3.14 Children and young people

Children and youth with mental illness present particular challenges that the system must attend to. About 50 per cent of the disease burden among young people aged 12 to 25 are accounted for by mental illness (McGorry 2007). Prevalence rates of mental illness in children are at 14 per cent, adolescents (19%) and youth (26%), which begins to demonstrate the magnitude of the challenge (National Advisory Council on Mental Health, McGorry 2011).

Dealing with mental illness in these age groups is made ever more complex when considering the effects of developmental stages (children to adolescence to adulthood), family and social environments, multiple agency involvement (including schools and at times police and hospitals), age-driven transitions across mental health services, geography, and system resource limitations.

Simplifying access and entry processes, improving pathways of referrals, improving after-hours and emergency response services irrespective of location, and closing identified gaps should each be given strategic priority. The Review has identified a specific imperative in relation to youths over 16 where support needs are approaching those of an adult.

A conceptual framework for child and adolescent services in Western Australia describes four tiers of service as follows:	
tier 1	Non-specialists in mental health provide development opportunities that promote mental health and wellbeing, initiate prevention strategies, identify mental health problems early and refer children for assessment. Some case management, advice and treatment are also provided. For example, Inspire.
tier 2	Identify children with mental health problems and disorders and assess less complex, severe or persistent cases. For example, headspace.
tier 3	Provide emergency services, assessment, and some aspects of treatment for complex, persistent and more severe cases; case manage multi-modal service provision; screen and refer to tier 4, train and consult to tier 1 and 2 services; undertake research and development programs. For example Child and Adolescent Mental Health Service.
tier 4	Provide complex assessment, treatment of the most complex, persistent or severe cases; contribute to services, training and consultation at Tiers 1, 2, and 3; undertake research and development programs. For example, YouthLink and Youth Reach South.

The responsibility for delivery of child and adolescent mental health services is currently with the Child and Adolescent Health Service (CAHS) in metropolitan Perth and with the WA Country Health Service (WACHS) for all other areas. The CAHS commenced in 2011 with 10 per cent of the mental health budget.

The Executive Director of CAHS informed the Review that the recent separation of child and adult services from the Area Health Services has enabled devolvement of the mental health model to a child-centric service delivery model. The treatment involves the parents and siblings, and aims to build the child's capital by enabling education, work and avoidance of the justice system.

CAHS focuses on children under 16. Youth presenting with a newly diagnosed condition at age 16 and over are excluded from most metropolitan CAHS services, including acute inpatient care and specialist programs such as eating disorders.

Many of the other mental illness of children cease in adulthood. The CAHS Chief Executive informed the Review that the needs of young people aged 16 to 25 are best met by adult mental health programs and CAHS is relinquishing governance of adolescent services to adult services.

3.14.1 Services for youth

3.14.1.1 Inspire – ReachOut – tier 1

Inspire is one of a number of Australia-wide services that support youth with mental illness with early recognition of mental illness and encouraging health seeking behaviour. The program commenced 15 years ago and targets youth aged 14 to 25. It features an online system with fact sheets and moderated chat lines (ReachOut forum) as well as information such as the contact details of local mental health services. Off-line programs encourage young people to get involved in promotional and benevolent activities.

The program has a philosophy of benevolence, encouraging young people to seek help, to help others, to become involved, to undertake training to become ambassadors at public events, and to 'ReachOut' to Members of Parliament.

The average 'user' of Inspire (person who accesses the program more than three times) is aged 15 to 18 and to date 500,000 use the website in this way.

3.14.1.2 Headspace – tier 2

Early detection and treatment anticipates a reduced risk of developing severe mental illnesses and disabilities in adulthood (Scott et al. 2012).

Headspace provides care for mild to moderate mental health conditions in youth-friendly venues where young people are comfortable to attend. Medical and specialist services such as drug and alcohol services, psychology, social work and psychiatry are colocated and bulk-bill (Scott et al. 2012). This 'under one roof' youth-friendly environment is non-threatening and attractive to young people (CCYP 2011).

Some 56,000 young people have attended Headspace services at Fremantle and new services are planned in the Kimberley, Albany, Bunbury, Esperance, Northam, Geraldton and Perth.

Headspace has memorandums of understanding with hospital and community-based mental health services. At Fremantle, five to seven referrals are received each day and some 15 new patients are registered each week. The service promotes mental health issues and services within schools and at major events such as Big Day Out.

A mental health clinician informed the Review that further service fragmentation is occurring as more preventive programs have emerged and this complicates service delivery. For example, Headspace extends services into local school communities, managing critical incidents around suicide, a role traditionally undertaken by local community groups and the community mental health services. At times, all groups are providing interventions in schools in an uncoordinated manner.

3.14.1.3 Acute community intervention team (ACIT) – tier 3

The acute community intervention team (ACIT) service is a recent tier 3 innovation at Princess Margaret Hospital. The service provides assessment, treatment and follow-up for young people who have been discharged from the emergency department or hospital until an appointment with the Child and Adolescent Mental Health Service (CAMHS) can be arranged.

