Youth
Affairs
Network of
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YANQ

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The Burdekin Mental Illness Inquiry:

Major Findings Relating to Young People

Tim Wilson, YANQ Policy and Research Officer

INTRODUCTION

I would like to present a brief outline of the major points raised by Burdekin in relation to young people in the mental health system, and then run through the report's recommendations. Later in the day we will hear from Dr Harvey Whiteford about the Health Department's response to the report. Throughout my talk I will also draw on some facts and figures from a report by Shane Solomon and Associates looking at the Capital Works Budget for mental health in Queensland.

As you will all be aware, the Report of the Human Rights and Equal Opportunity Commission's Inquiry into Mental Illness (the second 'Burdekin report') was tabled in Federal Parliament in October last year. It received a fair amount of media coverage at the time.

The report, which is about 1000 pages long, condemns Australia's mental health systems as committing gross abuses of the human rights of people with a mental illness. It presents evidence that they are denied access to treatment, particularly community based treatment, that patients in psychiatric hospitals are subject to widespread sexual and physical abuse, that many are accommodated in sub-standard boarding houses, and that rural mental health services are virtually non-existent.

Queensland's system was singled out for particular criticism. Queensland spends less per capita on mental health than any other state, though it does spend more than either the ACT or the Northern Territory. Most of this budget is spent on hospital or institution based care, with only around 10% allocated to services in the community (at the time of writing: this has since increased to 15%), and around 1% allocated to funding non-government organisations.

The report includes a chapter on the treatment of children and adolescents in the mental health system. Some of you may have seen the summary of this chapter in Network Noise, which is YANQ's newsletter.

PREVALENCE

This Chapter cites evidence that 15 percent of adolescents suffer from a recognisable psychiatric disorder, and about 5 percent suffer from serious disorders which warrant intervention. This translates into 13 800 young people aged between 12 and 17 in Queensland, according to 1991 Census data. About 1 percent have what they describe as a 'severe psychiatric disorder'.

The Report concedes that these numbers are based on research conducted overseas, because there has been very little research on prevalence of mental illness among adolescents carried out in Australia.

DEFINITIONS AND TERMINOLOGY

The report says that the problem of defining mental illness in adolescents has been complex, due to the range of factors which need to be considered in making a diagnosis, such as the young person's environment, their genetic pre-disposition, and their developmental stage.

It notes that the narrowness of definitions used in the past by various professions has limited access to services by young people. It says that many young people are denied admission to treatment services because they fall outside the narrow clinical definitions or admission criteria of relevant departments and institutions. A simple but inclusive classification of child and adolescent psychiatric syndromes is proposed. it covers emotional disorders, behaviour disorders, somatoform disorders (psychosomatic), learning disorders, psychosis, organic brain disorders and abuse disorders.

ASSESSMENT AND DIAGNOSIS

The report says that assessment and diagnosis of mental illness in adolescents is particularly complex, given the range of developmental and behavioural factors which affect young people which don't effect adults. In other words, it is hard to tell whether a young person is freaking out, or maybe withdrawn, due to mental illness or due to something else happening in their lives. There is also a reluctance on the part of many professionals to identify a young person as mentally ill, because of the stigma associated with mental illness. The result is that many young people with serious mental health problems are denied treatment.

CONTRIBUTING FACTORS

Burdekin suggests that the broad range of factors which can contribute to mental illness in young people were generally poorly understood by the community and even by some health professionals. This supports research carried out under the National Youth Affairs Research Scheme, which showed that youthworkers had little understanding of the causes of mental illness, particularly the genetic causes. The report focuses specifically on child abuse and neglect as receiving too little acknowledgment for their contribution to young people's developing mental illnesses.

CHILD AND ADOLESCENT PSYCHIATRIC SERVICES

The report discusses a number of factors which inhibit young people's access to appropriate treatment and support, including young people's limited knowledge of mental illness, the irrelevance or inappropriateness of existing services, and the stigma associated with mental illness. However the major factor which prevents young people receiving treatment is simply the absence of specialist services. The report says

> *Without exception, every witness presenting evidence about child and adolescent mental health referred to the appalling lack of provision for training, staff, facilities and services to assist children and adolescents in need of special care.* (p.618)

The report identifies particular types of services for young people which are lacking. They include:

- **Community crisis teams and support services** to provide young people and their families with treatment and support in their own surroundings. Mobile experienced mental health workers assess young people, and where possible provide treatment, in the young person's home.

