
Victoria's Mental Health Service

The Framework for Service Delivery

Child and Adolescent Services

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Foreword

The paper *Victoria's Mental Health Services: The Framework for Service Delivery* (1994), identified Child, Adolescent and Family Mental Health Services as one of the three key mental health programs that will operate within each regional service system. The target group was identified and broad service objectives set out.

This document, *Victoria's Mental Health Service: The Framework for Service Delivery—Child and Adolescent Services*, builds upon that earlier Framework. It follows extensive consultations with relevant H&CS personnel and service providers from all regions of the state and is an acknowledgement of Psychiatric Services commitment to the well-being of young people in Victoria.

The guidelines presented in this document provide the basis for a comprehensive regional planning process to enable resources to be maximised and new funds to be appropriately targeted, while ensuring the best possible standards of care.

The Framework provides contracted agencies with a clear statement as to the expectations of H&CS as to the nature, location and type of the services to be provided. Consequently, H&CS purchasing decisions will require services to orient their operations in a manner consistent with this policy.

As we move into the third year of a five-year reform process, I am confident that this document will provide a clear statement to consumers, service purchasers and providers of the future directions in this important area of mental health.

Implementation of these directions in the coming years will lead to significant improvements in the accessibility, nature, extent and quality of the child and adolescent mental health services available in our community.



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Introduction

Vision for child and adolescent mental health services (CAMHS): To improve the mental health of the children and adolescents of Victoria.

Context

Victoria's Mental Health Service: The Framework for Service Delivery, was released in March 1994. It outlined the policy framework for the delivery and redevelopment of psychiatric services, including a new program description of CAMHS. Previously, the development of these services had been guided by the plan prepared in 1985 for the Health Commission by Dr. Allan Mawdsley.

This document builds upon the 1994 Framework paper and it provides policy guidelines for the future direction of CAMHS to ensure that:

- Consumers are informed about available services.
- Service providers are made clear about what is expected from them.
- Scarce resources are maximised and new funds are appropriately targeted.
- The best possible standards of care are used.
- Providers of services are accountable for service outcomes.
- Regions are aware of the range of services required by children and young people.

All clients of public psychiatric services are to receive the best possible care, provided in the least restrictive environment consistent with effective treatment, which takes into account their individual, religious, cultural and language needs. Effective case management practices will ensure that carers and other services are appropriately involved in treatment planning and service delivery. Early intervention and prevention will also be a focus. Specialist mental health services are to be integrated, and often collocated, with acute health services to achieve continuity of care and an appropriate service mix for the needs of clients. Services are to

be comprehensive and accessible, and will be coordinated with other community services.

Mental health services will be organised on a regional and local area basis to provide a common foundation for health service planning and support linkages with other services. The regional structure will still allow the recognition of natural catchment areas that may sit across regional boundaries, but such service delivery arrangements will need to be formalised. The mental health budget will be redistributed to regions on the basis of a weighted population formula that combines population size, sociodemographic measures of service need, and the distance factor in rural areas. Funding arrangements will be time limited and relate to specific service delivery targets. Statewide services will be separately funded.

An identifiable regional mental health budget will be allocated between the components of the local mental health services, within the mainstream or general health administration, to give the best mix of service type for each area. Regional managers will be responsible for ensuring the planning and provision of a balanced range of services to reflect local needs, distributing budgets equitably and negotiating funding and service agreements with agencies which ensure the best mix of services through the most effective service provider arrangements.

Within this context, CAMHS will aim to alleviate serious psychiatric disturbance in children and adolescents through the provision of assessment, direct treatment and preventive services to young people and their families. They will provide indirect treatment through education, consultancy and collaboration with other services working with children and adolescents, to diminish the effects of psychiatric disorders on these clients and their families. They will conduct research into the aetiology, treatment and prevention of mental illness in childhood and adolescence, and contribute to

community education about the mental health of children and adolescents.

Specialist CAMHS are linked to general adult mental health services, but differ from them in the following respects:

- The patterns and types of psychiatric disorders presented by their clients.
- Their client's developmental and legal status.
- Clinical practices and models of service delivery.
- Service structures, distribution, and staffing profiles.

Psychiatric Disorders in Childhood and Adolescence

Epidemiological studies throughout the world consistently show that between 10–20 per cent of children and young people in urban settings suffer from diagnosable psychiatric disorders. Only a proportion of these conditions are identified and treated by specialist services. Primary services and supportive social systems can help psychosocial adjustment, or assist individuals with less severe disorders. However, three to five per cent of children have distressing or disabling psychiatric difficulties which require identification and treatment to relieve suffering and diminish the impact of persisting disorder on development, families and communities.

While there are similarities between some childhood psychiatric disorders and adult conditions (for example, anorexia nervosa), most conditions are peculiar to the early stages of life (for example, oppositional defiant disorder). Some disorders have proven continuities from childhood into adult life. These may simply persist unchanged, although their morbidity may be diminished with treatment (for example, autism), may wax and wane and must be controlled with ongoing or intermittent care (for example, Tourette's Syndrome), or can evolve into adult personality distortions and disturbances which themselves make other psychiatric disorders more likely in adulthood.

As young people develop at different rates, it is appropriate that there is overlap between CAMHS and adult services to ensure that appropriate services are available. There is currently debate over how to optimally provide services for youth (the 16–25 year group), and a pilot service is being developed in the Western Metropolitan Region in the Centre for Young People's Mental Health. In other areas, depending upon the developmental status of an adolescent, CAMHS will accept young people up to the age of 18 years and adult psychiatry services will accept patients from the age of 16 years. This means that ongoing coordination between CAMHS and adult psychiatric services is required.

Psychiatric Services for Children and Adolescents

In distinction to adult mental health services, which have historically been inpatient-oriented and often isolated, CAMHS have evolved as outpatient services, delivered through community-based clinics. Psychiatric inpatient services for children and adolescents are all integrated or collocated with acute hospitals. Since 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 are indispensable elements of modern practice. Assessment of individual psychological and biological strengths and vulnerabilities is critical to determining the most appropriate intervention strategies. Treatment aims to help patients to resume a normal developmental pathway and reduce secondary morbidity from social rejection, educational failure, or inappropriate self medication through drug abuse.

Treatment in the 1990s is individualised and multi-modal, addressing different dimensions of a young person's life at the same time. For example, a particular child with severe behaviour difficulties may require parent counselling and family therapy, group psychotherapy, special education strategies to address

coexisting learning disabilities, and medication. Social learning through outpatient psychotherapy and counselling is a key component of services provided to children, adolescents and their parents by CAMHS. Work with children and adolescents must take into account their cognitive level and motivation, and therefore, therapeutic approaches may be more action oriented and more playful than adult psychotherapies.

The developmental stages of childhood and adolescence have been associated with the evolution of specialist streams within child and adolescent mental health.

- Infant mental health is a sub-speciality developing in response to increasing knowledge about early infancy and childhood. Assessment of infants and the parent-child relationship, coupled with counselling and psychotherapy within the parent-infant relationship, can greatly assist the capacity of a parent to support the development of the troubled infant.
- Early childhood is also recognised as a distinct area of study where the early development of language, play, cognition and emotions is interwoven with attachment relationships and the social domain. Developmental assessments tease apart the respective contributions of biological, psychological and social factors, and guide appropriate treatment.
- Adolescent mental health is the longest established sub-specialty. In this developmental phase, the pattern of psychiatric morbidity increasingly merges into that of adults, and treatment approaches expect individuals to take responsibility for their own behaviour, although knowledge of developmental psychology and family involvement is still relevant.

The Specialist Interdisciplinary Field

CAMHS has evolved as an interdisciplinary field from its origins in the child guidance movement. Basic CAMHS clinical teams consist of a psychiatrist (and trainee), psychologist, social worker, psychotherapist

or occupational therapist, and psychiatric nurse. This may be varied for specific tasks and where other professional discipline skills are required. The multidisciplinary collaboration between psychiatrist, psychologist and social worker has helped understanding of the interactions between the biological, psychological and social domains in normal and abnormal psychosocial development.

The generic knowledge that resulted has informed modern approaches to treatment, and the field has been further enriched through the contribution of other allied professional disciplines such as nursing, occupational therapy, child psychotherapy, special education and speech pathology. Multidisciplinary teams provide the basic unit for comprehensive, community-based assessment, treatment and liaison services.

Well functioning CAMHS teams have skilled staff who communicate clearly, are open to learning, privilege empirical knowledge over ideology, have appropriate administrative support, and provide mutual support which helps to manage stress from a task that can be highly demanding, as well as rewarding.

Child and Adolescent Mental Health Skills

- Psychiatrists bring diagnostic skills to define the relative contributions of organic and psychological factors to psychiatric disorders, and prescribe medication and facilitate communication with other areas of medical care.
- Clinical psychologists bring skills in psychometric and neuro-psychological testing and diagnosis, and knowledge of developmental psychology and learning theories, as well as expertise with cognitive-behavioural therapy.
- Social workers bring skills in psychosocial assessments and inter-agency liaison, with a knowledge of the law, social policy and how social systems affect children and adolescents within families.

- Child psychotherapists have been trained in psychoanalytic child psychotherapy, and focus on understanding the inner emotional life of an individual child and how this affects their behaviour and relationships.
- Occupational therapists bring activity-based expertise in working with children and adolescents individually or in groups, to facilitate the expression and resolution of psychological difficulties.
- Child and adolescent psychiatric nurses specialise in milieu therapy in inpatient and day-patient units, or bring community nursing skills to assessment, treatment and liaison services and outreach work.
- In addition, for some patients, access to other specialists, such as speech pathology and special education teachers is essential.

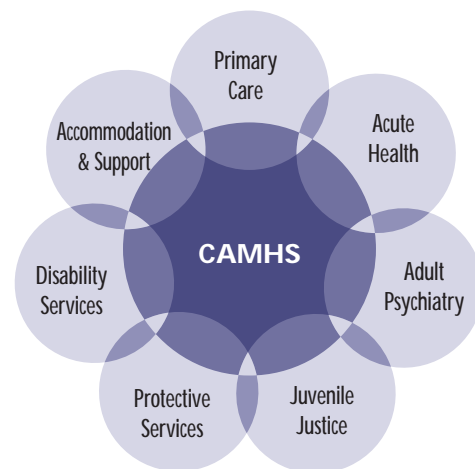
Specialist CAMHS workers from all disciplines have generally received further education in child and adolescent psychiatry. This involves training in child development, family systems, psychopathology in childhood and adolescence, assessment of young people and their families, models of psychological and behaviour change, and team work. Practice skills are required in individual, group and family psychotherapies through supervision by more experienced workers. Ongoing professional development is essential for all workers to maintain skills in assessment, diagnosis and treatment. Basic training curricula in psychiatry, medicine, nursing or allied health, would benefit from a greater focus on human development and child mental health, to create a broader knowledge base about the needs of children and adolescents in the professional community.

The Need for Service Linkages

Every child, adolescent and family has a unique mix of needs for services from the health, welfare and education systems and some of these may not be addressed unless these systems cooperate to put the interests of clients first. All CAMHS clients are concurrently

involved with other service systems and it is essential that these systems work collaboratively, since interservice conflict leads to significantly less effective outcomes. Many young people in the health, education, juvenile justice and welfare systems require special consideration in the establishment of service delivery mechanisms to ensure these are appropriate to their needs. This requires greater coordination across service boundaries than has been the case in the past. While CAMHS focus on the treatment of severe psychiatric disorders of children and adolescents and their families, other service systems provide primary mental health services to young people with less severe difficulties, as an element of their core business. Improving the mental health of children and adolescents is therefore a joint responsibility between psychiatric services and other key services. These include services provided within H&CS, and those from local government, non-government organisations, the Directorate of School Education (DSE) and the private sector.

Figure 1: Overlapping Service Systems in H&CS



CAMHS will maintain and further develop key linkages with the following.

- *Adult Mental Health Services* provide services to the families of adults with severe mental illness, including information and support. Service delivery to older adolescents and to children of parents with severe mental illness, requires coordination and collaboration.
- *Acute Health* provides assessment, treatment and prevention programs for children and adolescents with psychological responses to illness and disability, and behavioural paediatricians who assist many families to manage behavioural and adjustment difficulties.
- *Public Health*, through its Alcohol and Drug Program, provides a range of treatment, counselling, support and early intervention services to adults who may be parents, and to young people.
- *Primary Care* offers a range of services including counselling and health promotion activities with young people and families, as well as universal screening at critical developmental stages. This creates enormous potential to deliver primary treatment to children showing early signs of mental disorder, and provide advice and support to parents.
- *Child, Adolescent and Family Welfare (CAFW)* provides accommodation and support for children and adolescents who have been abused or are at risk, who have offended, are from families in crisis, or from families requiring respite care. These support services include the provision of counselling and other psychological assistance.
- *Protective Services* provide assessment and first line interventions for many children who have been abused or neglected. Protective workers deal with distressed parents and traumatised children who may need assistance to manage the stress of separation from their attachment figures, cope with loyalty conflicts, and deal with complex legal processes.
- *Juvenile Justice* currently provides a range of dispositions for juvenile offenders which aim at

rehabilitation and reintegration into society. Many of these young people have significant emotional and psychological vulnerabilities and Juvenile Justice staff includes psychologists and others who provide group or individual rehabilitation programs.

- *Disability Services* provide a broad range of services to clients with physical, sensory and intellectual disabilities. Behavioural intervention support teams (BIST) focus on clients with behavioural and psychosocial dysfunction.

Outside H&CS, other key service systems also have particular connections with children and families, and collaboration with these will maximise the opportunities for improving the mental health of children and adolescents with severe psychiatric disorders.

- *General Practitioners* hold a pivotal position in health care and are often the first point of contact for parents of troubled children. Linkages between CAMHS and the Royal Australian College of General Practitioners and with general practice divisions will be encouraged by Psychiatric Services in conjunction with the Victorian Postgraduate Child and Adolescent Psychiatry Training Program (VPCAPTP).
- *DSE* is responsible for schools which form a major part of the lives of all children and adolescents. The World Health Organisation Division of Mental Health has recently described a comprehensive model for promoting mental wellbeing, educating the community about mental health, and preventing and treating mental illness in schools. This will form the basis of discussions between Psychiatric Services and DSE. Ideally, the secondary school educational core curriculum for all young people will include an emphasis on human development, individual variation in physical and psychological make up, human emotional life and its relationship with social experience, developmental life stages and socialisation within families, as well as information about the health and welfare services available. Opportunities for providing parental education through schools and

possibilities for joint therapeutic activities in the school setting will be explored between Psychiatric Services, DSE and Primary Care.

- *Non-Government Organisations* provide many support services to children, young people and their families, including many individuals who require specialist intervention and consultation from CAMHS.

CAMHS will actively collaborate with these key services in order to coordinate the provision of psychiatric treatment and care, to support other professionals to assist children and young people with mental illness, and to realise preventive and treatment service initiatives.

Putting It Together

A systemic approach to improving the mental health of Victorian children and young people requires a shared vision, regional support, energetic cooperation between CAMHS and other services, skilled and committed staff, with contributions being made by many service systems.

Comprehensive CAMHS provision will include:

- Effective and responsive treatment services for psychiatric disorders in childhood and adolescence.
- Equitable access to services by children, adolescents and families.
- Education for parents about children's psychological and emotional needs, and parenting strategies which enhance children's development.
- Children and adolescents receiving information about their personal development and human relationships, so they may better understand their experiences and make informed choices.
- Individuals at high risk, and their families, being informed about specific disorders and coping strategies.
- Professionals in the general health, adult mental health field, education, and welfare systems trained in the recognition and treatment of psychiatric

disorders in childhood and adolescence.