Clinicians explained the team's functions to the Review. The service is limited to children under 16, for periods of up to four months. The team bridges the link between the hospital and CAMHS, with daily contact with patients in inpatient services where they contribute to the patient's discharge plans. They also provide assessment for patients within EDs of adult hospitals and provide community support, including case management, discharge planning and interventions. When children are discharged from the ED or hospital, ACIT provides community intervention services until CAMHS can activate the individual's referral. The team liaises with the child's other community services and school and maintains contact with the patients to local Child and Adolescent Mental Health Service. Education for parents about strategies to enable medication compliance is a high priority.

ACIT also provides proactive follow-up when children and their families miss CAMHS clinic appointments.

See Recommendation 8: Children and youth (8.3; 8.10.3).

3.14.1.4 Child and adolescent community mental health services (CAMHS) – tier 3

An example of entry processes was explained to the Review by the Family Community Service team at Bentley Health Service. They receive two to three referrals per day by fax from GPs and school psychologists. Patients who self-present to triage receive an assessment for risk and are then asked to attend their GP to obtain a referral.

Referrals are received and assessed by the duty officer—a nurse or social worker. The duty officer undertakes a phone assessment of the child's circumstances by contacting the family. Many families are not at home during the hours the service operates (9 am to 5 pm Monday to Friday) and it can take weeks to contact family by phone. A letter is often sent to request that the family contact the CAMHS. In rare circumstances, staff undertake home visits to assess the family's circumstances.

A weekly team meeting is held and referrals are allocated to one of two waiting lists—the general waiting list and the priority waiting list. Referrals on the priority list will receive assessment within 30 days.

Patients on the priority list, who are also of particular concern, receive a preliminary assessment by the mental health nurse. Outcomes of these assessments are then discussed at weekly intake meetings. The referral might be accepted or the patient might be redirected to organisations such as In focus, YouthLink or Headspace.

Where referrals are accepted, a Systemic Treatment Assessment Review Team (START) is activated to conduct a multidisciplinary assessment of the family and a medical assessment of the child. The treatment team comprises specialists according to need and a case manager is allocated. A letter is sent to the GP explaining the referral outcome within three weeks. In some areas, there are extra services available for children with risk of self-harm.

For example, a youth counsellor has been employed at Mandurah to focus care on youth with histories of deliberate self-harm.

Referrals accepted by rural CAMHS include conditions of low mood (50%), anxiety (25%), and conduct problems (25%). About 20 per cent express suicide ideation and 14 per cent have a history of deliberate self-harm. The number of patients presenting with eating disorder or psychosis varies between services.

CAHMS clinicians explained to this Review that services focus on therapy and treatment and less on rehabilitation. There are rarely opportunities to provide preventive care.

Services are most often provided for frequent short-term care episodes.

Re-triage, re-assess

Similar to adult entry processes, referrals for care are received from the specialist mental health hospitals and are triaged by CAMHS. Assessment and treatment plans are re-developed. Clinicians in mental health hospitals and EDs said entry to CAMHS is difficult and care is often delayed by waiting lists of five to nine months. This is unacceptable.

A clinician from the inpatient services also informed the Review that this is not a therapeutic process but a gatekeeping exercise to manage service demand.

Circumventing entry

For GPs, the lack of a coordination centre to assist system navigation requires the GP to identify the service in the patient's local area to make a referral.

ED clinicians informed the Review that GPs circumvent these onerous processes by advising the family to present to emergency departments where they can obtain immediate access to CAMHS. ED clinicians at Princess Margaret Hospital estimated that 80 per cent of patients with mental illness who present to the ED are referred to community care.

There needs to be a simple one-point referral system for all child referrals. In the opinion of the Reviewer, a central referral point is also essential to facilitate referrals and reduce the complexity of navigating mental health services by individuals and primary and general services.

Medications

CAMHS clinicians informed the Review that medications are cheaper for the patient when provided by CAMHS. To ensure compliance, CAMHS continue to manage the child's medication rather than refer the patient back to the GP when they are otherwise stable. Clinicians explained that this creates a bottleneck in the patient flow, that is, children on the wait list cannot be provided services until children with stable conditions are discharged. This problem is particularly evident with Aboriginal children requiring medication by injection.

Limited specialist psychiatrists for children

Clinicians explained to the Review that some CAMHS teams do not have a psychiatrist, and without community support or available psychiatrists, it is difficult for the family to comply with treatment regimes. Patients in these areas often present to EDs to receive regular medication.

Psychiatrist Dr Prue Stone provides child psychiatry services to rural and remote areas by video-linked assessments as well as consulting advice to local medical officers and adult psychiatrists. For example, in rural and remote areas, psychiatrists provide care to patients of all ages with Dr Stone's support for advice with children and adolescents on a needs basis.

CAMHS services in the Kimberley provide assessment and advice but not therapeutic intervention. Currently, there are no child psychiatrists in Broome. However, adult psychiatrists are available on a single telephone number (through the Broome switchboard) and can provide assistance 24 hours a day for children and adults. Adult psychiatrists informed the Review that they are not endorsed to care for people under 16 and child psychiatry requires an extra two years of training.