- **Inpatient assessment facilities** for those who become seriously disturbed or psychotic. A period of inpatient care may be required to carry out a full assessment of the young person's condition. Facilities for inpatient assessment are inadequate or non-existent in most parts of Australia.

- **Inpatient acute beds**. Queensland currently has no acute inpatient beds for young people. The Barrett Centre at Wacol has 16 medium-term inpatient beds. This one facility services all of Queensland.

- **Community Centre-based services** which provide a range of services both mobile and centre-based, so that young people can stay in their homes and schools and take part in normal daily activities as far as possible, while still obtaining appropriate therapy. Burdekin suggests that these services should form the basis of treatment for most young people and their families. Queensland currently has 16 community-based child and adolescent mental health services, 10 of which are in Brisbane. Three of the state's health regions have no services at all. According to Solomon, most of these services are understaffed and operate from sub-standard facilities. The Burdekin Inquiry was told that the clinics in Brisbane have waiting lists of at least a month, and up to 6 months in some areas.

- **Day treatment programs** and outpatient services where young people can receive substantial care and treatment without the dislocation of being admitted to an inpatient facility.

In the absence of appropriate specialist services, young people have been placed in children's general medical wards, adolescent acute wards, adult psychiatric hospitals and temporary foster care, and in some cases, in remand centres and lock-ups. Some of these placements, particularly those in adult facilities, place young people at risk of physical or emotional harm.

In those services which do exist, staff are typically few in number, and inadequately trained. Every state reported an acute shortage of child and adolescent psychiatrists and of training positions for child psychiatric staff. There is also a shortage of allied health professionals with training in mental health; nurses, social workers, family therapists, counsellors, specialist clinical psychologists, remedial education teachers, and occupational therapists.

Training for workers in other professions who have contact with young people with a mental illness, such as youthworkers, police, teachers, welfare workers and court officers, is limited.

In addition to the deficiencies in even basic services to young people, the Inquiry identified shortages in related services, including supported and unsupported accommodation, training and employment, education, and recreational activities for young people recovering from a mental illness.

PREVENTION AND INTERVENTION

The report criticises the lack of preventative or early intervention strategies targeting young people. It identifies a clear role for schools in identifying young people and children experiencing difficulties and referring them for assessment or counselling at an early stage. It argues that the education system has shunned its responsibility to these young people, by not providing adequate professional support staff in schools to carry out casework and to act as a resource for teaching personnel. The current response to the problems of these young people is to exclude them from schools, either formally, or through the application of informal pressure to leave. There is a group of youth sector workers who have been looking into this issue recently, and they have found ample anecdotal evidence that this is occurring in Queensland.

THE JUVENILE JUSTICE SYSTEM

Disturbed and mentally ill young people often end up in the juvenile justice system because no-one has identified or dealt with their underlying problems.

> *The number of young people who have thus been consigned to incarceration rather than treatment is in the thousands.* (p. 634)

Once a disturbed or mentally ill young person enters a correctional facility they have little chance of receiving assessment and treatment. In addition the facility itself can exacerbate pre-existing mental health problems. Few states have services to deal with the mental health needs of young people in detention. According to DFSAIA, 3 of the 4 juvenile detention centres in Queensland have a psychologist on staff and all have arrangements with private psychiatrists in the community.

YOUTH SUICIDE

Over recent years there has been an alarming increase in rates of suicide by young people. The rate amongst 15-19 year old males has increased from 7.3 per 100 000 population to about 21 per 100 000 in 25 years. The greatest increase in male youth suicides has occurred in rural areas and small towns, where families have been affected by the economic downturn and where access to services is minimal. Specific factors contributing to rural youth suicide include:

- the gap between the idealised myth of rural life and the reality of chronic unemployment and poverty;
- exposure to high levels of domestic violence and parental alcohol consumption;
- higher personal alcohol consumption; and
- ready access to firearms.

While there is no reliable way of predicting whether a young person will commit suicide a number of risk factors are discussed, including: a prior suicide attempt; mental illness or emotional disturbance; risk-taking behaviour; pressures of societal role expectations; media coverage of other youth suicides; and poor education or leaving school early.