- Service systems re-engineered to better suit the needs of young people and families and not simply maintained for historical reasons.
- Services linked for better cross-referral, joint programs, and enhanced access for patient populations with special needs.
- CAMHS cultures, structures and practices which support enquiry, ongoing program evaluation and feedback about outcome of interventions.
- Psychiatric disorders and their treatment researched so that preventive programs can be developed and improved.
- Effective treatment programs for particular patient populations developed through piloting and evaluating innovative projects.

Understanding the Client Groups

Consumers

There are two groups of consumers of CAMHS services:

- Patients who require clinical services. These patients will be registered with CAMHS in order to create a case record which helps to ensure service standards, aids case planning, and supports communication between different workers involved with the patient.
- Agencies, services or individuals connected to children and young people may require service information, consultation about child and adolescent mental health, case liaison, conjoint case planning and case management, primary, secondary and tertiary consultation.

Target Group of Patients

CAMHS will focus on children and adolescents up to the age of 18 years with serious psychiatric disturbance, or who are known to be at risk of such disturbance.

The term 'serious psychiatric disturbance' applies to those diagnosable psychiatric conditions that adversely affect the psychosocial development of children and young people, and contribute to major interactional difficulties in their social environment. These diagnoses are outlined in the international classification systems ICD9-CM and ICD10, and the United States' systems DSM-III-R and DSM-IV. They are a heterogeneous group of conditions with significant differences from those which appear during adulthood. Some are categorical entities (for example, adolescent bipolar disorder) where the disorder is either present or absent. Others (for example, phobic anxiety disorder) are more dimensional, and shade from normal variation into disorder. Where the line is drawn between mild and severe disorder is a clinical decision determined by the extent of the impairment or disability caused.

Preventive and early intervention treatment programs targeted at selected groups of children and young

people, especially at those individuals identified as having multiple risk factors for psychiatric disorders (selective prevention), and early signs (indicative prevention) are likely to ensure better access, earlier intervention and better outcomes in terms of reduced morbidity.

Where such programs can be developed conjointly with other service providers, and offered from settings that are community-based, their accessibility and acceptability to user groups of children, adolescents and parents is likely to be increased.

As children usually depend upon their caretakers to bring them to psychiatric services, utilisation of current services depends considerably on the parent or guardian's perception of the problem and their understanding of what can be done. This will be influenced by parental knowledge about children's psychosocial development, about child and adolescent mental health and the information they have about mental health services. Universal preventive programs, such as the parenting strategy currently being planned by Primary Care, will assist parents to better understand children, recognise their emotional status, provide sensitive support which encourages a sense of self-esteem, personal agency and self-efficacy. These programs will be encouraged and supported by Psychiatric Services and by CAMHS.

Services for Special Patient Populations

Services need to be planned, developed, structured and delivered in ways that meet the needs of particular client groups, as well as those with more general needs. Since resources are finite, CAMHS will be expected to ensure their services are configured so that they can provide for these clients in the most effective and efficient means possible.

Co-Morbidity with Acute and Chronic Illness and Physical Disability

The prevalence of psychiatric disorders in children and adolescents with physical illnesses and disabilities is significantly greater than in the general population, particularly if these physical problems affect the central nervous system. Hospital psychiatric consultation and liaison programs provide mental health services to children and young people with co-morbid psychiatric disorder and physical illness or disability who require ongoing medical care. These programs provide direct services to referred patients, and indirect services to a wider group of clients through consultation to acute health workers. Patients are referred for assessment and consultation, and ongoing links are developed with acute health care teams through attendance at ward rounds and liaison meetings. Over time, these liaison services enhance the skills of general health workers in the early recognition of psychological responses to physical illness, diagnosis of psychiatric morbidity, and provision of services in ways that are sensitive to the emotional needs of young people. CAMHS consultation and liaison links can be effectively developed in acute hospitals with paediatric wards, and the general model may also be applied in community settings with general practitioners, as well as with non-health services.

Most children and adolescents with chronic disabilities live with their families in the community. Those with brain injury, which does not result in intellectual disability but with some other cognitive impairment, are at high risk of psychiatric disorder. Referral processes for these children and adolescents outside hospital are less developed and it can be particularly difficult to provide appropriate and comprehensive services. A closer working relationship needs to be developed between CAMHS and specialist acquired brain injury services to improve coordination and effective intervention. Children and adolescents with other disabilities such as deafness, vision impairment

or severe communication impairment can also have difficulty accessing and benefiting from general CAMHS approaches. Regional and central linkages with specialist disability services are required to ensure that CAMHS interventions are available to these clients and effective in their responses.

Distressed Infants

Infant mental health is a new field focusing on the healthy psychosocial development of the infant and young child (birth to three years) within the parent-child relationship. Where parents have major difficulties in caretaking, this can lead to vulnerable infants being overwhelmed by emotions, and the development of inhibited or disinhibited behaviour patterns which affect feeding, sleeping and investment in relationships. These early disturbances of bodily functions, psychological status and social relations predispose to later difficulties in childhood and adolescence, and to a greater vulnerability to psychiatric problems in adulthood.

Infant mental health programs will be developed within all major CAMHS in each region through the reallocation of existing resources. Infant mental health clinics have already been established at the Royal Children's Hospital, the Austin and Repatriation Medical Centre, and Monash Medical Centre, and referral networks have been developed with maternal and child health nurses who are playing a key role in the recognition of parent-infant difficulties. Three early parenting centres exist in Victoria to support the mother-infant relationship, and a similar number of psychiatric units have been developed for mothers with psychiatric disorders to be admitted with their babies. These units require formal liaison linkages with regional CAMHS which will facilitate the recognition of infant psychological problems at an early stage, form linkages with adult psychiatry services, and consult to other services.

Suicidal Youth

Suicide rates have increased in recent years within the 19–24 year old population, but older adolescents are also at risk, particularly in rural areas. Many suicidal youth have psychiatric disorders with depressed mood, and well publicised services for the treatment of depression are essential, together with support for parents and families. Suicidal adolescents are priority patients and mental health services for suicidal children and young people must be responsive on a 24-hour basis, and be linked with acute medical services to deal with drug overdose or self-injury. CAMHS will each identify a 24-hour crisis response service which has links with the emergency department of its auspice hospital, in the metropolitan regions. Rural CAMHS will also need to develop formal arrangements with their major regional acute health service provider(s) to ensure that coordinated local responses are available.

A statewide Interdepartmental Youth Suicide Prevention Committee has been established to develop strategies for the 16–25 year old population. This will provide a focus for coordinating and evaluating current activity and developing a comprehensive plan. Statewide protocols and regional linkages will be developed between adult crisis assessment and treatment services (CAT services) and CAMHS to provide appropriate outreach services to adolescents who cannot easily be brought to hospital (see *Psychiatric Crisis Assessment and Treatment Services: Guidelines for Service Provision* (H&CS 1994, pp 63–4).

Homeless Youth

Homeless youth have a high incidence of emotional disturbance, particularly depression and behaviour problems. Many of these young people have left their homes following abuse and neglect by parents. This group of clients may only respond to services which are independent of parental involvement, are immediately available at times of crisis, and are accessible and non-stigmatising. Following the 1990 National Enquiry

by the Human Rights and Equal Opportunities Commission into Homeless Children, three workers for homeless youth were funded at major CAMHS.

The Homeless Agencies Resource Project (HARP) has improved access to mental health services through an innovative service delivery project operating in conjunction with accommodation and youth support services, adolescent acute health facilities, and community health centres. Clinical staff have worked collaboratively with other service providers to develop linkages, offer education about common psychiatric disorders, give consultative support and facilitate appropriate specialist referrals. The project has produced valuable written resource material. CAMHS are now expected to consolidate such activities within their core business, as specific funding for services to homeless youth is withdrawn. They need to review their outreach and consultation priorities to ensure appropriate linkages are developed or maintained with key agencies involved with homeless youth.

Socially Disadvantaged Youth

Protective, welfare and juvenile justice system clients are a consumer group that, by definition, have suffered family discord and abuse, or had inadequate support or inappropriate socialisation. Children's psychosocial development is at greater risk in all these situations, and also if parents are unable to provide care because of illness or intellectual handicap. Families may not readily access mental health services for their children because of disorganisation, chronic illness, suspicion, or other preoccupations. In adolescence, these young people have an increased incidence of high risk behaviours such as drug and alcohol abuse and unprotected sexual activity. While such individuals may sometimes be seen by others to present clear psychiatric difficulties and self-destructive or self-defeating behaviour, they may themselves refuse to cooperate with conventional outpatient-based treatments.

CAMHS will provide specialist support to this group in conjunction with several of the new programs being developed by CAFW services:

- Intensive youth support service teams are being expanded, with workers attached to non-government organisations (NGOs).
- Supported accommodation will include facilities for young people with emotional and behavioural disturbances, including suicidal behaviour.
- Adolescent protective teams are being established in each region.
- Sexual assault services are being redeveloped to ensure a focus on sexually abused children and adolescents and that a range of successful treatment strategies are used.

Offenders within the juvenile justice system also require assessment and access to treatment when psychiatric disorders are identified. While psychological services are currently provided from within this system, clients may sometimes require additional specialist mental health care. In addition, education in mental health and the impact of mental illness on families, is required by all welfare workers. Ongoing consultative linkages will be developed between CAFW and CAMHS at a central and regional level respectively, so that secondary consultation and psychiatric assessments are readily available.

There have been particular difficulties associated with providing services to adolescents between 15 and 18 years, whose behaviour is intermittently disturbed to the point where secure psychiatric care is needed, but who do not have a psychiatric disorder that can be effectively treated on an involuntary basis under the *Mental Health Act 1986*. These young people have often been abused and require the provision of support, accommodation and opportunities to develop trust in relationships. To assist these clients, psychiatric and welfare services will collaborate to provide a framework for care, treatment and rehabilitation.

CAMHS staff will work with intensive youth support services and NGOs providing supported accommodation to provide direct service delivery and liaison and consultation.

The Mental Health Act can be utilised for the involuntary treatment of any young people who exhibit specific signs of severe mental disorder, when their behaviour threatens harm to themselves or others, and when treatment is available. A person must meet all the criteria specified in section 8(1) before a person can be considered for involuntary admission. Treatment will be offered in a restricted environment for the shortest possible time and secure psychiatric beds must form only one component of a coordinated system of care.

Trauma Victims

Regional CAMHS are an integral part of the state disaster response. Victims of trauma and disaster may require responsive mental health services to provide debriefing and treatment for post-traumatic stress reactions, whatever their age. Where a disaster affects a whole community specialist assessment, treatment and liaison services are frequently best provided through primary services already established in that community setting. State disaster planning will provide a formal structure to build service networks with others such as the police, child protection workers, hospital casualty staff, and the school educational system to identify children in need of services, and ensure appropriate referrals are made early.

The model of post-traumatic stress disorder is being usefully applied in related fields such as sexual abuse, family violence and bullying in schools. Severe or chronic stress may cause persistent effects on biological and psychological systems which can adversely influence psychosocial and educational development. CAMHS will establish clinical programs for the treatment of psychological trauma which will provide a clear focus for the development of expertise in this

area. A research project on the treatment of post-traumatic stress disorder in children who have been sexually abused has recently been funded by the National Health and Medical Research Council (NH&MRC) at Monash Medical Centre. Additional sources of funding will be sought by CAMHS for research into the treatment of young victims of trauma, severe abuse, torture and disaster.

Children of Parents with Severe Mental Illness or Drug Abuse

Children of parents with severe mental illness, or drug and alcohol abuse, are currently not systematically identified or routinely provided with services. These children are at higher risk of subsequent psychiatric disorders and adjustment reactions as a result of a combination of factors including the intermittent absence of their caretakers. Regional linkages between adult psychiatric services and CAMHS are required to ensure the needs of children of adult psychiatry patients are appropriately considered. To assist the identification of those children who may be at risk, a routine psychiatric history taken on all adults admitted to an inpatient psychiatric facility, must include enquiry about the health and development of their children. Protocols will be developed to assist adult mental health services to consider the needs of children and provide information about what is happening to their parents.

Children with early signs of psychiatric disorder must be identified and provided with an appropriate intervention, including referral to CAMHS if necessary. The 'Children and Adolescents of Mentally-Ill Parents (CHAMP) Project' of the Mental Health Research Institute will pilot a number of intervention projects and develop educational material suitable for children and young people. Adult mental health services staff require core training in working with adolescents and recognising the signs of mental illness in children of parents with psychiatric disorder. CAMHS staff will be

involved in such training, as ongoing links will be necessary for appropriate consultation and support, and effective liaison.

The children of parents with drug and alcohol problems share similar difficulties, and Psychiatric Services will liaise with Public Health to develop linkages between CAMHS and Alcohol and Drug Services. The development of closer inter-service links will help to ensure that youth with both psychiatric and drug problems receive appropriate services as there is significant co-morbidity of psychiatric disorder and drug and alcohol abuse.

Children with Intellectual and Developmental Disabilities and Learning Disorders

Children at special schools, and those who are failing educationally in regular schools, are at higher risk of psychiatric difficulties, especially disruptive behaviour disorders. Similarly, all children with psychiatric disorders, especially attention-deficit and hyperactivity disorder, are at greater risk of learning difficulties and school failure. It is therefore important that further linkages are developed between CAMHS and special education staff. Inter-agency cooperation is necessary to minimise disruption to children's education, for early identification and to develop preventive programs. Most CAMHS have special programs for children and adolescents with learning disorders and psychiatric disorders, or for learning disorders which are thought to have a psycho-emotional basis. These specialist services are not substitutes for psychological services provided currently within the school education system, but complement them for young people with severe psychiatric disorders.

Dual Disability Clients have special needs. Psychiatric disorders are more likely to develop in children and adolescents who suffer from brain injury or developmental and intellectual disabilities. Clients of disability

services who show 'challenging' behaviours may be referred to Behavioural Intervention and Support Teams (BIST) by their client services teams. In complex cases, or when severe psychiatric disorders are suspected, it is appropriate for such teams to refer clients to CAMHS for further specialist assessment, consultation and treatment. The protocol established between Disability Services and Psychiatric Services is generally applicable to CAMHS. Referral of clients with dual disability can also occur through Primary Care staff and general practitioners.

The Monash University Chair of Developmental Psychiatry at Monash Medical Centre and the Developmental Disability Unit at Melbourne University, will greatly contribute to the training of general practitioners, allied health and nursing staff. This will increase skills of primary health care staff in recognising and managing clients with dual disability, and help appropriate referrals of children and adolescents with severe psychiatric disorders. These positions will also enhance research and understanding of the links between developmental disability and psychiatric disorder.

Autism is a biologically determined developmental disorder with significant social and emotional correlates and consequences for children and their families. Children with autism and allied disorders receive services from Primary Care's Specialist Children's Services, or Disability Services, and from DSE. Co-morbid psychiatric disorders are more likely in this population, and since some psychiatric disorders mimic autism these must be identified so they can be treated as early as possible. Adjustment disorders are more frequent in children with autism and families may need psychiatric support to help their children to manage normal developmental stages.

CAMHS team members participate in the current protocol for diagnostic assessment which clarifies eligibility for services, allows triage into appropriate

service systems, and provides psychiatric screening for children and their parents. This protocol, evolved under the auspices of the Autistic Services Coordinating Committee Victoria, provides a benchmark standard for assessment.

Adolescents with autism are more likely to develop epilepsy during this time, and the management of unusual behaviour may require specialist assessment and advice. It is appropriate for each regional CAMHS to develop appropriate expertise in assessment and diagnosis of autism and allied disorders, and to provide specialist mental health services to children and adolescents with autism and psychiatric disorders, and to their families.

Primary Care has established a working group, including Psychiatric Services, Disability Services and the DSE, to review and delineate respective roles and responsibility in relation to people with autism, and ensure smooth transitions between services when this is necessary. The establishment of consistent and appropriately funded diagnostic services, which are linked to relevant education, treatment and support agencies, is agreed to be important. A joint review of the needs of adolescents with autism and related disorders is in progress.