In the Great Southern, children who require inpatient care are admitted to the children's ward, with a staff member providing one-on-one supervision. Since psychiatrists are not available, clinical decisions are made by the medical officers in the ED and the treating GP with the assistance of RuralLink and input from a psychiatrist consultant. Youths may be admitted to the Albany mental health inpatient unit if their development stage allows; otherwise, they are transferred to Princess Margaret Hospital or to the Bentley Adolescent Unit.

CAMHS in Geraldton and the Midwest liaise with PMH specialist programs to receive guidance and support. PMH mental health teams visit the area regularly and provide training, clinical supervision and consultation about individual patients.

It is challenging to manage patients on community treatment orders, particularly when they are itinerant and this is particularly pertinent in Carnarvon. Clinicians liaise with the family and case managers, who often need to visit the home several times to meet up with the young patient. Midwest clinicians informed the Review that issues of trust are ameliorated when clinicians have had a long-standing relationship with the patients and community.

CAMHS clinicians explained that they communicate complex management and crises plans to all services involved in the youth's care and this includes the local ED. However, when the youth attends an out-of-area ED or is admitted to mental health inpatient services out of area, these plans are not available, and the new mental health team often repeats assessment processes and re-forms a care plan.

See Recommendation 1: Governance; Recommendation 2: Patients; Recommendation 3: Carers and families; Recommendation 4: Clinicians and professional development; Recommendation 7: Acute issues and suicide prevention; and Recommendation 8: Children and youth.

3.14.1.5 After-hour services for children in rural areas

The presentation of youth in emergency departments (EDs) is increasing due to the growing demand for mental health care and illicit drug use. Clinicians have noted that peaks occur in November when students are under pressure with exams and future concerns. Clinicians at Bunbury explained that the EMO subculture of emotional expression is also affecting youth and increasing the number of young people presenting with self-harm.

Outside the metropolitan area, CAMHS do not provide urgent or emergency case responses in after-hours care. When there is a call for urgent referral, the patients are advised to present to an ED. After-hours cover in rural and remote areas when there are no CAMHS services available children and adolescent care appears to be provided by adult psychiatrists except at Bunbury

Clinicians at Bunbury Hospital informed the Review there are no after-hour services for children and youths at Bunbury. The Child and Adolescent Health Service (CAHS) psychiatrists are not available and the adult psychiatrists will not provide consultation to children or youths. Therefore, a 15-year-old presenting with psychosis on Friday night must wait in the ED until Monday to be assessed.

Children with severe psychosis often require inpatient care, and the processes for obtaining a bed cannot be commenced without a completed psychiatrist's assessment. The reluctance of the adult psychiatrists in Bunbury to provide consultations to children after hours persists, even though training in child and adolescent mental health has been offered to the adult psychiatrists and child psychiatrists are available for telephone and video-link consultation from Princess Margaret Hospital.

At the Armadale ED clinicians commented on the difficulties in managing adult-sized youths with long-standing problem behaviours. The adult psychiatrists in Armadale are not comfortable with caring for children and there are no after-hours CAMHS services available. These children often wait 72 hours to be assessed and obtain an inpatient bed.

The lack of after-hours CAMHS services and psychiatric liaison clinicians in some rural and remote areas results in up to seven patients waiting for assessment by the mental health team on Monday mornings, either in the ED or in general hospital beds.

The Reviewer is concerned about the patchiness of mental health services for young children and youth.

Immediate action is needed to address the emergency response and after-hours service needs for children outside the metropolitan area.

See Recommendation 1: Governance (1.1.1); Recommendation 5: Beds and clinical service plan (5.5); and Recommendation 8: Children and youth (8.2).

3.14.1.6 Multi-systemic Therapy Program – tier 3

An award-winning program operating at Hillarys and Rockingham is the Multi-systemic Therapy Program. This program has won the National Institute of Criminology's Crime and Prevention Award; the Award for Excellence in Prevention and Community Education at the National Drug and Alcohol Awards; and the Department of Health's Healthy Communities Award 2008 (Gov. of WA2012; Healthy Awards, 2008[7]).

The program targets children aged 12 to 16 with 'diagnosed conduct disorders on the verge of school expulsion and/or being told to leave the family home' (Government of Western Australia 2012). Conduct disorder is strongly associated with substance abuse and the program aims to break the link by increasing the capacity of parents, families and the youth's school to modify the youth's behaviour.

3.14.1.7 YouthLink – tier 4

YouthLink services in north and south metropolitan areas and in Northam provide care to youths aged 13 to 24 with serious mental illness and those at risk of developing mental illness. This service focuses on youth experiencing barriers to other mental health services, for example, those without a fixed address, youth who are treatment-resistant (not attending clinic appointments), and youth who are unable or who are unwilling to respond to letters. These patients would not be eligible for CAMHS services. In addition, the service provides care for young people for whom the CAMHS family-based model of care is unsuitable, such as where families do not accept this formulation of the problem and view the 'problem' to be imbedded in the young person. These families include those that are damaged or damaging, with potential abuse of the young person.

Patients are referred to YouthLink by non-government organisation providers, accommodation providers, street-based youth programs (e.g. RUAH), EDs, drug and alcohol services, and the Departments of Child Protection and Corrective Services. The youth can also self-refer. More than 60 per cent of the patients receiving support are over 18. Many young people (14–15 years old) have brief encounters with YouthLink and then return for more consistent care at age 18.

