent relapse.

Individual level

The Future Direction for Child and Youth Mental Health Services policy statement notes that 'the social context of young people has a powerful influence on the onset, expression and remission of psychiatric disorder, working with families, schools and communities is a central part of treatment approaches. Effective case management practices will ensure that carers and other service providers are appropriately involved in treatment planning and service delivery'. *The National Standards for Mental Health Services* identifies the need for a family centred approach and relapse prevention strategies to maximise support to the client and decrease the sense of isolation which mental health problems can invite. Mobilising the caring network and inviting partnerships in treatment are key components in relapse prevention.

Organisational level

The *Second National Mental Health Plan* determines that mental health care is the responsibility of the entire health care continuum. Levels of responsibility are defined across primary, secondary and tertiary health care. Interventions in the universal range target whole populations utilising mental health promotion strategies. The selected and indicated range provides a combination of promotion and prevention strategies for those groups defined as being at risk of developing serious mental health problems. Early intervention is provided for those who are already experiencing mental health problems to minimise the impact of mental illness and prevent the development of additional problems. To ensure that services are provided in an appropriate and timely fashion, CYMHS need to develop partnerships at all levels within the health care system and with key agencies.

8.2 CONSUMER PARTICIPATION

The consumer is considered a partner, in the true sense of the word, in his/her treatment. The consumer no longer comes to services to have treatment provided by specialist services in an unequal relationship. It is now recognised that consumers can and should participate, and take responsibility for their own treatment. In many cases consumers are able to provide insights and possible solutions to their own problems.

Children and young people rarely refer themselves for treatment and often attend with a degree of reluctance. Adults or parents, acting as referral agents on behalf of the child or young person, usually initiate referral to specialist mental health services. The process of mental health reform acknowledges and invites both the child/ young person and his/her parents or care-givers to be partners in treatment, each defining his/her own treatment goals, which can be but are not necessarily the same.

Individual level

Assessment and treatment approaches need to be implemented in a manner that promotes collaborative and mutually respectful partnerships with the client and their family. The focus of assessment is to assist the client in the identification of treatment goals. The focus of treatment is progress towards the attainment of identified goals. On referral to the services clients and their families must be informed of their rights, consent to treatment, and principles of confidentiality. Client satisfaction measures should be incorporated into the consumer measurement outcome system

Organisational level

The National Standards identify the need for consumer participation in planning, delivery and evaluation. It is the responsibility of all service delivery sites to ensure consumer participation occurs at all levels of service delivery. Unlike adult services young people who attend CYMHS rarely attend for extended periods of time, which creates a difficult situation when consistency of participation is sought. Once the problem is resolved young people are usually reluctant to continue contact. A problem resolved is no longer a priority for them. Solutions for maintaining contact need to be sought in creative ways, such as holding focus groups around particular issues. Solutions to this problem should be sought through consultation with young people.

DISCUSSION POINT: Consumer Participation

What ideas do you have for increasing consumer participation in Child and Youth Mental Health Services?

Other Comments

9.0 MENTAL HEALTH PROMOTION, PREVENTION AND EARLY INTERVENTION (MHPPEI)

Child and youth mental health services will focus on collaboration with primary health care providers in the promotion of mental health, and prevention and early intervention for those children and young people who have, or are at risk of developing a mental illness. Interventions will aim to prevent the development of more serious problems, to incorporate the support of the client's social network in sustaining change over time, and preventing relapse.

The *Second National Mental Health Plan* has led to an increased recognition that effective mental health service delivery should incorporate the full range of mental health interventions. However, provision of all levels of mental health interventions is not necessarily the responsibility of specialist mental health services alone. It is widely recognised that community organisations such as schools and community health centres are more appropriately placed to provide ' whole of community' mental health promotion and prevention activities.

The spectrum (see Appendix B) encapsulates the range of mental health activities from population-level interventions that promote and support well-being through prevention, to individualised mental health treatment and aftercare. The range of invested parties and professional groups also varies across the spectrum, from whole of government and primary health care, to specialist mental health services as per a population mental health approach model (see also Appendix A).

DISCUSSION POINT: MHPPEI

What ideas do you have for programs that involve either mental health promotion or prevention or early intervention in child and youth mental health services?