Special Cultural Groups

Other patient groups may be defined, less by their 'high risk' status than by their particular cultural and language heritage which may render generic CAMHS unintelligible, unwelcoming or even frightening.

The Koori Kids Mental Health Network is a Koori mental health initiative, and consists of staff from the Victorian Aboriginal Health Service, the Victorian Aboriginal Child Care Agency, CAMHS, and the DSE. Its focus has been to educate professionals in the field about Aboriginal culture and family life, to educate the Koori community about emotional development of children

and the mental health problems they experience, and to provide primary and secondary consultation for Koori young people. Specialist consultations are provided by CAMHS staff from the major metropolitan centres and the project has aimed to develop Koori expertise in child and adolescent psychiatry. Several child care staff have received training through VPCATP, and specialist education input has been provided to the Koori Child Care course. This learning has been reciprocal as CAMHS workers have become more sensitive about cultural issues in their work with Koori families who use services, and now more readily utilise resources such as Koori hospital liaison officers.

Young People from Non-English Speaking Backgrounds utilise services less than might be expected from their numbers in the population. The development of service linkages with general health services utilised by particular cultural groups is encouraged, as well as the employment of bilingual staff and the utilisation of interpreter services provided through hospitals (Framework document, p. 46). The successful model of collaboration developed between mainstream services and the Koori community may be extended and modified for other distinct cultural groups. CAMHS will be encouraged to seek consultation and training from the Victorian Transcultural Psychiatry Unit to improve their understanding of cultural aspects of psychiatric disorders, and develop appropriate service delivery mechanisms.

Organisational Arrangements for Child and Adolescent Mental Health Services

The Regional Basis for Services

Regions are responsible for planning to meet the needs of consumers of a particular region or catchment area, and contracting with CAMHS to deliver quality services. Regions must examine current service provision and gaps as a means of informing their purchasing of services. This will take into account the distribution of the under-19 year old population, areas of population growth, and the location of people with special needs such as those with socioeconomic disadvantage. Psychiatric Services managers in all regions will need to define priorities for service development since this will depend upon funds being reallocated from other programs as well as on new funding becoming available.

Regional plans will identify the extent and location of required CAMHS activities including:

- Assessment, treatment and liaison services, including crisis responses.
- Day programs and inpatient services.
- Research and training activities.
- Key service linkages established or planned.
- Respite accommodation needed.

Regional planning will support the health service agreement process, ensure appropriate targeting of service delivery, identify capital developments that may be required to establish comprehensive services, facilitate regional inter-agency linkages, and consolidate the key service directions articulated within this document.

Regions determine, in a collaborative way, appropriate boundaries and catchment areas for CAMHS. This may entail a region purchasing services from another region if they are not otherwise available. Large regions may have different sectors within the regional boundary served by different CAMHS, although a mechanism for regional coordination of CAMHS will then be required

to ensure equitable resource distribution, reliable access and consistent service delivery.

All CAMHS will provide assessment, treatment and liaison services, with an outreach capability, capacity for crisis assessment and appropriate emergency psychiatric care. Major metropolitan CAMHS will be expected to provide a comprehensive range of services, including acute inpatient units. Rural CAMHS will be supported to develop a small number of acute beds which may be sited in paediatric hospitals, attached to acute adult psychiatric units, or established in conjunction with other welfare services. Day programs will be established in rural regions, possibly through joint ventures with other services such as those managed by CAFW, the DSE or NGOs. Metropolitan CAMHS will develop day programs as non-inpatient, intensive treatment and rehabilitation services. Access to respite care for behaviourally disturbed children and adolescents will also be required.

The size and staffing profile of a CAMHS will influence what services it can provide. Major services have more than three teams and can generally provide a range of assessment, treatment and liaison programs, as they can recruit and retain specialist staff. Major CAMHS will structure their services to allow triage into specialist assessment programs (for example, autism assessment), and specialist treatment programs or clinics which may support a research interest (for example, OCD or hyperactivity clinics). Smaller services, consisting of less than three teams, may be able to offer some specific programs but will need to formalise links with a larger service to obtain regular access to some specialist staff and specific programs.

Improving Service Linkages

Intra-service protocols between CAMHS and adult mental health services should be developed at a local level by service directors to improve coordination of

services to older adolescents and children of parents with serious mental illness. Inter-service protocols are useful for clarifying mutual expectations of services and standardising referral channels. Protocols have already been completed between Psychiatric Services, the Victoria Police, and Disability Services. A protocol with Protective Services is currently in draft form. Similar protocols will need to be developed between CAMHS and Primary Care agencies, and Child Adolescent and Family Welfare. These will provide a statewide framework for access to services.

To strengthen local service networks and facilitate inter-service developments, regional linkages will be forged between all services providing health and community services to children. In each region a new inter-service body will be established.

The regional Child and Adolescent Services Taskforce (CAST) will monitor and plan improvements in service delivery to client groups within the region who require inter-service links. Its main focus will be on clients where service delivery has not been satisfactory, to identify where service developments are required, recommend or pilot new cross-service initiatives, and resolve conflicts. It may also establish ad hoc work groups to expedite assessments, identify responsible services and case management structures, and support case management planning for particular clients.

The CAST will be chaired by the regional director and its membership will consist of the regional managers of all H&CS divisions concerned with services for children, adolescents and families. It will co-opt the heads of relevant major service providers including the regional CAMHS, and may invite appropriate representatives from Office of Youth Affairs, the DSE and NGOs. It is envisaged that the CAST will meet on a quarterly basis unless more frequent meetings are required.

The Boundaries of Child and Adolescent Mental Health Services

Between Generalist and Specialist Services

Primary mental health services for children and young people with less severe psychiatric disorders are provided within other services in the education, general health and welfare systems. General practitioners, paediatricians, welfare staff, disability workers, community health workers, teachers and school counsellors have the potential to identify psychosocial distress and behaviour problems, and also assist families, children and young people to manage these through providing advice and support. Primary service workers require training to recognise severe difficulties and high risk situations, and education to refer appropriately to specialist mental health services. CAMHS will provide consultation and support to primary service staff and aim to return referred patients back to this level of care as soon as possible.

The preferred auspice agencies for CAMHS will be acute hospitals which provide the infrastructure for professional development of the disciplines represented within the teams. Mainstreamed CAMHS have access to other medical investigative, consultative and treatment services, such as audiology, speech pathology, neuropsychology, clinical chemistry, and neurology, within the acute hospital system. However, while hospitals provide the most appropriate setting for those clients who require complex investigations and inpatient care, most CAMHS activities are community oriented. Community-based clinics or satellite centres are more accessible and acceptable to many consumers. CAMHS generally provide secondary and tertiary level services, and are thus distinct from staff in programs such as specialist children's services, Disability Services or general counselling services.

CAMHS do not usually provide mental health services to adults, including marital therapy, except where this occurs in relation to the treatment and management of a child or adolescent with severe psychiatric disorder. Similarly, CAMHS do not offer general family support services, although they may provide intensive family therapy as part of the treatment of psychiatric disorder. Less severe behavioural disorders or developmental difficulties may be successfully managed by paediatricians in public hospital clinics or in private practice. Referrals for court reports are not generally accepted unless the report is required as a part of the ongoing management of a client.

Private child and adolescent psychiatrists see patients with the whole range of psychiatric disorders but few practice outside the eastern and south-eastern suburbs of metropolitan Melbourne, and most do not routinely bulk bill. Many of these private psychiatrists have sessional appointments in teaching hospitals and are involved in training and supervising others in the public system. While there is overlap between the populations of patients who attend public and private services, many cases in the public system are involved with other agencies, have fewer resources, and require the specialist activities available within a team.

Between CAMHS and Adult Mental Health Services

The Directors of Clinical Services of all regional mental health services are encouraged to strengthen or establish links between adult programs and CAMHS programs in order to enhance local service coordination and planning. Such coordination and collaboration is particularly relevant for mothers and infants, older adolescents and some of the children of parents with severe mental illness.

The idea of mental health services specifically for youth has emerged in recent years because this group of clients may fall between adult mental health services and CAMHS. The pattern of psychiatric morbidity in this age group begins to resemble that of adults, and older adolescents may see themselves as distinct from younger adolescents and seek services which are separate. However, many of these young people are also likely to benefit from the developmental systemic approaches used by CAMHS staff. For those young people moving from CAMHS into the adult system, the model which exists at Monash Medical Centre between adult mental health services and CAMHS allows collaborative treatment and a seamless transfer of case management when appropriate, and may be used for the development of practices in other regions.

A Centre for Young People's Mental Health has been developed in the Western Metropolitan Region, through the integration of the Early Psychosis Prevention and Intervention Centre (EPPIC) and the Older Adolescent Service of the Royal Children's Hospital. EPPIC has successfully piloted a programmatic approach to the treatment of first episode psychosis, which often has its onset in late adolescence and early adulthood, and has a high risk of recurrence. While the majority of older adolescents who will present to the new service will not suffer from this type of disorder, it is expected that the research skills brought by this group will facilitate new models of service delivery. The centre is administered by the Royal Melbourne Hospital and will collaborate with the Royal Children's Hospital in service delivery through the Centre for Adolescent Health. It will be reviewed after three years of operation and the effectiveness of its service models will be evaluated against both adult services and CAMHS.

General Framework for Service Provision

Principles for Service Provision

Regions will ensure that CAMHS will:

1. Provide all children and adolescents with severe psychiatric disturbance with access to a comprehensive range of mental health services, whether inpatient or community-based.
2. Give priority to the most seriously disturbed children and adolescents and those most at risk for developing severe disturbance.
3. Manage less severe levels of disturbance by providing consultation, education, training and support to others in direct contact with the child or adolescent.
4. 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.
5. Provide individualised services according to the specific disturbance, developmental status, and attributes of the young person, and the strengths and limitations of their caretakers.
6. 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.
7. Assure patient confidentiality without obstructing effective cooperation between professional staff providing services to children and their families.
8. Be coordinated with health, welfare and education services in ways that ensure that children and adolescents have access to the particular mix of services they require.
9. Undertake such training and staff development to enable CAMHS professionals to apply a range of therapeutic approaches which are sensitive to the needs of young people.
10. Ensure efficient and effective use of resources to provide a range of support and intervention services which are timely and achieve quality outcomes.

Risk and Early Intervention

CAMHS are, and will continue to be, committed to early intervention on the basis that treatment provided at an early phase of a disorder reduces later morbidity from secondary complications and disabilities.

Cross-sectional and longitudinal epidemiological studies in many countries over the past two decades have confirmed that it is possible to identify stress and protective factors, and predict groups at highest risk. These client groups will receive priority in the development of preventive and early intervention programs. Generally such children or adolescents have identifiable vulnerabilities which handicap their psychosocial development, or are developing in contexts which expose them to severe stress not attenuated by parents or caretakers.

Particular combinations of genetic, constitutional or acquired biological predispositions, environmental settings, and social predicaments increase vulnerability or reduce resilience to psychiatric disturbance. Risk factors include the following:

- Chronic health problems and physical disabilities.
- Socioeconomic disadvantage.
- Physical, sexual or emotional abuse and neglect.
- Violence and disruption of relationships.
- Severe physical or emotional trauma.
- Exposure to drug and alcohol abuse.
- Severe parent/infant relationship problems and early attachment difficulties.
- Developmental disabilities, learning difficulties and intellectual disabilities.
- Brain injury or disease.
- Family history of specific disorders (for example, bipolar disorder).

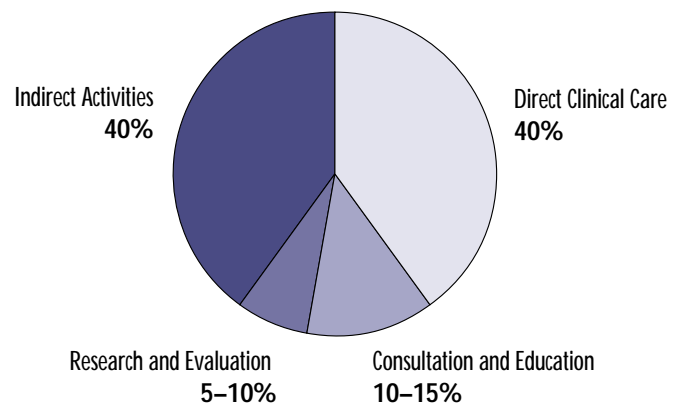
The presence of multiple factors multiplies the risk of psychiatric disorder. Identifiable groups of children and adolescents who are likely to have experienced several risk factors include:

- Children with chronic illnesses and disabilities.
- Youth presenting with suicidal ideation or suicide attempts.
- Homeless youth.
- Protective, welfare and juvenile justice system clients.
- Victims of trauma and disaster.
- Children of parents with severe mental illness, personality disorder, or drug/alcohol abuse.
- Infants and parents showing severe attachment difficulties and relationship problems.
- Children with learning difficulties at special schools and regular schools.

Direct and Indirect Services

Direct, face-to-face service delivery to clients requires a number of indirect activities including: telephone intake, consultation and liaison with referring agents or parents, case planning and coordination, recording, report and letter writing, supervision and training, case allocation and review in team meetings, quality improvement activities, staff development programs, agency administration and travel. Contemporary practice suggests that a service which deploys 40 per cent of its activity towards direct clinical care, 10–15 per cent towards direct community-related activities such as consultation and education, and 5–10 per cent towards research and outcome evaluation, requires up to 40 per cent of time for the indirect activities described above. Such activities underpin quality practice.

Figure 2: Direct and Indirect Care



There has been debate about how much client care should occur relative to consultative and educative activities with other agencies. This community-oriented work is needed to support primary care agencies to treat or manage the less severe mental health disorders. However, considerable research suggests that children with severe psychiatric disorders receive more effective treatment directly from specialist personnel. The specific proportion of resources allocated towards particular programs and particular patient populations, will be negotiated at a regional level between regional Psychiatric Services managers and CAMHS, and contracted within annual health service agreements.

CAMHS require administrative and secretarial support for dealing with reception, case records, communications with other agencies, and making practical arrangements for the efficient utilisation of resources. Each team requires some secretarial support and each service requires reception staff. Facilities for community outpatient services need to be bright and welcoming to children, young people and families. Clinical rooms must be available for small and large groups,

and video recording facilities and one-way screens are desirable for training and supervision of complex cases. Play material is a necessary diagnostic and therapeutic tool for work with children and requires constant replenishment. Access to postgraduate educational facilities, libraries, seminar rooms and lecture theatres is also essential.

