

# New Futures

A strategic framework for  
specialist mental health services  
for children and young people  
in New Zealand

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MANATŪ HAUORA

# Foreword

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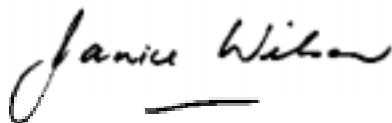
*New Futures* is an important and exciting development for mental health.

It addresses the needs of children and young people with mental health problems, focusing on those whose needs are severe. It puts specialist mental health services in context and provides a framework for the way in which effective and appropriate treatment can be provided.

We need services that provide good assessment and treatment for our children and young people and that work well with other agencies. We need increased skills for working with our distressed youth, and ways of sharing those skills in a way that works and makes sense. We need our services to be culturally sound and effective for our Māori children and young people, as well as for those from Pacific and other nations. This document explores ways in which we can work together to achieve these goals.

The co-operation needed in good mental health services has been reflected in the development of *New Futures*. I would like to thank all those who have generously shared their views, aspirations, time and experience with the Ministry team working on this project.

Children and young people have long been a neglected group in mental health, but now the spotlight is on them. I am confident that this framework will help to guide the Health Funding Authority and providers in creating a better mental health service for future generations of children and young people.



Janice Wilson  
Director of Mental Health  
May 1998



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# Treaty Implications

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The Government regards the Treaty of Waitangi as the founding document of New Zealand.

The Government acknowledges that it must address the health needs of Māori and will do this through its strategic policy directions for Māori health, which include:

- a Crown objective for Māori health; improvements are achieved in Māori health status so that in the future Māori will have the opportunity to enjoy the same level of health as non-Māori
- designating Māori health as a health gain priority area
- focusing on:
  - greater participation of Māori at all levels of the health sector
  - resource allocation priorities which take account of Māori health needs and perspectives
  - the development of culturally appropriate practices and procedures as integral requirements in the purchase and provision of health services.

Active participation requires meaningful consultation with Māori and Māori involvement in the planning of mental health services. It is expected that the development of mental health services for children and rangatahi will involve consultation with Māori at all stages in the development of mainstream and Māori services.

There are many mental health services for children and young people which do not currently meet the needs of Māori. This document acknowledges this gap and promotes the need for real equity in accessibility, service provision and positive outcomes for Māori. It specifies the need for more Kaupapa Māori services for tamariki and rangatahi, and encourages the provision of services which will improve the mental health outcomes for Māori.

# Executive Summary

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Specialist mental health services for children and young people need to be expanded and strengthened to more effectively meet the needs of children and young people with severe mental health disorders. This document provides a strategic framework for delivering comprehensive mental health services for children and young people. It aligns with the Mental Health Commission's (MHC's) draft *Blueprint for Mental Health Services in New Zealand* (1997), and expands on the principles espoused in that document by clarifying how these would be applied to mental health services for children and young people.

This document focuses on the functions of specialist mental health services for children and young people, and the way in which these services need to link with other health and non-health services to ensure that there is a continuum of treatment options for children and young people.

There is no attempt to quantify the resources which are necessary to provide these services. Work on quantifying need and determining the staffing to meet this need is currently being undertaken by the Mental Health Commission (MHC) in partnership with the Ministry of Health. The function of determining population need and purchasing to meet that need within financial constraints is the role of the Health Funding Authority (HFA). It is not the function of this document to usurp either of these tasks.

What this document does is clarify the strategic vision by defining more clearly the functions of specialist mental health services for children and young people, explaining how these services will develop, and pointing to areas that need to be developed further. It also emphasises the need for flexibility and responsiveness to local needs in service provision.

## Age range

The age range covered by this document is 0–19 years inclusive. This aligns with the MHC blueprint and recommendations by Dr Peter McGeorge in his 1995 report to the Ministry of Health. The current document highlights the need for the age recommendations to be used positively and with sensitivity rather than restrictively. The specific needs of the individual child or young person will determine which service they receive and who provides that service. Services are encouraged to respond flexibly. This implies that there will be an age overlap between services for young people and those for adults depending on the developmental stage and needs of the particular young person.

## Benchmarks

This document acknowledges that prevalence rates of mental health disorders for children and young people increase with age. This acknowledgement allows a clearer view to be taken of benchmark figures and raises questions about service provision. Prevalence of mental health disorders for young people aged 15–19 is considerably higher than that of younger children. The interpretation of the revised benchmarks in terms of service configuration is the responsibility of the HFA in consultation with providers.

## Severity

This document recommends that the American Psychiatric Association publication, the *Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV)*, be used as the standard classification method for diagnosis, and that the severity of mental health problems be determined by an assessment which comprises: diagnostic assessment, degree of impairment and an analysis of the circumstances affecting the child or young person and their family and whānau. The DSM-IV may not emphasise cultural factors sufficiently, and it is essential for effective assessment and treatment to consider these factors in combination with other aspects of diagnosis.

## Functions of specialist mental health services

Child and adolescent mental health services (CAMHS), for children and young people up to and including the age of 19 years, can either be provided for the whole age range, or with separate services for children under 15, and those 15–19. These last are known as youth specialty services (YSS). Most specialist mental health services will be community based providing specialist assessment and treatment primarily on an outpatient basis. However, this document also outlines the roles of other specialist services such as daypatient, respite and residential services as well as acute treatment services, including crisis and inpatient services.

## Consultation/liaison

A fundamental role of CAMHS and YSS is to provide consultation/liaison support to primary health providers and other professionals. The advantages of consultation/liaison are that the process allows the skills of the specialist services to be passed on to other professionals to support children with less severe or urgent problems. At the same time, this allows the specialist mental health services to focus on those children and young people with the most severe mental health problems.

## Intersectoral co-ordination

Linked with consultation/liaison is the concept of intersectoral co-ordination which allows the needs of the child or young person to be responded to effectively by all the agencies involved in their care. This document highlights the need for services to improve service co-ordination in line with *Making Links: Guidelines on service co-ordination for children and young people with severe mental health problems* (Ministry of Health 1997b).

## Tamariki and rangatahi

The needs of tamariki and rangatahi are addressed at some length in this document. This area needs major development. The document brings together and highlights some of the factors which have been identified as essential to Māori mental health. It is important that rangatahi and their whānau have a choice of providers; Māori workers should be employed in all mainstream services, and the development of specialist Māori mental health services must be fostered.

## Children and young people with drug and alcohol problems

The assessment and treatment of children and young people with severe drug and alcohol abuse and dependence problems is another of the roles of specialist mental health services. Such problems will often coexist with other mental health disorders. This is an area which has historically been weak and requires considerable training for clinical staff.

## Consumer involvement

An additional challenge for specialist services for children and young people is the involvement of consumers and their families or whānau in decisions about how services are provided. Clearly the involvement of very young children is not realistic, but their families can be consulted, while older children and young people certainly need to be part of the planning process in these services. This will be a major challenge for many services.

## Future planning

The key principle of future planning is that development should build on what already exists. Service coverage needs to be expanded and strengthened. The expectation is that current small services will grow into experienced multidisciplinary teams which will provide consultation/liaison services to other professionals and outreach services to more distant areas. Over time, where appropriate, the outreach services will themselves grow into larger services until they too are able to provide consultation/liaison, as well as their core services, and support the development of additional services. Dedicated services for adolescents and services working with specific groups such as early psychosis and eating disorders will be set up according to population need.

The development of Māori services may well be different, and will need to be developed in consultation with local iwi. However, the principle of building on what already exists remains. New services must be well supported by both mainstream and Māori services in order to ensure that there is a sound basis for appropriate and effective service provision and for further development of Māori services.

## Work to be done

### Primary mental health services

This document commits the Ministry of Health to explore, with the HFA, the MHC and other Government agencies, a clear strategic direction for advancing primary mental health services for children and young people which will be in line with the National Child Health Strategy, currently being developed, and with key documents of the other agencies.

### Workforce

The MHC is leading a project on workforce development for the mental health sector. Lack of skilled, experienced personnel is one of the key limiting factors in developing appropriate mental health services for children and young people. This document emphasises the need to balance

issues of quality service provision with workforce expansion to ensure that safe, appropriate and effective services are provided. It also highlights, as have many documents before it, the major workforce needs in Māori mental health services and the need to develop the Pacific workforce in areas with high Pacific populations.

## **Inpatient services for adolescents**

Treating adolescents in adult or child inpatient units is inappropriate. While mental health service provision is based on the principle of least restrictive intervention, there are times when inpatient admissions are needed. There is more work to be done to determine the need and appropriate level of service provision for inpatient care for children and young people with severe mental health problems. Assessment of need and purchase of appropriate services falls within the role of the HFA.

## **Secure inpatient service**

This is a very complex issue which this document does not attempt to address since the work necessary to determine need and appropriate service provision in this area is yet to be done. However, this document identifies the need for interagency collaboration between Health, Justice, Social Welfare and Education in any consideration of secure inpatient services.

# Introduction

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In recent years there has been an increased emphasis by Government on mental health services. The National Mental Health Strategy *Looking Forward: Strategic directions for the mental health services*, was released by the Ministry of Health in 1994, and was followed in 1997 by *Moving Forward: The national mental health plan for more and better services*. *Moving Forward* provided a clear plan of objectives and targets to implement the principles of *Looking Forward*. Mental health services for children and young people were a key target area in both of these documents.

The development of this document is another target defined in *Moving Forward*.

## OBJECTIVE 3.1

To improve the delivery of mental health services for children and young people with moderate and severe mental health problems.

### TARGET 3.1.1

By July 1998, a blueprint defining the **parameters of specialist mental health service provision for children and young people** will be developed

Ministry of Health 1997d: 22.

This document is not intended to be a rigid prescription of service design nor to stifle innovation or espouse any one model of service organisation. Rather, the document identifies:

- the target client groups for specialist mental health services for children and young people
- the range of service types within the specialist model and the functions of each of these
- the way that specialist mental health services fit into the whole context of mental health service provision
- issues that shape service provision to children, young people and their families and whānau
- principles and processes in service provision
- the role of consultation/liaison, service co-ordination and intersectoral links
- issues for service provision to tamariki, rangatahi and their whānau
- the future development of mental health services for children and young people.

# Section 1: The Context of Mental Health Services for Children and Young People

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## 1.1 The current situation

Mental health service provision for children and young people in New Zealand lacks consistency both nationally and regionally. Child, Adolescent and Family Mental Health Services (CAMHS) or Youth Speciality (YSS) mental health services do not exist uniformly across the country. Some community mental health services include mental health services for children and young people, while in several cases, mental health services for children and young people may be structurally part of the general child health services. Even within the limited range of services, Māori and Pacific children and their family and whānau are often dealt with poorly and inappropriately, and therefore experience ineffective outcomes.

These inconsistencies have arisen out of the historical lack of priority for developing mental health and specifically the mental health of children and young people. As a result of this document and the advent of a national funding agency for health, the Health Funding Authority (HFA), a climate has emerged which promotes more consistency in the scope and direction of services while allowing local flexibility to deliver services in the way which is most appropriate for each community.

### 1.1.1 The Mason Report

In 1996, the report of the Inquiry under Section 47 of the Health and Disability Services Act 1993 in Respect of Certain Mental Health Services (the Mason Report, Mason et al 1996) was released. In response to this report, the Mental Health Commission was set up, and additional funding was committed for the next five years to increase the services available to those suffering from mental health problems. The expansion of specialist mental health services for children and young people was one of the priorities for the first year of funding (1996/97), and the expectation remains that services will continue to increase with the ultimate goal of meeting the benchmark targets.

### 1.1.2 Gaps and problems in current service provision

In 1996, an interdepartmental working party on mental health services for children, young people and their families and whānau (the *Making Links* Working Party) reviewed service adequacy from a qualitative perspective. The following gaps were identified in the *Making Links* reports and have been repeatedly noted since:

- lack of specialist mental health services for children and young people

- insufficient access to existing specialist mental health services. This results in long waiting lists and a feeling that the services are not responsive to client needs.
- lack of access to primary mental health services
- poor communication between specialist mental health services and other organisations and agencies dealing with children and young people
- lack of culturally appropriate service provision for tamariki and rangatahi and their whānau. The effect of this is exacerbated by the reality that most teams have no clinical staff who are Māori.
- lack of culturally appropriate services for Pacific families
- lack of information about what services are being provided and the efficacy of treatments being used
- shortage of skilled staff for recruitment into specialist mental health services for children and young people.

In addition, there is an increasing awareness of the need for more services for refugees and migrants. More services are also needed for children and young people who have both intellectual disabilities and severe mental health problems.

It would be tempting to assume that these gaps are best addressed by a large increase in funding which would allow the purchase of more services. There is no doubt that more specialist mental health services are needed for children and young people. This is being addressed through the Mason funding and the Government's continued focus on child health as a priority.

However, there also needs to be agreement over:

- the separate and specific roles and responsibilities of each specialist service
- how such services are to be provided
- the need to provide services to children and young people within the whole life context of the child or young person and their family
- the ways in which specialist mental health services integrate most effectively with primary health services and other sectors
- what are the most effective treatments for specific mental health disorders and what are the roles of each agency in this treatment. This applies particularly to problems such as conduct disorder, autistic spectrum disorders and drug and alcohol abuse and dependence disorders where good co-ordination is essential.

It is this focus on *better* as well as *more* services which has driven the development of the current document.

## 1.2 Children and young people in context

### 1.2.1 Age group

The age group covered by this document is 0–19 years inclusive.

There is no Government policy on the age group which is to be covered by specialist mental health services. However, both the 1995 McGeorge report and the Mental Health Commission (MHC) blueprint use 20 years as the cut-off for entry. This is also the age range on which the benchmarks for service provision outlined in *Moving Forward* have been developed.

McGeorge also proposes a further age differentiation:

- children (0–9 years)
- younger adolescents (10–14 years)
- older adolescents (15–19 years).

The use of the upper age of 19 years and the distinction between children and younger and older adolescents **are guidelines** only. The developmental, social and emotional needs of the client need to guide where children are most appropriately assessed and treated.

The ways in which this differentiation translates into service provision is discussed more fully in Section 3.1: Community specialist mental health services.

The key to appropriate service provision must be meeting the needs of the individual child or young person, rather than treating them according to their age. **Flexibility** in access to service provision is essential.

### 1.2.2 Epidemiology

Epidemiological studies throughout the world show that there is a wide range of prevalence for mental health disorders in children and young people. Wallace et al 1997 give a range of 5 percent to 25 percent for all mental health disorders. Anderson and Werry (1994), using both New Zealand and overseas information, quote a range of studies which have found prevalence rates from 5 percent for a study looking at 10-year-olds, to 26 percent for another which studied 8–11-year-olds. More recent information from the Christchurch Health and Development Study, and the Dunedin Multidisciplinary Health and Development Study indicate a prevalence ranging from 17.6 percent at age 11 to 36.6 percent at age 18 (Fergusson, Horwood and Lynskey 1997: 138).

Many of the mental health disorders experienced by children and young people can be managed by primary services and supportive social systems, and do not need the intervention of specialist mental health services. Anderson and Werry (1994) also note that, except for a few disorders, spontaneous remission is high and treatment for persistent disorders is not particularly effective.

However, serious problems need specialist intervention to relieve suffering, to lessen the impact on the child or young person, their family, whānau and community, and to ensure that the development of the child or young person is optimised.