Submissions to the Inquiry called for the expansion of prevention and intervention services, and of critical incident counselling to assist in dealing with the aftermath of a suicide.

APPROPRIATE RESPONSES

The report suggests that the priorities for service provision should be community based psychiatric care services, acute admission facilities for young people with serious psychiatric disorders and medium-term residential facilities for young people who need transitional accommodation between hospital and home. It discusses the possibility of developing services which mix private and public facilities.

The report discusses the importance of effective coordination and cooperation of agencies involved in the integrated care of young people with a mental illness, such as mental health services, accommodation services, school guidance officers and teachers, and family support workers. Examples of effective collaboration between agencies are discussed.

It also says that there is a need for further research in a number of areas, including suicide, vulnerability to disturbance, treatment approaches, and factors which contribute to the development of psychosis in mid to late adolescence.

CONCLUSION

The report summarises the issues of young people's mental health services as follows

> *... the overwhelming picture is one of inadequate funding, inadequate provision of facilities, inadequate staffing, inadequate training of health and other workers, inadequate inpatient care, inadequate community and home-based care, inadequate coordination between agencies, inadequate knowledge, inadequate research, inadequate data collection and inadequate commitment to the establishment of prevention and intervention services.*

OTHER FINDINGS

A number of other chapters in the report touch upon issues affecting young people. The Inquiry finds that families caring for members with a mental illness receive virtually no understanding, recognition or support from government agencies, health professionals or the general community. In particular, there is a desperate lack of respite and domiciliary care, counselling and family therapy, and willingness to listen to carers and provide them with information.

The report also discusses the impact that living with a parent with a mental illness can have on young people. Young people are likely to undergo stressful experiences at school and social environments, as well as disruption in the home. The report cites one case where the mother of a 13 year old girl attended a parents' meeting in a florid mental state. The child later was subjected to criticism and scorn by her schoolmates about her mother. A range of supports are recommended for young people in this situation.

The report refers to findings from the previous Inquiry into Youth Homelessness. It finds that while it is impossible to establish a firm figure of the number of young homeless people with a mental illness, it is clear from available evidence that the incidence of mental illness among the homeless is increasing. The most common mental illness among the homeless is schizophrenia.

Finally, the report looks at the special needs of rural and isolated communities, Aboriginal and Torres Strait Islanders, and people from non-English speaking backgrounds.

RECOMMENDATIONS

- ❑ Governments should allocate increased funding for child and adolescent mental health services as a matter of urgency.

- ❑ Health departments should allocate significantly increased resources for the establishment or augmentation of adolescent community mental health clinics, drop-in centres for disturbed or mentally ill adolescents, and child and family outreach and home support services.

- ❑ Health departments should allocate substantially increased resources to acute inpatient assessment and treatment facilities for children with a mental illness or severe emotional or behavioural disturbance. Facilities should not be restricted to children with a diagnosable mental illness.

- ❑ All medical students should receive training in child and adolescent mental health.

- ❑ Education and information should be provided to GPs and mental health professionals about the diagnosis and treatment of mental illness and other serious disorders in children and adolescents.

- Outpatient and day-patient mental health services for adolescents should be appropriate for the client group.

- Government departments involved in the delivery of services for children, families and adolescents must ensure improved inter-agency coordination of services. Private and non-government service providers such as clinical psychologists, family therapists, GPs and relevant NGOs should be involved in developing procedures for interagency coordination.

- State and Territory mental health services, in collaboration with departments of family and community services, should provide more day programs for children, adolescent and family counselling and therapy and more in-home support. An appropriate campaign should be undertaken to increase awareness of and access to such services for families under stress.

- Where mandatory reporting of suspected child abuse is introduced it must be accompanied by sufficient resources to enable reported cases to be properly followed up.

- Child and family services should develop protocols in consultation with GPs, health services, schools, social workers, police services, and any church or non-government organisations which may be relevant to follow-up action in cases where child abuse is established.

- Teachers should receive special in-services training in identifying children who are at risk; referring children to relevant services, and where appropriate, integrating children and adolescents with mental illness and emotional or behavioural disturbance into the classroom.

- Education authorities and tertiary institutions should seek to increase the number of school clinical psychologists in training and increase the numbers appointed to schools.