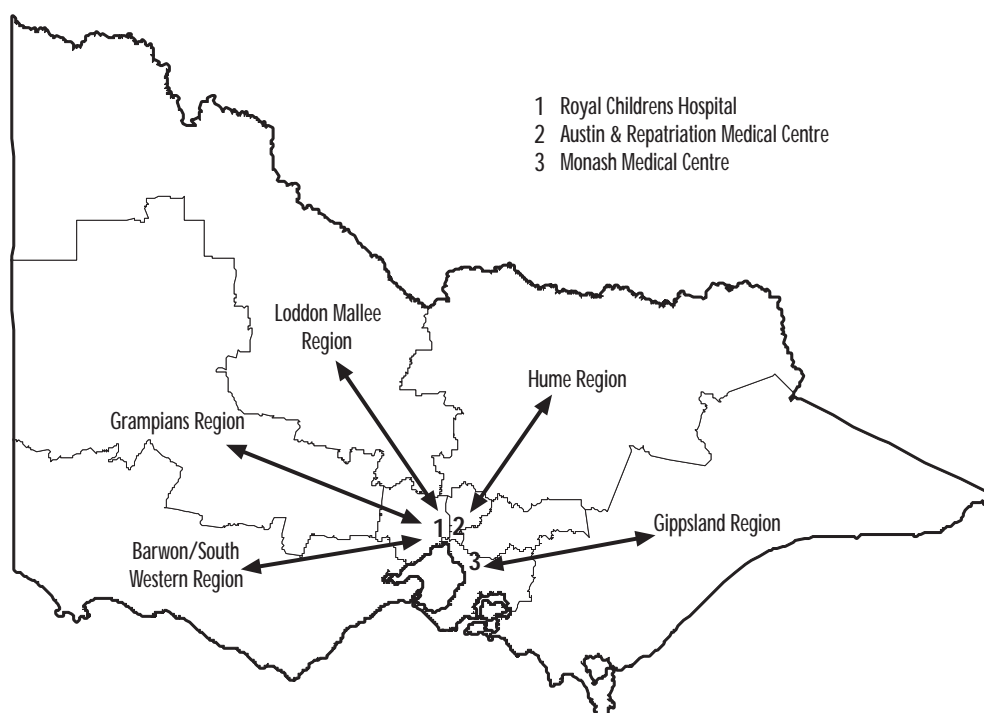
Rural Services

As rural CAMHS staff and clients frequently must travel large distances, satellite clinics, visited on a weekly or fortnightly basis, are appropriate. For consistent quality services, rural services must be of an adequate size to ensure continuity of care, and a broad range of skills and experience. The practice of establishing isolated positions in small rural centres is to be avoided, as it is unlikely to support specialist practice and may create idiosyncratic services. Rural CAMHS require medical

input and, if child psychiatrists are unavailable, consideration should be given to alternatives such as employing sessional paediatricians with child psychiatry training or an equivalent, adult psychiatrists or general practitioners who might undergo further training with supervision from a specialist centre.

Specialist opinion for complex cases and some residential treatment will need to occur through formal links with metropolitan centres. Such links allow the contracting of consultative and specialist support services, including further education and training for inservice staff development. Currently, the Barwon, Grampians, and Loddon-Mallee regions have links with the Royal Children's Hospital in the Western Metropolitan Region; Hume Region has links with the Austin and Repatriation Medical Centre in the Northern Metropolitan Region, and the Gippsland Region has links with Monash Medical Centre in the Southern Metropolitan

Figure 3: Metropolitan CAMHS Consultancy to Rural CAMHS



Region. This is an appropriate arrangement although rural regions will be able to choose between centres in purchasing services. Preliminary work at the Royal Children's Hospital suggests that primary consultation and even assessment is possible in CAMHS through ISDN telephone video conference technology. The development of video conferencing between rural and metropolitan centres will increase access to primary and secondary consultation, supervision and education, for rural CAMHS.

Psychiatric emergencies in rural areas may be appropriately managed in the following ways:

- Urgent assessment and psychiatric treatment on an outpatient basis.
- Respite care for behaviourally-disturbed children through arrangements with CAFW or NGOs, where case management of psychiatric disorders is provided by CAMHS staff.
- Intensive at-home treatment, with after-hours support available.
- Day programs may be developed in conjunction with special education/guidance staff of DSE, or with NGOs which provide family support services.
- Short-term inpatient programs for acute containment and treatment provided through paediatric hospital units, or sections of adult psychiatric units which allow separation from disturbed adults, where CAMHS staff provide case management and support to other staff.
- Complex cases requiring specialist investigation or a longer admission will continue to be admitted by arrangement to a metropolitan inpatient unit.

Rural CAMHS program managers who develop links with a major metropolitan service may require access to their specialist inpatient beds. A small multi-purpose, two-bed admission unit is being developed in Ballarat and may serve as a model for other rural CAMHS. This will be adjacent to an acute admission adult unit and may be used for up to two children or adolescents, or

mothers and babies, or a family of a disturbed child. Inpatients will be case managed during the admission by the community child and adolescent mental health team, with a pool of appropriately trained psychiatric nurses. While the CAMHS team will have the primary use of the beds, the adult services may negotiate access for work with families.

Child and Adolescent Mental Health Services at a Glance

Community Consultation and Liaison

- Inter-agency case liaison, primary, secondary and tertiary psychiatric consultations, collaborative treatment activities with other agencies.
- Court opinions.
- Program consultation and community development activities.

Levels of Clinical Care

1. Assessment, Treatment and Liaison Services

Centre- or Clinic-Based

- Emergency assessments and consultations.
- Bio-psychosocial generic psychiatric assessments and specific assessments.
- Home-based or outreach assessments.
- Individualised multi-modal treatments.
- Specific therapy programs.

Home-Based Services or Community Outreach

- Community or home-based intensive interventions (intensive case management).

Hospital Consultation and Liaison

All of the above services are provided in a hospital context to referred patients and each hospital unit is a client in the same sense as community agencies.

2. Day Program Services

- Intensive assessments.
- Intensive individualised multi-modal treatments.
- Milieu¹ experiences for resocialisation and rehabilitation.

3. Inpatient Services

- Acute seven day-a-week, 24-hour short-term inpatient treatment programs.
- Capacity for secure intensive seven day-a-week, 24-hour containment and psychiatric care and treatment.

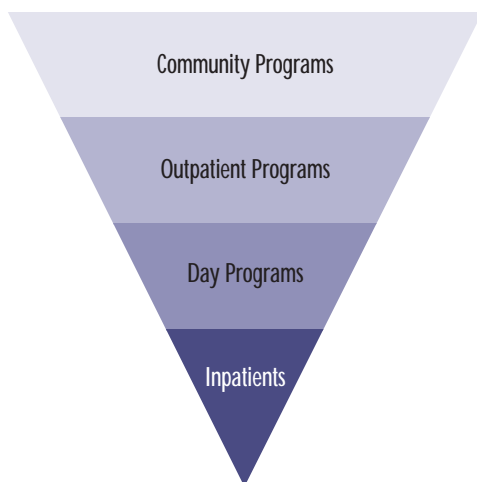
¹ The *milieu* is the total environment of day programs and inpatient programs which includes the schedules, expectations, responsibilities and program elements arranged for clients.

Comprehensive Child and Adolescent Mental Health Services

Community Consultation and Liaison

CAMHS offer a continuum of services which focus both on the needs of an individual patient and on working with the community in a variety of ways. Recent experience in providing mental health programs for homeless youth has underlined the importance of a proactive stance in reaching out into the community, maintaining a place in the service network, and providing information and consultation on an ongoing basis to those involved with youth at risk. These approaches empower and support families and other professionals, and enhance possibilities for improving the mental health of groups of children and adolescents in the community.

Figure 4: Focus of CAMHS Activities



Each CAMHS should develop a community plan to support a coordinated service response to other agencies in the community by its clinical staff and provide a framework for supervision, training and support for community-focused activities in the agency. It is recommended that an identified staff member carries portfolio responsibility for community program development. The plan will:

- Identify current and desirable key service linkages in the region served.
- Describe current and desirable community programs and the individuals responsible.
- Establish priorities for their development.
- Develop standards for providing, coordinating and recording community consultation.

During this process CAMHS will consider service development projects aimed at increasing their responsiveness to particular patient populations from non-English speaking backgrounds. Feedback about community needs and the roles required of CAMHS in the service system will be gained through membership of a regional coordinating committee (CAST) and mechanisms such as community surveys, in addition to the feedback available through network membership and consumer forums.

CAMHS telephone information and intake services will provide information to potential service users about CAMHS and about mental health of young people, to facilitate appropriate referrals and support the agency's response to urgent referrals. CAMHS should also produce written information material about their services, providing clear directions about gaining access to these services.

Conjoint activities with other services to develop or deliver mental health programs for specific populations of children and young people will be encouraged in a variety of ways. The opportunities for collaboration are extensive and include, for example, psychiatric consultancy for self-esteem raising programs for children in care, jointly run psychotherapy groups for children with learning or behavioural difficulties at a DSE school, or participation in post-traumatic debriefing at a secure welfare unit. To design services which will meet the needs of children and young people, CAMHS need to be flexible and support innovative arrangements. The regional CAST will help service managers to determine priority initiatives.

Case liaison activities, case conferences and case consultation on patients receiving services concurrently from other agencies will continue to occur. Primary, secondary and tertiary consultation will be provided, and recorded, in ways that ensure quality standards are achieved. Regular consultations will be formally developed on an inter-service agreement basis between CAMHS and key link services. Specialist staff may meet regularly with other service staff for consultation, supervision, case planning and case work focused on clients with coexisting psychiatric disorder. Inter-service agreements provide a structure to regularly review and modify consultation liaison services.

Community educational activities are an appropriate activity for CAMHS. Information about the mental health of children and adolescents, and the services available, may be provided to other health, welfare and education professional staff through workshops, seminars and written material. It is appropriate for academic CAMHS staff and the VPCAPTP to be involved in curriculum development for training programs for all professions working with children, adolescents and their families.

Levels of Clinical Care

There are three main levels of care provided by CAMHS, each requiring more intensive services and a greater degree of resource utilisation:

- Assessment, treatment and liaison services (including outreach).
- Day program.
- Inpatient services (acute care and secure care).

A comprehensive range of services for children and adolescents with severe psychiatric disorders and disabilities also requires access to welfare support programs, including special respite care, supported hostels, specialised foster programs and periods of secure welfare care.

Assessment, Treatment and Liaison Services

Centre or Clinic-Based

Psychiatric assessments must be comprehensive enough to allow accurate diagnosis and effective case planning. Diagnostic formulations identify the major factors which perpetuate difficulties or prevent their resolution, note the strengths which can be mobilised and provide the basis for an initial service plan. Crisis assessments may occur at a clinic, or hospital, or in the community if an outreach capability is available. Services will be available on a 24-hour basis through the emergency departments of the hospitals providing major CAMHS services. Otherwise most assessments will be centre or clinic-based.

An assessment includes taking a history of the presenting difficulties, developmental and health status of the young person, educational and peer relationships, and family relationships, and evaluating the child's mental status and family functioning. By using a focused and semi-structured approach to interviewing, a crisis assessment and initial case planning may be accomplished within two hours. General assessment and presentation of feedback to the family may be completed within three hours by a well-trained specialist clinician. Where workers are inexperienced, or there is evidence of perceptual or cognitive problems, developmental problems, history of abuse or other complicating factors, more extended assessments may be necessary.

Treatment is to be provided in the least restrictive and most focused manner appropriate to the particular case. This means that short-term, focused interventions will generally be utilised as the treatment of first choice, unless this intervention is unlikely to be adequate for the particular presenting problem. Where clients require an extended intervention the service plan will clearly specify the management or treatment

goals and the case will be regularly reviewed by the team. It is understood that a proportion of children and young people with chronic difficulties require ongoing support and advice, or may be intermittently referred by others or their families.

In the development of comprehensive services, regions will ensure that CAMHS build consultative linkages with the key service providers described earlier, and that specialist clinical programs are developed. These programs are for particular patient populations which require specific assessment skills, or utilise treatment approaches which are best applied to groups of patients. It is expected that the following programs will be established in all regional CAMHS or that access will be available to them:

- Homeless youth (for example, HARP model).
- Depressed and suicidal youth.
- Koori Kids Mental Health Team (ensure consultation and support continues).
- Infant clinics.
- Clinics for specific disorders (for example, disruptive behaviour disorders, attention deficit hyperactivity disorder, obsessive compulsive disorder).
- Children of parents with severe mental illness and drug abuse.
- Children and adolescents with dual disability.
- Child/adolescent psychological trauma clinics.
- Group therapy programs.
- Juvenile Justice centres and secure welfare units (psychiatrist sessions for Parkville, Ascot Vale and Windsor to be funded through CAFW).

Home-Based Services or Community Outreach

Outreach activities include attending other agencies and centres to make contact with clients or their families, accompanying children in anxiety desensitisation programs, home visiting or providing intensive home-based treatment. This level of care is only utilised after a CAMHS intake assessment has

determined its appropriateness, because two staff are usually needed to ensure occupational safety. Historically, it has been provided on a limited basis, mainly in relation to pre and post-admission negotiations with families, or establishing working relationships with special patient groups, such as children with school refusal. For certain patient groups however, treatment provided on an outreach basis can establish a relationship which leads to clinic attendance, or may help to avoid the necessity for more intensive levels of treatment.

CAT teams have changed the practice of public sector adult psychiatry services, but will not be developed within CAMHS, as the pattern of psychiatric morbidity and care of young people is different from that of adults. However, some adolescent populations require mobile responses and flexible service delivery arrangements. Intensive case management is a proven alternative to residential treatment for some patient groups which include disadvantaged, homeless, and suicidal youth, and others whose behaviour is disturbed. Intensive case management capabilities will be established in all regions, with an outreach capability to respond on a 24-hour, seven-day-a-week basis through linkages with on-call services within CAMHS, or Intensive Youth Support Service (IYSS) teams.

Hospital Consultation and Liaison Services

Hospital consultation and liaison teams may provide assessment, treatment and liaison services in a hospital context to referred patients, with an emphasis on the provision of assessment and specialist opinions to referring agents, and triage into appropriate regional services where possible. Each hospital unit is a client in the same sense as community agencies, and secondary consultation and collaborative patient management commonly occurs. Regional CAMHS should establish consultation liaison links with local paediatric inpatient services, if these are not already in existence.

Day Program Services

These weekday services provide structured activities, groups, and individual therapy, which are designed to provide intensive psychosocial support and rehabilitation for young people when their home or school environment is unable to support adequate care. A social milieu is developed to create experiences with peers and staff which lead to appropriate social learning. Family involvement is actively encouraged as an effective partnership between parents and the treating team is essential. Parents are assisted to learn new skills and to change any dysfunctional family interactions thought to contribute to the presenting difficulty. Because children and adolescents have different developmental needs, separate day programs are ideally organised for these age groupings. Child day programs are more activity-oriented, and adolescent programs use more language-based therapeutic approaches. However, where there are insufficient numbers for separate child and adolescent groups, conjoint programs may be successfully conducted with separate streams for certain activities.

Within a day program, individualised programs will be developed for each young person. Comprehensive programs require the contribution of special education teachers to cater for educational needs concurrently with needs for treatment. To achieve coordinated and focused care, a focal treatment planning model is appropriate for both day programs and inpatient programs (Nurcombe & FitzHenry Coor 1987; Nurcombe 1987a; 1987b; 1989). This defines a biopsychosocial formulation of the psychiatric disorder and identifies the pivotal problems which restrain treatment being possible at a less intensive level of care. Clinical progress, and the appropriateness of goals, is then regularly monitored, and reviewed in detail on at least a four to six-weekly basis. Day programs for children and adolescents have been underdeveloped in Victoria and are required in all metropolitan regions. Successful models are provided

by the Brief Intervention Program at the Austin and Repatriation Medical Centre, and the Royal Children's Hospital, Older Adolescent Service Day Program.

Inpatient Services

Acute Care

Inpatient units provide episodes of assessment, acute treatment and care on a 24-hour basis, in a structured environment, usually as part of a longer term treatment plan. The aim is to provide the appropriate treatment for each problem, not to provide the same treatment for all problems. Admissions occur when the child or adolescent's social system is unable to safely manage their behaviour, or where treatment cannot satisfactorily occur at a less intensive level of care. Access to inpatient beds only follows assessment and referral by qualified CAMHS staff. This may be done electively or as a crisis assessment in emergency departments. Alternatively, urgent admissions may be arranged after a telephone consultation with the unit by a suitably qualified professional, that is, an experienced CAMHS staff member, or community child and adolescent psychiatrist who has made an outpatient assessment.

Inpatient services require adequate staffing by trained staff to ensure safety and the provision of appropriate high quality treatment. Intensive or special nursing care is given when a patient requires close observation and protection from themselves, and involves continuous contact with staff until the risk status diminishes. The focal treatment planning model is useful in developing clear treatment goals, objectives, strategies, responsibilities and timeframes to achieve these, before case review. Detailed case reviews need to occur throughout an admission for all clients, with progress being reviewed at least weekly by the team.