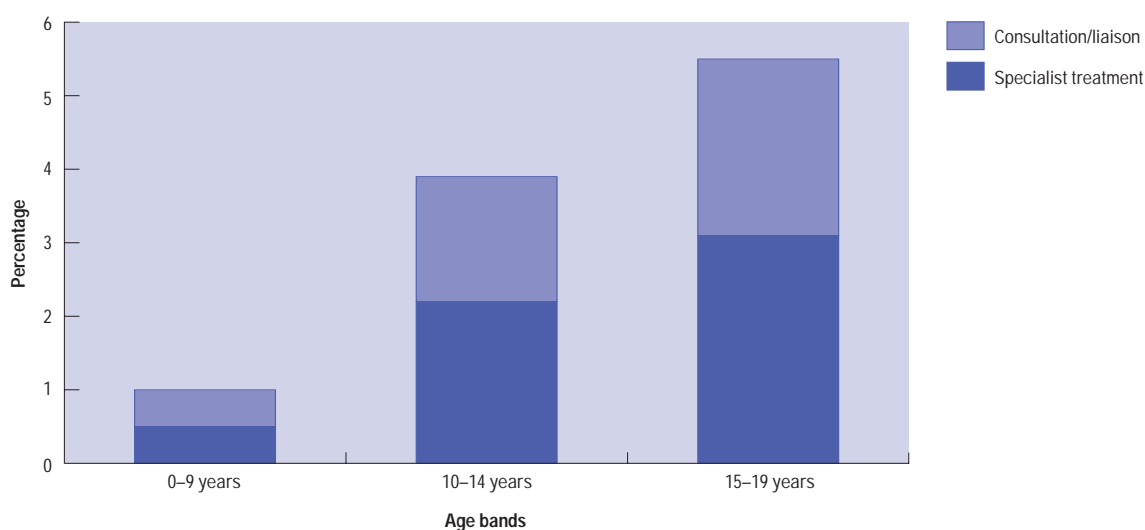
## 1.2.3 Benchmarks

One of the national objectives of *Moving Forward* is to increase access to mental health services for children and young people to 5 percent of children and young people in any one month.

This benchmark for access to services is based on national and international evidence of the prevalence of serious mental health problems in the population of children and young people (McGeorge 1995) and a best guess of the numbers who would require specialist assessment and treatment. It includes the treatment of moderate and severe alcohol and drug problems and the provision of consultation/liaison services to other agencies dealing with children and young people who have less severe problems.

The 5 percent access target is being reviewed by the Ministry of Health in the light of new and better evidence of appropriate service provision. At the same time, the Mental Health Commission (MHC) is reviewing its draft benchmarks for service provision. Initial information from this latter review of benchmarking indicates that considering children and young people from birth to 19 years inclusive as a homogeneous group is too simplistic. It is important to acknowledge the variation in access need across the various age groups. Figure 1 below gives a general picture of the ways in which access to services needs to change with age.

Figure 1: Percentage of children and young people needing access by age band



Based on provisional information from work on benchmarking being done by the Mental Health Commission (1998).

The graph above shows the provisional findings of the work currently being done which is based on New Zealand prevalence and international information on access to services. It shows that about 0.5 percent of young people aged 0-9 years would be expected to present with severe mental

health problems and would need access to specialist services. In addition to this, approximately another 0.5 percent would have less severe disorders and would be seen by other agencies but might need to consult with staff from specialist mental health services. The figures for 10–14-year-olds are 2.2 percent requiring specialist mental health services and 1.7 percent needing consultation/liaison. Of those aged 15–19 inclusive, 3.1 percent need access to specialist mental health services while 2.4 percent require consultation/liaison. The divisions between these two types of service provision need to be flexible and reflect local needs.

The trend showing increasing need for access to services with increasing age is expected to remain stable. However, the actual figures needing access at each age band reflect current knowledge, and will be constantly revised in light of new information. The mental health information project which is currently being implemented nationally by the New Zealand Health Information Service will provide a much clearer picture of service utilisation when it is fully operational at the end of 1999.

The steep increase in the need for specialist services and consultation/liaison services in the 15–19 age group reflects both the type of disorders which are more prevalent at that age and the effects of co-morbidity with alcohol and other substance abuse and dependence. This co-morbidity increases the severity and complexity of the presenting problems. The disproportionate impact of alcohol and other substance abuse on the overall prevalence of mental health disorder is highlighted in both the Christchurch and Dunedin studies (Fergusson, Horwood and Lynskey 1997).

It is important to note that the figures above, like the flat 5 percent benchmark, reflect a national view. They do not necessarily indicate what needs to be provided in any particular area, or to specific groups in the community, such as, Māori or Pacific children and young people. The assessment of local needs and funding of appropriate services to meet those needs is the responsibility of the Health Funding Agency (HFA). The interpretation of the revised benchmarks in terms of service configuration is also the responsibility of the HFA in consultation with providers.

## 1.2.4 Mental health disorders in childhood and adolescence

Mental health disorders in this client group can be categorised in three ways:

- *Those that are usually diagnosed in infancy, childhood or adolescence.* These would include disorders such as autistic disorder, Asperger's disorder, attention deficit/hyperactivity disorder, and attachment disorders.
- *Those that are similar to adult conditions but may present differently in children and young people.* These would include disorders such as depression, anxiety disorders, schizophrenia, and bipolar disorder.
- *Those that can evolve into adult personality disorder and disturbances and that make other psychiatric disorders more likely in adulthood.* For example, conduct disorder in a child or young person may evolve into antisocial personality disorder as an adult.

In addition to psychiatric problems, many drug and alcohol abuse and dependence problems have their genesis in adolescence.

Studies indicate that many children and young people have multiple mental health problems existing at the same time. For example, in their 1997 review Fergusson, Horwood and Lynskey

show that in a New Zealand population of 18-year-olds, those with a depressive disorder had over six times the risk of having an anxiety disorder, while those with a conduct disorder had over 15 times the risk of having a substance abuse disorder. They also state:

*For both the Christchurch and Dunedin data, at age 18 years in the region of 40 percent of those who met criteria for a psychiatric disorder met criteria for two or more disorders.*

Fergusson, Horwood and Lynskey 1997: 146.

In summary, mental health disorders in children and young people are wide ranging, have an increased prevalence with age and a high level of co-morbidity. These are some of the factors which need to be addressed in developing appropriate service provision for children, young people and their family and whānau.

### 1.2.4.1 Risk factors

Both mild and severe mental health problems may exist in the presence of risk factors. These are factors which increase the probability of developing mental health disorders and the probability that, once developed, these disorders are more likely to become chronic. However, the presence of risk factors alone does not indicate the need for specialist intervention.

Risk factors can relate to:

- the child, for example, other health or developmental problems the child faces
- the parents and family, for example, relationship problems, health problems of parent or family, abuse or neglect
- the social, cultural and economic environment
- other environmental factors, for example, bullying at school
- specific life events, for example, death or other traumatic events.

There has been a great deal of work done both internationally and in New Zealand attempting to identify key risk factors for specific disorders, and for mental health disorders in general. Fergusson, Horwood and Lynskey (1997) identify a set of generic risk factors for externalising disorders (conduct problems and substance abuse disorders), and another set of risk factors for internalising disorders (depression and affective disorders).

For externalising disorders, the risk factors include:

- socio-economic disadvantage
- marital dysfunction
- impaired parenting
- exposure to abuse experiences
- parental psychopathology.

For internalising disorders the risk factors include:

- socio-economic disadvantage

- family history of depression
- exposure to childhood adversity
- factors within the child which predispose to affective disorders.

#### 1.2.4.2 Protective factors

In the same way that risk factors in themselves do not indicate the need for specialist involvement, the existence of protective factors should not prevent a child with a serious mental health problem from accessing specialist services. However, it may mean there is a possibility that the contact with the service will be shorter and the likelihood of a full recovery might be higher.

Protective factors include those:

- internal to the child, for example, having a particular personality structure or coping mechanisms, high intelligence
- within the family or whānau such that the child is nurtured and supported to overcome or cope with a serious mental health problem. The presence of a warm, supportive relationship with at least one significant adult may act to protect against the effects of adversity.
- within the wider social system where the child or young person may have organisational support which helps them to cope more effectively. There is some evidence that strong interests outside the family may help develop resilience.

In summary, the mental health of children and young people is affected by a number of risk and protective factors. Understanding these allows for an awareness of populations most in need of services, and provides a framework for planning for mental health service provision.

### 1.2.5 How do child services differ from adult mental health services?

A suggested model of care for adult services has been outlined by the Mental Health Commission (MHC). This emphasises a recovery model, especially for people with chronic mental health disorders. The essential factors of the recovery approach are outlined in the *Blueprint for Mental Health Services in New Zealand: Working document 1997*.

Although the principles of the recovery model are applicable to all people with mental illness, the focus is slightly different when working with children and young people and their families and whānau. Here, the developmental context is all important, and the main goals are to ensure that the ongoing effect of any mental health problems is minimised and the developmental milestones appropriate to that child continue to be attained.

These milestones are based on the physical, social, intellectual, educational, cultural, and emotional needs of the child. The range of possible impacts on the child and the multiple interactions needed in working effectively with children and young people make this a very complex client group.

In summary, service provision for children and young people differs from adults in that:

- the developmental needs of children **must** be taken into account in the service provision
- good communication with children and young people requires more time and skill
- the range of disorders is different in children, although there are continuities of many disorders from approximately the age of 15 to adulthood
- common disorders, such as depression, may manifest differently in younger people
- different needs require different service provision from those provided to adults, for example, different kind of respite care and different criteria for that care
- children and young people need to be cared for in the context of their family and whānau
- work with children, families and whānau is more staff intensive and requires a higher level of involvement with other non-health services associated with the child, for example, schools, CYPFS, as well as iwi and community agencies. Such combined service delivery needs co-ordinated management.
- because of the high intensity of work required with children, young people and their families, staff will be spending considerable time with each family, and this needs to be reflected in caseload allocation
- some of the legislation and international conventions guiding intervention with children and young people are different, for example, The Children, Young Persons and Their Families Act (1989) and *The United Nations Convention on the Rights of the Child* (UNICEF 1989) to which New Zealand is a signatory.

## 1.2.6 Severity

Specialist mental health services are expected to work with children and young people with severe mental health problems. It is therefore essential to be able to define when a problem is severe.

The term 'severe mental health problems' applies to diagnosable psychiatric conditions that undermine the psychosocial development of children and young people and cause significant difficulties in the way they interrelate.

The severity of a mental health problem depends on:

- the type and duration of the mental health condition
- the circumstances affecting the child or young person and their family and whānau
- the capacity of the child or young person to resolve the problems (Ministry of Health 1997a: 8).

In addition, two other factors need to be taken into account:

- the degree of impairment of functioning caused by the mental health problem. In children and young people this will often be reflected in some interference with normal development.
- the extent to which the child or young person is at risk of self-harm or causing harm to others.

### 1.2.6.1 Diagnosis

Systems of characterisation and classification of mental health problems exist to guide clinical practice by assisting in the diagnosis, classification and recording of mental health problems.

In his 1995 report, Peter McGeorge suggested that specialist services for children and young people adopt the use of the fourth edition of American Psychiatric Association's (1994) *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) as a uniform classification system to define situations where the involvement of specialist professionals is appropriate. Responses to McGeorge's report indicate that there is general agreement on the use of the DSM-IV as the preferred standardised defining tool.

DSM-IV has a multidimensional diagnostic approach that takes into account other issues affecting the client, including psychosocial and environmental problems, and an assessment of overall functioning (the GAF scale). It does not, however, extensively discuss issues relating to severity of problems in children and young people (which need to be seen within the developmental and family context), and the existence of risk factors that can affect severity.

DSM-IV acknowledges the need for a cultural formulation and lists some 'culture-bound' syndromes. This term denotes 'recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category' (American Psychiatric Association 1994: 844). Despite this attempt to acknowledge cultural differences in presentation and formulation, this aspect of the classification system is underdeveloped. Clinicians working with Māori, Pacific people and people from other cultures must take into account cultural factors which may impact on both the severity of the problem, and the provision of effective and appropriate treatment. Particular attention needs to be paid to developing mechanisms to ensure that culturally-specific behaviour is not incorrectly interpreted as a mental illness.

These factors need to be considered *in addition to* the DSM-IV diagnosis to determine the severity of the problem and the appropriateness of specialist involvement.

There is much scope for development in the area of diagnosis. For example, some organisations such as the Autistic Association consider that DSM-IV does not accurately define the range of disorders which comprises the autistic spectrum. Despite its shortcomings, in the interim, the Ministry recommends continuing with DSM-IV as the tool used to standardise mental health diagnosis, but acknowledging that cultural, relationship, socio-economic, intellectual, and other factors also influence the severity of the problem.

### 1.2.6.2 Degree of impairment

The severity of a mental health disorder in a child or young person will often be evidenced by some degree of functional impairment, that is, a change from a previously higher level of functioning, or an inability to attain appropriate developmental milestones. Bill Watkins, Senior Lecturer in Child Psychiatry (Canterbury University, Christchurch), in his submission on this document, defined severity as follows:

- a. moderate to severe personal suffering or distress
- and/or b. the child is significantly impaired in terms of school functioning
- and/or c. there is significant impairment of peer relationships
- and/or d. significant impairment of the child's functioning within the family.

### 1.2.6.3 Safety

The extent to which a child or young person is at risk of self-harm or of harm to others is a significant factor in the determination of severity. It is important for any previous suicide attempt to be taken very seriously since previous suicidal behaviour is one of the best indicators for later suicide (Patton and Bowes 1998). Studies also show that over 90 percent of people who commit suicide had been suffering from a psychiatric disorder with depression being the commonest condition (Skegg 1997).

In summary, consideration of *diagnosis, degree of impairment and risk of self-harm or harm to others*, combine to determine the severity of the problem and hence the appropriateness of involving specialist mental health services.

## 1.2.7 Consumer involvement

Consumers are primarily the children and young people receiving services, but also include family or whānau and/or other caregivers. All consumers need to be involved in service planning and delivery options and also in evaluating and reviewing services. The development of consumer advocacy for children and young people should be proactively supported by the HFA.

The need for children and young people to be consulted is espoused in Article 12 of *The United Nations Convention on the Rights of the Child* which states:

*States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.*

UNICEF 1989: Article 12(1).

Young people who were consulted as part of the development of this document talked about the value of being able to discuss their illness with others of the same age group. They also commented on how useful it would have been to have had people who had been through the mental health services to talk with them in organised sessions at school. They needed to hear a message of hope and recovery from those they perceived as real people who had been through the process as well as from professionals.

Māori involvement in designing culturally appropriate services is critical. In addition, whānau need to be actively involved in the delivery of services. Similarly, in areas of high Pacific population, Pacific people need to be consulted about ways to make the services more culturally accessible, safe and effective.

# Section 2: The Spectrum of Mental Health Services

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Specialist mental health services which are the focus of this document provide treatment for children and young people with difficulties at the severe end of the spectrum of mental health problems. The concept of severity has already been defined at Section 1.2.6.

There is a widespread belief, notably held outside the specialist sector, but even apparent within it, that unlike physical health problems, most mental health problems require the involvement of specialist services. Much of the concern about the adequacy of mental health service provision has concentrated on specialist services. To some extent, this concern is appropriate but does not take account of the full range of actual and needed mental health service delivery.

## 2.1 Community-based primary mental health services

Like physical health problems, many of the mental health problems faced by children and young people are mild/moderate or transitory. A high proportion of these problems either resolve spontaneously or are resolved by the child or young person with the support and guidance of family members, peers or other friends.

In most cases, a family or whānau member may seek help on behalf of a child or young person. Sometimes, young people with mental health problems will themselves seek help from a professional. In most situations, the responsibility for assessing and supporting mild or moderate problems lies with what could be called primary mental health workers. Primary mental health workers include: general practitioners (GPs), early childhood workers, Māori community health workers, school staff including guidance counsellors, Plunket nurses, public health nurses, Well Child/Tamariki Ora services, private practitioners, school or community-based youth services, and some community-based agencies such as youth services and community or iwi-based counselling agencies. These people or people within these agencies are often the first point of contact for a child or young person (or their family or whānau).

Youth one-stop shops provide a primary point of contact for a number of health issues including mental health and drug and alcohol problems. They can provide a safe non-threatening environment for young people to connect with volunteers/workers who help to resolve mild to moderate problems, or who can guide the young people towards more specialist help if required. Clearly such organisations need to have good links with the specialist services.