- Education authorities should ensure that schools provide extra support or remedial education to children who have mental, emotional or behavioural problems themselves, or who are known to live in a violent or dysfunctional family.

- Departments of family and community services should provide more appropriate accommodation for children and adolescents in crisis to avoid the placement of these young people in correctional or detention facilities.

- Juvenile justice agencies should ensure that young people with mental illness or severe emotional or behavioural disturbance who are in detention receive specialist psychiatric assessment before being brought before the courts. The psychiatrist's assessment report must be provided to the magistrate or judge prior to determining placement of the young person.

- Juvenile justice agencies should ensure that young people with a mental illness who are already under detention in either the juvenile justice system or the adult corrections system receive appropriate psychiatric assessment, ongoing treatment and regular psychiatric review.

- Education authorities and mental health services should establish protocols for the provision of critical incident counselling programs in schools after a student has committed suicide.

- Those governments which have not already done so should establish a multi-agency youth suicide prevention task force to devise a range of strategies to counter the rising incidence of youth suicide.

Young People with a Mental Illness and Youthworkers

Bettina Judd, HIV/AIDS Youthworker at Brisbane Youth Service

INTRODUCTION

Hello, I'm Bettina Judd and I work at Brisbane Youth Service (BYS) as the HIV/AIDS Youthworker. As part of my work I inform and educate young people and youthworkers on HIV/AIDS, STD's, safe sex and safe drug use. My so called "expertise" is on sexually transmitted diseases, not on mental health. I have been asked to talk on my experience of working with young people who have had some contact with the mental health system in Queensland.

At BYS we work on a relationship model, in that we form stable relationships with young people. This often is a first time experience for young people. These relationships can last from a few weeks to several years. During my three years at BYS I have worked with several young people who have been involved in some way with the Queensland mental health system. In most of these cases this has not been a positive or beneficial experience, although this has been dependant on the professionals that the young people have encountered within the system.

I felt the best way we could inform people of what young people have experienced in the mental health system is to talk about specific young people and what they have experienced. During this look into young peoples' lives we will be glimpsing other peoples' personal past, and I would like it if all of you could imagine how you would feel if this was your life and how you think you would cope. This information will be non-identifying.

CASE STUDY 1

Donna had worked in a office and had been living with her fiancee for about six months. Unfortunately for Donna, her fiancee had put them both into debt, owing many places money in both their names. Donna's fiancee decided he couldn't cope and left, leaving Donna with the responsibility of the debts. Donna felt overwhelmed and shocked. She had believed that her life was planned and set. Like many young women, she was dependant on her partner in most aspects of her life. Donna had wrapped her future in his. Within a short time, her life had been shattered. Donna began to want to stay in bed all day and not worry about her appearance, and she put on lots of weight, which worried her. She didn't pay her rent or electricity and eventually was evicted from her flat. She felt very depressed and hopeless. Finally she decided life was not worth it anymore, and climbed a bridge over the Gold Coast highway so that she could jump into the fast moving traffic. It was on the bridge the police found her and took her to the hospital, where she was admitted to the psych ward. There,

Donna met a psychiatrist who prescribed her Valium and told her she was having a nervous breakdown, and after talking to her on only two separate occasions, that she had a personality disorder. However he did not tell her why he thought this was the case. After two weeks Donna was placed at a women's hostel in the Valley on a sickness benefit, which required her to see a doctor every month for a medical certificate. Donna was confused, frightened and felt alone.

Donna arrived at BYS with another young person who had bought her in because she wanted to find new accommodation. Donna seemed quite distressed and wanted to talk to someone. This was the start of a relationship that lasted 12 months. When I first met Donna she was living in a women's hostel which she found demeaning and distressing. She told me on several occasions that she wasn't used to living "that way". Donna complained of breathing difficulties and chest pains and visited the doctor at the BYS clinic several times. Donna was different in some ways to many of the young people who frequent BYS in that she arrived on time for most of her appointments, and if she did not make the appointment she would contact me.