Secure Care

All CAMHS inpatient beds will be gazetted under s. 94 of the Mental Health Act in order to remove any legal

impediments to admitting patients involuntarily and provide a legal basis for secure psychiatric care. Secure inpatient beds are needed in Victoria for adolescents who require intensive supervision, containment and treatment to ensure their safety. Services will be developed with a secure care capacity within all CAMHS inpatient services. Additional funding was provided to Monash Medical Centre for the development of 10 secure beds for adolescents. These were opened in 1995. For this to be possible without jeopardising the treatment and safety of other patients, the basic requirements are:

- Structural changes to units involving some capital works.
- Flexible staffing ratios which are responsive to care needs.
- Staff training in the management of acute psychiatric disturbance.

Each adolescent inpatient unit will require an area that can be isolated and staff arrangements which allow increase or decrease in psychiatric nurse numbers according to need. Adequate staff ratios will enable a more intensive level of observation and supervision, short-term specialising of those inpatients who are at risk, an outreach response to facilitate admissions of highly disturbed adolescents in the community and liaison with adult CAT teams, and assist integration of clients into the next level of care. Where units have not previously admitted adolescents with acute disturbance, or where there are concerns about managing acute psychosis, drug intoxication and aggression, additional staff training will facilitate safe care.

Access and Service Responsiveness

Concept

Victorian CAMHS have at times been criticised by other services for their inaccessibility, unresponsiveness, inflexibility, isolation and long waiting lists. Such descriptions suggest that there have been difficulties in how CAMHS are resourced, located, configured, managed and integrated into other service systems. They also imply confusion about what can legitimately be expected from CAMHS. Several factors influence access to services:

- Prevalence of severe psychiatric disorder.
- Motivation of individual communities and families to use services and transport available.
- Availability of other health and family support services.
- Primary mental health services available to children and adolescents.
- Physical location, appearance and reputation of a mental health service.
- Level of staffing and resources relative to size of population served.
- Information about the service and consultative linkages with other services.
- CAMHS intake policies, and assessment, consultation and treatment programs available.
- CAMHS management effectiveness, staff structures, cultures and work practices.

Good access requires adequate resourcing of services for children and adolescents, together with mechanisms which ensure their efficient utilisation. Appropriate service usage by parents and young people is enhanced through community education and by CAMHS becoming more consumer focused. CAMHS operate within a network of services. Professional education, formal consultative linkages between CAMHS and other services, and referral protocols, will facilitate appropriate referrals.

Planning must ensure services are sited where they will be accessible to their clients and the use of centres or

clinics located close to population centres will be encouraged. CAMHS are usually hospital or centre-based, but they may also provide services from other sites. Staff may travel several days a week to provide services from a satellite clinic (for example, the Werribee model), or specialist staff may travel from the centre or hospital to work with a team based at the satellite centre (for example, the Frankston model). This latter arrangement resembles that existing in rural CAMHS, where individual specialists may be contracted from a metropolitan unit on a sessional basis to complement the skills available in the team, and ensure that all appropriate specialist components are available to a community. Using other H&CS facilities for sessional services will enhance cost savings and build inter-service linkages.

Service Demand

It has been noted that 10–20 per cent of children and adolescents in westernised urban communities have identifiable psychiatric disorders, with 3–5 per cent requiring specialist treatment. If only half of these young people with severe problems can be appropriately recognised and referred, then 20,000–30,000 young people each year from the Victorian under-18 year old population will seek services from CAMHS. Other young people must be assisted through providing mental health education and consultative support to other services, and to families and young people themselves. This can only be achieved through new inter-service initiatives aimed at the needs of young people and families.

Referral Pathways

There has been considerable variation between services in pathways of referral. Referral routes to CAMHS must be flexible, simple and inclusive rather than exclusive, and therefore, both written and telephone referrals are to be acceptable. If more information about a written referral is required to decide its

appropriateness, CAMHS themselves will take responsibility for gaining it. Telephone information and intake services will continue to be provided by all CAMHS. Several models for these services exist, but it is more effective when a service deploys a small number of staff dedicated to telephone information and intake. Many aspects of the task can be managed by a well-trained and well-supported administrative staff member who consults clinical staff when required (Austin and Repatriation Medical Centre model). Clinical staff can also legitimately carry out the role (Monash Medical Centre model), particularly where administrative aspects are largely automated.

A framework of standards for administrative and clinical aspects of telephone and referral services is needed and the CAMHS Directors and Intake Workers Forum may be appropriate for the development of such a document. Individual CAMHS will develop written information material to facilitate appropriate referrals from potential referring agents or clients, and orientate consumers to their services. Psychiatric Services Branch will prepare general referral information about Victorian CAMHS. This will enhance community understanding and provide general advice to primary services about how to make referrals and what responses can be expected from specialist services.

Criteria for Intake

CAMHS will accept referrals of children and adolescents up to the age of 18 years inclusively, if they present difficulties that suggest the presence of severe psychiatric disorder, or that there is high risk of such disorder. CAMHS will not exclude clients because of variables such as school attendance, stability of residence, pending court appearances, unstable placements, or ambivalent motivation of client or parent, although these factors will influence what kinds of intervention are possible. Services normally require a decision by the carer of the child or adolescent to

attend and to consent to treatment, but older adolescents may engage independently.

A full range of services may not be available in every CAMHS, which will affect the capacity to accept referrals. Referrals may not be accepted if they are thought to present psychosocial adjustment difficulties which are likely to resolve, or the problems seem primarily school-based, or when it is considered that other agencies are better able to manage the presenting difficulty (for example, child protection, disability services, acute health, adult mental health services, private practitioners). These judgements will be made by experienced practitioners or by intake workers in consultation with such staff.

Cases referred primarily for medico-legal reports may also not be accepted by public CAMHS. Services without the full range of adequately trained specialist staff will have limited assessment and treatment options and may continue to use explicit exclusion criteria which relate to services which are not provided. Clients will *not* be excluded for criteria which relate to their having offended, or to be suffering from a personality disorder, although the initial response to clients thought to have an antisocial personality disorder and are posing a threat to others may primarily be the responsibility of Protective Services, secure welfare or Victoria Police.

Service Priorities and Case Disposition

Service priority will be given to suicidal, psychotic, and severely disturbed children and young people whose behaviour is causing risk of harm to self and others. These patients will be regarded as psychiatric emergencies and will be seen for assessment within hours of the referral. Similar situations with a lesser degree of risk, or where the family or caretakers can provide immediate containment and safety, will be regarded as priority cases and given priority appointments within five working days of referral.

When the referral rate greatly exceeds the capacity to manage them, services need to use a range of strategies. These include monitoring a waiting list, informing referral sources of long waiting times, actively managing the list and reviewing the priority of cases, and utilising service delivery approaches such as offering assessments to groups of clients or using single session interventions. Allocation of referrals to clinicians after intake will depend upon how the case is initially perceived, the priority it is given, and the availability of staff to offer assessment appointments. CAMHS appropriately triage a significant number of referrals to other services, including private practitioners, paediatricians, general practitioners, family support and counselling services. When this occurs there must be opportunity for a re-referral, if the alternate service is unsuccessful.

Clinical Care

Intake and Case Flow

It is essential that all referrals to CAMHS are processed systematically so that referring agents and clients can know what to expect. Consistent with other specialised health services, CAMHS referrals will generally come via other professionals in health, welfare or education. Concerned parents may seek advice, and their children may be directly accepted as clients if a severe psychiatric disorder seems likely. Parents who self-refer their children may be asked to consult initially with their general practitioner to exclude medical conditions.

The intake process will record all referrals, determine an appropriate initial response, and assign a suitably qualified clinician or clinicians, depending on the perceived needs of the case and the skills of available staff members. All referrals require early feedback to the referring agent. Any referral not accepted for clinical assessment must be discussed with the referring agent, a clear rationale provided and alternate possibilities offered. These may include secondary consultation, advice about eligibility criteria and information about

other services. Otherwise the assigned clinician will assume the case manager role and arrange assessment appointments in a clinic or community setting, and involve other case workers in specialist assessment roles if necessary.

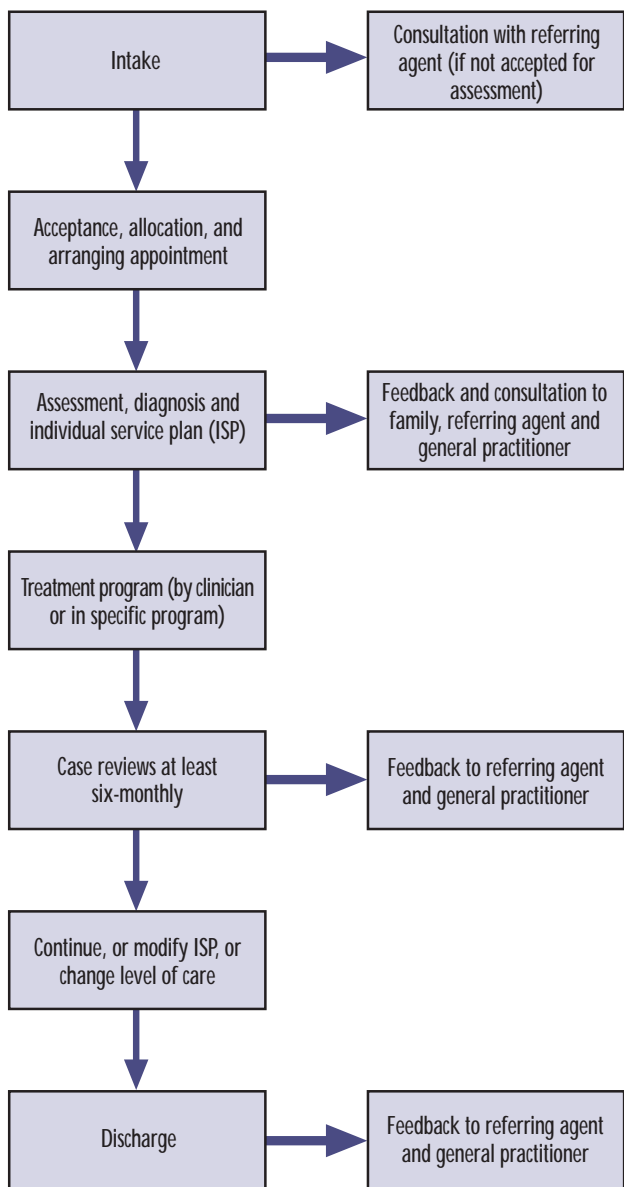
Following the completion of an adequate assessment, a diagnosis and case formulation will be made, and an individual service plan (ISP) will be constructed. This may lead to a consultation with the referring agent who resumes the care of the patient, to further specialised assessment, to triage to another service, or to negotiation of a treatment contact with the patient and family. Treatment programs will be tailored to the presenting difficulties and take account of the strengths and vulnerabilities of young person, family and community, the severity of disturbance and the degree of risk. Service delivery will utilise the following case management standards.

Case Management

Each consumer must have a named staff member who has case management responsibility. Case managers within CAMHS have the following responsibilities in providing coordinated client care, consistent with the general H&CS client services model:

- Engaging the family.
- Ensuring clients who require immediate treatment or action are attended to immediately.
- Arranging a comprehensive assessment which may involve other specialists if required.
- Making a diagnosis and formulation of the problem.
- Constructing an ISP for case management.
- Providing feedback to the family and referring agent.
- Negotiating the ISP with young person and family.
- Consulting with relevant other service providers.
- Ensuring adequate documentation.
- Implementing the plan and reviewing its progress until discharge.

Figure 5: Case Flow Diagram



CAMHS will utilise the case management principles defined in the H&CS document *Victoria's Mental Health Services: Improved Access through Coordinated Client Care*. The ISP will detail:

- The current situation and definition of problem/s.
- The goals to improve the situation and indicators of their achievement.
- The strategies for achieving the goals.
- The person(s) responsible for implementing these strategies.
- The date of review.

A multidisciplinary CAMHS team provides its members with specialist consultative advice during this process, and relevant professional supervision will be arranged by the service if required. Complex cases may require two staff members, one of whom acts as the case manager and the other as a co-worker with defined responsibilities. Protocols for transfer of cases will ensure maximum continuity of care between parts of a service; for example, community staff will resume the care of a client after discharge from inpatient care.

A proportion of clients with chronic difficulties will require extended care and specialist support over periods of years. All such clients in extended treatment will be regularly reviewed by the team or team leader, that is their ISP will be evaluated on a six-monthly basis, or after 20 sessions. This is to ensure case management is appropriate and that ongoing benefit is being derived from the implementation of the plan. CAMHS which do not already utilise such practices will need to develop mechanisms to ensure case reviews are introduced, and that they reliably occur. When management or treatment goals have been achieved, patients will be discharged from the service unless new ISPs are established. Prior to this case closure, a patient remains the responsibility of the case manager, team and service.

Inpatient Admission and Discharge Processes

Within the general hospital context, the decision to offer admission rests with the consultant psychiatrists and team leaders of the CAMHS teams. It is appropriate that all psychiatrists and team leaders in the service have admitting rights in order to maximise bed utilisation when admission is thought to offer benefit. When considering admission, clinicians will need to address the ability of the child or adolescent to consent to treatment. Where the child or adolescent is unable to consent then the consent of a parent or guardian is sufficient authority to treat a child under 18. Adolescents who meet the criteria for involuntary admission (under s.8 of the Mental Health Act), and are unable to give informed consent to necessary inpatient treatment, may be admitted to gazetted beds.

When parents maintain responsibility for care they retain legal authority to consent and must be involved closely in all aspects of treatment for their children. There may be tension when caretakers or other service providers seek admission for a client and there is no bed available, or inpatient admission is not thought appropriate by the CAMHS. In these circumstances, the regional CAMHS has an obligation to provide an alternative appropriate intervention at a less intensive level of care.

Case managers will plan for the discharge and follow up care of all admitted patients from the time that admission is being considered. During admission, more detailed consideration will be given to the timing of discharge, the provision of appropriate community support, reintroduction to the school education system or vocational training, and how to continue treatment at a reduced level of care.

ISPs at discharge will involve young people and their parents or guardians in their preparation, will specify the responsibilities of individual staff, and will be

communicated to other professionals involved in the care of the patient within three working days of the discharge date.

Specific Access Problems and Their Solution

In the past, several factors have restrained services from being consistently and adequately responsive to the following groups of referrals:

- Children who are awaiting court decisions with placement implications.
- Young offenders with persistent offending patterns.
- Clients or families who are not motivated to attend.
- Requests for psychotherapy for children in care prior to an established placement.
- Mild psychiatric disorders or those already in treatment at other agencies.
- Requests for admission of aggressive adolescents in crisis.
- Requests for admission of adolescents with severe personality disorders who are ambivalent about the admission, and who have no exit placement.

Court reports must be provided within short time frames, which means that booked appointments with other clients in busy clinics must be cancelled or postponed. Specialist forensic psychiatry services for children and adolescents do not exist in Victoria, although Juvenile Justice employs psychologists to provide rehabilitation programs. Currently the Children's Court Assessment Service, within the Justice Department, provides psychiatric assessments at the request of the Children's Court magistrates. Requests for court reports from solicitors will continue to be passed to fee for service private psychiatry practitioners, although clients with severe psychiatric disturbances will continue to be accepted for treatment by public CAMHS.

Requests for psychiatric assessments from other H&CS staff (for example, Protective Services or Disability Services) which may be presented in court, but whose primary purpose is to assist case planning on complex cases will continue to be accepted by CAMHS. Juvenile Justice centres should develop contracts with regional CAMHS to secure consultant child psychiatrist input to their service, to complement services provided by their existing psychologists and psychiatric nurses, and ensure that comprehensive mental health services are available to their clients. This has the advantage of helping to mainstream clients back into the general system after their discharge back into the community.

