INQUIRY INTO MENTAL HEALTH IN AUSTRALIA

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I have worked in the mental health field since the early 1970s, as researcher, lecturer, clinician, and clinical supervisor. I have a PhD in the field of Autism and Developmental Disabilities. From 1994 to 2002, I was Professor/Director of the Department of Psychology at Royal Children's Hospital, Melbourne. I retain my research program at that hospital whilst continuing my academic work at the University of Melbourne. I have also worked for many years in the Aboriginal Health Service in Melbourne in their Family Counselling Centre.
I have worked in both adult and child mental health but my work has been predominantly in the latter, hence I will confine my comments to the field of child and family mental health. Although I am familiar with, and have worked within both the international and national scenes, my experience has been mostly in Victoria so my comments apply to conditions in this state particularly.

Expressions of concern:

1. Services for families and children with mental health problems are totally inadequate in terms of quantity and quality. The National Child Mental Health Survey identified a high level of need for professional services, and a prevalence rate of significant clinical problems in at least 14% in children and adolescents. It also showed that a very small minority of children who need services actually accessed them. Mostly, troubled children saw their GP or a School Counselor, neither of whom are trained to deal with significant mental health problems.
2. My daily experience working within child mental health services was with long waiting lists, meaning that most children were not seen when they needed to be, if they were seen at all. Public services are very thinly spread and few families can afford private options, especially in disadvantaged communities where the needs are highest.
3. Much of the treatment provided in current Child and Adolescent Mental Health Services is not evidence based. Two salient examples illustrate this point. Numbers of children with anti-social or conduct disorders are seen in psychotherapy over long periods of time. Not only is this absorbing scarce funds but it is known that this mode of treatment is ineffective for children with such difficulties. Children with anxiety disorders often do not receive the treatment for which evidence of effectiveness is strong, i.e. Cognitive Behaviour Therapy.
4. Many clinicians working in this field are significantly under trained for the work that is required, lacking specialist graduate qualifications in child and adolescent mental health. The wholesale adoption of the generic model in these services means that treatment is not matched necessarily to the assessed needs of the client, and when a referral is taken up it is likely to be 'pot luck' what kind of professional (e.g. nurse, occupational therapist, psychologist etc.) is allotted to the

case. Further, those professionals who are well trained in this specialist field often do not have adequate opportunity to practice the assessment and therapy skills in which they have been trained and which are needed, because of pressures for 'case management' work.

5. In the context of gross shortage of services, much of the available resources go to short term crisis management with little or no opportunity for follow up treatment which is essential for any real improvement which might reduce the chances of further crisis. This is a further example of inefficiency and waste in the system. Moreover there is a shortage of acute beds and intensive care for children presenting with extreme problems; where these do exist young people are often discharged after short periods before they and their families/carers are ready to cope. They commonly present again and again to differing services.
6. Working in these Cinderella style services is demoralizing for staff who battle every day to manage their job within a poorly functioning system. In general staff feel undervalued and unsupported, and constantly stressed. They feel that the children and families they see are not getting the quality of service they require.
7. It is well accepted that prevention and early intervention is the best approach for dealing with mental health problems. There is a wealth of literature to show that for a large proportion of cases, problems are identifiable in early childhood and are persistent (Prior et al. 2000). By the time many children are seen in mental health agencies (if they are ever seen there) problems are entrenched and very difficult to change. The predictors of mental health problems are clearly evident; hence we have a good basis for the design of early intervention programs. While governments have been taking steps in this direction, there needs to be a much larger investment in early intervention across Australia, along with evaluation of what works, for which families, in which kinds of situations. We now have evidence that early intervention is cost effective and therefore economically as well as socially beneficial.

In a well functioning mental health system which truly cares for children, services should be child centred, family focused, community based, and culturally sensitive, with adequate access to a variety of services suited to their needs including clinic, home-based, school based services, crisis services, residential treatment centres, and social services which provide attention tailored to their individual needs. In order for this to happen **the health, community and education sectors need to be integrated** for families requiring assistance. (Rones and Hoagwood, 2000).

I am aware that this is the rhetoric of government and an expressed ideal. The National Mental Health Strategy was full of good ideas and intentions. However, the current system provisions are light years away from this ideal. If a larger proportion of those who need services were to actually present to mental health agencies it would be even more impossible than it is now to deal with the numbers.
I do a considerable amount of work with school liaison, and the constant problem is that schools are overwhelmed with the psychosocial problems of their students, and frequently have no agency to which they can reliably refer and know that the child will be

seen in a timely fashion. A vast amount of mental health and family counselling work is being done by schools (see recent Catholic Education document re the scope and nature of welfare issues at http://www.cecv.melb.catholic.edu.au/funds/body.htm#welfare

Given all of the above, I believe that the delivery of mental health services to young people needs to be completely revised. It needs to be centred on, and delivered in schools. Schools and pre-schools are the most universally attended setting for children and adolescents and one where most behavioural and emotional difficulties are seen every day. In addition there is a strong association between behavioural and learning difficulties, hence these sets of problems should not be considered in isolation from each other (Prior 1996). Teachers spend a large part of every day dealing as best they can with family problems and child adjustment difficulties. Services based in schools offer a better way to:

a) access more children needing help especially in the early years, thus enhancing the chances of intervention which will reduce the likelihood of entrenchment of untreated problems (with their follow on effects into adolescence and adulthood);

b) provide a much less stigmatizing environment than mental health agencies do, and therefore greater acceptability of assistance offered in and through the school;

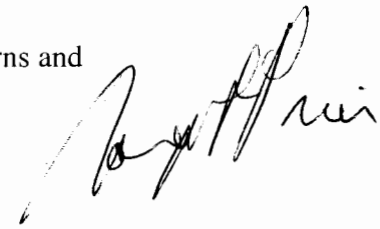
c) provide schools and teachers support and on site expertise so that they can manage in the classroom better, do the job they have been trained to do, and spend less of their teaching hours engaged in student welfare responsibilities;

d) engage parents in programs aimed at supporting and enhancing their parenting skills;

e) achieve better outcomes for children, families and schools.

This approach requires the kind of collaboration and integration of community services, health, and education systems which is so conspicuously lacking in Australia, and which leads to great inefficiency, wastage of resources and less than optimum service provision. It also requires a major increase in the training of mental health professionals with the expertise to really make a difference over the short and longer term, to the lives of affected children and families.

In the interests of brevity, I have provided here just an outline of my concerns and suggestions. I would be happy to expand on any of the above if requested.



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