Western Australian Child and Adolescent Mental Health Services Advisory Committee submission to the Senate Select Committee on Mental Health

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The West Australian Child and Adolescent Mental Health Services Advisory Committee (CAMHSAC) is made up of representatives of the public child and adolescent mental health sector in Western Australia and acts as an Advisory Committee to the Division of Mental Health of the Department of Health (WA). This submission from the West Australian Child and Adolescent Mental Health Services Advisory Committee is in response to the Senate Select Committee on Mental Health's inquiry and addresses the terms of reference. The opinions provided are those of the Committee and may not reflect the opinions of all clinicians in the sector or the WA Department of Health.

Executive summary:

The current funding of CAMHS in WA is inadequate to meet the national standards for mental health.

The exclusive focus on clinical care for acute presentations as a result of inadequate resourcing has a negative impact on the capacity to respond to:

- Special needs and disadvantaged groups;
- Early intervention and prevention;
- Education and research;
- Development of new models of care;
- Facilitating links with other organizations and service providers involved in the care of children and adolescent with mental disorders including government and non government services;
- Improving the capacity of primary health care providers;
- The need for adequate outcome evaluation;
- The need for the development of effective coordinated emergency services for children and adolescents.

Responses to the terms of reference:

a. the extent to which the National Mental Health Strategy, the resources committed to it and the division of responsibility for policy and funding between all levels of government have achieved its aims and objectives, and the barriers to progress;

For a number of years CAMHSAC has advocated the development of a statewide coordinating body with policy and planning functions specifically dedicated to the mental health needs of children, adolescents and their families/carers. The child and adolescent mental health sector is frequently the poor cousin to mental health services for adults which operate with greater political imperative due to high profile public concerns about emergency and inpatient services for adults. Consequently the policy intent of moving downstream into early intervention and prevention is frustrated by the relatively low level of resourcing provided. Child and adolescent mental health services in WA operate with considerable waitlists and little capacity to move resources from the provision of acute services (responding to overwhelming demand for clinical services) and developing dedicated strategies for early intervention and prevention.

The CAMHS sector in WA is frustrated by poor coordination, fragmentation and little cohesion exacerbated by the need to operate within organisational contexts which pay little regard to the specialist requirements of the sector. Enhanced coordination and cohesion would assist with lobbying for adequate resourcing, the provision of appropriately skilled staff through staff development and upskilling, standardization of clinical and other operational procedures to ensure equity of accessibility to a comprehensive range of services for all children, adolescents and their families in WA.

CAMHSAC is constantly frustrated with the inability to attend to these issues due to the absence of capacity to marshal resources given the relative position of camhs providers within the current organizational structure and the demand for acute clinical services. The current organizational structure is based on mental health district's in which CAMHS service leaders report to the local mental health district Clinical Director who are almost always preoccupied with adult mental health services requirements and imperatives. This leads to a tendency to overlook the needs of children, adolescents and their families and carers and to view them as the "next issue" needing attention. "When the needs of adults are fixed then we will attend to the needs of children" This has been the refrain of senior mental health management for decades.

In rural and remote mental health services a programs approach has been adopted with the CAMHs program being run within a generic mental health service usually managed by adult mental health team leaders/mangers/psychiatrists with only CAMHS specialists available by video conference only. This is likely to result in a broad range in the capacity of services to provide specialist CAMHS clinical services particualry in rural and remote areas.

Models for the funding of adequate rural and remote services should be based on a population weighted formula as rural and remote area services frequently perceive that little consideration is given to the needs of rural and remote services for young people.

Tertiary "state-wide" services are not really accessible to rural and remote families as the programs only cater for people who live in metropolitan WA or who can readily access the statewide facilities which are metropolitan Perth based and are run on a Monday to Friday basis. There is little or no suitable accommodation provided for rural family members to be near their children who have been admitted to inpatient facilities.