Gradually, Donna was able to tell me about her feelings of rejection, and said that she blamed herself for everything that had happened. She wanted to know if I thought that if she changed she could get her fiancee back. Donna was ashamed at her suicide attempt, and felt she would always be depressed and anxious because of her "personality disorder". She felt trapped by this label and unable to move on with her life. Often Donna would arrive at BYS feeling anxious and full of self-doubt, attributing these feelings to her "personality disorder" rather than to the environment in which she found herself, or the fact that someone she loved and trusted let her down terribly. It was only when Donna started to realise that she wasn't totally responsible for what had happened, and that she had a legitimate right to feel angry, rejected, anxious, hurt and depressed that she was she able to gradually move on with her life.

CASE STUDY 2

Emily is homeless; she has nowhere to stay and is not yet receiving a Social Security benefit. Emily arrives at BYS with a large group of young people who are in a similar situation and who are squatting together in a building in the Valley. This young woman looks tired, and obviously has not showered for at least a week. Emily is hungry and wants food, but not necessarily somewhere safe to stay. The youthworker talks to Emily about alternative places to stay, like refuges, and where to get something to eat. Emily informs the youthworker that she does not want to stay in a refuge because she is happy to stay at the squat with her friends, and that refuges have too many rules and Emily wants to be free to do her own thing. During this discussion, the youthworker notices that Emily has slash marks up her arm which seem to be slightly infected. The youthworker tells Emily that they will be able to get her on to benefit which would at least give her some money every two weeks. The youthworker also talks about the different services at BYS, including the clinic.

Very gradually over the next few months, Emily comes into BYS to use the needle exchange and to talk to the youthworker who helped get her onto a benefit. During these conversations Emily explains to the youthworker that she hates her parents and that she does not want to go home; that being on the street is preferable to being at home. Emily hints to the youthworker that something frightening and scary happens at home, and when she starts thinking about home she has a strong need to slash up. Emily is now regularly coming into BYS where she has formed a stable relationship with the youthworker. Slowly, more information about Emily comes forward. Emily is under a psychiatrist's care and has spent some time in a psych hospital. The reason Emily gives is that she has tried to kill herself on a few occasions. Emily tells the youthworker emphatically that she is not insane; that she has reasons for what she

does and these are private and no-one else's business. Emily is now also working as a sex worker on the street to help pay for the drugs that she takes every day. She has been prescribed Stelazine by the psychiatrist and is using speed (amphetamine) on top of it. Emily is told by the psychiatrist that it would be preferable that she did not double up on her drugs, but the psychiatrist does not stop the Stelazine.

One day Emily comes into BYS very out if it. She can hardly stand, and is slurring her words and wants to sleep. The youthworker and the nurse decide that Emily could be in some danger, as they are not to sure what she has taken. They call the hospital and ask for an ambulance. The ambulance people arrive and start asking Emily questions like "What have you taken?" and "Do you know if you have Hepatitis?" in loud voices. Emily states she will not go to the hospital and the ambulance leaves, leaving Emily at BYS. Later that night, Emily is found on the street, almost unconscious. She is taken to hospital and eventually placed in the psych ward. She tells the psychiatrist at the hospital that she is feeling depressed and did try to kill herself. Emily is then scheduled and placed in a psych hospital. In the hospital, she is given tranquilliser drugs to keep her calm. This is not something new for Emily; Valium is what she overdosed on. For a few days at hospital Emily is very tired and wants to sleep all the time. Emily tells the youthworker that she does not know whether it's the Valium still in her system or the tranquilliser the hospital has given her. Eventually the hospital lowers the doses, and Emily is soon feeling more lively. She has basically been left alone. No-one seems to have taken the time to find out why she is feeling depressed. Emily's psychiatrist is consulted about the situation, but not Emily.

Emily gets bored with sitting around all day without any stimulus. She cannot go back to the psych hospital she was at a year ago, which specialises in adolescents and has activities and school, because you are only allowed to go that hospital once. Emily absconds, but no-one at the hospital tries to find out where she is, except for the social worker who contacts BYS once.

Emily is still coming into BYS and still has not told anyone about her family past. Emily tells the youth-worker that the next time she is feeling depressed and wanting to kill herself, she is not going to tell "psych people" because "what's the point?"

This is not meant to be a knocking exercise and Emily has made one strong relationship with a person within the mental health system. What we do question is the use of drugs with a group of young people who are already using drugs regularly; the inability to do in-depth individual work in an area which is already overcrowded; and the use of labels which take away people's individuality.