There is still much work to be done in the primary mental health area, including:

- encouraging workers in primary health areas to acknowledge mental health as one of their areas of responsibility

- promoting agreement between providers and the HFA and other funders, that primary mental health be part of the service which is funded
- developing the skills of providers in identifying and treating mild mental health problems and appropriate referral to specialist services if the problems are severe
- expanding consultation/liaison support from specialist mental health services as needed.

## 2.2 Specialist services without a specific mental health focus

Agencies from non mental health sectors such as Education and Social Welfare may also work with children and young people with mild to moderate mental health problems.

School guidance counsellors are involved with young people with a range of mental health issues. In many areas of the country, Specialist Education Services (SES) provide psychological and other services to help teachers manage children and young people with problems specifically related to school or to learning. Some comments during the consultation phase of this document indicated that there is a perception that these services are decreasing and that many learning problems are being identified for the first time by specialist mental health services due to a lack of communication between SES and health services. Processes such as those outlined in *Making Links* should facilitate communication between key agencies and allow such anomalies to be addressed.

One component of the new *Special Education 2000* programme targets children and young people with severe behaviour difficulties. This new initiative will result in a significant increase in SES services to schools to help them manage these young people more appropriately.

The Children, Young Persons and Their Families Service (CYPFS) also provides specialist psychological services in some parts of the country for children and young people with care and protection and/or offending problems, and their families or whānau.

In addition, some medical specialist services, notably paediatrics, which have a lot of contact with children and young people and their families and whānau, will often deal with mild and moderate mental health problems as part of their treatment.

The contribution made to primary mental health service provision by the people and groups mentioned above is seldom recognised as a mental health service. The lack of strategic planning and training in primary mental health has led to a reliance on secondary level services. It has also contributed to an uncertainty about referral protocols (to and from specialist services) as well as different practices relating to access by specialist services. Contacts between the primary and specialist mental health services should be strengthened through the consultation and liaison function of specialist mental health services.

## 2.3 Secondary and tertiary mental health services

While some mental health problems presenting in childhood and adolescence will resolve spontaneously and others can be managed well in the primary sector, a small proportion of mental health problems will require specialist mental health intervention.

At the specialist end of the spectrum there are a range of services and modes of service provision. These include services designed for particular age groups or for particular mental health problems, and include community-based service provision, day treatment and inpatient care. The structure and function of the specialist mental health services for children and young people is discussed in Section 3 of this document.

In summary, there are a number of primary health services and other agencies who work with children and young people with mild to moderate mental health problems. However, there is no clear strategy for their ongoing co-ordination and development.

This document commits the Ministry of Health to explore, with the HFA, the MHC and other Government agencies, a clear strategic direction for advancing primary mental health services for children and young people which will be in line with the National Child Health Strategy currently being developed and with the key documents of the other agencies.

Figure 2: Service configuration based on severity of mental health problem

SEVERITY	PERSONNEL/SERVICE
Mild/transient problems	<ul style="list-style-type: none"> <li>• Self/parent/whānau/lay diagnosis and treatment</li> </ul>
Moderate problems	<ul style="list-style-type: none"> <li>• GP/PHN/private practitioner/paediatrician/family counselling services</li> <li>• Māori community health worker</li> <li>• School/SGC/SES</li> <li>• NGO</li> <li>• CYPFS</li> </ul>
Severe/chronic problems	<ul style="list-style-type: none"> <li>• CAMHS/YSS</li> <li>• SES/CYPFS/GP/paediatrician/<i>with consultation/liaison support from CAMHS and YSS</i></li> <li>• Specialist Māori mental health services</li> <li>• Other specialist services, eg, Drug and Alcohol; Early Intervention; Eating Disorder</li> </ul>
Chronic/life threatening problems	<ul style="list-style-type: none"> <li>• CAMHS/YSS/other specialist services and hospital staff</li> </ul>

**Key:**

GP	general practitioner
PHN	public health nurse
NGO	non-Government agency (community agency)
CAMHS	Child and Adolescent Mental Health Services
YSS	Youth Specialty Services
SGC	school guidance counsellor
SES	Specialist Education Services
CYPFS	Children, Young Person and Their Families Service

Adapted from McGeorge 1995: 12.

# Section 3: Specialist Mental Health Services for Children and Young People

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This section focuses on the range of specialist secondary mental health services and their functions. It also considers issues around the provision of services for Māori.

## 3.1 Community specialist mental health services

Most community specialist mental health services for children and young people are currently provided by Child, Adolescent and Family Services (CAFS). This term has been used historically and is derived from the old term 'Child and Family Services'. Neither of these terms specifies the mental health focus of these services. In this document, we will refer to secondary mental health services that provide assessment and treatment services for children and young people up to, and including 19 years as Child and Adolescent Mental Health Services (CAMHS). This is in line with the terms used in both Australia and the United Kingdom.

In some areas, services devoted specifically to young people aged 15–19 years have developed. These are referred to as Youth Specialty Services (YSS).

In areas where YSS have been developed, CAMHS may work primarily with those aged 0–14 years with flexibility in the older age range, to allow for the needs of the individual child.

This is broadly in line with Peter McGeorge's recommendations (1995), except that he proposes that YSS focus on older adolescents from 15–19 years who have left home and school (emancipated youth). This focus on services solely for emancipated youth is not supported in this document. It is expected that YSS will provide assessment and treatment service for all young people in this age band.

### 3.1.1 Child and Adolescent Mental Health Services (CAMHS)

These are currently the core services purchased by the Health Funding Authority (HFA). Their primary functions are to provide:

- secondary community mental health assessment and treatment services for children and young people up to and including 19 years of age, and their families and whānau
- specialist consultation and liaison services to other agencies
- advice and back-up to mental health crisis services on a 24-hour basis
- specialised treatment services (for example, for drug and alcohol problems or eating disorders)

- respite options for children and young people with severe mental health problems who are in crisis
- safe, age appropriate inpatient services and day programmes.

CAMHS are expected to have strong links with paediatric services, preschools and schools (including kōhanga and kura kaupapa), Children, Young Persons and Their Families Services (CYPFS) and the Specialist Education Services (SES) to ensure the appropriate management of children and young people within the context of their family and whānau.

Currently, many CAMHS do not provide this whole range of services, and for some, especially rural services, the provision of inpatient and day programmes in particular may not be appropriate or cost effective. These core services are, however, expected to be part of the configuration of services which would be available to children and young people with severe mental health problems, even if in some cases there is a need to travel to areas where more specialised services are available.

Māori children's cultural needs should be addressed by appropriate involvement of Māori workers either from the CAMHS service or externally. It is important that Māori clients are made aware of the treatment options available to them, including the ability to have Māori support staff involved in their treatment. All staff should have an understanding of Māori mental health issues, and ideally all CAMHS should have Māori staff. However, if a clinically qualified Māori person is not available, then a Māori support person skilled in dealing with Māori families in a cross cultural setting should be involved to assist the non-Māori clinician to understand the cultural context of the family or whānau. It is up to the client and/or whānau to refuse the offer of Māori involvement in their treatment if they choose.

In areas of New Zealand with large Pacific communities, it would be ideal for staffing to reflect the demographics of the community. If this is not possible, the use of cultural consultants when working with Pacific families will help to create a culturally safe environment as the basis for appropriate and effective service provision. Refugee or other ethnic communities also need to have consideration given to their specific requirements.

Individual needs would govern whether older adolescents should be seen in CAMHS services or in YSS or adult services. Protocols should be developed around the movement of teenagers from CAMHS to adult mental health services.

### 3.1.2 Comments from young people involved in the consultation process

People can have Depression at any time in their life and It can reoccur at any time.

Groups led by people who have been through such an issue - They take a group and talk about their life and recovery.

Mental health needs to be discussed at schools.

Don't ever say "I know what it's like" because unless you've been that sick you don't know what it's like.

I hope we could speak to people who have gone through what we are going through & give us hope.

Rangiora need youth counselling services.

People need to talk and be honest It helps!

### 3.1.3 Youth Specialty Services (YSS)

Young people are often reluctant to access mental health services in times of need (Horwood and Fergusson in press). Discussions with adolescent consumers identified a number of barriers to access which included:

- lack of information about mental health problems at schools which led to young people being unable to identify that they may be unwell, for example, young people thinking that everyone felt really sad and cried most of the time
- physical placement of YSS (in the grounds of psychiatric institutions). They would like to have YSS close to transport and centrally located.
- having to repeat their problems many times in the referral process from primary services
- stigma around mental illness
- lack of information about the existence of YSS. They talked about the possibility of using posters or putting material on the internet to make more information available to young people.

Young people also discussed the need for assertive follow-up when they start to miss sessions. They were clear that they did not want to be nagged, but felt a sense of comfort and belonging when their case worker phoned to check that they were well, if they missed a session, and to arrange another appointment.

These comments identify that it is essential for such services to be accessible to the young people they serve. It may be that the general principle of secondary referral to specialist mental health services is waived for YSS so that young people can access those services directly. If direct access to these services is encouraged, it should still remain clear that only those with severe mental health problems will be treated. Others, who can be managed by less specialist services, must be referred on.

In order to make services more accessible to older adolescents and more appropriate to their requirements, they often need to be separated from the services provided to younger people. Also, the age boundaries between the YSS and the CAMHS must be flexible and designed to meet the developmental, social and emotional needs of the young person seeking treatment. It is essential that where there are both CAMHS and YSS they work together smoothly to ensure that the needs of their client group are appropriately met.

It is also important that the links between YSS and adult services are acknowledged and strengthened, and that the positioning of the YSS in relation to both adult and child services is debated so as to allow the most appropriate service provision for the 15–19-year-old age group.

Although staff in the YSS would be expected to provide the same services as their CAMHS colleagues, they would also have specific skills in dealing with the mental health needs of young people. These would include:

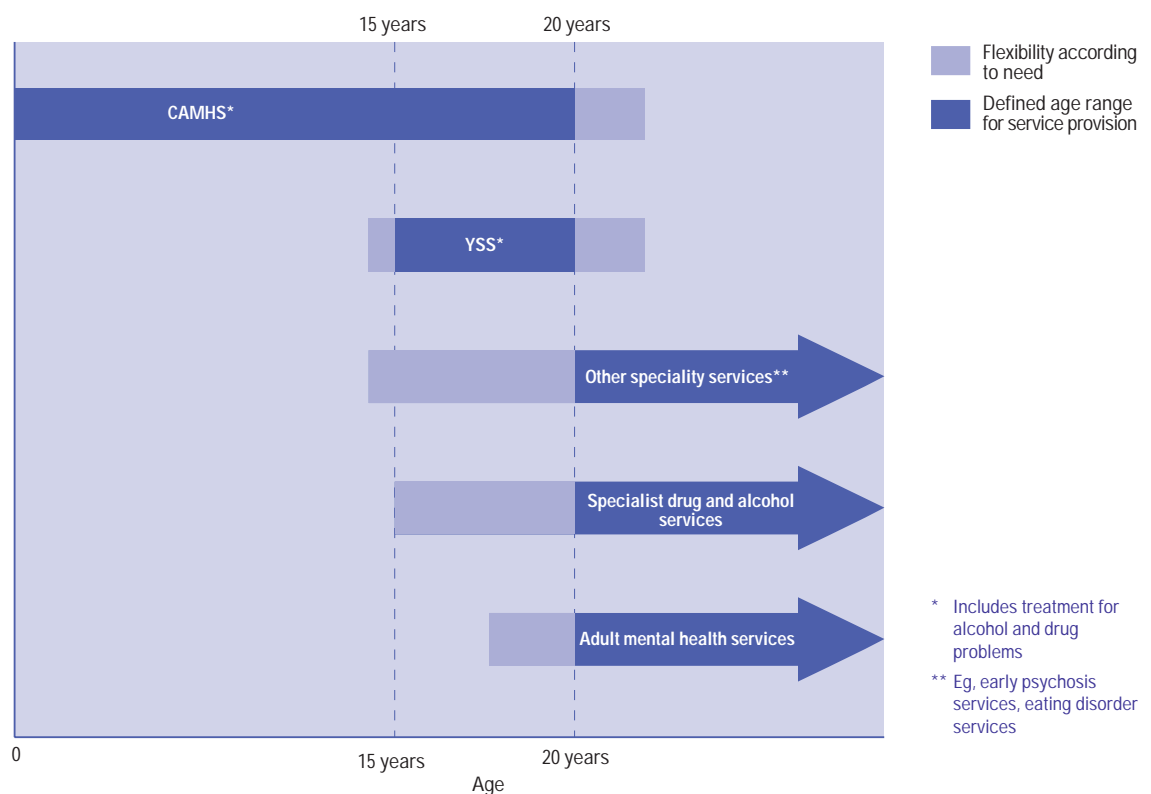
- a good knowledge of the developmental tasks of adolescence and the ways in which these differ from those of children and adults
- skills in identifying and treating drug and alcohol abuse and dependence
- skills in identifying and treating illnesses which often present in adolescence/early adulthood, such as, schizophrenia

- an ability to make good links with adolescents and work with them to improve service provision
- good consultation/liaison links with secondary schools and other appropriate agencies
- the ability to identify and manage young people at risk of suicide
- the ability to liaise effectively with both adult and child services to ensure that the appropriate support and treatment processes are put in place for each client.

There must be flexibility of service provision between CAMHS, YSS, adult mental health services, and drug and alcohol and other subspecialty services to ensure that children and young people are helped in ways which are most appropriate to their age and developmental stage.

Services should be matched to need regardless of age.

Figure 3: Relationship of mental health services



In order to ensure the needs of clients are met, there need to be good relationships between all services.

# Section 4: Functions of Specialist Mental Health Services

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There is a range of activities in which clinicians in specialist services are involved on a weekly basis. Only a proportion of these will be direct clinical interventions with children and young people. The amount of time which should be spent in each aspect of service provision and support is a matter of debate and discussion, and reflects the main functions of the team and the demographics of the client group. For example, rural teams would spend more time on travel than those in urban areas where clients are more likely to come to the services.

The state of Victoria, Australia, has recently published a framework document outlining mental health services for children and young people to be provided in the state. That document gives an example of the proportions of direct clinical care and other service delivery.

*“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 ... indirect activities.*

*“(Indirect activities include) telephone intake, consultation and liaison with referring agents or parents, case planning and co-ordination, recording, report and letter writing, supervision and training, case allocation and review in team meetings, quality improvement activities, staff development programmes, agency administration and travel.”*

Psychiatric Services Branch, Victorian Government Department of Health and Community Services 1996: 20.

## 4.1 Consultation and liaison

Consultation and liaison services are provided by specialist mental health services **to other professionals** working with children and young people. In some cases, the process of consultation/liaison may involve direct client contact. More often, though, it will involve the provision of advice and support to professionals dealing children and young people who have less severe mental health problems.

Existing models of consultation and liaison in New Zealand have been developed to complement clinical services. They involve a range of activities, including:

- an established first point of contact between local services or organisations (for example, schools, local sexual abuse support services, etc) and the local specialist mental health service
- support and advice as requested by local professionals from the Welfare, Education and Community sectors working with children and young people, either over the phone or in person

- support and advice as requested by other health professionals including other mental health specialists, GPs, paediatricians, etc
- organised training sessions on the role and activities of specialist services
- training by Māori mental health services on working appropriately with tamariki, rangatahi and whānau
- organised training sessions on specific issues, such as, early recognition of severe problems or behaviour management for children and young people with behavioural difficulties
- assessment of the need for specialist mental health service input with specific children and young people followed by a referral to a more appropriate service or continued treatment by the CAMHS.

Given the limitations of current service provision, consultation and liaison is a means of using scarce specialist skills as effectively as possible, while ensuring that the gap between primary and secondary service provision is addressed. It also ‘empowers’ or enables other professionals to assess and treat children and young people with mild to moderate mental health problems. For these reasons, it is seen as a key priority for development, within a strategy of overall service expansion.

Some concerns were expressed during consultation about the lack of sufficient skills in the community to adequately treat those children and young people with mild to moderate problems. Concerns were also expressed about the unevenness in services provided by other agencies, such as the Children, Young Persons and Their Families Service (CYPFS) and Specialist Education Services (SES) throughout the country. It is these and allied issues which need to be addressed by the intersectoral work on primary mental health care recommended in this document.