That inpatient beds in the statewide inpatient facilities (PMH and Bentley hospital) are limited (3 authorised beds at Bentley) resulting in young people being admitted to adult facilities. Recent funding for more authorised beds only went to the adult sector. CAMHSAC would like to see appropriate "youth friendly" beds made available for the 13-25 year olds.

b. the adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care;

The commoditization of clinical services within the current health services paradigm has inadvertently led to the devaluing of relationship development. The current political and economic imperative is to direct resources to clinical activity and to view investment in relationship building as a diversion of funds from clinical activity. Prevention and early intervention strategies are necessarily relationship intensive as they require partnerships and collaboration across the government and non government sectors. A number of small projects based on evidence based practice have taken place in the WA CAMHS sector and demonstrate the potential for effective collaboration in this area. Once again however the culture of silo's is a major restraint which will require significant investment in the development of relationship networks and collaborative ventures and strategies to develop effective joined up government and non government services directed towards population needs.

Current per capita resourcing for community mental health services, whilst difficult to estimate accurately, appears to be distributed according to the developmental status of the population group. That is, mental health services for children and adolescents receive a per capita figure in the mid to late teens ($16 to $17 per capita), mental health services for adults receive a per capita amount equivalent to middle age ($45 per capita) and mental health services for seniors receive a per capita figure equivalent to old age ($65 per capita). These figures reflect the fact that 25% of the population have allocated for their mental health needs approximately 12% of public mental health funding.

The problem of coordination and cohesion (lack of joined-up-ness) is also an issue for clinical and support services. This is highlighted by the prevalence of poorly coordinated and poorly integrated small non-government services with little capacity to invest in

attending to agency interfaces and coordination with other clinical and support services. This leads to frustration for many consumers who are faced with an intricate and complex jigsaw to negotiate so as to access a comprehensive range of often contradictory and competing services. Such an environment compromises equity of access and acts as a restraint to entry and effective continuity of care.

In particular young people between the ages of 16 years and 18 years have no dedicated emergency response for acute mental disorders and frequently are hospitalized in adult facilities which are not adequately resourced, staffed and structured to meet the needs of this population. Recent funding for the South Metropolitan Intensive Youth Community Services will assist provide assertive community case management of young people at risk of mental disorder due to accommodation problems and poor psycho social support however WA does not have a dedicated acute response capacity for this population.

c. opportunities for improving coordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided through out the episode of care;

Due to the above mentioned systemic and organizational problems many opportunities exist for improvements which would be supported by a dedicated statewide research based approach to early intervention and prevention. A number of initiatives including the joint services planning approach; full services school model and prevention approaches including Aussie Optimism, PPP, Early Years and to some extent Strong Families indicate the potential for success. However more work is required to facilitate a cultural shift away from unilateral agency control to greater community led collaboration.

The recent Multi Systemic Therapy (MST) implementation process highlights the coordination problems within government services. Juvenile Justice has funded a number of MST type teams after collaborating with a health led planning and implementation process but became frustrated when health were unable to fund the planned services. Subsequently (eighteen months later) the WA Department of Health has funding to implement two metropolitan MST teams. Departmental coordination and appropriate memorandum of understanding are required to re establish the previous cooperative context and resourcing needs to be dedicated to these tasks.

A major failing of the WA mental health system is the lack of resources dedicated to consumer and carer input and involvement in mental health service planning and provision. CAMHSAC is an advocate of dedicated resources being available to enable the development of appropriate infrastructure to support meaningful consumer and carer involvement.

d. the appropriate role of the private and non-government sectors;

As has been mentioned above the lack of coordination and cohesion of services for children, adolescents and their families and carers leads to problems of access, continuity and quality of care, as well as duplication and contradictions in service delivery models. Investment is required to provide an integrating planning framework with a broader remit than to commoditize clinical services. The development of appropriate relationship systems and cultures is costly, however would appear to promote long term savings through greater effectiveness of the sector. The Camhs sector would like to be able to dedicate resource to the provision of liaison, training and consultation services to primary care providers, including GP's. However as GP's are responsible for about 35% of referrals to CAMHS, approximately 35% are from schools and school support services, the function of capacity building extends beyond general practice.