What opportunities do see in your District for working in partnership with other services to support and/or facilitate programs in the area of: -

a) Early Identification of Mental Health Problems

b) Mental Health Promotion

c) Improved Mental Health Literacy

Other Comments

APPENDIX A

Table A-1: Child and Youth Mental Health Service Model

Focus of Activity

Population

- Epidemiology: 14-18% of children affected
- Risk and protective factors
- Prevention and health promotion
- Monitoring population outcomes
- Working in partnerships

Individual

- Assessment and diagnosis
- Individual care plans and treatment
- Discharge planning and follow-up
- Individual outcome monitoring
- Working in partnerships

Components of Care

*Note: * denotes principal programs*

Mental health Promotion

- Generic, eg. Schools

Prevention*

- Conduct disorder
- Anxiety and depression
- Children of parents with mental illness
- Suicide prevention

Early Interventions*

- Depression and anxiety
- Psychosis
- Co-morbid depression and anxiety
- ADHD
- Eating disorders

Emergency Care

- Acute disturbance
- Suicide risk

Case Identification and Treatment*

- Conduct disorders
- Anxiety/depression
- More complex, eg OCD

Acute Treatment

- Community unless high risk

Recovery/Rehabilitation*

- Development
- Family
- Social
- Education

Long-term/Chronic Management

- Sustaining function/development

Maintenance

- Preventing further deterioration
- Living well with chronic disorder
- Quality of life

Levels of Care

Primary Care-community-based

Workforce

- General practitioners
- Maternal and child health nurses
- Youth health services
- Community health
- Teachers/school counsellors
- Paediatricians
- Aboriginal health workers
- Non-government sector

Functions

- Contributing to prevention partnerships
- Assess and manages simple disorders
- Refers complex and works in partnership for management

Secondary Care-specialist child, adolescent and family mental health workers – community-based

Workforce

- Nurses
- Psychologists
- Social workers
- Registrars
- Psychiatrists
- Paediatricians
- Other professionals, eg OTs, speech pathologists
- School link – education/school partnerships
- Specialist non-government services

Functions

- Backs primary care
- Partnerships for spectrum of care
- Assesses and may treat most complex disorders eg. Co-morbidity, life risk
- Educational recovery through education/school-based program components
- Consultation/liaison to general primary health care, child and adolescent general health care

Tertiary Care – specialist child and adolescent mental health services – inpatient and specialist clinics

Including specialist assessment and treatment programs: neuropsychiatric disorders, eating disorders

Workforce

- Nurses
- Psychologists
- Social workers
- Registrars
- Psychiatrists
- Paediatricians
- Other professionals, eg OTs, speech pathologists
- School linkages and liaison

Functions

- Backs secondary care
- Partnerships for spectrum of care
- Assess and may treat referred complex rare disorders

Partnerships

- Carers, families and consumers
- Child care, pre-schools and primary and secondary schools
- Non-government sector (including volunteers)
- Health and other government services (eg child and adolescent health, welfare, child protection, juvenile justice)

Source: Raphael (October, 2000) p.41

Figure A-1: Supporting Health Outcomes for Children and Young People across the health continuum