The degree of consultation and liaison provided by specialist services varies considerably around the country. Some services currently dedicate a significant percentage of specialist time to consultation and liaison. These services report a closer and more efficient relationship with referrers from other sectors, increased effectiveness around referral with referrers having a greatly improved understanding of the roles, responsibilities and processes of specialist mental health services, and a better ability to manage intake processes.

Consultation and liaison is clearly an important adjunct to clinical treatment, but it can not replace appropriate direct intervention by specialists if the problems faced by the child or young person are severe. There was concern expressed during consultation that some CAMHS are currently providing consultation/liaison services at the expense of specialist assessment and treatment services. This is certainly not the intention — there needs to be a balance to ensure that both are happening to optimise appropriate service provision.

Priority needs to be given to the development and definition of consultation and liaison services around the country and we must support primary mental health professionals and professionals from other sectors in dealing with at risk children and young people. This will leave mental health assessment and treatment services to focus on those children and young people who most need specialist clinical treatment.

## **4.1.1 Client groups with specific needs for consultation and liaison services**

There are some groups of children and young people who 'get lost' in current specialist mental health service provision. This may be because they are largely invisible (as in the children of parents with severe mental health problems) or because the boundaries of responsibility with other agencies are unclear.

These groups are discussed below to provide a focus for developing appropriate consultation/liaison services.

### **4.1.1.1 Children of parents with severe mental health problems**

Children and young people with a parent who has severe mental health problems, particularly a personality disorder in either parent, face a much higher risk of themselves developing severe mental health problems. International literature suggests that the child of a mother with severe mental health problems has up to four times the normal likelihood of developing severe mental problems themselves. Similarly, a child whose parent has schizophrenia is eight to ten times as likely of developing the disorder themselves (Wallace et al 1997).

Some of this risk will be genetic and some environmental. It is imperative that the children in families in which one or both of the parents have a serious mental illness have the illness explained to them in a way which is developmentally appropriate. This includes developing processes which limit the amount of responsibility that the child takes for the parent's problems. This can be facilitated through the consultation and liaison services of the CAMHS who could train adult mental health service workers in the skills needed for these interventions. In some cases, the situation will warrant the child becoming a full client of the CAMHS.

### **4.1.1.2 Children and young people with severe behavioural problems/conduct disorder**

Conduct disorder is characterised by a constellation of antisocial behaviours, in which the key factor is a repetitive and persistent violation of major age-appropriate social norms and the basic rights of others (McGeorge 1997).

Conduct disorder, more than any other mental health problem, has been the subject of considerable focus recently, as well as debate among the sectors involved with children and young people. Overseas studies, such as those by the Institute of Medicine, Washington (1989) and by Offord et al (1987), indicate that conduct disorder is the single most prevalent and costly form of developmental psychopathology. Anderson and Werry (1994) comment that about 40 percent to 50 percent of children with conduct disorder still have it or another externalising disorder four to five years later. There is a high level of co-morbidity with other mental health problems and substance abuse disorders. Moretti et al (1997) indicate that the most promising interventions occur with children who are preadolescent, and even in the preschool ages. The primary interventions which have been found to be effective are parent management training and problem skills training.

Debate, in New Zealand and internationally, has often focused on the split in responsibilities for the care (or treatment, or support) of such children and young people. Peter McGeorge (1995)

proposed that CYPFS should have the primary responsibility for children with conduct disorder (including sexual offending), and should provide case management and residential services with the support of the Ministry of Health and SES. This is the model used in the Youth Horizons project which has been developed in Auckland. It is also the model that is being used in the STOP programmes in Wellington and Christchurch and the SAFE programme in Auckland which all manage moderate/high risk young people who sexually abuse. In most cases, the key role for CAMHS and YSS with these programmes will be consultation/liaison rather than treatment services.

The Department of Social Welfare (DSW) has taken on the responsibility for treating young people with conduct disorder, and those who sexually abuse who are also CYPFS clients. There is no departmental or Government policy which expects DSW to take on the responsibility for all young people with conduct disorder. Specialist mental health services have a continuing role in assessing and treating young people with severe conduct disorder who present to these services, and providing consultation/liaison services for those agencies who deal with children and young people with mild to moderate conduct disorder.

Many children and young people with serious behaviour problems will be managed appropriately outside specialist mental health services with consultation/liaison as necessary. At times, where behavioural problems do not necessarily indicate a severe mental health problem, but have become intransigent and unmanageable, it may be necessary to involve specialist mental health services.

*Special Education 2000* has accepted the responsibility of the education system to manage children with severe behaviour problems so that their learning outcomes can be optimised. At times, it will be appropriate for the staff of mental health services to assess children with such problems to ensure there is no severe mental health problem at the core of the behaviour. In some cases, Social Welfare services will also need to be involved. Guidelines for the development of protocols for managing individual cases have been set out in *Making Links*.

#### **4.1.1.3 Older teenagers moving to adult mental health services**

Whilst not really a special population group, young people moving to adult services from CAMHS or YSS have a particular set of needs to be met. Many of these young people will be better seen by adult services but will also still need a developmentally appropriate approach. This may mean that services for children and young people need to provide consultation and liaison services to adult services to facilitate management of treatment of these young people by adult services.

#### **4.1.1.4 Children and young people at risk of suicide or who have attempted suicide**

Suicide in young people is a major problem in New Zealand.

The New Zealand Youth Suicide Prevention Strategy has now been published. It provides a high level framework for youth suicide prevention, and has both a general population component, *In Our Hands*, and a specific Māori component, *Kia Piki te Ora o te Taitamariki* (Ministry of Youth Affairs et al 1998). From July 1998, the Ministry of Health will have the responsibility for working with other Government agencies to develop an implementation plan for the strategy. This plan will outline the steps being taken by each of the Government agencies to help reduce youth suicide.

Studies of suicide behaviour of young people consistently report that the majority (approximately 90 percent) of young people who die by suicide or who make serious suicide attempts have a recognisable psychiatric disorder at the time of their attempt. Many of these disorders will not be severe, but amongst the small minority with severe mental health disorder risks of suicide and suicide attempts are likely to be very high (Beautrais 1998).

Specialist mental health services have a definite role in ensuring that suicidal behaviour is identified early and that young people get appropriate help to keep themselves safe. However, all services working with children and young people need to be aware of the possibility of suicidal thoughts and need training in how to manage young people at risk of self-harm. There are many agencies such as drug and alcohol services who are working with vulnerable young people, and who need ongoing training in this area, as well as having consultation/liaison support available from CAMHS or YSS when needed. Specialist mental health services and emergency services need to have good working relationships to ensure that young people who have attempted suicide or engaged in deliberate self-harm and who are treated by emergency services get appropriate help.

All young people with serious suicidal ideation and those who have attempted self-harm must be assessed for ongoing risk of self-harm or suicide. This assessment must be done by people who are skilled in assessing the ongoing risk of the young person. Consultation/liaison can aid in upskilling non mental health service professionals who work with children and young people in assessing and managing suicide risk.

CAMHS and YSS also have a role in working with schools and communities affected by the suicide of a young person or people to minimise the possibility of 'copycat' suicide attempts and to encourage discussion which has been shown to be helpful in such circumstances.

#### **4.1.1.5 Children and young people with intellectual disability**

As the deinstitutionalisation of people with intellectual disability increases, the lack of mental health service provision for the children and young people in this group is highlighted. Children and young people with intellectual disabilities are particularly at risk of mental health problems not being diagnosed or treated. The greater the intellectual disability, the greater the difficulty in assessing and treating severe mental health problems, and the higher the risk of mistreatment. Many of these young people's needs will be appropriately met through the consultation/liaison function of the mental health services. However, discussions with providers indicate an expectation of increasing demand for assessment and treatment services for this group as well.

It is the Health Funding Authority's (HFA's) role to clarify the need for more mental health services for children and young people with intellectual disability, and to discuss with providers the best way to ensure appropriate services are provided.

In summary, consultation/liaison is a defined function of specialist mental health services. It enables CAMHS and YSS to support those who work with children and young people with mild to moderate mental health disorders. It allows mental health assessment and treatment services to be focused on those who most need specialist treatment.

This section has identified a number of groups of children and young people who have specific consultation/liaison needs. Some of these may also need direct intervention from specialist services.

## 4.2 Service co-ordination

Service co-ordination means collaboration, co-operation and joint planning between the agencies and services involved with children and young people. Comments from consultation on this document indicate that there are concerns in some parts of the country about the changes happening in the roles of the three sectors — Health, Education and Social Welfare. Some CAMHS and YSS see themselves as now providing services which rightly fall into the domain of one of the other sectors. Although each sector has its own key role, everyone who works with children and young people and their families and whānau is responsible for making sure that the services and support they provide are jointly co-ordinated around the needs of the individual child or young person. This may involve considerable negotiation with other agencies and clarification at regional and national levels where the needs of the client cannot be accommodated.

The *Making Links* guidelines (Ministry of Health 1997b) have been developed for use primarily by the three sectors most directly involved with children and young people with severe mental health problems, that is, Health, Education and Social Welfare. The guidelines describe how effective service co-ordination can be developed in each community through a system of case management with lead agency identification. Such a system is to be developed locally and incorporated in local protocols agreed to between the services and sectors involved with children and young people who have severe mental health problems.

The guidelines form part of a wider national strategy to improve services for children and young people at risk, through collaboration between the sectors. This strategy is part of the Government's *Strengthening Families* initiative which is actively supported at all levels of co-ordination, from the Chief Executives of Health, Social Welfare and Education to the local level. This strategy means that all those working with children and young people will increasingly be involved in service co-ordination as part of the provision of appropriate and effective treatment. The key principles and practices for service co-ordination are contained in the *Making Links* guidelines. A summary of the guidelines is included as Appendix 2.

For Māori community health providers, service co-ordination is part of their core business. To access Māori clients, co-ordination and planning of service delivery needs to involve those Māori providers who are the first point of contact for many Māori.

## 4.3 Specialist treatment in the community

### 4.3.1 Specialist assessment

Referral and assessment may themselves bring about changes in the problems experienced by clients and some services are now increasingly using assessment as a therapeutic intervention. Because the differentiation between assessment and treatment may be arbitrary, specialist assessment is included as a category of treatment.

It is possible also to consider assessment as a part of consultation and liaison services. This may be a particularly effective means of undertaking assessments. This assessment role of the specialist mental health services also allows for the early identification and treatment of severe mental health problems before they become chronic.

Most assessments are carried out in order to allow accurate diagnosis and case planning (including multi-agency case planning where appropriate). They inform treatment and management both within the service and in other services/agencies that are also involved with the child or young person (such as, CYPFS, schools, etc).

In an assessment, a clinician reviews and evaluates the:

- nature and history of the presenting problems
- developmental and health status of the child or young person
- educational, peer and family relationships of the child or young person
- functioning of the child or young person's family.

A comprehensive assessment results in a formal diagnostic categorisation in line with DSM-IV, as well as full formulation of the problems including the establishment of predisposing, precipitating and maintaining factors, prognosis and plans for intervention. Depending on the skills and experience of the clinician and the complexity and severity of the presenting problems, a comprehensive assessment often needs to be developed over time. For further discussion, see Section 1.2.6 Severity.

At present there is a trend in mental health services for children and young people to explore the possibility of standardised assessment protocols. The development of such protocols will need to involve Māori, to ensure that clinicians will make appropriate and accurate assessments of the complexity of relationships and functioning of tamariki and rangatahi within whānau and hapū structures.

### 4.3.2 Core specialist treatment

A variety of treatment and management procedures can be employed to respond to the mental health needs of children and young people. As noted earlier, only a proportion of these will be direct clinical activities. The essential aspects of service provision for mental health services have been defined in the Ministry of Health's *The National Mental Health Standards* (1997e) and *Mental Health Common Base Definitions* (1997c). The way that these are relevant to the assessment and treatment of children and young people is expanded in Appendix 1.

An increasing range of specialised services catering for specific severe mental health problems is currently under development around the country. However, over the coming years most core specialist services will continue to treat the full range of severe mental health problems faced by children and young people.

It is expected that, in the child and youth mental health area, as in the adult field, interventions with children and young people and their families or whānau will be soundly based on the best evidence of appropriateness and effective outcome and cost-effective treatment.

This is easier said than done. Weisz and Weiss (1993) conducted a major meta-analysis of the effects of psychotherapy with children and adolescents. They found that 230 different forms of therapy existed at the time, that most of these lacked empirical evidence of efficacy and that the three therapeutic models most often endorsed by practitioners were psychodynamic, behavioural and cognitive. Unfortunately, while research studies showed significant positive effects from therapy, clinic studies were not so positive.

Weisz and Weiss suggest that this may be in large part due to the different choice of treatment models between research and actual clinical practice. Clinicians in practice often use models of treatment which are primarily non-behavioural such as psychodynamic therapy, family therapy and eclectic approaches. These have been shown to be less effective than the cognitive-behavioural and behavioural approaches which are more often used in research studies.

A recent discussion paper from the Institute of Psychiatry, London indicates that in addition to appropriate medical input, behavioural, cognitive, interpersonal, and family therapies are the most appropriate forms of treatment for children and young people with severe mental health problems (Goodman 1997). These therapies tend to focus on behaviour change in the child and their family, and offer practical techniques which empower change. Wallace et al 1997 give a summary of the kinds of interventions which to date have been shown to be effective with different disorders.

The lack of solid evidence for specific treatments for specific disorders highlights the need to carefully monitor individual cases during treatment and to be prepared to change the approach if the current treatment is ineffective.

### 4.3.3 Drug and alcohol treatment

Problems of drug and alcohol abuse and dependence by children and young people are considered in and of themselves to be severe mental health problems. In addition, drug and alcohol use will be a contributing factor in other problems being presented to specialist mental health services. Information from both the Dunedin and Christchurch health and development studies indicates that drug and alcohol disorders are a major contributor to the prevalence of mental health disorders at age 18 (Fergusson, Horwood and Lynskey 1997).

The provision of drug and alcohol assessment and treatment services for children and young people is a core function of the CAMHS and YSS services. Staff therefore need to maintain and develop expertise in the treatment of drug and alcohol problems, and the interaction of such problems with other mental health disorders. For many CAMHS and YSS services, it is acknowledged that the growing emphasis on the treatment of drug and alcohol abuse and dependence problems will have implications for staff training and ongoing staff development. This is compounded by the growing awareness of co-morbidity of drug and alcohol and other mental health problems.

Although CAMHS and YSS are expected to assess and treat children and young people with alcohol and other substance abuse disorders, there are other specialist drug and alcohol services being funded by the HFA and other agencies to provide assessment and treatment for this age group. Again, as in all mental health service provision it is expected that young people will be treated in the most appropriate environment for their needs. Where this is not the CAMHS or YSS, consultation/liason will be available to ensure that the care of the clients is well co-ordinated, safe and appropriate to their age and culture.

## 4.4 Other specialist services

New specialist (or subspecialist) services have recently been developed, such as early psychosis identification and treatment services and eating disorder services. These services are often being provided from their own separate setting and cater for young people as well as adults. The establishment of such services is new and is appropriately based in the larger centres where there is a good base of skilled clinicians, and where the incidence of these problems allows for teams to build up a good base of experience. In many cases these services will, at least in the first instance, focus on assessment and consultation/liaison with other services such as CAMHS and YSS.

Comments from more rural CAMHS during consultation indicate that mechanisms need to be developed to allow smaller population services to either access the subspecialty services directly, or for this expertise to be more readily available through training and/or supervision of local staff. The specific needs of Māori when moving from their own area to receive specialist services add an additional complexity to the safe and appropriate provision of subspecialty services.

It is important that the establishment of such subspecialist services enhances overall service provision rather than fragmenting and undermining existing services. Clear protocols will need to be developed around consultation and liaison, referral, care co-ordination, and discharge of clients.