Referrals are triaged and interim case management is provided. There is a waiting list of 10 to 12 places in YouthLink, and this clears within the month. Case managers have a 10 to 12 person caseload.

Services include psychotherapeutic interventions and case management (advocacy and support), and YouthLink works closely with community social and recreational support services.

The service staff include 0.2 FTE psychiatrist, clinical psychologists and social workers, and a nurse triage officer. The biggest gap is in consultant psychiatry and this impedes the provision of comprehensive care. To bridge the gap, YouthLink operates in shared arrangements with the local area's CAMHS services. The itinerant nature of the youth complicates shared arrangements and frequent changes of mental health services occur along with a multiplicity of arrangements.

[7] http://www.health.wa.gov.au/hrit/docs/publications/Healthy_WA_Awards_2008.pdf

Accommodation options are often limited by the behavioural difficulties of the youth such as drug and alcohol use and self-harm behaviour. YouthLink works closely with Life without Barriers (a recovery program to assist young people to resolve homelessness for individuals). However, there are some young people who are also too complex for this program.

The YouthLink Chief Executive informed the Review that the difficulty of locating suitable accommodation sometimes results in youth being discharged from inpatient settings to their family, even when the volatility of relationships is likely to result in this becoming a short-term solution.

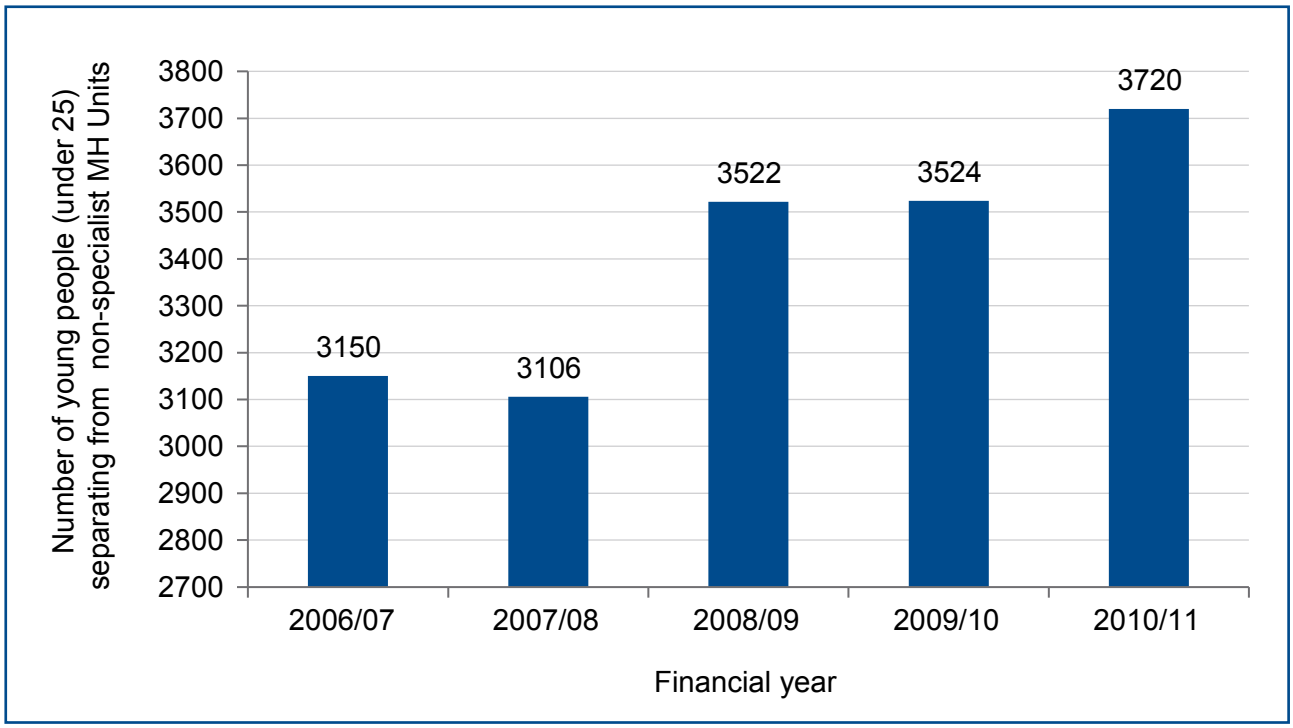
YouthLink also inreaches to the Bentley Adolescent Unit with weekly visits to maintain contact with youth and get to know young people before they are discharged. This process supports the program's assertive follow-up.

Youth aged 16 to 18 cannot access ED services at Princess Margaret Hospital (Area Mental Health Clinical Reform Group, 2011). In 2012 the acute community intervention team (ACIT) commenced as described below. However, this service is limited to the metropolitan area.