I thank you for your time and hope that this might start people looking for alternatives in mental health.

The Queensland Health Department's Response to Young People and Mental Health

Dr Harvey Whiteford, Queensland 's Director of Mental Health

INTRODUCTION

The consultations conducted in preparation for the Youth Health Policy in 1993 by the Youth Health Policy Unit revealed that in every region of Queensland, mental and emotional health was seen as the highest priority.

The Burdekin Inquiry into the rights of people with mental illness called attention to the poor track record in caring for mentally ill or emotionally disturbed young people.

The Health Department is aware that there are many gaps in service provision in this area and that the needs of young people have changed, while the models of service delivery and the levels of resources, have not.

REFORM TO SERVICES

Queensland is currently undergoing a process of significant reform to its mental health services, both in the structures and approach. This has resulted from the release of the first National Mental Health Policy and Plan in 1992. This was then followed in September 1993 by the release of a Mental Health Policy Statement For Queensland .

Key Directions include:

- the integration of hospital and community mental health services;
- the mainstreaming of mental health services with other health services .;
- regional self sufficiency;
- inter-sectional links between health services and social/disability services;
- accountability of services; and
- outcome oriented services.

Additional key directions include the strengthening of the partnership with non-government organisations, and increasing participation of consumers and careers in service planning and monitoring service provision. Children and young people are now the first priority for the Mental Health Branch as we move into the development of policies for specific groups.

In 1992 a Discussion Paper was circulated on Child and Adolescent Mental Health Policy. Fifty-three responses to the paper were received. A reference group has now been convened, including James Finn of Youth and Family Service in Logan City, and a position paper is being prepared by the Mental Health Branch, based on feedback from the initial discussion paper, for further consultation. This process may seem tedious, but the history and current orientation of the services need to be born in mind, and consultation is seen as extremely important, especially where significant change is intended.

PROFILE OF YOUTH MENTAL HEALTH NEEDS

Since the child guidance clinics were established in Queensland in the late 50s and early 60s, the profile of youth mental health needs has changed dramatically. Much of this is due to changes in our social conditions, eg: the number of young people experiencing dysfunctional family environments, unemployment, homelessness, and incidents of physical, sexual and emotional abuse.

The Mental Health Branch is required by the National and State Mental Health Policies to give priority to people with mental disorders and serious mental health problems (ie: those at the more severe end of the spectrum) - in the youth sector this means those who are severely disturbed and dysfunctional .

Known "at risk" groups of young people include:

- those who are at high risk of abuse or who have survived abuse or trauma;
- those whose parent or parents have a mental disorder, chronic physical disability or abuse substances;
- those who have been through multiple out-of-family placements;
- homeless young people;
- young people with an intellectual disability, who have a 3-4 times higher risk of developing a mental illness;
- hearing impaired young people;
- young people with early onset psychosis;
- young people in conflict with the law; and
- young people who have attempted suicide.

As you know many young people, including those at risk, do not access traditional health services for a number of reasons:

- they perceive health services as unsympathetic;
- health service providers are often not trained to be sensitive to youth culture and needs;
- young people often have needs and expectations of confidentiality and consent which are often overlooked. The Law Reform Commission has been examining the question of young people's ability to consent to medical treatment; and
- many mental health services require family involvement and support.

The current policy development process will address these issues and propose models of service delivery that are appropriate to the particular needs of young people. Strategies will include:

- Working more closely with other sectors, for instance, providing consultation and liaison services to primary health services and non-government youth organisations.

- Integration with youth services- going to the settings where young people are- schools, CES, social security , shelters, youth drop in centres. Services will need to move away from an office-based system if they are going to effectively deal with the most marginalised young people.

- Providing services with a 24 hour response capacity. Currently young people often experience crisis after hours and over weekends, and present at youth services for assistance.

- Case management for at risk youth. Caseloads are currently too large, with young people only receiving limited assistance. There is too little time available to develop a relationship with young people. Services will have a smaller caseload, with sufficient time to provide follow-up.

- Clear and flexible arrangements between the child and adult mental health services and hospital services to ensure a smooth transition between systems and provide continuity of care.

- Early psychosis detection and prevention.