Such services allow for specialisation in these clinically complex areas, however, core mental health services will remain the main providers of assessment and treatment for all severe mental health problems.

### 4.4.1 Daypatient services

Currently, daypatient services are being purchased in Christchurch and Auckland. Such services need to be created in all the large centres.

Daypatient programmes aim to provide more intensive input than is possible from the community resources of the CAMHS or YSS services. Daypatient programmes may be treatment services or intensive assessment of clients which cannot be done effectively within a community setting. Daypatient programmes may operate on weekly or sessional attendance, depending on the assessed need of the client, and may include the child or young person alone, in groups or with their family.

In addition to providing a treatment service in themselves, daypatient programmes can be used as a step-down service from inpatient services, or, in some cases, as an alternative to inpatient treatment, allowing the child or young person to maintain school and community contacts while receiving the intensity of treatment needed for their care.

Daypatient programmes will need to employ specialist or specially trained staff. In addition, these staff may be supported by professionals working in core specialist services, either through consultation and liaison or direct clinical involvement. Appropriate schooling also needs to be provided for children and young people in both daypatient and inpatient or residential services.

## 4.4.2 Respite services

These are home based, residential or other services provided to children and young people who would otherwise need to access inpatient services. The aim of respite services is to give the child and young person and/or the family the opportunity to have some time apart while working therapeutically to address problems and issues which may be a concern. These services are offered to clients for a limited time only and are usually delivered as part of a package of care.

There are currently few respite services available in New Zealand for children and young people with severe mental health problems, although some innovative work is being done in this area. The development of such services would complement the activities of specialist community services, especially where appropriate inpatient facilities are not available.

## 4.4.3 Residential treatment services

Some residential treatment services currently exist for young people, primarily in the drug and alcohol area. CYPFS also provides some residential services for children and young people with conduct disorder, adolescent sexual abusers and children with care and protection needs. There are ongoing questions about whether more residential services are needed, whether such provision is the province of Health, Education or Social Welfare, and whether residential services are in the best interests of the child or young person and their family and whānau.

Decisions about new residential treatment service provision needs to be made in the light of evidence about appropriateness and best practice in this area, and with intersectoral agreement.

# 4.5 Acute treatment

## 4.5.1 Crisis services

Service availability needs to be sufficiently flexible to respond to crises. It is important that children and young people get the same possibility of response to crisis needs as adults. Some CAMHS and YSS supplement the adult crisis services by providing consultation/liaison on a 24-hour basis. This will often mean managing the availability of same-day urgent appointments, or the availability of urgent consultation and liaison, directly or by phone.

In most emergency situations, specialist therapeutic input will be most needed after the actual emergency has passed, once the child or young person is safe and sufficiently recovered for follow-up intervention. It is important that there is good communication and clear referral pathways between adult services, emergency departments and specialist mental health services for children and young people. Communication between these areas needs to be particularly well developed in relation to dealing with young people who have made suicide attempts, or deliberately self-harmed.

There is little national information on the numbers of children and young people with acute needs seen by mental health services and the difficulties they present. This information will become routinely available at the end of 1999 when the national mental health information project is fully implemented.

## 4.5.2 Inpatient services

In some cases, children and young people cannot be managed in the community and need to have inpatient services available to them at times of acute need. Inpatient services always need to be part of an overall treatment plan which will generally include treatment by community services both before admission and after discharge, along with the possibility of other less restrictive options such as day treatment or respite care.

The hospital inpatient unit provides stabilisation of acute symptoms and a highly specialised assessment and short-term treatment programme within a range of services. Because of the social disruption of inpatient admission on children and young people, this is very much a setting of last resort for assessment and treatment. Thus it is important to keep children and young people within their normal environment with appropriate respite and other support as much as possible.

Nevertheless, there are times when the use of inpatient settings is essential for assessing and treating a child or young person. At such times, the service being provided must be highly specialised with sufficient staff experienced in the inpatient assessment and treatment of this client group. Currently there are few specialist psychiatric wards for children and young people, with most children needing mental health admissions managed in paediatric wards, and adolescents managed either in paediatric or adult wards.

Comments from both clinicians and adolescent consumers during the development of this document highlight the need for separate inpatient services for adolescents. The general view of both clinicians and consumers is that space for adolescents in adult inpatient wards remain adult focused and do not provide appropriate or safe treatment environments for the young people.

Inpatient units need to be child or adolescent friendly and staffed by appropriately trained and experienced staff. It is generally not adequate to allocate underutilised areas of an adult psychiatric ward to accommodate children, adolescents, and families when a young person is experiencing mental health difficulties.

Young people who had experienced inpatient admissions in paediatric wards spoke about the awkwardness of being the biggest with lots of little children and having to sit in little chairs. Others spoke about the fear and loneliness they felt after acute admission to an adult ward with people running around screaming and talking about killing themselves. One young woman expressed the issues succinctly when she explained that it was difficult enough dealing with her own illness without being forced to be aware of everyone else's.

## 4.5.3 Secure inpatient

There is a limited need for secure inpatient mental health facilities for children and young people who have offended. It is highly likely that these children and young people will have particularly severe behavioural problems and often other severe mental health disorders as well. At present, no separate or specialist secure inpatient facilities exist for such children and young people.

The whole issue of the appropriateness of secure facilities, the interagency issues with CYPFS, Justice and Education and the best way to collaborate to provide such facilities if they are needed is a complex one. This is an area where further scoping, clarification and policy work needs to be done collaboratively by all the agencies.

To summarise, this section has outlined the range of assessment and treatment services which are needed to ensure that children and young people with severe mental health problems are adequately catered for. These include: community assessment and treatment, daypatient treatment, respite care, residential treatment, crisis responses, and inpatient care.

The number and configuration of these services is determined by the HFA in consultation with providers.

# Section 5: Service Models

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## 5.1 Multidisciplinary teams

Specialist community services for children and young people are made up of multidisciplinary teams in order to allow the children, young people and their families and whānau to have the advantage of the particular skills of all the mental health disciplines either individually or in combination.

Peter McGeorge (1995) proposes a model for the suggested staffing numbers for a multidisciplinary team which is reproduced as Appendix 3. This document generally supports the staff profile recommended by McGeorge. It is noted, however, that the actual composition of multidisciplinary teams may vary depending on the needs of children and young people of the particular area and the way in which evidence about best practice indicates those needs are best met.

Within the New Zealand context, it is important that multidisciplinary teams include Māori mental health workers and, where appropriate, Pacific mental health workers. It is imperative to employ Māori and Pacific mental health workers or, where this is not possible, to closely involve cultural workers or consultants in mainstream services to ensure that services are delivered in ways that are appropriate to the needs of the client. Other ethnic groups also need to have services delivered in ways which meet their particular needs. This may be done by involving/employing consultants.

Regardless of the combination, all staff in the teams will:

- be trained in working with children and young people and their families
- have proven ability of working effectively with tamariki, rangatahi and their whānau
- be familiar with the major disorders of childhood and youth, including familiarity with symptoms of early psychosis, suicidality and the identification of alcohol and drug problems in children and young people
- do full assessments which include looking at severity
- contribute to the formulation of diagnoses
- understand the need to have good links with paediatric services, other mental health services and with non-health services relevant to the needs of their client group. This will generally include CYPFS, schools and school guidance counsellors. Links may also be needed with preschool services, police youth services, whānau, hapū, iwi and Māori organisations, and other cultural support groups.
- combine their talents in a way which makes good use of scarce resources and allows the treatment methods to best address the needs of the clients
- treat effectively and appropriately, or refer on for effective and appropriate treatment either within the CAMHS team or outside it
- maintain a good knowledge base about the most effective and appropriate forms of treatment for children and young people with specific mental health problems.

The issue of who should be able to diagnose was raised a number of times during consultation on this document. Some people considered that only psychiatrists or clinical psychologists, who are trained in formal diagnosis as part of their professional qualification, should be able to diagnose. Others considered that the diagnosis could be done by any well trained staff member regardless of their initial profession. Some teams allow staff to give provisional diagnoses which are then confirmed either by a trained psychiatrist or psychologist or in a team meeting.

This variation reflects the present evolutionary stage of CAMHS and YSS. The essential issue about diagnosis is that it should be based on a full assessment of the situation and symptoms and that it be accurate, reliable and valid. Diagnosis is an aid to appropriate treatment, and should be part of the full assessment.

In multidisciplinary teams, there can be a tendency for team members to aspire to a generic treatment model rather than working together to ensure that the child or young person and their family benefit from the disparate skills of team members. Conversely, there may be a tendency for staff to work independently to maximise throughput, often ignoring the possibility of more appropriate input by other team members. The key issue with a multidisciplinary team is the way in which the multiple skills of the team are brought together to provide the best possible treatment for an individual child or young person.

Currently, some teams have little access to psychiatrists or psychologists. Many have no access to cultural workers or consultants. Some lack a range of mental health disciplines within their staff profile. The development of fully staffed multidisciplinary teams within core specialist community services is a key priority.

During the consultation, the issue of appropriate facilities and support was raised. This document has assumed that all teams would have adequate and appropriate facilities and therapeutic tools to enable them to diagnose and treat their clients and evaluate their work. It is also assumed there will be sufficient reception, clerical and technological support and appropriate training and supervision.

## 5.2 Māori mental health services

Māori mental health services for tamariki and rangatahi are even more poorly served than mainstream services. Figures from the 1996 Census show that 22.7 percent of the population of children and young people under the age of 20 in New Zealand are Māori. Table 1 gives the breakdown by Health Funding Authority (HFA) divisions, showing that the Midland region has the highest percentage of young Māori (34.9 percent), while the Southern region has the lowest (11.8 percent). The higher percentage of Māori in the younger age bracket indicates that we can expect further increases in the percentage of rangatahi in our population and need to ensure that mental health services are effective and appropriate to their needs.

There are few Kaupapa Māori services for adults and only a minority of these allow for tamariki and rangatahi with their specific needs. In 1995, the Government defined Māori, mental health and children as three of its health gain priority areas. This focus has continued into current funding expectations. Since mental health services for Māori tamariki and rangatahi combine all three of these priorities, they will be a primary focus for purchasing and service provision.

When considering mental health in particular, *Moving Forward* (Ministry of Health 1997d) has stated objectives which move the sector towards providing more and better services for Māori. These objectives are:

- to encourage Māori involvement in planning, developing and delivering mental health services
- to increase the responsiveness of mainstream mental health services to the special needs of Māori.

Mental health services for children and young people are also targeted in *Moving Forward* with the specific stated objective:

- to improve the delivery of mental health services for children and young people with moderate and severe mental health problems.

Together, these objectives give a clear mandate for the priority provision of culturally appropriate mental health services for Māori tamariki, rangatahi and their whānau.

When discussing services for Māori, it is assumed that the principles outlined in the rest of this document apply to Kaupapa Māori services which deal with tamariki and rangatahi, as well as to mainstream services. The focus of this section, then, is on the specific needs of tamariki and rangatahi with severe mental health problems, and how both mainstream and Kaupapa Māori services need to adapt to meet these needs.

**Table 1: Percentage of Māori children by HFA division**

HFA Division	0–14 Years			15–19 Years			Total Population	Total Māori	% Māori
	Non-Māori	Māori	% Māori	Non-Māori	Māori	% Māori			
North Health	220,710	63,909	22.45	71,820	16,272	18.47	372,711	80,181	21.51
Midland Health	117,588	65,496	35.77	36,237	16,788	31.66	236,109	82,284	34.85
Central Health	154,875	46,743	23.18	50,505	12,651	20.03	264,774	59,394	22.43
Southern Region Health	142,247	20,085	12.37	52,638	5,964	10.18	221,061	26,049	11.78
Total	635,420	196,233	23.60	211,200	51,675	19.66	1,094,655	247,908	22.65

Based on information available electronically from the *1996 Census of Population and Dwellings by Territorial Authority of Usual Residence and Ethnic Group for Population Aged 0–14 and 15–19 Years, Usually Resident in New Zealand*.

## 5.2.1 Principles for culturally effective service provision for Māori

One of the most well known models of health which reflects Māori world views is Whare Tapa Whā, also known as the four cornerstones of Māori health, which describes the four dimensions that contribute to wellbeing (Pomare et al 1995). These are:

- *te taha wairua* (spiritual aspects)
- *te taha hinengaro* (mental and emotional aspects)
- *te taha whānau* (family and community aspects)
- *te taha tinana* (physical aspects).

All of these need to be taken into account when considering effective and appropriate service provision for tamariki and rangatahi. However, it is not enough just to acknowledge that these dimensions are important to Māori. It is also essential that services for Māori are provided in a way which ensures that these dimensions are respected and that health and Māori development are integrated.

Mason Durie et al (1995) list five principles for purchasing culturally effective services. These provide a framework for service provision that is compatible both with mental health goals and with Māori development policies. The five principles are:

<i>Choice:</i>	The need for a range of services so that options for different types of services are available
<i>Relevance:</i>	Services that are culturally meaningful and able to address actual needs
<i>Integration:</i>	Mental health services should not exist in isolation from other health services, and intersectional connections should be strengthened in line with a holistic approach to Māori development
<i>Quality:</i>	In any service, high standards of care and treatment are necessary, and this should be reflected in outcomes
<i>Cost effectiveness:</i>	Services must give value for money; limited resources make economies of scale important.

It is worthwhile considering how these principles can be put into practice when providing mental health services for tamariki, rangatahi and their families and whānau.

Mason Durie notes that Māori live in many and diverse realities (Durie et al 1995). For some Māori, the elements outlined below will be important, but for others they may not appropriately reflect their view of their culture.

### 5.2.1.1 Choice

All mental health services need to be culturally safe and to provide appropriate services for Māori.

Currently, there are a number of services which Māori tamariki and rangatahi and their whānau can access. These are:

- mainstream services with no direct Māori input
- mainstream services which have Māori mental health workers and provide a safe but not separate environment
- Kaupapa Māori services which are a part of Crown health enterprises (CHEs)\* but work in a Māori way to provide appropriate services to their tūroro. Services for tamariki and rangatahi may be part of 'whole of life' services (including adult mental health services) or may be separate.
- specialist Māori mental health services which are not part of a CHE
- iwi-based services which may be accessed by whānau on a private or koha basis.

For some Māori, the most appropriate service provision may be in a Kaupapa Māori service where services for tamariki and rangatahi with serious mental health problems may be provided within a total life span context, by Māori clinicians working within a Māori model. The expectations of Kaupapa Māori services for tamariki and rangatahi is similar to that of mainstream services, that is, a high standard of clinical input, high quality assessment and treatment services as well as consultation and liaison services with other agencies involved with children and young people, such as schools, GPs, CYPFS and community/non-government agencies.

The provision of Kaupapa Māori services may not always be possible, because the services have not yet been set up, because there is not the population to maintain such services, or because the Māori workforce is not yet trained in the specific skills necessary to provide quality services to tamariki, rangatahi and their whānau. It may also be that some Māori do not want to be treated within a Kaupapa Māori setting. In order to cater for these situations, mainstream services need to employ Māori workers, or if this is not possible, to have provision for access to Māori networks and support systems. This can be done by including Māori support workers in work with Māori families and whānau, or by the service having strong links with Māori community services which can provide the cultural support that is essential to service provision for Māori.

When consulted, some Māori wanted their Māori services for children and young people to be autonomous under the umbrella of an iwi or mainstream service. This would allow them to easily access both specialist and generic support already be in place in the larger services.

Having options also means that Māori should be able to exercise choice about the mode of service provision available to them. In some cases, where there are no Māori mental health services in an area, it may be appropriate for Māori families and whānau to be offered treatment by a Māori mental health service in another area, or for specialist Māori mental health services to contract out to a number of CHEs for their services. Families and whānau should be given reasonable choice according to the available resources and the needs of the child or young person involved. Where there are no Māori services, the least that Māori clients can expect is the right to Māori advocacy.

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\* The term CHE is being superseded following the Budget announcements of 14 May 1998. The new term for these entities has not been finalised at time of printing.