Specific requests for intensive psychotherapy for clients who are in unstable placements or changing care settings will not usually be accepted, although assessment, consultation and other relevant treatment will be provided. Children require a stable point of reference in a changing world, and continuity of a relationship with an adult who demonstrates an ongoing interest and commitment is crucial. Psychotherapy confuses children who have no committed caregiver, although a substitute care figure may benefit from specialist consultancy and support when taking on a child whose life has been in turmoil and who has failed to attach in previous placements. Once a person with primary responsibility for care taking has been identified, and this relationship is being established, then psychotherapy may be indicated for some children.

Where potential referring agents are concerned about a child, but parents do not seem interested in attending, a consultation may be requested from CAMHS about the case and how motivation for seeking services might be enhanced. Options here include secondary consultation aimed at increasing parental understanding of the need for referral or reducing anxiety about services, arranging a clinic visit or home visit together with the referring agent, and negotiating a home-based assessment if problems seem severe.

Additional adolescent psychiatric inpatient and day patient places will be created so that adolescents under the age of 16 need not be admitted to adult psychiatric facilities as the only choice of treatment. Inpatient places for children and adolescents must cater for patients with a heterogeneous range of problems. As many of these patients are particularly vulnerable, units can only safely manage a small number of disinhibited or aggressive patients at any one time without jeopardising the treatment of other patients. Adolescents who present primarily with disinhibition and aggression may be better assessed by a CAT service or brought to CAMHS on-call psychiatrists in emergency departments, if a major psychiatric disorder is suspected. Secure acute psychiatric beds for adolescents will be developed within the current adolescent units in each metropolitan region.

Another group of adolescents with personality disturbances may present with suicide threats and self-injury, ambivalence about psychiatric admission, re-enacting past experiences with current care staff. These young people require containment, care and treatment, but do not consistently demonstrate the type of disturbed behaviour that would warrant involuntary detention under the Mental Health Act. Psychiatric treatment programs for these clients will be designed within the current service system through the auspice of appropriate NGO supported accommodation services, with the support of IYSS teams which include psychiatric personnel who occupy a mental health intensive youth support (MHIYS) role. Containment during periods of crisis will be provided in secure welfare facilities under the provisions of the *Children and Young Person's Act 1989*, or through admissions to psychiatry inpatient units, with continuity of care being provided through the mental health intensive youth support worker.

The components of a comprehensive framework for service delivery to these clients will be:

- Regionally-based hostels (managed by NGOs) with a support/rehabilitation focus and input from mental health staff and IYSS teams.
- Formal consultative linkages between CAMHS and these services to develop appropriate care plans and treatment services.
- Access to a holding environment in secure welfare settings when this is required during crises. Psychiatric Services will encourage an interpretation of the Children and Young Person's Act which enables a period in secure care to be extended in some circumstances.
- Comprehensive regional CAMHS will include access to acute psychiatric inpatient care, rehabilitation-oriented day programs, and treatment services for clients with post-traumatic stress disorder.
- CAMHS will be funded to develop a mobile mental health intensive case management capability, to operate within IYSS teams, to provide psychiatric treatment when this is required, and continuity of care and transition into other programs.

Planning and Resourcing

Resourcing for Services to Children and Adolescents

Mental health services in some areas of Victoria have struggled to meet the needs of children and adolescents with severe mental illness. Because of limited regional inpatient facilities, young people under the age of 16 years have had to be admitted to adult psychiatric units, or to beds far from their area of residence. Referral rates to CAMHS have increased in most areas as local communities have become more aware of the mental health needs of children and adolescents and the services available. Therefore further development of mental health services for children and adolescents in Victoria must occur.

CAMHS will be given high priority in the allocation of new funds as they become available, and services will be redeveloped to maximise their responsiveness and effectiveness. Victoria's Mental Health Service: The Framework for Service Delivery foreshadowed that some of the resources made available from the closure of adult inpatient facilities may be transferred to CAMHS. Regions will be encouraged to redistribute resources to achieve the service targets described here. This redistribution process is exemplified in the Barwon South Western Region which has been able to utilise efficiency gains in adult services to further increase the size of their regional CAMHS.

A portfolio area dedicated to child and adolescent mental health has been established within Psychiatric Services Branch with responsibility for implementing the program direction of CAMHS, for monitoring its appropriateness and effectiveness, and for ensuring ongoing coordination and support of the regions and hospitals. In CAMHS, the aim will be to provide the maximum proportion of services through community-based interventions, although it is recognised that more intensive treatment will be required by some patients. This will be delivered through outreach, day programs and inpatient services.

Funding Approach

CAMHS community-based services will be developed within the context of the weighted population resource allocation formula outlined in *A Funding Framework for Mental Health Services in Victoria*. This development will reflect the distribution of the under-19 year old population within Victoria, the general socio-economic status of their families, and whether they live in a rural area. These factors all influence service use by families. This needs-based approach, which allocates resources to a population through applying weightings for demographic factors, allocates a global budget for mental health services to regions. The resources allocated to children and adolescents are not intended to fall below current levels and will aim to achieve an increased proportion of the regional Psychiatric Services allocation.

Regional directors and Psychiatric Services managers will be responsible for determining, in a collaborative way, the most appropriate mix, structure and location of services in each area, after considering the distribution of the population and demand for services. While regions will be able to purchase services from outside their boundaries where appropriate services are not locally available, it is expected that, over time, regions will develop relationships with a single service provider which will deliver comprehensive CAMHS to the region or sub-region.

Guidelines for Regional Service Development

Currently some regions are served by several different CAMHS, and some regionally-based centres provide cross-regional services. For example, the Austin and Repatriation Medical Centre CAMHS, based in the Northern Metropolitan Region, provides services to the inner sector of the Eastern Metropolitan Region, while the Royal Children's Hospital CAMHS, based in the

Western Metropolitan Region, provides services to the western sector of the Northern Metropolitan Region. It is planned that, in the future, services will be developed more clearly on a regional basis, whilst, so far as practicable, accommodating the natural flow of clients along existing transport corridors. In the immediate term, new service elements will be established using existing infrastructures in adjacent regions. For example, Monash Medical Centre will auspice some services for the middle and outer areas of the Eastern Metropolitan Region until facilities become available at Maroondah Hospital.

Regional planning will aim to develop comprehensive mental health services for children and adolescents. For rural regions some specialist services may need to be provided through formal arrangements with a suitable metropolitan service. Planning will consider the population distribution and growth areas to determine where community-based services, day programs and inpatient facilities are optimally located, including consideration of satellite centres.

The development of new services will occur in a staged process as staff become available. The first priority is an equitable distribution of community assessment, treatment (including day programs) and liaison services within the regions, and the development of an intensive case management (outreach) capability. A further priority is developing regular liaison links with local paediatric services for primary service provision and consultation, and establishing secondary consultation arrangements with the major welfare service providers, which includes services to homeless youth, and school education facilities. Existing staff roles may need reviewing in some services.

Community-Based Child and Adolescent Mental Health Services

The components of a comprehensive community-based CAMHS are described earlier. The order of priority for the basic service elements is as follows:

- Intake and emergency or crisis responses.
- Assessment and treatment services.
- Intensive case management (mobile support).
- Community consultation and liaison.
- Specific clinical programs.
- Day programs.

A basic community CAMHS clinical team, which can provide assessment and treatment skills in the biological, psychological and social domains, has been described. The specific mix of disciplines and size may be varied for different settings, depending on the responsibilities and size of the service, the resources available, and the staffing profile of related services. For example, a team may want to develop an activity-based group program for children and therefore employ an occupational therapist with skills in group work and psychodrama.

Similarly, a rural team may use sessions to employ a part-time paediatrician with child psychiatry training, and contract visiting sessional services from a private metropolitan-based psychiatrist when a full-time psychiatrist is not available. Services that do not have access to experienced staff from one particular discipline, may employ a greater proportion of the others, as long as a comprehensive mix of assessment and treatment skills is available.

While the concept of a single team is valuable in service planning, experience has shown that in order to function effectively over time such a team requires connections with a larger professional staff complement, and strong and consistent linkages with other

CAMHS. Such arrangements create the depth of staffing to allow continuity of client care, an appropriate mix of skills necessary for quality services, and appropriate staff development and professional support.

Using the guide of a planning ratio of 20 clinical EFT per 100,000 population aged under 18 years would result in a total of 242 community EFT positions for the whole State. Table 1 below shows a regional distribution of community CAMHS clinical EFT positions across Victoria based on the weighted population share described in the Funding Framework for Mental Health Services in Victoria (August 1994).

Day Program Services

Each region will identify the extent of the need for psychosocial rehabilitative day programs for children and adolescents, in conjunction with the major service providers. Community-based services will be expected to deploy staff to establish day programs in regions where these do not already exist as distinct programs, or as service elements attached to inpatient units. Access to these programs may be from a community team or an inpatient stay. Day programs require open space for recreational activities and activity-oriented therapeutic programs, in addition to internal areas for group activities and individual interviewing rooms.

Further consideration will need to be given where the population is less than 100,000 children and adolescents. In regions where the total under-19 year population is less than 200,000 it may be necessary to combine children and adolescents in the same program, with appropriate modifications to meet the developmental needs of each group. Experience has demonstrated that day programs for six to twelve children or adolescents can be offered by a small team of part-time psychologist and other allied health or nursing staff who provide group therapy programs and family interventions. These staff require support from medical staff and special education teachers as well as clerical support.

This group size allows cost-effective staff/client ratios. Appropriate educational activities are vital in day programs, and these will need to be developed in conjunction with special education teachers from the DSE, or with other staff from welfare or preschool agencies in the case of younger children. Alternatively joint programs may be negotiated at a regional level with the DSE to meet the psychiatric and educational needs of clients.

Table 1: Community-Based Services Clinical EFT Staff by Region

Region	Barwon	Gramps	Loddon Mallee	Hume	Gipps.	West Metro	North Metro	East Metro	South Metro	All
Wghtd. Target	18.6	11.1	16.2	15.2	14.3	37	41.4	31.2	57	242.0
Current	14.5	10.6	10.2	9.0	6.8	28.9	20.3*	21.3**	43.1	167.7
Reqd.	4.1	0.5	6.0	6.2	7.5	8.1	21.1	9.9	13.9	77.3

* includes 6 EFT at Royal Children's Hospital who provide services to Northern Metropolitan Region.

** includes additional 12 clinical staff funded during the 1994-95 period.

Inpatient Services

Each region requires accessible and responsive acute psychiatric inpatient services attached to, or collocated with, an appropriate general or paediatric hospital. This provides acute health services and support for children and adolescents with complex difficulties. Young people require more intensive supervision and concurrent family intervention than adults, and the appropriate resourcing levels for a ten to twelve bed acute psychiatric inpatient unit have been established.

As a minimum, the staffing profile will require experienced psychiatric consultant staff, medical officer or psychiatric registrar, clinical psychologist, social worker, and occupational therapist, as well as CAMHS psychiatric nurses. Access to paediatricians, other allied health disciplines and investigative services is also necessary. Services will need to create a pool of nursing staff to ensure adequate care when additional patient supervision is required, and develop a mechanism for funding this intensive care, such as use of a behavioural nursing dependency index.

Inpatient services will provide acute treatment programs for a wide range of disorders, and develop referral and follow up networks with other regional service providers. Regional units will provide flexibility of service provision and enhance access and continuity of care within a particular service and area. Capital works may be necessary to ensure that all existing

units can provide a more secure environment during periods where intensive supervision is required.

With the development of outreach intensive treatment programs, the use of shared innovative acute inpatient facilities in rural areas, and an expansion of day programs, the demand for psychiatric beds required in Victoria is estimated to be one bed per 15,000. This means approximately 70 beds are required (Table 2).

Further planning for the most equitable distribution of inpatient beds will await the experience of regional services once adequate community CAMHS services have been operating effectively, day programs are in place and a pilot project of a home-based intensive treatment service has been evaluated.

Statewide Services

These specialist services provide training to professionals, or assessment, treatment and support to children, adolescents and their families from all regions. Because they support, or complement the CAMHS activities of all regions, the funding for these services is not included in the regional weighted allocations. Child and adolescent mental health statewide services comprise:

- *Bouverie Clinic* provides a clinical service which is linked with its training functions in the field of family systems therapy. The programs provided by this service are not confined to CAMHS, and its clients come from all regions of Victoria.

Table 2: Numbers of Child and Adolescent Inpatient Beds by Region

Region	Barwon	Gramps	Loddon Mallee	Hume	Gipps.	West Metro	North Metro	East Metro	South Metro	All
Target	2	2	2	2	2	18	12	12	20	72
Current	0	0	0	0	0	16	16	0*	20	52
Reqd.	2	2	2	2	2	2	- 4	12	0	20

* 10 beds commissioned at Monash Medical Centre now provide services to the Eastern Metropolitan Region.

- *VPCAPTP* is the only accredited program to provide specialist training to psychiatrists, paediatricians, allied health professionals, welfare and Koori health workers from all parts of the state.
- *Statewide Tertiary Specialist Paediatric Care* is provided from the Royal Children's Hospital and Monash Medical Centre, and their CAMHS consultation liaison services provide assessment, consultation and treatment to children and adolescents from all regions.

A review of inpatient service delivery to children and families will be undertaken in 1996 with the aim of determining the best service profile to meet the low need for inpatient services for this group.

Child and Adolescent Mental Health Service Outcomes and Accountability

Service Outcomes

The desirable outcomes for CAMHS clients are as follows:

For individual patients:

- Reduced emotional and behavioural symptoms of psychiatric disorder through appropriate consultative and treatment programs.
- Improved wellbeing and self-esteem through enhancing family and social relationships.
- Improved social functioning and quality of life through treatment, support and collaboration with other services and support systems.
- Reduced deterioration of psychiatric disorder through appropriate early intervention services to young people at risk.

For the community:

- Increased knowledge about psychiatric disorders in childhood and adolescence through research and evaluation.
- Reduced prevalence of severe psychiatric disturbance through professional and community education about risk and protective factors in child and adolescent mental health.
- Increased knowledge among other professionals about current CAMHS and enhanced capacity to work with children and adolescents.
- Improved collaboration and coordination between services through provision of consultancy and support to other services working with psychiatrically disturbed children and adolescents.

Management

These specialist services will be identified, funded and managed as a discrete program within their host organisation. Psychiatric Services has established program budget accountability with specific conditions for service providers outlined in the Framework and the Expressions of Interest documents. A number of conditions are mandatory, including:

- Funds provided for the provision of mental health services must be separately identified and directed solely to the provision of services for the target group of clients.
- The mental health service must have a single point of management and accountability with a designated position responsible for psychiatric program direction, management, achievement of service standards and outcomes of health service agreements.
- All service activity is to be reported using PRISM, according to PRISM coding and computer user manuals.

The intention of the above is to ensure that these funds are specifically directed to the target population of children and adolescents, and not to related groups. The person responsible for the management of these mental health services and accountable for service outputs, requires the formal authority to determine the discipline balance, recruitment, and staff deployment in their particular programs. Program management needs the flexibility to arrange staffing based on best practice rather than historical precedent. They must establish and maintain close relationships with clinical managers to ensure quality and appropriateness of treatment. Since CAMHS multi-disciplinary teams are the core working units for service delivery, organisational structures must be primarily designed to support the work of these teams.

Discipline-based departments of auspice health organisations will play an important role in staff selection and specific professional development, as the contribution made by each discipline must be maintained at the highest quality. Other professional development may be better supported through the multi-disciplinary program, particularly in the areas of team work, generic assessment, case management, and treatment skills. The provision of comprehensive services depends upon ongoing collaboration and consultation between team members with different professional

skills. This need not mean that experienced workers from any discipline cannot manage patients on their own. It does mean that lone CAMHS workers cannot be established in any setting without reducing the quality of the service, restricting the types of patients who can be successfully managed, and exposing these workers and clients to unrealistic expectations.

Mechanisms for Service Accountability

Services are accountable through their management and that of their auspice agency. Accountability is achieved through the financial and activity reporting process of the agency to the regional office. Activity and financial data will be submitted as specified in the health service agreement. This data may be monitored and compared across services by Psychiatric Services Branch. All inpatient services will use PRISM for reporting activity. Hospitals which currently do not use PRISM for outpatient services will report this data in a PRISM-compatible format until the current review of PRISM is completed.