3.14.2 Children admitted to general hospitals

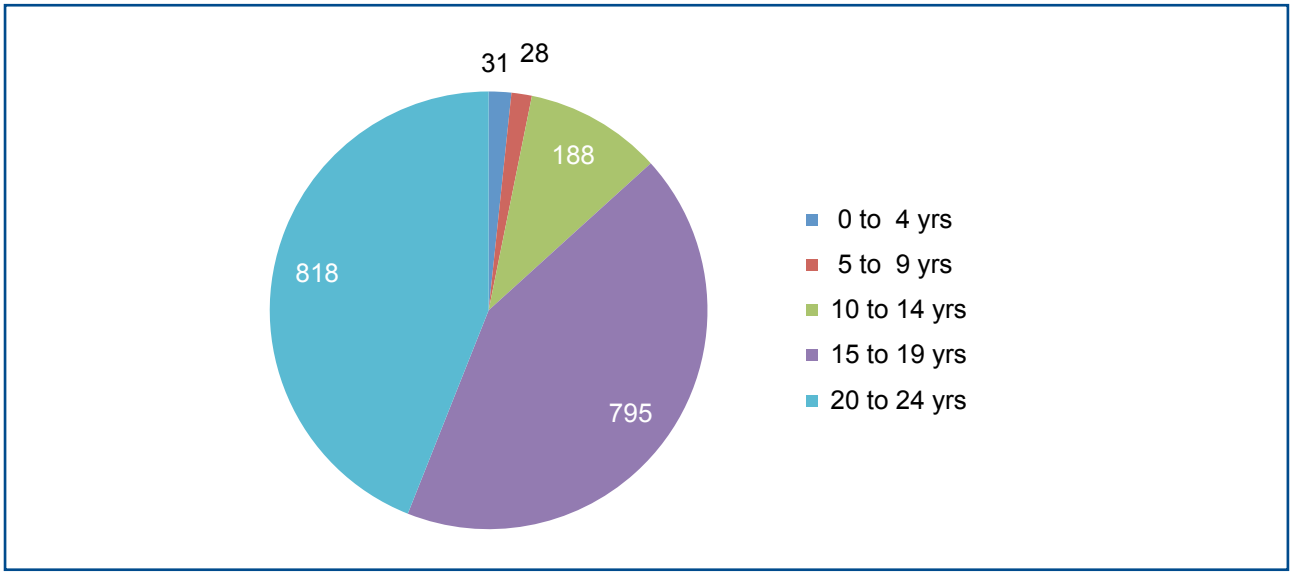
Some children and young people (under 25 years of age) are admitted into general hospitals with mental illness for short lengths of stay of one to four days (see Figure 42). The majority are 15 to 24 years of age (see Figure 43). These admissions occur across all health areas, with the majority in the north metropolitan and country health areas and the numbers are increasing (see Figure 44). The children in general hospitals are cared for by general hospital staff and CAMHS do not always provide inreach to guide care.

Figure 42 **Number of separations of patients 0–24 years, 2006–11**



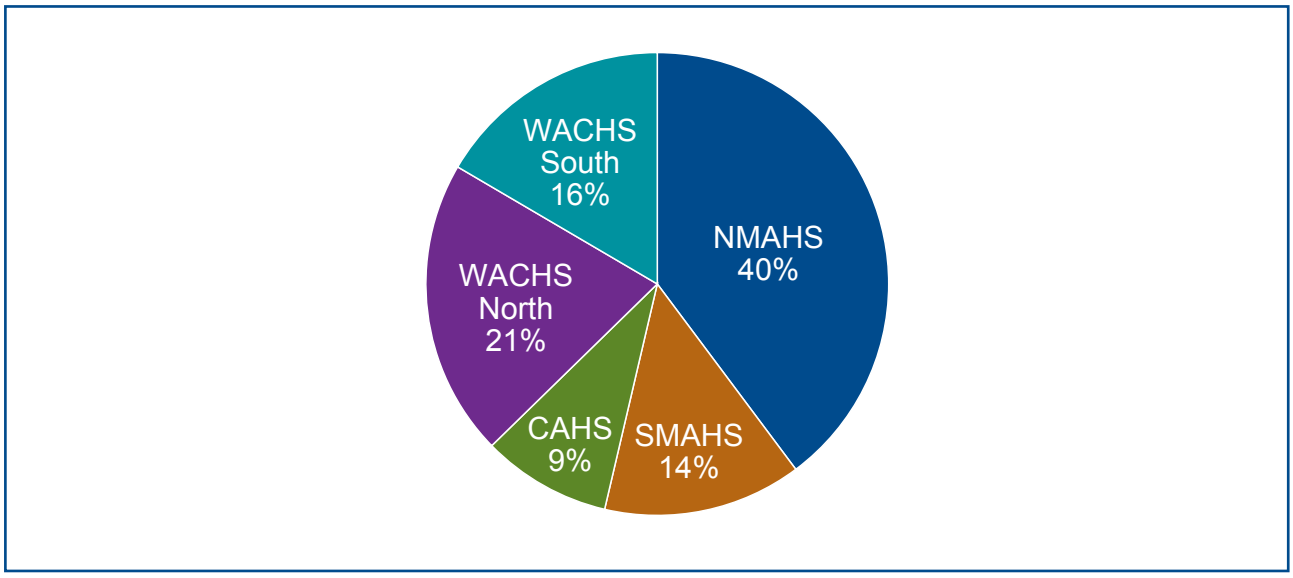
Source: MHIS DoH (2012).

Figure 43 **Age distribution of children admitted with mental illness to non-specialised hospitals, 2010–11**



Source: MHIS DoH (2012).