### 5.2.1.2 Relevance

Services provided to Māori should be culturally meaningful and be able to meet actual needs. Mason Durie's 1995 study confirmed the importance of the following in providing culturally appropriate services for Māori clients (Durie et al 1995).

#### Cultural assessment

This refers to the process of assessing the relevance of culture to the client's mental health problems. Currently, a cultural assessment tool for mental health services is being developed on behalf of the Ministry of Health, by Professor Mason Durie and Te Pumanawa Hauora ki Manawatu. An assessment tool for mental health services for tamariki and rangatahi has yet to be developed.

#### Whānau participation

The participation of the family and whānau is an accepted part of the treatment of tamariki and rangatahi. However, in some cases rangatahi may not want their parents or whānau to be present during mental health treatment. Services need to have protocols for dealing with rangatahi who are unwilling to talk in front of the family/whānau, but clearly need help. Protocols should also be developed around dealing with whānau when their involvement is not in the best interests of the tamariki/rangatahi.

#### Te reo Māori

There is no doubt that using a language which is not native to the client can be a major barrier to effective assessment and treatment of mental health. There are a number of Māori for whom English is a second language. Such people should have the choice of a Māori interpreter if required, in the same way that other non-English speakers might. In Kaupapa Māori services there is an expectation that Māori is available as a language of choice for Māori clients. Equally, it should not be assumed that because a client is Māori that they will speak te reo Māori.

#### Tikanga Māori

Tikanga Māori refers to the adaptation of Māori protocol for use in treatment settings. In the mental health services this would include the way in which families and whānau are greeted and received, and the help of koroua and kuia at appropriate stages of treatment. Working within tikanga Māori means that the environment is made appropriate for the intervention that is about to take place, and will often facilitate the process for families and whānau and allow them to feel more comfortable and able to talk even in mainstream settings.

#### Māori leisure pursuits

Professionals working with tamariki and young people therapeutically often use non-verbal methods of communication, such as drawing and play, to assess the emotional state of the child or young person and to help in both diagnosis and treatment. In most cases the 'tools' of this form of communication are those used by the mainstream culture. In working with tamariki and rangatahi, it may be that traditional Māori leisure activities, such as drawing, bone-carving, weaving, wood-carving, may facilitate more effective communication with the rangatahi than more contemporary equipment. Clearly these tools would be used more effectively by Māori workers who themselves feel comfortable with the media and with the therapeutic process. It must, however, be

acknowledged that our children and young people are all the offspring of two cultures, so therapeutic responses need to reflect the diversity of Māori rather than assuming that all Māori are the same.

### **Karakia**

The use of karakia or prayers in the mental health setting is one which often does not sit easily in mainstream services. However, it is an integral part of Kaupapa Māori service provision as a response to the need for spiritual health as part of mental wellbeing.

In mainstream mental health services, there needs to be an openness to spirituality as a part of mental health, and an awareness that karakia may be an integral part of the journey towards health for a Māori child or young person and their family. As mainstream services employ more Māori health workers, and become more familiar with Māori ways of working, the use of karakia will become a more familiar process and clinicians will be more likely to see it as an integral part in providing holistic mental health care.

Key issues relating to the practice of karakia in mainstream settings are the development of appropriate policies on the use of karakia, staff training and a safe environment for the practitioners.

### **Rongoā**

Rongoā Māori refers to the entire range of traditional Māori healing services which include herbal remedies, physical therapies such as massage and manipulation and spiritual healing. It encompasses practices which are unique and particular to Māori.

In terms of mental health services for tamariki and rangatahi, rongoā Māori has not been used within mainstream services. However, Mason Durie et al (1995) report that rongoā are used as adjuncts to treatment in adult mental health services and the concurrent use of rongoā and psychotropic medication is not generally regarded as problematic.

As mental health services for children and young people working within a Kaupapa Māori framework increase, so should the use of rongoā to complement clinical treatment of tamariki and rangatahi.

### **Involvement of tohunga/traditional healers**

The belief that mental health and mental illness happen within a cultural context underpins the need for cultural understanding and treatment within a cultural context. There is no doubt that most of our Māori youth are children of two cultures, and it makes logical and clinical sense that their poor health is affected by this, and hence their return to health will be aided by the integration of western clinical and Māori cultural forms of healing.

Not all tamariki, rangatahi and their whānau will need to be seen by tohunga or traditional healers, but services need to consider how to make these resources available when they are needed, and to develop good ways of assessing when their input is appropriate.

The use of tohunga is complicated by the fact that many consider that their healing skills are gifts and not to be 'contracted for' in the mainstream model. Services will need to develop creative ways of accessing tohunga services which allow for the traditional values to be respected while ensuring that they are also appropriately recompensed for their important work.

## A Māori workforce

*Towards Better Mental Health Services* (Ministry of Health 1996b), which explores mental health workforce development, acknowledges the shortage of Māori health professionals, but also recognises that there is little detailed precise information about how many Māori are working specifically in mental health. This report identifies some strategies for increasing the numbers of Māori health professionals. However, the needs of services for children and young people are not addressed in detail. The Mental Health Commission is currently reviewing the best means by which Māori workforce needs can be met.

During consultation, one of the issues consistently raised was the need for health professionals to gain a better understanding of what Māori believe to be *well* mental health in its entirety, rather than as a component of mental *illness*.

Workforce issues identified as part of the consultation process include:

- the need for Māori to know more about the CAMHS and YSS services and when it is appropriate to use them
- appropriate, ongoing on-the-job training
- more training available within provincial and rural areas
- training in group facilitation models
- peer support workers need appropriate bicultural and Kaupapa Māori training models, that is, pōwhiri, te Whare Tapa Whā, whakawhanaungatanga
- teaching/sharing appropriate mental health knowledge.

These were identified as additional to the basic personal attributes which include:

- cultural skills applicable to the youth culture
- genuine feel (love) for youth
- passion for the work.

For workforce development and the western model of mental health to be of benefit to Māori, there needs to be a professional exchange, acknowledgement and validation of perspectives. In recognising the differences in approach and philosophy, workforces can be developed that will better meet the needs of Māori.

### 5.2.1.3 Integration

For Māori families and whānau, the provision of appropriate service is made more complex by overlaying cultural requirements on the already complex treatment responses needed for children and young people generally. Services will have to balance Māori knowledge and clinical expertise, to allow the most appropriate mix of services to be provided for the client. It is important that our young people get the best of both worlds in their treatment, and that the potential for conflict between cultural and clinical values is minimised. This requires understanding on both sides, and an openness to new ideas, rather than one culture trying to fit the other.

The integration of services for tamariki, rangatahi and their whānau requires mainstream services to have ways of accessing support and culturally appropriate treatment for Māori, and providing a culturally safe environment for Māori families and whānau.

Comments by Māori during the consultation process came up with the following practical suggestions. To ensure the cultural safety of Māori CAMHS and YSS clients who choose to use mainstream services, Māori and non-Māori employed in these services should be required to:

- prove their commitment to youth and Māori by the models they use when working with Māori CAMHS
- have Māori tikanga/youth cultural components as compulsory units of training or upskilling
- ensure Māori tikanga/youth cultural components are built into performance related reviews for both clinical and non-clinical services, management and employees
- have strong links and accountability back to youth and iwi.

The concept of integration requires Kaupapa Māori services to access mainstream services when they may need additional clinical support and treatment. Kaupapa Māori services are also expected to provide consultation/liaison services to other organisations which may be dealing with children who have less severe mental health problems but who need good culturally safe assessment and treatment services.

#### **5.2.1.4 Quality**

Tamariki, rangatahi and their whānau are entitled to a quality service. This means that mental health assessment and treatment services are provided by well trained staff in a safe, appropriate environment and with the knowledge that the outcomes being achieved are health enhancing and do not develop client dependency on the mental health system.

Mainstream services will need to either employ Māori workers or access culturally appropriate services to enhance their clinical competence. Kaupapa Māori services may also need to augment their clinical skills by calling upon the specialist clinicians. Unfortunately, there is only a limited number of such clinicians currently available in the Māori workforce.

#### **5.2.1.5 Cost effectiveness**

The reality of Māori mental health service provision, and in fact all mental health service provision, is that it is, and will continue to be, costly. It is also true that there is a long way to go to reach the benchmark targets for service provision for children and young people with severe mental health problems. It is therefore important that interventions are cost effective, based on evidence, and that limited resources are used co-operatively and effectively, with an emphasis on good culturally-appropriate service provision for this client group.

## 5.2.2 Components of a Kaupapa Māori CAMHS service and a rangatahi day programme

Consultation with 25 rōpū in the Hawke's Bay area came up with the following requirements for a successful Kaupapa Māori CAMHS service and rangatahi day programme:

1. skilled clinicians who are youth- and Māori-appropriate and who have proven commitment to the Māori values of Te Whare Tapa Whā, pōwhiri and whakawhanaungatanga
2. Māori kaimahi from the community to support the clinicians (includes rangatahi peer support workers)
3. experienced Māori management
4. appropriate and enough resources — vehicles, training, supervision
5. appropriate day programme resources:
  - appropriate accommodation — big enough premises
  - central for youth but not too obvious
  - flexible hours/quiet places
  - youth appropriate activities to emphasise and teach basic life skills, including cooking, cleaning, laundering, as well as, study, employment, transitional learning, etc with bicultural and Kaupapa Māori values to give benefit of both traditional and modern-day models.

All programmes aim to help rangatahi realise their identity and sense of belonging in order to make liberating choices, that is, their sense of:

- turangawaewae
- mauri (their contribution to mana, aroha, wehi, ihi is valued)
- tino rangatahi.

## 5.3 Pacific peoples' mental health services

The Pacific community of New Zealand does not consist of a single culture. There are six main ethnic groups which originate from the Pacific region and have established identifiable communities in New Zealand. The 1996 Census (Statistics New Zealand 1998b) identified that 50 percent of the Pacific population living in New Zealand are Samoan. A further 23 percent are Cook Island, 16 percent Tongan, 9 percent Niuean, 4 percent Fijian and 2 percent Tokelauan.

The mental health needs of Pacific people were identified by the Ministry of Health in its 1995 publication *Strategic Directions for the Mental Health Services for Pacific Islands People*. Sadly, there has been little movement in terms of appropriate and effective service provision for Pacific people. The National Child Health Strategy, which is currently being finalised, identifies Pacific children as one of its priority groups.

**Table 2: Territorial authorities with populations of Pacific children and young people greater than 2,000**

	Pacific People 0–9 years	Pacific People 10–14 years	Pacific People 15–19 years	Total Pacific People 0–19 years	Total Population	% Pacific People
Manukau City	23,304	10,443	9,840	43,587	88,479	49.3
Auckland City	19,572	7,773	6,852	34,197	93,198	36.7
Waitakere City	6,198	3,108	2,820	12,126	49,857	24.3
Porirua City	5,013	2,130	2,322	9,465	16,488	57.4
Lower Hutt City	3,060	1,464	1,284	5,808	29,514	19.7
Wellington City	2,832	1,302	1,464	5,598	40,077	14.0
Christchurch City	2,622	1,137	1,062	4,821	83,457	5.8
North Shore City	1,431	618	675	2,724	48,102	5.7
South Waikato District	1,155	540	483	2,178	9,330	23.3
Papakura District	1,206	384	411	2,001	13,101	15.3

Based on information available electronically from the *1996 Census of Population and Dwellings by Territorial Authority of Usual Residence and Ethnic Group for Population Usually Resident in New Zealand*.

From the information in Table 2, it would seem there are areas in New Zealand where it would be both desirable and appropriate for mental health services for Pacific children and young people to be provided in a way which was sensitive to the needs of Pacific people.

Murray Bathgate and Fuimaono Karl Pulotu-Endemann give a very full analysis of the mental health needs of Pacific people in the 1997 Ministry of Health publication *Mental Health in New Zealand from a Public Health Perspective*. They identify the need for information on the prevalence

of mental illness among Pacific people and the need for good information on drug and alcohol use, abuse and dependence.

Although their work is focused on the public health aspects of mental health, Bathgate and Pulotu-Endemann's report identifies some general points which apply just as well to clinical assessment and treatment services as they do to prevention services:

- clinical services and workshops on mental health promotion need to focus more on the family group than the individual
- clinicians need to become more aware of cultural beliefs and family-based decision-making processes if they are to provide a receptive environment that will encourage more Pacific people to present for clinical treatment, especially at earlier stages in their illness
- services need to come to Pacific families. Home based services would be appropriate in cases where there is a reluctance to present family members early, or at all, for clinical assessment because of a fear that they will be separated from the family while they are treated.
- more Pacific people need to be involved in mental health promotion work and in identifying illness within families. For this to occur there needs to be increased training and development of Pacific mental health workers.

Although the issues for Pacific people are different from those of Māori in many ways, as far as mental health services for their children and young people are concerned, there are many similarities. There is a need for appropriate services, cultural sensitivity and safety in service provision, an understanding of the cultural imperatives and cultural constructs of mental health and a willingness by non-Pacific clinicians to learn from Pacific people and share their clinical knowledge with them.

On a practical level, this means that in areas of significant Pacific population, specialist mental health services need to build strong consultation/liaison links with existing Pacific networks and Pacific leaders and use Pacific styles of communication both with the general community and with children, young people and their families.

# Section 6: Planning for the Future

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The aim of this section is to guide the expansion of child and youth specialist mental health services.

Discussion in Section 1.2.3 Benchmarks identifies the work that is being done to more clearly identify the national access level for specialist mental health services for children and young people by age band.

According to an unpublished national stocktake undertaken on behalf of the Ministry of Health in 1995, and more recent information from the Health Funding Authority (HFA), less than one percent of children and young people currently access specialist mental health services. Information about access at various age levels is not currently available, but will be available nationally by the end of 1999 when the national mental health information project being run by the New Zealand Health Information Service will be fully implemented. Despite the lack of accurate current access figures, it is clear that there is a requirement for considerable growth in the service provision. The growth needed in specific regions of the country will depend on what is currently available and the perceived needs of the client group. Determining this need and defining appropriate services is the role of the HFA.

The development of specialist mental health services for children and young people is recognised as a priority by the Government and the HFA. Even given this prioritisation, expectations of growth in service provision need to be realistic.

## 6.1 The national population

According to figures from the *1996 Census of Population and Dwellings* (Statistics New Zealand 1998a), there are currently just over one million children and young people under 19 years of age living in New Zealand. In the five years between 1991 and 1996 the total population under 20 years of age fell slightly.

Given that services have experienced some growth over the past two years, it is estimated that about 10,000 children and young people under 20 years of age are currently being seen in any one month by specialist services. This is one percent of the total population under 20 years of age. Each month there will be some new clients, and some will drop off. There will also be a core of clients seen for more than a month.

Using the interim figures on work currently being done, as set out in Section 1.2.3 Benchmarks, access figures over one month for children and young people in the three age bands would be as set out in Table 3.

**Table 3: Children and young people's access to mental health services for a one-month period**

Age	Population	Needing direct specialist services		Needing consultation/ liaison services		Total
		%	number	%	number	
0–9 years	567,985	0.5	2,840	0.5	2,840	5,680
10–14 years	264,168	2.2	5,812	1.7	4,491	10,303
15–19 years	262,978	3.1	8,152	2.4	6,311	14,463
<b>Total</b>	<b>1,095,059</b>		<b>16,804</b>		<b>13,642</b>	<b>30,446</b>

Based on provisional information from work on benchmarking being done by the Mental Health Commission.

The figures above are based on the best information about prevalence and need for specialist and consultation/liaison services available at the present time. Although the trend of increasing prevalence by age band is not expected to change, the percentage of children and young people needing access will be adjusted as new information comes to hand. It is important that the boundaries between direct treatment by specialist services and consultation/liaison are seen as flexible. These figures are indicative only and should not limit service provision.

The changes in need by age of children and young people raise questions about service provision. This is an issue which is yet to be addressed by the HFA in consultation with providers, as it considers the funding of appropriate services.