The PRISM review, currently being undertaken by Psychiatric Services, will include consultation with senior CAMHS staff, so that the minimum psychiatric services data set for Victoria is designed to be appropriate for all Psychiatric Services programs, including CAMHS. The process will also consider appropriate outcome measures and performance indicators. A standard minimum Victorian CAMHS data set will provide a common platform for clinical evaluation and research across CAMHS and be compatible with other states. The review will take place against the development of a national health information model and a revised national data set under the auspice of the Australian Health Minister's Advisory Council (AHMAC). This will necessitate refinement of existing systems but will provide a basis for common activity indicators for all publicly funded health services in Australia.

It is understood that CAMHS have an interest in systematically collecting other data for particular research purposes, and for internal service monitoring and evaluation. Service evaluation and research is increasingly dependent on the development of computer-based information systems that provide easily retrievable data about service activity and outcomes. Services require information about the pattern of referrals, the numbers of cases assessed and managed, their clinical diagnoses, indicators of clinical complexity, and the service activity required for the comprehensive care of these patients. They also need to monitor the community services they provide to the general population and other agencies. Regions and CAMHS each require information about the costs of service delivery to enable accountable management. Psychiatric Services Branch requires comparable utilisation data for equitable service monitoring and planning. The CAMHS data set therefore will be standardised, and the system of data collection made as simple as possible.

Assessment, treatment and liaison service activities currently contain some anomalies which must be overcome in order to develop an aggregate measure of service activity which reflects the costs of providing services to clients. Whether or not a contact is face-to-face has previously been one of the dimensions used to classify a service, but with the development of video conference assessments this distinction becomes less clear. In the immediate term these services will be counted separately. Group therapy, which provides services to several patients at the same time, is generally to be encouraged as a treatment of proven effectiveness. However, if each patient contact is credited for the time of a group service, this creates an artificially inflated measure of service output. Conversely, if only one patient is credited as having received the service, this creates an equally artificial underestimate of services provided. Therefore a formula will be developed which compensates for the fact that group therapy requires more preparation, supervision and recording than other approaches.

Measures of service activity do not need to count every facet of service delivery, as they do not reflect their relative importance in the business of providing clinical care. Data regarding telephone calls need not be routinely collected, although services may choose to do this for internal purposes. In the past, only case managers have recorded service activities, however it is more appropriate for all clinical staff to record their non-inpatient and non-day patient activities, as this better reflects true clinical costs. Measures must be simple, and capable of being summed to create activity indicators that can be related to the number of equivalent full time clinical staff in the service, (for example, total contact hours for community assessment, treatment and liaison services will be created from total individual patient contact hours, adjusted group contact hours, family contact hours, community liaison contact hours, video conference contact hours, and outreach outpatient contact hours).

Performance indicators for assessment, treatment and liaison service teams will include the number of outpatients accepted for services per clinical positions, the proportion of new to continuing care patients, and the length of time between referral and first appointment. These will need to be interpreted in conjunction with measures of the effectiveness of service outputs, in terms of the outcomes achieved for clients. Day patients and day attendances will be monitored, as will inpatient admissions/separations and occupied bed days, together with measures of length of stay. Service outcome measures will be developed to provide feedback about quality, and to enable services to properly evaluate their effectiveness. These measures will need to include the perspective of several parties including clients, and be multi-dimensional. They may include: client satisfaction, relative symptom reduction (effect size), measures of general functioning and health, and relative increase in quality of life measure scores. The development of appropriate measures is a major challenge, but is seen as a critical component in the evolution of future funding mechanisms.

Ensuring Service Standards

The establishment of clear standards and the setting of performance benchmarks are required to support clinical staff to deliver quality mental health services. All CAMHS auspiced by acute hospitals will be expected to meet the accreditation standards of the Australian Council of Hospitals. These standards cover most aspects of service functioning such as case recording, medical records, report writing and communication with other agencies. The AHMAC process now underway for developing outcome standards for mental health services will include services for children and adolescents.

The document Victoria's Mental Health Services: Improved Access through Coordinated Client Care, describes H&CS standards for clinical case planning and case management, which will be the minimum expectation for all CAMHS staff.

Ongoing research and evaluation, staff development and training is required in all CAMHS so that all staff are able to utilise the most effective assessment and treatment approaches possible for their patients. Clinical audit and peer review of case practice must occur routinely, together with ongoing professional education and supervision. Case plans for all patients receiving assessment and treatment services will be reviewed at least six-monthly, and be approved and signed off by the team leader or consultant child and adolescent psychiatrist. Each service must ensure that appropriate case recording and communication with outside professional staff reliably occurs.

Clinical service standards are generally the responsibility of the director of clinical services of the particular CAMHS, or the auspice agency of a smaller service. Professional standards are the responsibility of the senior discipline member within that service and its auspice agency. Clear organisational arrangements are necessary so that all staff are aware of accountability

lines. Health service staff owe patients a duty of care, and clinicians are expected to perform their duties in ways that are consistent with the practice standards of that profession. Directors of clinical services must ensure that case management meets appropriate standards for quality care, and that there are processes to resolve disputes over case management. Quality management practices are required, such as quality improvement cycles or quality assurance processes, which focus on service systems. These provide essential feedback to service providers about where processes may be improved.

Services should aim to foster consumer feedback through such mechanisms as establishing community reference groups, supporting consumer advocacy groups, and surveying consumer satisfaction. Team reviews or service clinical review meetings also provide opportunities to identify how clinical casework and case management practices can be improved. Quality performance indicators may usefully focus on situations where patients require treatment of unusual complexity or length, where outcomes have been poorer than expected or clients have complained, or where case management has been extremely effective. Measures of service effectiveness will include the average cost of treatment or contact, given agreed benchmarks of satisfactory outcome.

Research, Training and Education

Research

Research in CAMHS is essential to guide service development, improve clinical practices and stimulate new service initiatives, in the same way that ongoing evaluation maintains and improves service quality. The creation of academic positions in child and adolescent psychiatry in Victoria has been successful in helping to recruit and retain staff with research and teaching skills in the public sector. However, the distribution of these positions is skewed.

To support equitable regional development any further academic child and adolescent psychiatry or allied health positions will be located in regions where these do not exist currently. Such positions may have links with the VPCAPTP, to develop and support research expertise among CAMHS allied health staff, and enhance training programs in child and adolescent mental health for allied health and nursing staff.

Research projects in child and adolescent psychiatry will generally be funded from external grants. Academic staff are expected to generate additional research income through grant applications from research funding bodies. Psychiatric Services funded CAMHS academic staff are expected to contribute to applied research in target patient populations. Experience in preventive programs in child and adolescent psychiatry has demonstrated the feasibility and effectiveness of early secondary preventive intervention. The development of primary preventive programs, in conjunction with primary care and other services is also required. The incumbents of academic positions funded through H&CS will be expected to contribute actively in the areas of service evaluation, development of new service delivery models, and appropriate outcome measures in child and adolescent psychiatry, as well as to continue their important role in the teaching and education of undergraduate and postgraduate staff.

Training and Education

CAMHS are specialist services which can only be offered by adequately trained staff. This requires knowledge acquired through empirical investigation, research and evaluation, and the systematic education of trainees in all professions. Current links between clinical and academic institutions provide a strong base for teaching, as well as research, for all health and other disciplines associated with the psychological and social development of children and adolescents. To implement national and State plans for child and adolescent mental health it is necessary to have adequate numbers of child and adolescent psychiatrists, clinical psychologists and other allied professionals who have received appropriate postgraduate training after completing their basic training.

The VPCAPTP is well placed to continue specialist training for psychiatrists, clinical psychologists, child psychotherapists and other disciplines. Training must focus on modern eclectic approaches to treatment and include an emphasis on brief psychotherapies, as well as continue a strong focus on child development. Psychiatric Services will work with the VPCAPTP and service provider representatives to identify key training areas and establish appropriate strategies.

A new three-year Doctorate in Clinical Psychology program specialising in child, adolescent and family psychology commenced at LaTrobe University last year. This program has been funded by Psychiatric Services to help meet the need for specialist practitioners. It will have a strong clinical focus and the course content will integrate cognitive-behavioural and systemic theoretical frameworks with a strong practice base. Students will be placed in supervised clinical internships within CAMHS in their final year.

There is a particular need for child and adolescent psychiatry nursing postgraduate training to prepare staff for the specialist community and milieu roles

required within CAMHS. The psychiatry component of contemporary Victorian undergraduate nursing training is one aspect of a three year university course, with only limited input on child and adolescent psychiatry. While some of the pre-registration courses offer an elective in child and adolescent psychiatry in the final year, only small numbers avail themselves of this and recruitment into the field has often been difficult. An increase in the intensive treatment facilities available for young people will require more trained nursing staff to ensure their effectiveness.

Higher training now occurs only on an informal basis within CAMHS. Therefore a training course will be jointly developed between the VPCATP and one of the tertiary training institutions with a curriculum which includes general developmental psychiatry and training in milieu therapy to ensure adequate preparation for a community nursing role and an inpatient nursing role. In conjunction with this development, CAMHS will need to nominate an appropriate number of nursing positions as training posts within current child and adolescent inpatient units and in outpatient teams.

In addition to an academic CAMHS training and supervised case management practice, all clinicians require competencies in family therapy and individual psychotherapy. Junior staff will be encouraged to seek training at a recognised course, such as those offered by Bouverie Family Therapy Centre and the VPCATP. CAMHS themselves must ensure that there are opportunities available for training and supervision for less experienced clinicians by more experienced staff. Ongoing staff development programs within CAMHS will be necessary to complement training, and to provide opportunities for extending skills in facilitating child development and behaviour change.

The VPCATP, with its academic links, is also well placed to contribute to the curriculum development and teaching of other health, education and welfare

professionals. The mental health needs of children cannot be met by CAMHS alone and the training of primary care staff needs to include a greater emphasis on the psychosocial development of children. Other key contacts for postgraduate training include primary health care personnel, particularly general practitioners, and welfare practitioners in protective services, juvenile justice and accommodation and support. The VPCATP will be encouraged to establish links with the Royal Australian College of General Practitioners to develop training courses for general practitioners, and to cooperate with the H&CS Staff Development Branch to explore possibilities for further education in child and adolescent mental health within H&CS.

Progress in 1995–96

A number of major steps are being taken to improve CAMHS services across Victoria:

- In 1994–95 two new CAMHS assessment, treatment and liaison teams were established to service sectors of the Eastern Metropolitan Region (Knox/Waverley and Box Hill). These will be managed initially by Monash Medical Centre.
- A new senior mental health position has been created in each of the metropolitan regions, attached to IYSS teams, to provide psychiatric intensive case management services to young people in supported accommodation who are suicidal or are engaged in self-injurious behaviour.
- A new ten-bed adolescent psychiatric inpatient unit has been opened at Monash Medical Centre, to provide secure services when necessary for young people living in the Eastern and Southern Regions.
- The decommissioning of Lakeside Hospital in the Grampians Region will allow the creation of a two-bed child, adolescent and family inpatient annexe attached to the redeveloped Adult Psychiatry Unit at Ballarat.
- Psychiatric Services Branch has established a statewide Interdepartmental Youth Suicide Prevention Committee (with representation from H&CS, Youth Affairs, DSE, non-government officials and individuals with appropriate expertise) to coordinate and develop youth suicide prevention strategies.
- A Centre for Young People's Mental Health for the 15–25 year old population is to be opened in Parkville, following the amalgamation of EPPIC and the Royal Children's Hospital Older Adolescent Service. This centre aims to provide a focus for the support, development and evaluation of innovative services to youth, and education of other professionals dealing with the severely mentally ill.
- Non-recurrent, CAMHS innovative project grants have been allocated to create incentive for new service initiatives, encourage services to be designed around the needs of the consumers, and promote a culture of enquiry and comparison.
- H&CS Staff Development Branch will develop specific education programs for primary care professionals in child and adolescent mental health, and training in working with children and adolescents with mental health problems and their families.
- A new three-year Doctorate in Clinical Psychology Program specialising in child, adolescent and family psychology commenced at LaTrobe University in 1995.
- Child and adolescent psychiatry academic linkages are being established in the Eastern Metropolitan Region, between Maroondah Hospital and Monash University.
- Psychiatric Services will establish linkages with the DSE to build more effective inter-service collaboration in the recognition, support and treatment of children and adolescents with mental disorders and those at high risk through psychosocial dysfunction.

The Need for Change

Adoption of this policy will lead to varying levels of change in CAMHS. A systematic review will be commenced in 1996–97 to assess the degree to which CAMHS have adopted the measures outlined in the document and to identify any further activity which might be required.

Features of an Effective CAMHS

Referral routes to CAMHS must be simple and inclusive, rather than exclusive. CAMHS will take responsibility for gaining additional information, if required.

All CAMHS will provide telephone information and consultancy, and these services are best provided by staff who specialise in this role.

Emergency psychiatric referrals will be assessed within hours of referral. Priority appointments will be seen within five working days of the referral. Waiting lists will be managed to ensure patients receive appropriate services as soon as possible.

CAMHS will give priority to young people with severe mental disorder, where there is a risk of suicide or harm to self or others. Clients will not be excluded because they do not have a family, are thought to have a personality disorder or have offended.

All clients will have a written individual service plan and a named case manager. All clients will have a clinical diagnosis and all clients in extended care over six months, or for more than 20 sessions, will have their ISP reviewed.

CAMHS will use short term interventions as the treatment of first choice, unless this is unlikely to be adequate for the presenting problem. A proportion of children and young people referred with chronic difficulties will require ongoing care.

Day programs and inpatient services will use a focal treatment planning approach to regularly review treatment goals, strategies and progress being made.

Admission to inpatient services will only occur with the authority of a CAMHS psychiatrist or team leader. It is not acceptable to deny access to inpatient services where a family is not prepared to arrange for all members to be admitted.

All discharged (separated) patients will have their ISP, including discharge plans, communicated to general practitioners, and other relevant professionals concerned with the care of the patient, within three days of the discharge date.

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Appendix 1: Child and Adolescent Mental Health Services at November 1995

Regions and Sectors

Victorian CAMHS have historically operated on an area basis to ensure coverage of the State and to develop linkages with other community-based services for children and adolescents. Changes to other health, welfare and education systems in recent years have made these links difficult to maintain. Area boundaries are not rigidly adhered to and in the metropolitan area consumers may prefer to use a service from an adjacent health region, because of natural transport corridors or ease of access. Some regions are divided into sectors which are served by different CAMHS. Many regions have made significant progress towards the development of detailed sector plans for children and adolescents with severe psychiatric disorders.

The state of Victorian CAMHS was surveyed in September 1994 and the data reconfirmed in November 1995. Population figures are estimated from the ABS 1991 Census.

Barwon South Western Region

The Barwon Child, Adolescent and Family Psychiatry Service at Berada House, Geelong serves the eastern Barwon part of the region with a population of 56,400 under-19 year olds. This team is staffed by a psychologist, with sessions provided by social workers, an occupational therapist and a child psychiatrist (7.5 clinical EFT staff). A limited intake service is available, outpatient assessment and treatment services are provided, and consultation is available on a limited basis to paediatric units and the adult psychiatry service.

The Warrnambool and District Child and Adolescent Service, a program of the Warrnambool and District Base Hospital, services the Glenelg sector under-19 year old population of 38,800 from Warrnambool. This team of clinical psychologists, psychiatric nurses, and social workers (9.3 EFT) provides a telephone intake

and information service, assessment and treatment service, consultation and community liaison, outreach services, and community education. A consultation service for complex cases is provided by the Royal Children's Hospital Mental Health Service.