e. the extent to which unmet need in supported accommodation, employment, family and social support services, is a barrier to better mental health outcomes;

Young people between the ages of sixteen and eighteen with mental disorders currently have no dedicated, specialist, supported accommodation available in WA. This leads to unnecessary admissions to costly mental health inpatient facilities and is likely to promote the development of mental health and physical and social health morbidities due to poor and inadequate accommodation, limited and inadequate social supports, and limited educational and occupational opportunities. Education is a major predictor of both psycho social adjustment and health status.

Many child and adolescent mental health services receive a high volume of referrals related to parent-child conflict, family relationship problems and parenting difficulties. Most of these referrals could be more adequately dealt with by a primary care sector which was able to provide affordable (frequently this means at no cost) family support and intervention services which would limit the medicalisation of behavioural and relationship problems and enhance the capacity of communities to assist and support families and young people. The enhancement of accommodation, family and social support services within communities would offer an opportunity for early intervention which may just go some way to reducing the demand on camhs.

Outside the metropolitan area only some regional centres have any youth accommodation facilities, for example, Geraldton has STAY (short-term accommodation for youth) but this only caters for up to 8 short-term youth with 3 units for up to a 1 year stay. This accommodation is not designed for youth with mental illness but often the young people accessing it have multiple mental health issues that require specialist assessment and support which is not readily available. STAY is only really available to young people within Geraldton and not for the outer lying towns.

Within the metropolitan area the coverage of non government family psycho social support services is also patchy. Many of the rapidly expanding outer suburban areas have very poor community support services resulting in families needing to travel to central facilities to access parenting and family support services.

f. the special needs of groups such as children, adolescents, the aged, Indigenous Australians, the socially and geographically isolated and of people with complex and co-morbid conditions and drug and alcohol dependence;

The problems of indigenous Australians require particular attention, both at the clinical care level, and the level of systems collaboration. Experience within CAMHS indicates that extensive community liaison and relationship building is required to augment the employment of indigenous clinicians. Two roles have emerged; that of the indigenous liaison worker, to develop relationships and collaborative partnerships and pathways as well as assist in the development of cultural change amongst mainstream clinicians, as well as indigenous clinicians who are available to provide clinical services and provide consultation and liaison.

Young people with drug and alcohol problems and associated psycho social problems and mental disorders are not always managed well. A silo approach is common with drug issues referred to specialist drug and alcohol problems and the response to mental health issues frequently dependent on the ability of the young person to access clinic based services. The implementation of Intensive Community Youth Mental Health Services in the South Metropolitan Area provides an assertive outreach model of engagement for young people within their environment of choice and is based on a model of expanding the accessibility of services through effective assertive engagement. Such assertive engagement and collaborative models require further promotion and funding as well as effective evaluation.

g. the role and adequacy of training and support for primary carers in the treatment, recovery and support of people with a mental illness;

As a consequence of increasing the threshold for acceptance of referrals (due to resource constraints) CAMHSAC has become aware of the limits of the primary care sector in confidently assessing, treating and managing children and adolescents with mental disorders. A large proportion of GP's demonstrate a preference for referring on their concerns regarding the mental health of young people and are reluctant to accept the opportunity to continue the care and management of young people with mental disorders.