## 6.2 Māori population

In contrast to the slight drop in total population under the age of 20, the Māori population under 20 years of age increased by over 16 percent between 1991 and 1996. Given the need to provide services to Māori within an appropriate Māori service model, the growth in the Māori youth population has special implications for planning for the growth of services to Māori.

The role of specialist Kaupapa Māori mental health services must be built into overall planning for service growth. An appropriate overall level of service provision cannot be based solely on planning calculations for mainstream specialist services, but must take into account appropriate specialist services for children and young people within specialist Māori services. Such services may be dedicated to Māori of all ages, as is currently the case. It may also be appropriate, in some parts of the country with high numbers of Māori under 20 years of age, to establish separate Māori child and youth specialist services that are not part of a service for all ages. The decision about what shape Māori services should take in any area should be made by local Māori in consultation with the HFA.

## 6.3 Expansion of services

The release of the Mental Health Commission's (MHC's) draft *Blueprint for Mental Health Services in New Zealand: Working document 1997*, signalled a major change in the perception of the number of mental health professionals needed to provide services for children and young people.

Ongoing work by the MHC, the Ministry of Health and the HFA aims to clarify appropriate national full-time equivalent staffing levels (FTE) for CAMHS and YSS. It is expected that information on the actual access to services, which the new national mental health information system will provide, will significantly improve our ability to estimate further needed service growth.

### 6.3.1 Youth Specialty Services (YSS)

15–19-year-olds currently make up nearly 30 percent of the total population under 20 years of age. There is a much higher incidence of severe mental health problems amongst this older group, as indicated in the provisional information from the MHC's blueprint. A recent study from the Institute of Psychiatry, London, claims that "comprehensive mental health services for individuals up to their 18<sup>th</sup> birthday may cost around twice as much as similar services that end at people's 16<sup>th</sup> birthday" (Goodman 1997). These comments highlight the higher prevalence of mental illness disorders in this age group and the greater degree of possible impairment of functioning.

Notwithstanding the need for specialist mental health services for all under 20-year-olds, there is a priority need for services amongst 15–19-year-olds. This is the age of onset of major mental health problems which last into adulthood. Based on the information in Table 3, it would be expected that at least a third and perhaps up to a half of total specialist mental health resources should be targeted to this age group.

Such targeting would include early identification and treatment of psychosis and other major mental disorders, eating disorders and the provision of effective treatment of major alcohol and drug problems in this client group.

Separate YSS need not be set up throughout the country. In many areas, because of low population, the provision of services to 15–19-year-olds will need to remain part of services provided by CAMHS. Where this is the case, it is still expected that the appropriate amount of resources and staff skills will be targeted to 15–19-year-olds.

### 6.3.2 Daypatient, respite, residential and inpatient services

The Mental Health Commission (MHC) accepts the McGeorge (1995) recommendations for these additional services and estimates the rate per 100,000 total population accordingly. McGeorge states that at any one time, the national requirement for these services is:

- 36 acute inpatient beds for children and young people with serious mental health problems
- 15 secure inpatient beds for young people who need to be kept safe
- 29 community-based respite beds
- 144 places in day programmes
- 36 places in community residential programmes.

The Ministry of Health accepts these figures on the understanding that they only reflect the state of current knowledge. They may need revising with further work done on them as more information on need and the appropriateness of various forms of service provision comes to hand.

The number of children and young people needing services at this very specialised end of the mental health spectrum is not large. It is therefore important that where the services are provided, this is done in a way which integrates community and more restrictive care in the best interests of the child or young person and their family. This may mean that creative ways of providing some of these services are needed.

In line with the principle of least restrictive intervention, daypatient and respite facilities for children and young people needing intensive assessment and treatment would be seen as a higher priority than increasing inpatient beds. The question of how many inpatient services are needed and how the issues of appropriate service provision are to be met will ultimately be decided by the HFA in its purchasing plan. One suggestion made during consultation was that there be specialist adolescent inpatient wards in Auckland, Wellington and Christchurch, with elsewhere a choice of going to an inpatient unit or a local ward with 1:1 staffing and private rooms and individualised programmes.

## 6.4 Planning issues

Planning for the expansion of services requires a broader perspective than growth in the traditional model of mainstream community services. A strategy is needed that combines growth in traditional services with the ongoing development of other service models and an expanded range of specialist service functions. The development of such a strategy is the role of the HFA.

Within the range of required specialist services and functions, there are clearly options around how services are configured. Whether or not such services and functions are provided from one service or from separate settings, a key requirement is that all services are co-ordinated around the needs of the child or young person, and that, for older adolescents, these are linked with adult mental health services as appropriate.

### 6.4.1 The priorities

There is an increasing awareness of the needs of children and young people with severe mental health problems. This has put the focus on to the specialist mental health services for children and young people.

The twin priorities for these services are:

- to assess and treat those with the most severe mental health problems
- to ensure support and advice for other professionals involved with those with mild to moderate mental health problems.

The emphases of the strategy to increase services are:

- the expansion of existing core community services — CAMHS and, where appropriate, YSS — into full sized multidisciplinary teams (as discussed in this document)

- the provision of culturally appropriate services, both within mainstream core services and through the development and expansion of Kaupapa Māori specialist mental health services
- the development and expansion of consultation and liaison services from CAMHS and YSS to other professionals involved with children and young people.

## 6.5 The strategy

The strategy is that *development should build on what exists*. This means the initial focus is to build up and expand the services of existing core CAMHS, YSS and Kaupapa Māori services, emphasising the expansion of consultation and liaison services. In this way, existing services and the existing skill base will be strengthened to support and sustain the subsequent establishment of new services. Once current services become larger and more effective, new small community teams should be established in locations identified as priority areas.

This strategic approach is discussed below.

### 6.5.1 Expansion of existing teams

Recent service development has tended to focus on the establishment of new ‘subspecialist’ services, such as eating disorder or early (psychosis) intervention services that include children and young people under 20 years of age in their client group. The success of such services depends on the development of sufficient mature CAMHS and YSS services to provide the foundation for subspecialist development.

Existing multidisciplinary teams need to be built up to meet the optimal size and appropriate staffing as recommended by McGeorge (1995). Once existing teams are full-size and operating effectively, they should be capable of sustaining part-time ‘outreach’ clinics to provide specialist treatment and consultation/liaison services to outlying areas. These clinics will then be developed into new core specialist community services for children and young people (see 6.5.3 below).

Within existing services, it is important that all tamariki and rangatahi be offered services that are culturally appropriate.

In line with the overall strategy for developing existing specialist service provision, current specialist Kaupapa Māori mental health services would be enlarged so as to increase the services they provide for tamariki and rangatahi in their area.

### 6.5.2 Expansion of consultation and liaison services

Consultation and liaison services are not yet extensively provided around the country. This is a strategic priority. The expansion of consultation/liaison services allows for an overall increased skill base, more co-ordination of care, and the provision of advice and support for other sectors. As has been noted earlier in this document, consultation/liaison services are there to enhance the provision of direct assessment and treatment services. Concerns have been expressed during the development of this document that consultation/liaison services may weaken the direct treatment component of CAMHS and YSS. This is not the intention.

As new, small mental health services are set up, the provision of consultation and liaison services from larger mental health services ensures appropriate training, supervision and safety. It also minimises the impact that small, new teams will experience of working outside a multidisciplinary team.

### **6.5.3 Establishment of new services**

As proposed in this strategy, new teams would be established as the second phase of the expansion of specialist mental health services. In general, new mental health services would grow from outreach clinics that are established by full-size CAMHS, YSS or Kaupapa Māori services.

Outreach clinics that are to develop into new services would be established in priority areas. Prioritisation could be based on identified need as well as factors such as demographics, distance from existing services, the socio-economic and cultural profile of the area, and the availability of existing 'alternative' service provision, such as adult services that provide limited services for children and young people. The establishment of new specialist services for Pacific children and young people would be considered.

Small core specialist teams would be established in these priority areas. The establishment of a small team would require two full-time equivalent staff (FTEs) as a minimum. These teams would be supported by existing established CAMHS or YSS teams who share their expertise and experience and provide clinical and cultural supervision. Links to larger, existing teams could be supplemented by two-way secondments and visits. Small teams would grow over time into self-supporting multidisciplinary teams.

### **6.5.4 Expansion of specialist Māori mental health services**

There are currently few specialist Kaupapa Māori mental health services covering any of the population centres with the largest tamariki and rangatahi populations (see Appendix 4). The ongoing growth in tamariki and rangatahi populations reinforces the need for increased provision of Māori models of service delivery.

It is particularly important that Māori services develop expanded two-way consultation and liaison services to other professionals working with tamariki and rangatahi with severe mental health problems.

New small Māori services could be developed around outreach clinics in priority locations, supported by larger regional Māori services and also by mainstream services. Because of the particular shortage of Māori mental health specialists in the child and youth area, support for new Māori services is a critical issue. Strong consultation and liaison links between established and new Māori services are a means of clinical upskilling. Māori services also need to be supported by local mainstream services through consultation and liaison.

Some new services may be stand-alone tamariki and rangatahi services and not part of Māori services covering the full age-range. While this represents a change from the current model of service provision across all ages, the intention is to avoid developing new specialist Māori tamariki and rangatahi services that are dependent on growth in adult service provision.

## 6.5.5 Increasing the existing skill base

A culture of professional development for all mental health staff ensures a contemporary skill and knowledge base and supports the expansion of services. Areas which have already been highlighted in this document as needing ongoing development are:

- assessment and treatment of young people who have drug and alcohol problems with or without other mental health disorders
- working appropriately with Māori and Pacific children and their families and whānau
- development of consultation/liaison services and skills in supporting primary mental health service providers
- identification and management of children and young people at risk of suicide or self-harm.

In many parts of the country, children and young people with serious mental health problems are currently treated and supported by other health professionals, such as paediatricians, GPs, public health nurses and adult mental health services. In cases where such services are likely to be maintained while specialist mental health services for children and young people are in a developmental stage, the health professionals working with these children and young people would benefit from direct advice and support related to the specific management of individual children and young people.

There is also a need for more training programmes both for workers in specialist mental health services (post-entry) and for those who are outside services but would like to increase their skills in working with children and young people with mental health problems (pre-entry).

In general, consultation and liaison services from existing services should assist in upskilling all professionals involved with children and young people. This will include, among other skills, behavioural management, management of self-harming or suicidal children and young people, and the early recognition of serious problems.

## 6.5.6 Daypatient and respite services

There are currently few non-inpatient services for children and young people with severe mental health problems who need intensive treatment (and/or assessment). McGeorge (1995) indicates levels of daypatient and respite services that are currently believed to be required.

The establishment of new daypatient and respite services is seen as an important step for service development. As with core community services, appropriate priority locations would need to be identified for new services. New services will need to be developed with the support of consultation and liaison services from existing core services, including Kaupapa Māori services.

## 6.6 Issues

### 6.6.1 Workforce

The shortage of child and youth mental health specialists is a major constraint on the short- and medium-term service development. This shortage of mental health professionals affects the whole mental health sector. The Mental Health Commission (MHC) is currently leading a strategic project, sponsored by the Health Funding Authority (HFA) and the Ministry of Health, which is aimed at identifying the issues around the recruitment and retention of an appropriate workforce.

The purchase of post-entry training (that is, for those already employed in the health sector) is the responsibility of the HFA through the Clinical Training Agency (CTA). In 1998, child and adolescent mental health training will be available for 56 individuals. This will represent about 5 percent of the total purchase of the CTA. The availability of training will need to continue to increase in subsequent years to support the needed expansion of services.

Members of the clinical advisory group commenting for this document highlight the need for specific increases in child and adolescent psychiatrists and psychologists. This is particularly important as the specialist mental health services focus more on those children and young people who have serious mental health problems.

In addition to providing appropriate clinically trained staff, all staff need to have a level of cultural competence which allows them to practise safely and effectively with tamariki and rangatahi as well as with Pacific children. Refugees and other ethnic groups also have the right to be treated appropriately and with sensitivity to their particular cultures. Training in cultural safety is an essential component of workforce development and good service provision. This is particularly important in regard to employing overseas clinicians to boost low staff numbers in our specialist services.

It is clear that there is a need for more staff with the skills to provide appropriate, safe and effective assessment and treatment for children and young people with severe mental health problems. Comments during the consultation process were that we need:

- training and development programmes for new and existing staff
- an acceptance that some workers will need to learn on the job and that this training will need to be resourced and encouraged
- a focus on training Māori to work either within Māori or mainstream services
- good career pathways to encourage the retention of skilled staff.

Clearly workforce development is a priority, but it is vital that the expansion of the workforce is not done at a rate which compromises quality. The balance of increasing the workforce and maintaining safe, high quality, effective services is one which will need ongoing discussion both at central and local levels.

## 6.6.2 Information and evaluation

The ability of the sector to know what services are being provided, to whom and with what outcomes rests largely on good, uniform information systems.

Recent works on child and adolescent mental health services (for example, Wallace et al 1997; Weisz and Weiss 1993; Goodman 1997) emphasise how little evidence exists to support the use of some treatments and therapies for children and young people with severe mental health problems. Of course, the impact of interventions is complicated by a range of factors relating to the whole environment of the child or young person. However, summaries of research and clinical findings are starting to indicate the effectiveness of multidisciplinary treatments for specific disorders.

Certainly, here in New Zealand, little is known about the effectiveness of many treatment approaches believed to be currently in use. In fact, there is a dearth of information on which approaches are commonly being used by clinicians around the world.

We need to begin gathering this information as well as data on outcomes in order to better support our service development. We need workable, efficient, culturally appropriate outcome measures for all interventions with children and young people.

A new mental health information data collection system has been developed under a major project by the Ministry of Health and the New Zealand Health Information Service. The system is currently being implemented in services around the country.

In order for this system to work effectively, the data that is being collected needs to be complete and accurate. One of the identified shortfalls is accurate ethnicity information. The lack of services for Māori, and the identification of increased service provision for Māori as one of the national strategic directions highlights the need to collect accurate and consistent ethnicity information. Once accurate information on ethnicity is being routinely collected, we can start to measure progress in the assessment and treatment of Māori and Pacific people, as well as other cultures more effectively.

Using this information over the coming years, the sector will be better informed about progress towards achieving benchmark levels. Information collected will also aid research on issues such as epidemiology, prevalence of disorders and patterns of service usage. This does of course assume that CAMHS and YSS will have adequate and appropriate technological resources to support their work.

In addition to this data gathering, measures will need to be developed to allow the validation of outcomes by independent outcome measures, provided by teachers, social workers, parents, other family or whānau, and the client themselves.

Goodman (1997) suggests that clinically auditing some cases at regular meetings of external stakeholders (for example, GPs, teachers, paediatricians, guest clinicians, etc) is particularly useful, especially regarding clients in complex, difficult or unusual situations.

The HFA, working with the Ministry and the MHC, is developing a research and development strategy for mental health. Nationally, we are starting to foster a strong research culture within the sector in order to find out more about what works well in our environment. To achieve this we need a sector with close academic links, a nationally co-ordinated information and evaluation base and the establishment of collaborative and comparative trials.

### 6.6.3 Innovative approaches

It is important that services are delivered in a way that specifically suits those to whom they are directed. This is especially true of services for adolescents. Successfully creative solutions for service delivery to adolescents already exist around New Zealand. Innovative service models for adolescents include the 'one-stop shop' approach that has been developed at a number of centres throughout the country. Such services can effectively incorporate primary health service delivery (including primary mental health service delivery) as well as links to services provided by other sectors.

Other innovations already exist to improve accessibility of services. These include changing opening hours to better suit clients, linking in with primary mental health services, providing services from a range of sites, and using video and phone conferencing technology. Clearly, there will be advantages and difficulties associated with new creative approaches and the best balance needs to be found.

In general, the sector should support, build on and generalise from successes. Effective outcomes result from investment in developing successful processes, which are subject to regular review.