Grampians Region

The Grampians Child and Adolescent Psychiatry Service, based in Ballarat, serves a population of 52,700 under-19 year olds. The team is staffed by a child psychotherapist, psychiatric nurses, social worker and clinical psychologists (up to 6.5 EFT). It provides a telephone information and intake service, outpatient assessment and treatment, outreach services, and consultancy and liaison and education services, as well as a satellite clinic at Horsham which is operated by two full time clinical EFT. A consultation service for complex cases is provided by the Royal Children's Hospital Mental Health Service.

Loddon Mallee Region

The Child, Adolescent and Family Services Team, is part of the Department of Psychiatry at Mildura Base Hospital, and serves the Mildura area and northern Mallee area, with a population of approximately 19,000 under-19 year olds. This small team is staffed by a psychiatric nurse and a social worker (2.9 clinical EFT), who can provide limited outpatient assessment and treatment and outreach services. The team also has strong links with the Bendigo team, and both receive an extensive consultation service from the Royal Children's Hospital Mental Health Service.

The Bendigo Child, Adolescent and Family Team, a program within the Bendigo Healthcare Group, serves the Southern Mallee Area with a population of 61,300 under-19 year olds. This team is staffed by clinical psychologists, social workers and psychiatric nurses, (10.1 clinical EFT), and provides outpatient assessment, treatment and management, crisis intervention and

outreach, community liaison and consultancy, education and training.

Hume Region

The Goulburn CAMHS based at Goulburn Valley Base Hospital, Shepparton, serves the Goulburn Valley with a population of 41,300 under-19 year olds. The team is staffed by a medical officer, clinical psychologist, social workers/family therapists and a psychiatric nurse (5.6 clinical EFT). It can provide telephone information and intake, outpatient assessment and treatment, community liaison and consultancy services, training and education, and some limited outreach.

The North East CAMHS, based at Wangaratta, serves the north east sector with a population of 34,300 under-19 year olds. This team operates mainly through part-time staff including a clinical psychologist, psychiatric nurses, and a full time social worker (4.2 clinical EFT). It provides a similar range of services as the above. Both of these Hume region services have consultation links with the Austin Hospital Department of Child, Adolescent and Family Psychiatry.

Gippsland Region

The Gippsland Region has a population of 72,400 under-19 year olds and is currently served by both the Gippsland Child and Adolescent Psychiatry Service and the Monash Medical Centre. The Gippsland Region expects to provide all community outpatient services from within its own boundaries when local service development allows. Visiting consultative services are provided from Monash Medical Centre Department of Child and Adolescent Psychiatry.

The Gippsland Child and Adolescent Psychiatry Service has its main site at Traralgon, with satellite centres at Sale and Bairnsdale. It serves the middle and outer sector of the region with a population of 50,700 under-19 year olds. The team is staffed by a team of clinical

psychologist, social workers, psychiatric nurses and an occupational therapist (6.8 clinical EFT), who provide telephone counselling, crisis assessment services, outpatient and outreach assessment, brief therapy and other treatments, community liaison and consultancy, and education. Monash Medical Centre Child and Adolescent Psychiatry Service (described in more detail under Southern Metropolitan Region below), provides a monthly consultation service to the south and western part of the region.

Western Metropolitan Region

The Western Region has a population of 172,300 under-19 year olds and is divided into two sectors served by the Western Hospital and the Royal Children's Hospital respectively.

The Child and Adolescent Psychiatry Unit at the Western Hospital in Sunshine serves the mid western sector of 62,400 children and young people and provides a telephone intake and information service, outpatient assessment and treatment services, hospital liaison and consultation, and community consultations. The service is staffed by a team of psychiatrist, clinical psychologists, social worker and psychiatric nurse (5.1 clinical EFT). This service also hosts a Homeless Outreach Worker.

The Royal Children's Hospital Mental Health Service serves the southern and northern sectors of the Western Region with a population of 109,900 young people, and the western part of the Northern Region with an under-19 year old population of 55,400. This major service operates from the hospital campus in Parkville and a campus at Travancore Centre in Flemington. Community OP Service is provided by four teams with the full range of specialist clinical staff (35.2 clinical EFT). The largest of these teams specialises in older adolescents, while the others provide services to a geographical sector. A satellite clinic staffed on a part-time basis operates in Werribee. Services include

outpatient assessment and treatment services, super-specialist programs (including assessment for autism and learning disabilities, group programs, Koori mental health, infant mental health), community liaison and consultation, educational programs, research and training. Specialist consultative services are also provided to the CAMHS in Barwon South Western and Loddon Mallee regions. A 24-hour crisis service is available through the Psychiatry Duty Worker during the day, and after hours through the duty CAMHS Registrar or the Accident and Emergency Department. Academic positions in the service are linked with the University of Melbourne.

The Royal Children's Hospital provides a statewide tertiary paediatric service to Victoria, and within the hospital two specialised hospital consultation-liaison teams serve patients referred from paediatric units and wards who require urgent assessment, or who regularly attend the hospital for paediatric care. These teams have the entire range of specialist staff (14 clinical EFT) and provide assessment, consultation and treatment programs for selected patients, as well as liaison and educational programs.

Day programs are provided for older adolescents (2.1 clinical EFT) and for children and younger adolescents through activities attached to the inpatient programs. There are two inpatient units, one for primary school-aged children (eight places) and one for secondary school-aged adolescents (eight to ten places). Both teams have the full range of specialist professional staff available (33.3 clinical EFT total). These programs offer short-to-medium term informal admissions on a crisis or elective basis to children and young people who cannot be treated successfully at a less intensive level of care. Involuntary patients can be admitted to the adolescent unit, but patients may be excluded if they are violent, likely to abscond, or require extended containment.

Northern Metropolitan Region

The Northern Region has a population of 168,600 under-19 year olds. The western sector is served by the Royal Children's Hospital and the services are described above. Other services are provided by the Austin and Repatriation Medical Centre.

The Austin and Repatriation Medical Centre Department of Child, Adolescent and Family Psychiatry at Heidelberg provides specialist services to the majority of the region, with a population of 113,200 under-19 year olds, together with a significant part of the inner Eastern Region with a population of 127,000. This major service provides an efficient telephone intake and information service, comprehensive assessment and treatment services including a number of specialised programs (including assessment for autism and learning disabilities, group programs, a homeless outreach program), a 24-hour crisis service, extensive consultation and community liaison, education and training. These are provided by two teams one of which specialises in children and the other with adolescents. The teams contain the full range of specialist staff (14.3 clinical EFT), who also provide a hospital consultation-liaison service. The crisis service is available through the day via the Intake Coordinator, and after hours through the Adult Psychiatry Registrar on call or the Accident and Emergency Department. An innovative Schools Options Program provides consultation to schools designed to promote safety and reduce bullying and conflict. Specialist consultative services are provided to the CAMHS in the Hume Region.

An innovative brief intervention day program has been developed for up to eight adolescents (2.5 clinical EFT) and two teams provide inpatient services. The Adolescent Inpatient Unit has eight places for secondary school-aged adolescents and the Family and Child Unit can admit up to two families at one time, although the admission of individual children can be considered (27.2 clinical EFT). These programs offer short-to-

medium term informal admissions on a crisis or elective basis to children and adolescents who cannot be appropriately managed in the community. Special education teachers contribute to these programs through arrangements with DSE.

Eastern Metropolitan Region

The Eastern Region has a population of 242,700 under-19 year olds and is organised into an outer sector which has services provided from Maroondah Hospital and an inner sector served by the Austin and Repatriation Medical Centre Child, Adolescent and Family Psychiatry Service and Monash Medical Centre Child and Adolescent Psychiatry Service.

Maroondah Child and Adolescent Mental Health Service at Maroondah Hospital serves the outer eastern sector of the region with an under-19 year old population of 115,700. An intake program has a designated intake worker, and outpatient assessment and treatment services are provided with community consultations and education. The service has piloted an innovative single session intervention program and offers group programs, outreach services to homeless youth, and training. The service is staffed by a team of psychiatrists, registrar/medical officer, clinical psychologists, social workers, occupational therapist and psychiatric nurses (12 clinical EFT). A consultation liaison service is provided to the adult psychiatry unit for adolescent patients. Major service developments are planned and two clinical academic positions have been established in conjunction with Monash University.

The Austin and Repatriation Medical Centre Department of Child, Adolescent and Family Psychiatry serves the inner eastern sector with an under-19 year population of 127,000 and the services provided are described in detail above.

Southern Metropolitan Region

The Southern Region has a population of 258,700 under-19 year olds and is divided into an inner sector served by the South Eastern Child and Family Centre and Wellington Youth Mental Health Service, and an outer sector served by Monash Medical Centre Child and Adolescent Psychiatry Service.

The South Eastern Child and Family Centre in Melbourne serves the inner area of the southern region with an under-19 year old population of 89,400, as well as seeing clients from adjacent parts of Eastern Metropolitan Region. In addition, it provides specialist consultative services to the eastern and central parts of Gippsland Region. A full range of community outpatient services are available including telephone intake and consultation, assessment and treatment services, specialist programs (including assessment of autism and developmental disabilities, learning disabilities, Koori mental health, trauma, and preschool child development) community consultation and development, education and training. The teams have the complete range of specialist clinical staff available (21.1 clinical EFT). The Preschool Child Development Program offers day places for between 15 and 18 young children.

Wellington Youth Mental Health Service located in Melbourne serves the same population in the inner area of the Southern Region, except that its clients are aged between 16 and 20 years. A full range of community outpatient services is provided including telephone services, psychiatric assessment and treatment, community liaison and support, consultations to community agencies, education, and community development. Priority is given to disadvantaged groups, clients with autism, secure welfare clients, Koori clients and homeless youth. All major disciplines are available (7 EFT).

The Monash Medical Centre Child and Adolescent Psychiatry Service in Clayton provides a comprehensive

range of specialist services to the outer area of the Southern Region with a population of 169,300 under-19 year olds, and the inner area of Gippsland Region with an equivalent population of 21,700. This major service operates from the main hospital campus at Clayton and a clinic at Frankston. The full range of community outpatient programs are provided including telephone intake and consultation, assessment, treatment, rehabilitation and support, and specialist programs (assessment and consultative programs for children with school refusal, autism and pervasive developmental disorders, organic psychiatric disorders, and intellectual disabilities, as well as group programs for adolescents and mothers and children). Community consultations are offered to some community agencies. These community programs are provided by teams which contain specialist clinical staff from all core disciplines (15 clinical EFT). Services are offered on a 24-hour basis from the Frankston and Clayton campuses through the day, and after hours from Monash Hospital Accident and Emergency Department. The service has recently appointed two community network coordinators to link the service to community-based agencies and ensure continuity of care after discharge. Links with Monash University support a major investment in training, education and research.

A Hospital Consultation-Liaison Service is provided to the hospital paediatric units and the Accident and Emergency Department, which follows up patients with psychiatric and physical co-morbidities referred from these areas, and collaborates in the program for young people with eating disorders. Clinical staff (3.2 EFT) from the disciplines of psychiatry, psychology and speech pathology, provide direct and consultative services.

The Adolescent Inpatient Service provides intensive psychiatric care for up to ten adolescents who have a severe psychiatric disorder which seriously impairs development, where community management has

failed or is likely to fail. Adolescents are admitted only if they have legal guardians and places of abode, to avoid discharge placement difficulties. Involuntary patients and those with a recent history of violence are excluded, and the unit attempts to maintain a therapeutic milieu by limiting the numbers of patients with eating disorders (two places) or acute disturbance (two places). Staff from all core disciplines are available (22.5 clinical EFT), and secondary-trained special education teachers contribute to the program through arrangements with the DSE. A new adolescent ten bed unit has recently been opened.

Statewide Services

Bouverie Family Therapy Centre is a statewide agency which provides family therapy and family consultation services, and through its links with Latrobe University, offers several training programs in family systems therapy. Clinical services are currently provided to families who have children with serious relationship difficulties, serious mental illness or sequelae from sexual abuse, and to families of members with acquired brain injury, and HIV/AIDS (7.9 clinical EFT funded through Psychiatric Services). Several of the above programs are linked to specific research projects funded by external grants. Training courses include a five day introductory course, a one year certificated course, a graduate diploma in family therapy, and a clinical masters course. Part-time students attending are allied health staff from a variety of disciplines who work in human service agencies including CAMHS, Protective Services, non-Government welfare organisations, adult psychiatry services, and acute health services.

Victorian Postgraduate Training Program in Child and Adolescent Psychiatry (VPTPCAP). This well-established training program for child and adolescent psychiatrists has played an important role in developing child and

adolescent psychiatry in Victoria. The training program has offered five courses for several years:

- Child and Adolescent Psychiatry (targeted at psychiatrists and offering RANZCP certification of training in child and adolescent psychiatry).
- Developmental Psychiatry (targeted at community CAMHS allied health and nursing staff and offering certification of satisfactory completion).
- Child Clinical Psychology (targeted at clinical psychologists and offering degree of Melbourne University Master of Psychology).
- Child psychotherapy (Monash University Master of Psychoanalytical Psychotherapy).
- Child psychiatry course for paediatricians.

The program is accredited by the Royal Australian and New Zealand College of Psychiatrists and is linked closely to the University of Melbourne through the Professor Director. All of the Child and Adolescent Mental Health training has a clinical base with supervised practice as well as an academic component with a strong developmental focus. The VPTPCAP works closely with the directors of CAMHS in metropolitan centres to provide appropriate clinical case supervision and ensure the course continues to focus on relevant clinical practice in public psychiatry settings. A process of program redevelopment is currently reviewing the training curriculum and course structures.

Forensic Child and Adolescent Services

In 1992, the Children's Court Clinic Service was reorganised into separate assessment and treatment services. A subsequent review led to the transfer of the Children's Court Clinic Assessment Service to the Justice Department and the redeployment of the staff of the treatment service into different settings within Juvenile Justice. Children's Court assessment services and court reports are currently provided by the clinic through their own staff and contracted independent private practitioners who bring skills in particular areas without interrupting public treatment services. Referrals

for assessments are made by Children's Court magistrates, who may be alerted to the need for reports by parents or other professionals involved with a child or adolescent. As well as producing reports, assessments also lead to triage of children and young people to appropriate regional treatment agencies. Children's Court Clinic staff may also be involved in crisis intervention with young people who demonstrate disturbed behaviour during supervised adjournments or interim protection orders.

Offenders remanded in the secure welfare system are also assessed by this service. Those who live in country areas may travel into the clinic but treatment services are then coordinated by rural CAMHS. Juvenile Justice employs psychologists, social workers, and psychiatric nurses within their teams in order to provide treatment and management services for children with psychiatric disorders who are in secure welfare or on remand. They have developed contractual arrangements with certain CAMHS for child and adolescent psychiatrist sessional input which allows primary and secondary consultation, and specialist input to case planning.

Private Services

Pathway Centre is a private psychiatry service run by Ramsey Health Care, which offers adolescent mental health services and a service for mothers and infants. Pathway Centre Adolescent Unit offers a 15-bed inpatient program, day patient and outpatient programs to young people whose families have private health insurance. Crisis admissions can be accepted 24-hours a day, seven days a week. The five week residential program can be extended for clients who require further care. The Mother and Baby Unit is a five bed unit for mothers experiencing relationship difficulties with their infants.

Private Child and Adolescent Psychiatrists are relatively available in Victoria compared to other states. However, it is difficult to estimate the actual level of private

services provided to children and adolescents because many private practitioners have a mixed practice of children and adults, or work only part-time. There are approximately 60 Victorian members of the Faculty of Child and Adolescent Psychiatry of the Royal Australian and New Zealand College of Psychiatry, and many of these currently work sessionally in the public sector focusing on providing supervision and training, consultation or clinical programs for specific patient groups. Psychiatrists in the public system also have limited rights of private practice. It is estimated that approximately 15 EFT private psychiatrists provide direct services to children and adolescents, mainly in the eastern suburbs of Melbourne.