Figure 44 **Separations of persons under 25 years of age by Area Health Service, 2010–11**



Source: MHIS DoH (2012).

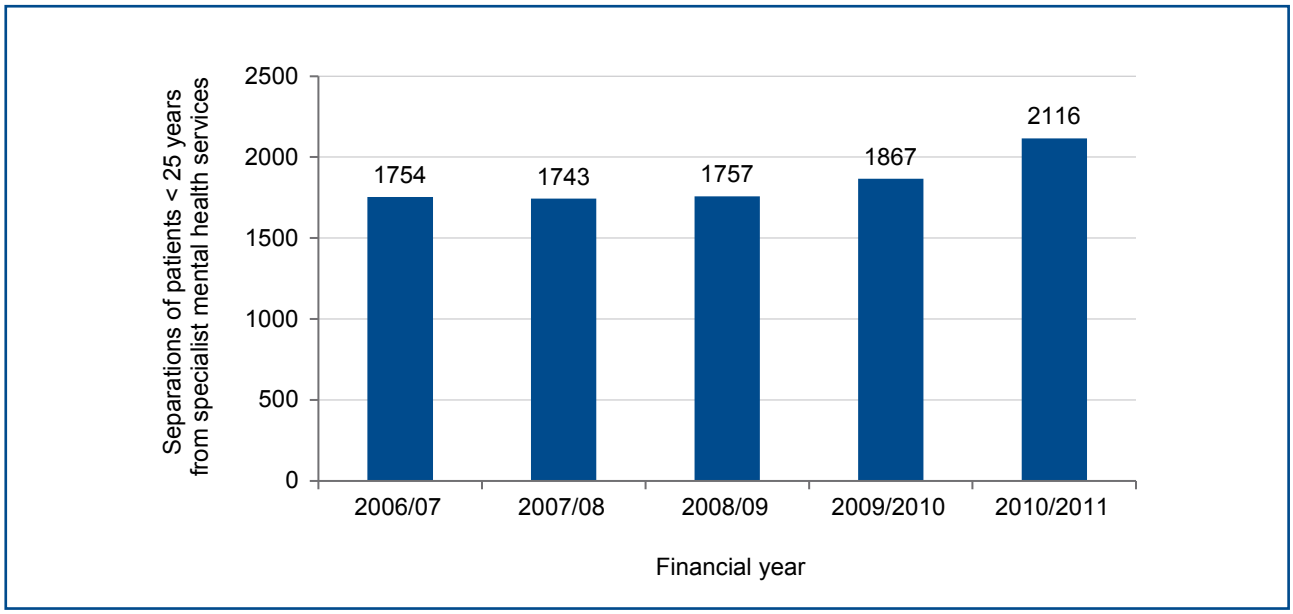
There are no specialised mental health inpatient beds for children and adolescents in rural areas. Young people are sometimes admitted to the general ward if this is safe and appropriate; otherwise, they are transferred to Princess Margaret Hospital or the Bentley Adolescent Unit.

See Recommendation 2: Patients (2.8).

3.14.3 Specialist mental health inpatients for children and youth

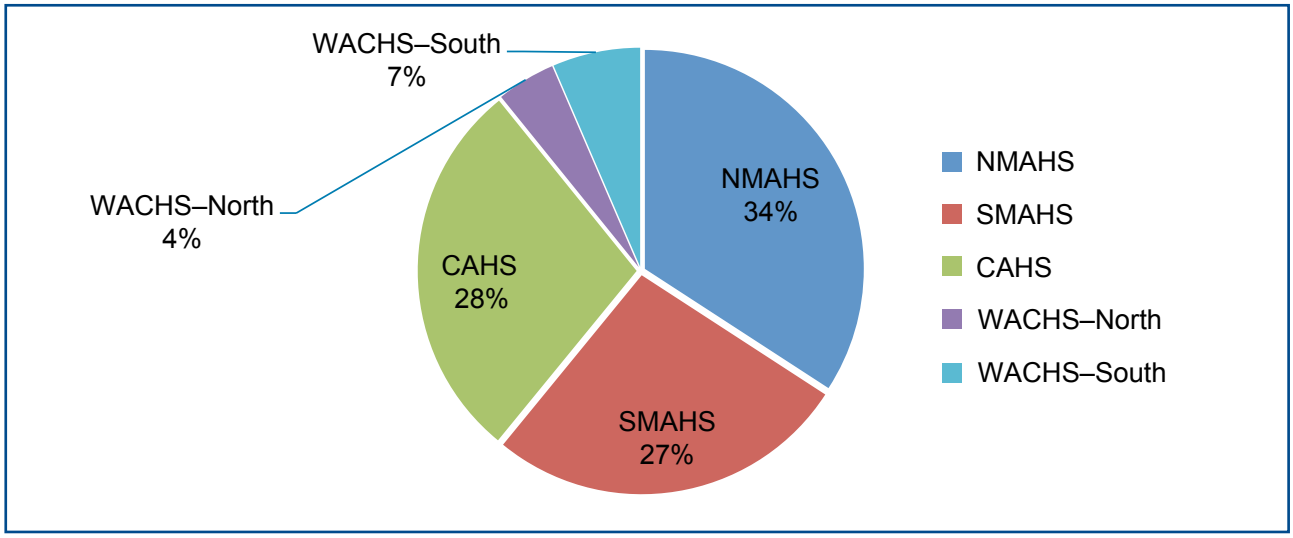
Increasing numbers of young people (under 25 years of age) are also being admitted to specialist mental health facilities (see Figures 45 and 46).