Whilst a considerable amount of resource has been dedicated to the training and support of general practitioners so as to enhance the capacity of the primary care sector, CAMHS practitioners are aware of many young people referred by GP's who do not meet the intake criteria but many end up in the system due to a desire to work collaboratively with GP's.

h. the role of primary health care in promotion, prevention, early detection and chronic care management;

Whilst some effort has been dedicated to capacity building in the primary care sector, the sector remains widely heterogenous in its capacity and willingness to assess, treat and manage children and adolescent with mental disorders. Better coordination and the targeting of resources to child and adolescent mental health issues is likely to increase the capacity and willingness of the primary care sector to dealt with children and young people with mental disorders, it is unlikely to fully address the need for specialist clinical services or the need to assist in the prevention of the development of morbidity and acuity of mental disorders in Western Australia. There is an increasing skills and knowledge gap between primary care and specialist clinical models of care. The expectation that GP's can be upskilled to become specialists in all areas of general practice is unrealistic. Clearer demarcation regarding disorders requiring specialist intervention versus those that are appropriately managed by the primary care sector are required through partnerships with the primary care sector. Currently very little resource is available to reduce the double and triple handling which frequently results as a consequence of the complexity of this interface.

i. opportunities for reducing the effects of iatrogenesis and promoting recovery-focussed care through consumer involvement, peer support and education of the mental health workforce, and for services to be consumer-operated;

CAMHSAC would like to see resources dedicated to effective consumer and carer involvement in the planning and management of services, the support of consumers and carers and the training of both staff and consumers and carers. A number of approaches have been trialled including the allocation of portfolio responsibilities, consumer and carer representatives on committees, support groups, consumer and carer survey's and focus groups. However the attempt to address the needs of consumers and their carers of the mental health system through a unitary consumer involvement system has led to the marginalization of young people and their families and carers.

The lack of mental health trained specifically to assess, manage and treat mental disorders in young people results in a large number of young people who attend adult facilities experience secondary trauma as a result of their contact with acute mental health services. This applies particularly to young people who are hospitalised in acute adult inpatient facilities or attend hospital emergency departments.

j. the overrepresentation of people with a mental illness in the criminal justice system and in custody, the extent to which these environments give rise to mental illness, the adequacy of legislation and processes in protecting their human rights and the use of diversion programs for such people;

The Department of Justice in Western Australia and mental health services for children and young people (together with a broad range of other government and non government providers) attempted to develop a collaborative approach to the provision of multi

systemic therapy (MST) services. However much remains to be done to realize the potential for more collaborative approaches to addressing the mental health needs of young people in the care of the criminal justice system. Inter agency cultural differences and the complexity and heterogeneity of both the mental health and justice systems present challenges which need careful analysis and the development of appropriate strategies. Diversionary programmes often provide mental health services with a reluctant and disengaged client, making the provision of clinical services problematic. Collaborative projects and supportive infrastructure are required (eg MST) to develop models of care appropriate to the effective use of diversionary programmes. Currently this frequently leads to the "dumping" of a hostile and unwilling client onto a concerned and anxious clinician.

k. the practice of detention and seclusion within mental health facilities and the extent to which it is compatible with human rights instruments, humane treatment and care standards, and proven practice in promoting engagement and minimising treatment refusal and coercion;

Post Traumatic Stress Disorder (PTSD) as well as being a consequence of an acute episode of a mental disorder is also often a consequence of detention and seclusion. PTSD may become a disabling and chronic mental disorder with significant health, social and economic costs. Humane treatment often assists in reducing the impact of the traumatic experience of acute symptomatology and associated hospitalization. The current trend towards increasing levels of control and surveillance in response to agitation and arousal appears to be developing into a self sustaining spiral which is informing the development of an industry of control and insecurity. In the child and youth sector clear expectations and boundaries seldom require depersonalizing environments and skilled and experienced clinicians are the best antidote to high levels of anxiety and agitation.

l. the adequacy of education in de-stigmatising mental illness and disorders and in providing support service information to people affected by mental illness and their families and carers;

The CAMHS sector has enjoyed long and productive relationships with both the government and non government education services with more than one third of referrals being sourced from these education services. Plans are currently being implemented by the Education department to provide mental health liaison officers within the metropolitan areas to further enhance and support this collaboration. A joint project of the City of Rockingham, CAMHS and the Department of Education has provided a part time, time limited project worker to assist secondary schools with the implementation of the Mind Matters project which has enjoyed limited and partial adoption by schools, often due to resource limitations.