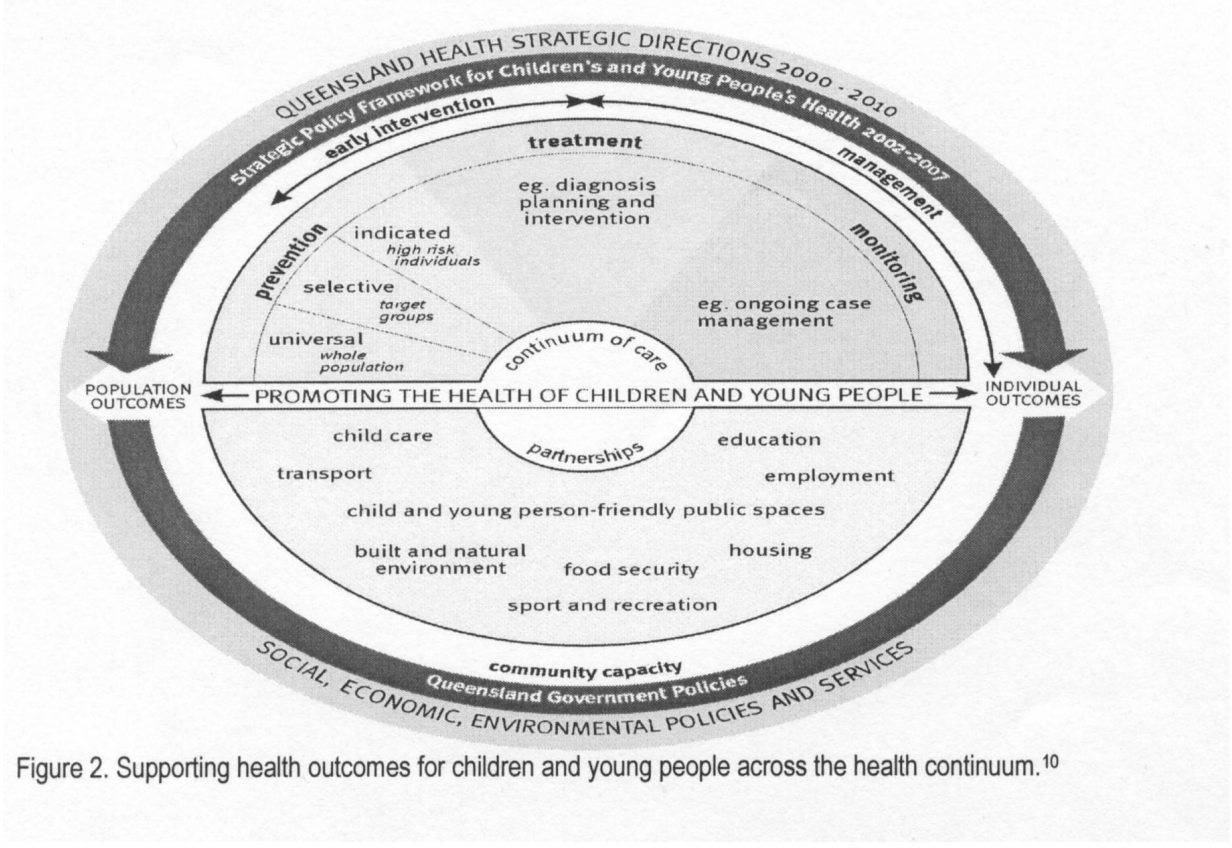

Figure 2. Supporting health outcomes for children and young people across the health continuum.[10]

Source: Promoting Health with Schools: A Queensland Health Position Statement (Draft) p.10

APPENDIX B

Figure B-1: Spectrum of Mental Health Interventions

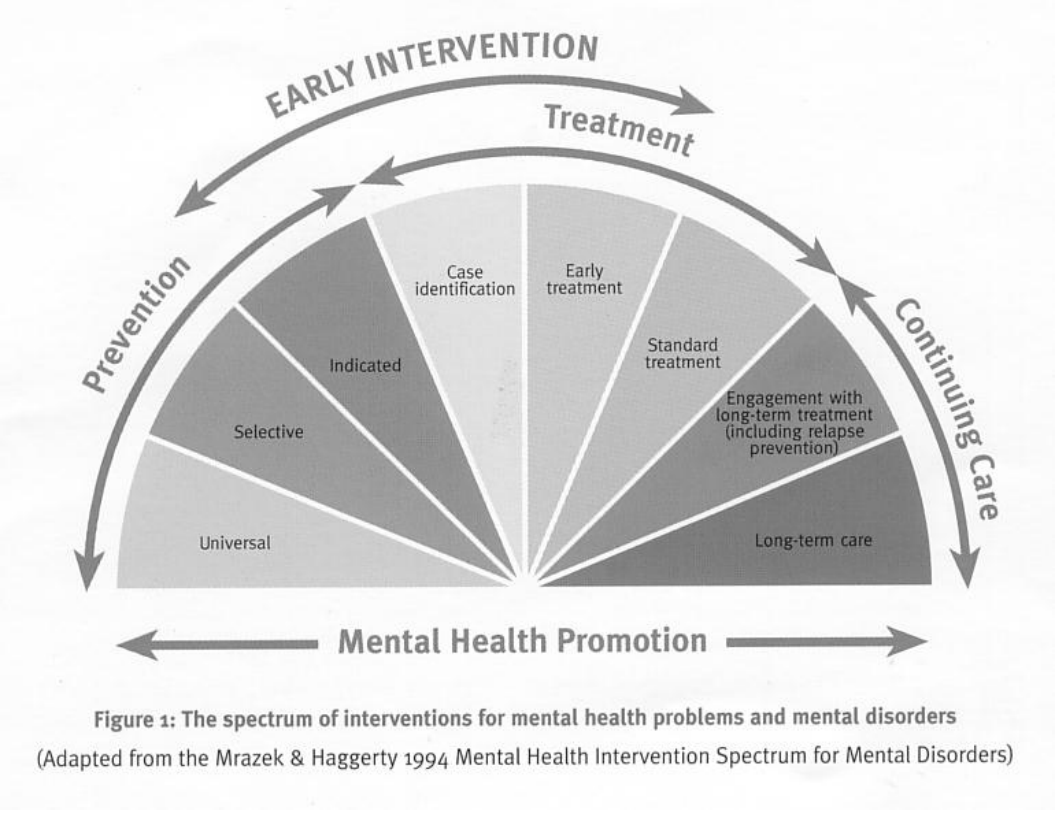

Figure 1: The spectrum of interventions for mental health problems and mental disorders
(Adapted from the Mrazek & Haggerty 1994 Mental Health Intervention Spectrum for Mental Disorders)