Figure 45 **Numbers of separations of patients 0–24 years, 2006–11**



Source: MHIS DoH (2012).

Figure 46 **Separation of patients under 25 years from specialist mental health services by Area Health Service, 2011**



Source: MHIS DoH (2012).

There are two State specialist mental health units for children and youth—an eight-bed unit for voluntary patients at Princess Margaret Hospital and a 12-bed unit for involuntary patients and youth at the Bentley Adolescent Unit (BAU). A 20-bed unit is planned in the new children's hospital currently under construction at the Queen Elizabeth II Campus in Nedlands.

In the Reviewer's opinion, more attention must be given to providing physical and dental care for children in specialist mental health services.

Communication problems similar to those described in the adult specialist mental health services exist between child inpatient and community CAMHS services and at transition points from child to adult services, especially in the metropolitan area. Community CAMHS clinicians in rural and remote areas informed this Review that discharge summaries from inpatient facilities were sometimes delayed and CAMHS was not always notified when a patient was discharged. The entry processes to BAU were unclear to rural CAMHS and patients are sometimes sent to metropolitan EDs rather than directly to the BAU to gain access to specialist inpatient care.

The current children's unit at Princess Margaret Hospital is restricted to children and adolescents aged 6 to 16 who present with a range of severe or complex mental health problems (Child and Adolescent Health Services, PMH 2007). Further exclusions include care for patients with the following primary presenting issues:

- containment, and/or accommodation
- drug and substance abuse
- forensic
- where admission may reinforce maladaptive aspects of behaviour, including severe aggression or it is deemed to be counter-therapeutic to the individual or the ward milieu.
- Ward 4H is not approved to diagnose pervasive developmental (disorders) (CAHS, PMH 2007).

The children excluded from PMH can be admitted to the Bentley Adolescent Unit.

The BAU provides care for youth aged 12 to 18, including involuntary patients.

Clinicians, Judge Reynolds, the Commissioner of Children and Young People and the Council of Official Visitors (COOV) informed this Review of their concerns about the mixture of patients at the BAU.

BAU is the only State hospital to admit children on hospital orders issued by the courts. Data from COOV indicated that seven to 14 children are ordered to the BAU by the courts each year, and they remain there for periods ranging from one to 78 days (COOV Annual Report 2010–11. In addition, there are young people with mental health conditions linked to substance abuse, such as drug-induced psychosis, and younger children admitted with involuntary status. It has been difficult for the BAU to provide a therapeutic environment to meet the needs of this combination of conditions.

This issue was also raised in the recent review of the BAU, the Orygen Youth Health Report (2011). This Review supports the recommendations of that report.

A progress report on the Orygen recommendations was provided to this Review by the Child and Adolescent Health Service (CAHS) and indicates that two of the Orygen (2011) recommendations are beyond the authority of CAHS to implement:

- Recommendation 11: Explore opportunities to provide developmentally appropriate inpatient facilities for 12–15 year olds and separate facilities for 16–18 year olds.
- Recommendation 12: Although beyond the remit of CAMHS, it is recommended there be the establishment of a dedicated forensic mental health unit for young people within the State.

The Chief Executive of CAHS proposed to this Review that a specific unit for young people aged 16 to 24 be established. The current number of inpatient beds is not adequate to meet the needs of children and adolescents and it is not appropriate to have very young children within the same units as well-developed adolescents.

A step-down facility is also required to provide care for children who are floridly acting out and not requiring acute intervention (personal communication Chief Executive CAHS). The development of step-down units should include the capacity to care for very complex groups and groups who are currently excluded.

In the opinion of this Reviewer, the services recommended by Orygen, along with step-down units for youth, are essential components to be considered in the State's Mental Health Clinical Services Plan.

See Recommendation 1 Governance; Recommendation 2: Patients; Recommendation 3: Carers and families; Recommendation 4: Clinicians and professional development; Recommendation 5: Beds and Clinical Services Plan; Recommendation 7: Acute issues and suicide prevention; Recommendation 8: Children and youth (in particular 8.4; 8.6.1); and Recommendation 9: Judicial and criminal justice system.

3.14.3.1 Recovery programs

The Transition Unit at Bentley is a Monday to Friday day-program based on a recovery model that also provides inreach to the Bentley Adolescent Unit.

Youths from the BAU, in addition to community-dwelling youth, attend the program daily as part of their recovery.

The program engages youth in life skills such as cooking, woodwork and education. As a centre-based program, some children and families have difficulty in attendance, and the clinicians would like to have additional satellite programs.

See Recommendation 8: Children and youth (8.5; 8.6).

3.14.4 Youth transition to adult services

Youth informed this Review that their needs differ from those of younger children and adults. Age-appropriate environments and therapeutic approaches to youth rehabilitation programs are needed. The Mental Health Commissioner also informed the Review that specific programs that recognise and address the specific needs of youth aged 14 to 25 are required.