Based on close working relationships over a number of years it is apparent that educational services are stretched beyond the capacity of current resources and

consequently have in recent years sought to redefine core business. This has led to a decrease in strategies targeting the destigmatisation of mental disorders with the consequent expectation that mental health services have greater responsibility in this area.

Greater efforts are required to develop partnerships and collaboration between the CAMHS sector and educational facilities. The Department of Education is to pilot a trial of CAMHS liaison workers in the north and south metropolitan areas (one per area).

m. the proficiency and accountability of agencies, such as housing, employment, law enforcement and general health services, in dealing appropriately with people affected by mental illness;

Efforts have been made at senior management levels (government departments) to increase collaboration when responding to the needs of children, young people and their families. Local initiatives and projects have also sought to pursue similar objectives. However little coordination is evident between the two levels even within the public health system. In the experience of CAMHSAC the most valuable collaboration takes place within local communities, on the ground, so to speak, however the disjuncture between higher level communications and these local initiatives reflects the fragmentation of child and adolescent mental health services and the work to be done to integrate government and non government services into a comprehensive continuum of care.

Generally there exists a poor level of knowledge and skills amongst the staff within both government and non government (non mental health) services (housing, employment, law enforcement, and community development [DCD]). Training and consultation programmes are required to assist develop knowledge and capacity within these agencies. Such initiatives would also reduce the demand on camhs as secondary level services through the enhancement of the capacity of these primary care and other secondary care services.

n. the current state of mental health research, the adequacy of its funding and the extent to which best practice is disseminated;

The Institute of Child Health Research has developed expertise and capacity and is a very valuable resource to support the development of needs based services and is a strong advocate of early intervention and prevention strategies. This resource could be utilized to greater effect by the Health Department when planning mental health services for children and young people. Greater collaboration would add value to the advocacy of early intervention and prevention strategies. However dedicated resources are required to focus research activities and the contributions of research to planning and service development for children and young people.

The current mental health structure provides little opportunities for enhancement of the interface with Paediatric and other child care services.

o. the adequacy of data collection, outcome measures and quality control for monitoring and evaluating mental health services at all levels of government and opportunities to link funding with compliance with national standards;

CAMHSAC is pleased that efforts have been made to recognize the importance of data collection as an aid to clinical care and service accountability and planning. However the adequacy of data collection systems and outcome measurement for the camhs sector is of concern to many clinicians who have felt somewhat disengaged from the planning and development process, are concerned that the instruments add little value to clinical assessment processes and are frustrated with inadequate hardware which increases the time cost of recording clinical services. This is likely to lead to poor compliance with data capture. Data collection instruments must be relevant to clinical activities, and assurances must be provided as to the security and confidentiality of centralized data base systems if they are to be accepted by busy clinicians focused on the next child or young person in crisis.

p. the potential for new modes of delivery of mental health care, including e-technology.

Electronic technologies have been developed in an ad hoc and poorly integrated manner, generally reflecting the interests of mental health clinicians with specific interest and skills with electronic data systems. More effective and enduring partnerships between clinicians and technical electronics experts are required to develop the necessary infrastructure and innovative culture to support electronic systems development. Clinicians are wary of further top down initiatives which appear driven by imperatives contrary to clinical practice. The potential of e-technology is far from being realised.

CAMHSAC is a strong advocate of a dedicated training programme for clinicians in the sector and for new clinicians entering the sector. There is considerable risk that the introduction of new clinicians at a volume which cannot be managed by the current informal apprenticeship/mentor model will lead to a reduction in the quality of clinical services. A dedicated training programme based on recognized core competencies integrated with on the job training and education has been advocated by CAMHSAC to enhance and develop the required workforce.

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