# Glossary

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<b>CAMHS</b>	Child and Adolescent Mental Health Services. Working with children and young people, from birth to 19 years of age inclusive, who have severe mental health problems including alcohol and other drug abuse.
<b>CHE</b>	Crown health enterprise (Crown owned entities that provide health and disability support services). The term CHE is being superseded following the Budget announcements of 14 May 1998, but the new term for these entities has not been finalised at time of printing.
<b>CTA</b>	Clinical Training Agency. The division of the Health Funding Authority responsible for the purchase of post-entry clinical training.
<b>CYPFS</b>	Children, Young Persons and Their Families Service — a division of the Department of Social Welfare which provides child protection and child abuse services.
<b>DSM-IV</b>	The American Psychiatric Association publication, the <i>Diagnostic and Statistical Manual of Mental Disorders</i> Fourth Edition (see references).
<b>FTE</b>	Full-time equivalent staffing.
<b>GAF</b>	Global Assessment of Functioning scale, as defined in DSM-IV.
<b>Hapū</b>	Groups of whānau with common ancestral links.
<b>HFA</b>	Health Funding Authority. The national agency which is responsible for purchasing services according to the needs of the population and in line with Government strategic directions.
<b>Hui</b>	A meeting or gathering of people for a specific reason.
<b>Iwi</b>	The people of the local area, tribe.
<b>Kaimahi</b>	Worker.
<b>Karakia</b>	Prayer.

<b>Kaupapa</b>	Foundation, rule.
<b>Kaupapa Māori services</b>	In this document, this term is used to define specialist Māori mental health services run by Māori for Māori.
<b>Kōhanga Reo</b>	Māori language ‘nests’; describes an organisation established by Māori in the 1960s to teach Māori language to preschool children.
<b>Kura kaupapa</b>	Māori language schools.
<b>Mauri</b>	Spiritual strength, life force.
<b>MHC</b>	Mental Health Commission.
<b><i>Moving Forward</i></b>	The national mental health plan for more and better services which provides a guide on the implementation of the National Mental Health Strategy ( <i>Looking Forward</i> ) (Ministry of Health 1997d).
<b>Pacific peoples</b>	Diverse consumer group including people from Tonga, Samoa, Fiji, Cook Islands, Tokelau and Niue.
<b>Rangatahi</b>	Young adults.
<b>Rongoā</b>	Medicine, remedy.
<b>SES</b>	Specialist Education Services.
<b>Special Education 2000</b>	An education policy currently being implemented which aims to develop a fair system to ensure that students with special needs receive appropriate support wherever they may be and according to their level of need.
<b>Tamariki</b>	Children.
<b>Tāngata whenua</b>	The people of the land, the indigenous people of New Zealand.
<b>Te Puni Kōkiri</b>	Ministry of Māori Development.
<b>Te reo Māori</b>	The Māori language.
<b>Te taha hinengaro</b>	The intellectual (thought) dimension, mental wellbeing.
<b>Te taha tinana</b>	The physical (bodily) dimension, physical wellbeing.
<b>Te taha wairua</b>	The spiritual dimension, spiritual wellbeing.
<b>Te taha whānau</b>	The familial dimension, family wellbeing.
<b>Te Tiriti o Waitangi</b>	The Treaty of Waitangi.

<b>Te Whare Tapa Whā</b>	A Māori health model that suggests that good health is described in relation to the four walls of a strong house: <b>te taha wairua, te taha hinengaro, te taha tinana</b> and <b>te taha whānau</b> . A person is considered unwell if any of these foundations are weak. For a person to be healthy, all four walls need to be strong.
<b>Tikanga</b>	Customary practice, rule.
<b>Tohunga</b>	Expert, specialist.
<b>Tūrangawaewae</b>	Literally translates to ‘a place to stand’, however, more broadly refers to one’s source of identity.
<b>Tūroro</b>	A Māori person who engages with a mental health service.
<b>Whakawhanaungatanga</b>	Establishing or improving relationships between groups of people, kinship.
<b>Whānau</b>	Family.
<b>YSS</b>	Youth Specialty Services. A subgroup of CAMHS working with young people aged 15–19 years inclusive who have severe mental health problems including alcohol and other drug abuse.

# The Consultation Process and Contributors

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The consultation process for the draft of this document was developed around three phases which commenced in July 1997 and were completed in March 1998.

**Phase 1:** A hui was held in Palmerston North to discuss what Māori would consider needed to be in a document to define the range of appropriate service provisions for tamariki and rangatahi and their families and whānau. A Māori advisory group was identified as a result of this hui. At the same time, a mainstream advisory group of clinicians was set up to clarify their views.

**Phase 2:** The first draft of the document was circulated to members of the two advisory groups, key sections in the Ministry of Health, and to the Mental Health Commission and Health Funding Authority for comment. A focus group of young people was held in Christchurch.

**Phase 3:** On the basis of the comments received on the first draft, a second draft was developed and circulated widely amongst government departments and specialist mental health services. Comments from this consultation have been incorporated into the final draft.

The project team thanks the many individuals and groups who have contributed to the development of this document either through face-to-face consultations, in writing or by telephone. We apologise to any whose names may have been left off this list inadvertently.

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Children, Young Persons and their Families Service	Hastings
Hine Ko Tou Ariki	Napier
Ikaroa Rangatahi Social Services	Hastings
Kahungunu Executive Services	Hastings
Kahungunu Health Services	Hastings
Kahungunu ki te Wairoa Executive	Wairoa
Nga Ti Pahauwera Hauora	Raupunga
Ngati Pahauwera Inc Soc	Wairoa
Rangitane Tamaki Nui a Rua	Dannevirke
Taiwhenua-o-Whanganui-a-Orotu	Napier
Tamaki Health Enterprise	Dannevirke
Tamatea Consultants for Youth	Waipukurau
Tangoio/Kahupatiki	Clive
Te Hauora o te Wheke a Nuku	Wairoa
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Te Puawai o te Whanui	Hastings
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Te Roopu-a-Iwi Trust	Napier
Te Taiwhenua o Heretaunga	Hastings
Te Whanganui-a-Orotu Trust	Napier
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Waikaremoana Health Centre	Wairoa
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# Appendix 1:

## Essential Aspects of Service Provision

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The following are the essential aspects of service provision which have been defined in other documents as the appropriate continuum of care for mental health clients. These have been agreed to by the Ministry of Health, HFA and MHC in work being done on the mental health workforce. *The National Mental Health Standards* (Ministry of Health 1997e) have set standards for this service provision. This version of the continuum of care is set out in the *Mental Health Common Base Definitions* (Ministry of Health 1997c) and expanded here to illustrate how it may apply to the assessment and treatment of children.

### Access

*The services are accessible to the designated client group, and:*

- *are easily located*
- *operate at times appropriate for the client group*
- *are developed around identified client needs.*

In working with children and young people, accessibility is a complex issue. This means that services need to be:

- **Physically accessible**

This includes aspects such as ensuring that parents with prams and pushchairs and people with disabilities are easily able to access the building. It also includes closeness to public transport, sufficient car parking, and client-friendly waiting rooms with age-appropriate activities and reading material.

Accessibility may also mean that many mental health services for children and young people need to provide outreach services to allow the treatment to be more reachable for the young person and their family and whānau. Similarly, services may need to be provided in settings other than the community clinic.

- **Culturally accessible**

The issue of cultural accessibility and appropriateness is discussed at some length in this document. The emphasis is on a choice of appropriate services provided by skilled clinicians and cultural workers in ways which work for Māori, Pacific people and other ethnic groups.

- **Timely access**

This includes accessibility to crisis services and flexibility in opening times to ensure that children, young people and their families can access services without undue inconvenience.

## Entry

*Entry to the service is facilitated through an efficient arrival/entry process for clients and carers, who are made aware of their rights and responsibilities in an appropriate and timely manner.*

The entry of a child or young person and their family to the service is critical to effective treatment and management of the problem. Good entry processes are clear, respectful of total client needs, clinically effective, appropriate, and thorough. *The National Mental Health Standards* specify that entry to mental health services is assisted by a qualified, experienced mental health professional (Standard 14.3).

Information relating to the ethnicity of the client needs to be collected on entry so that service provision can be culturally appropriate. Collection processes should be amended to ensure that ethnicity information about children and young people is collected through self-identification rather than identification by an observer (Privacy Commissioner 1994).

Information about the services being provided to the child or young person and their family should be given in a way which ensures that it is understood by all family members, and that the rights and responsibilities of both clinicians and clients are made clear.

## Assessment

*Client care treatment and support are based on a comprehensive assessment which is completed by a health team with appropriate knowledge and skills.*

*The National Mental Health Standards* have a detailed section on assessment (Standard 15), along with specific information about the needs of children and young people (Standard 4).

It is important that assessment and subsequent treatment reflect the most effective and appropriate ways of working with that child or young person and their family and whānau. This may not be the preferred mode of treatment of the clinicians involved, and may entail links with other services or cultural providers to work with clinicians on managing and treating the problem.

## Care planning

*A co-ordinated plan of care, incorporating goals, is developed through collaboration between the child or young person and their family, mental health workers and other appropriate agencies.*

Following a full assessment, the most effective and appropriate form of treatment needs to be identified and clarified with the child or young person and their family. The care plan should address all relevant facets of the child's life which were identified during the assessment and should outline the role of any other agencies involved.

Within specialist mental health services for children and young people, it is expected that the care plan will be reviewed by the multidisciplinary team. The aim of such a review should be to ensure that the most effective and appropriate service is being provided in the most efficient and holistic way to meet the assessed needs of the child or young person within the context of their family.

## Care implementation

*Care delivery is co-ordinated and provided according to the needs of the client and the plan of care.*

The co-ordination of service delivery between agencies, needs to be part of the ongoing management of the treatment of the child or young person. Much of the international literature on 'wrap round' services shows that the best outcomes occur when all the support services work together in the best interests of the child (Evans et al 1996; Bruns et al 1995).

## Care review

*Care delivery is reviewed by the health and/or disability team to ensure care continuously meets client needs and facilitates improvement of care provision.*

One of the principles in the MHC *Blueprint for Mental Health Services in New Zealand* (Mental Health Commission 1997) is that service interventions should be limited to those strictly necessary to assist and promote recovery. This principle of minimal intervention is important in treating children and young people because of the pervasive negative effects of creating dependency on health systems in early years.

Regular reviews of service provision undertaken by clinicians with the child or young person and their family ensure that the treatment being provided is having positive outcomes. They also ensure that the family or young person have other community supports which will allow them to continue to progress once contact with the specialist mental health service is discontinued.

## Discharge/follow-up

*Clients and carers are prepared for and are confident about continuing co-ordination of client care on leaving the service. Care must be integrated between services/service components and community (services) to ensure client needs continue to be met.*

Discharge planning is an essential part of good clinical management. In the case of specialist services for children and young people, most of the treatment will be provided in the community and the concept of 'discharge' is not strictly applicable. It is important that there is a clear process of final review of service provision with the child or young person and their family. Follow-up services or referrals to other agencies are arranged, if appropriate, and all documentation is completed in a timely and professional manner.

Clear protocols are needed to establish procedures for re-entry after discharge. Procedures for re-entry need to reflect the principle of prioritising responsiveness according to the severity of clinical needs.

## Appendix 2:

# *Making Links: Guidelines on service co-ordination for children and young people with severe mental health problems*

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The *Making Links* guidelines describe how effective service co-ordination can be developed in each community between specialist mental health services and services provided by the Education and Social Welfare sectors.

The purpose of the guidelines is to establish key principles for service co-ordination and, using these principles, to provide a guide to the development of a local interagency protocol on service co-ordination.

The guidelines include Principles of Service Co-ordination. The principles establish that services for children and young people will be provided in a co-operative, collaborative and co-ordinated way. The introduction to the principles notes, “The Principles include the development of agreed protocols to establish specific procedures for collaboration and co-ordination between local agencies and services. Protocols are to be established at the local agency level where services are delivered because it is at this level that relationships and detailed agreements need to be co-ordinated around how to co-ordinate service delivery”.

The guidelines discuss the components of an interagency protocol:

- case management/service co-ordination
- identification of the lead agency
- role of the lead agency
- the case manager
- assessment
- culturally appropriate service intervention
- dispute resolution
- joint staff training and development between agencies
- privacy issues
- Family Group Conference
- links with adult services
- monitoring, evaluation and review.

The *Making Links* guidelines form part of a wider national strategy called *Strengthening Families*. The aim of this strategy is to improve services for children and young people at risk, through collaboration between the sectors.

The *Making Links* guidelines are available from the Assistant Support Officer, Mental Health Services, Ministry of Health, PO Box 5013, Wellington, tel. 04 496 2375.

# Appendix 3: McGeorge (1995) Recommendations on Staffing

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Peter McGeorge (1995) recommends the following staff profile for Community Specialist mental health teams, with one team per 40,000 child and adolescent population.

1 FTE	Psychiatrist
1 FTE	Psychiatric Registrar
1 FTE	Psychologist
1 FTE	Psychology Intern
1-2 FTE	Nurses
1-2 FTE	Psychotherapists
1-2 FTE	Social Workers
1 FTE	Occupational Therapist
2-4 FTE	Community/Cultural Workers
2 FTE	Clerical Assistants

It is assumed that teams will be adequately supported by management, administration and technological systems.

# Appendix 4:

## Territorial Local Authorities with Populations of Māori Children and Young People Greater Than 4,000

Territorial Authority	0–14 years			15–19 years			Total 0–19 years	Maori Total 0–19 years	% Māori
	Māori	Non-Māori	Total	Māori	Non-Māori	Total			
Manukau City	16,773	50,715	67,488	4,230	16,761	20,991	88,479	21,003	23.7%
Auckland City	10,161	59,430	69,591	2,934	20,673	23,607	93,198	13,095	14.1%
Rotorua District	8,250	8,883	17,133	2,193	2,619	4,812	21,945	10,443	47.6%
Far North District	8,511	6,189	14,700	1,779	1,602	3,381	18,081	10,290	56.9%
Waitakere City	7,764	30,909	38,673	2,019	9,165	11,184	49,857	9,783	19.6%
Christchurch City	7,380	52,605	59,985	2,349	21,123	23,472	83,457	9,729	11.7%
Hamilton City	6,807	17,214	24,021	2,229	7,866	10,095	34,116	9,036	26.5%
Gisborne District	7,116	5,583	12,699	1,728	1,482	3,210	15,909	8,844	55.6%
Whangarei District	6,432	10,449	16,881	1,494	3,093	4,587	21,468	7,926	36.9%
Hastings District	5,850	10,947	16,797	1,461	3,267	4,728	21,525	7,311	34.0%
Lower Hutt City	5,193	17,526	22,719	1,497	5,298	6,795	29,514	6,690	22.7%
Whakatane District	5,085	4,146	9,231	1,215	1,179	2,394	11,625	6,300	54.2%
Tauranga District	4,560	12,138	16,698	1,230	3,645	4,875	21,573	5,790	26.8%
North Shore City	4,014	31,092	35,106	1,257	11,739	12,996	48,102	5,271	11.0%
Waikato District	4,110	6,645	10,755	966	1,920	2,886	13,641	5,076	37.2%
Wellington City	3,465	25,983	29,448	1,179	9,450	10,629	40,077	4,644	11.6%
Porirua City	3,618	9,381	12,999	819	2,670	3,489	16,488	4,437	26.9%
Palmerston North City	3,291	11,865	15,156	1,119	6,081	7,200	22,356	4,410	19.7%
Papakura District	3,498	6,567	10,065	888	2,148	3,036	13,101	4,386	33.5%
New Plymouth District	3,399	12,609	16,008	972	3,900	4,872	20,880	4,371	20.9%
Taupo District	3,543	4,398	7,941	774	1,155	1,929	9,870	4,317	43.7%
Napier City	3,222	8,592	11,814	897	2,844	3,741	15,555	4,119	26.5%
Wanganui District	3,204	7,524	10,728	837	2,448	3,285	14,013	4,041	28.8%

Based on information available electronically from the 1996 Census of Population and Dwellings by Territorial Authority of Usual Residence and Ethnic Group for Population Aged 0–14 and 15–19 Years, Usually Resident in New Zealand.