Child-focused services address developmental stages and the unit of care is the family. The family is expected to attend assessment and therapy sessions with the child. Adult services focus on the individual and illness management (DoH 2011b). Adults and adolescents usually attend their assessment and therapy alone, and family/carers are involved in care with the patient's consent. Patients therefore experience differing service delivery models with different clinicians providing care at each transition step.

The risk of the patient's condition(s) deteriorating at program transition points was the impetus for the development of the State's Paediatric Chronic Diseases Transition Framework (Child and Youth Health Network 2009). In order to assist the patient to adapt, this framework highlights the necessity of introducing the patient to the clinicians, the transition environment and to independent appointment attendance in a planned and gradual manner.

This Review was informed by CAMHS outside the metropolitan area, that child, adolescent and adult services are integrated and the transition between them is seamless. The close working relationship between clinicians in rural and remote areas assists the transition of adolescents to adult service. Staff said transitions are also smooth on an interpersonal level.

The shared spaces of colocated services also increases the patients' awareness of other services, and clinicians informed the Review there are few problems in transitioning between services.

In the metropolitan area, CAMHS are governed and located separately and therefore smooth transition from one age-specific program to another requires planning and patient preparation, and this is not standard practice (Child and Youth Health Network 2009).

Currently Youth Reach South facilitates the transition of adolescents from the BAU to adult services and this appears a satisfactory arrangement for patients involved with those services.

Clinicians informed this Review that children transitioning from PMH to the Bentley Adolescent Unit is administratively smooth. However, a carer informed the Review that his daughter's transfer was sudden and occurred from the ED at PMH when there were no available beds in the hospital's mental health unit. The father described the contrasting environments, of the child-friendly unit of PMH with its Snow White images on the wall to the bare and institutional environment of the BAU[8]. He was concerned that his child would not feel safe in this new environment.

A submission to this review by the Commissioner of Children and Young People, Michelle Scott, places emphasis on the careful processes required at transition points of children to adolescent services and adolescent services to adult services.

A submission to this Review from Carers WA suggested that the Paediatric Chronic Diseases Transition Framework be implemented in mental health services to support young patients and their family carers.

This Review supports the adaptation of a transition framework to assist young people and their family/carers to transition across programs.

See Recommendation 1: Governance (1.2); and Recommendation 8: Children and youth (8.10.10).

3.14.5 Comprehensive children and young people services

The Commissioner of Children and Young People, Michelle Scott, informed the Reviewer that four out of five children with acute mental health disorders do not receive services or assistance. The Commissioner said there was work to be done at every level of mental health care for young people.

The Commissioner expressed concern that mental health services focus on severe disorders and less attention is provided for children with mild and moderate illness. The continuum of care is inclusive of promotion, prevention and early intervention in addition to the treatment of mild, moderate and severe disorders (CCYP 2011). Prevention strategies for psychosis, pre-pregnancy counselling and early intervention in pre-school are not currently provided in WA (CCYP 2011).

[8] Reconstruction is currently improving the environment of BAU as recommended in the Orygen Review 2011.

Continuity of care within an integrated service system is essential for effective and comprehensive services (McGorry 2011). This necessitates collaboration between all sectors of child care, including juvenile justice and legal services. The Commissioner said 'service gaps at any stage of the continuum must be eliminated so as not to compromise the effectiveness of care'.

In addition, children and parents should have access to specialist psychiatric services through teachers as well as school psychologists. These specialists should provide schools with advice, consultation and training in the care of children with mental illness. In addition, WA needs a model to address the issue of children who lack the ability to self-regulate.

When children approach mental health services, they need to be taken seriously and consideration should be given to eligibility criterion such as the arbitrary amounts of weight loss required to meet a diagnosis of anorexia; these make little sense to the child or their carers (pers. comm. CCYP 2012).

In WA a number of programs have been established to meet youth needs as are described above. However, there is no clear governance structure; services for youth between 16 and 18 appear to be particularly tenuous and responsibility for them outside the remit of current governance structures.

All specialised mental health beds for children are located in the metropolitan area. Clinicians explained that children at risk outside the metropolitan area were accommodated in the local general hospitals where family supports could be maintained.

CAHS suggested to this Review that youth services should have a separate governance structure and that models of care specific to youth need to be developed and implemented.

The Youth Mental Health Working Party developed 26 recommendations to address youth's needs under a specific youth director (DoH 2011c). The recommendations are summarised here:

- Establish a youth specific lead.
- Establish a youth specialist mental health stream.
- Establish early psychosis intervention programs.
- Create and strengthen collaborative partnerships with the NGOs.
- Enhance WACHS (WA country health service) youth mental health.
- Develop a youth-specific inpatient unit, youth-friendly ED and specialised eating disorder unit.
- Enhance Aboriginal youth services.
- Develop an attention deficit hyperactivity disorder (ADHD) program for adults with youth transition options.

The Reviewer supports these recommendations.

See Recommendation 2: Patients; and Recommendation 8: Children and youth (8.6; 8.6.3; 8.7; 8.8; 8.9; 8.10.1 – 8.10.10).