Queensland Health has recognised current deficiencies in resources in the area of child and youth mental health services and $6 million in additional funds are being dedicated to service provision in the area over the next three years. There will be an additional $500,000 this financial year, increasing to $2m next financial year. This is being used to established child and youth specialist mental health workers throughout Queensland.

From the capital works budget a 12 bed adolescent and psychiatric unit is being developed at the Royal Brisbane Hospital. This will be attached to the general psychiatric unit which will replace Rosemount. Further inpatient units are required in Brisbane South and in North Queensland.

Additional resources are needed to assist in developing links between mental health services and non-government youth organisations. Generalist services must become more accessible to people with a psychiatric disability. Links between the responsible government departments needs to be drastically improved.

Training must be provided in the community sector. Mental health workers should have access to training in skills used in the youth sector. Talks are already underway with the Youth Sector Training Council regarding this training.

Community Education resources must be increased. There are a number of current programs which could be expanded, such as the ARAFMI Schools Awareness Program and the QAWA

Regional Workshop Outcomes

Workshop participants were broken into small groups, based on the Regional Health Authority region in which they worked. One group was comprised of workers from regions from which there were insufficient workers to form a distinct group. The small groups identified strategies which should be pursued at regional and statewide levels to increase access by young people with a mental illness to appropriate services and support.

STATE LEVEL STRATEGIES

- ❑ Need for accommodation services and case management teams, catering to the needs of "difficult" young people who are not able to be catered for in existing youth services. These services would provide transitional support to help young people access appropriate accommodation and community based support. A service of this sort would be valuable for assisting young people leaving hospital with limited support networks in the community. Services should be provided from appropriate, accessible facilities, and funded at an adequate level to deal with identified needs.

- ❑ Interpretations of 'child' and 'adolescent' and adult' definitions must be flexible. Consumers may need to exercise some choice about which type of service is most appropriate for them. Two groups suggested that services for adolescents should be distinct from those for children.

- ❑ All groups identified a need for organisations to resource existing youth services to deal with young people with a psychiatric disability. This resourcing role could be provided by new mental health services, or by specialist full-time community consultant/liaison/ assessment services which would support a range of organisations which work with young people, including school counselling services, youth accommodation services and generalist youth health workers. Another group suggested that adult psychiatric clinics could release appropriately trained staff to provide support to agencies as a mobile assessment service.

- ❑ Adolescent alcohol and drug detoxification units are urgently required to deal with those young people with dual disorders. These services are required for young people generally.

- ❑ Private psychiatrists should bulk-bill.

- ❑ All groups identified a need for ongoing training for institutional and community-based mental health workers, and for mainstream youthworkers, in the area of adolescent mental health.

- ❑ Two groups felt that there should be closer links between Child health services and adolescent mental health services.

- ❑ Employment of mental health workers in community based agencies and schools. The group felt that it was important that mental health workers were based in non-government organisations with a community focus. They felt that services' being based outside hospital grounds did not automatically imply they had a community-based

philosophy. Community development officers should be employed in hospitals.

- ❑ Commitment to common regional boundaries across government departments. Responsible departments should liaise on a regular basis.

- ❑ Ensuring that there is adequate accessibility to services in the various regions. Transport should be particularly considered in the location of services. It is vital that services be provided in outlying areas, away from regional or metropolitan areas. Costs associated with services should be minimal. Areas of rapid population growth should also be targeted for funding

- ❑ One group suggested that education of doctors should be broader to develop expertise in adolescent mental health. Child Psychiatry training programs should be urgently upgraded.

- ❑ Higher profile for young people's health generally, eg: through the provision of specialist in-patient care for young people. One group suggested that a Youth Health Coordinator should be appointed in each of the Regional Health Authorities. The focus of youth health services should be preventative.

- ❑ Need to consider the full range of mental health issues, rather than just severe cases. Workers felt it was important that mental health services moved towards developing ongoing relationships with consumers, rather than simply relying on a clinical framework.

REGIONAL RESPONSES

Brisbane North

* Brisbane North has statistically the highest proportion of young people yet services are at Nundah, Redcliffe and Spring Hill. Pine Rivers is starved for services.
* More creative ideas in working with young people with mental health problems
* More accommodation in the community for young people being discharged from hospitals.
* No acute adolescent beds

Brisbane South

* There is a need for a separate adolescent team to fill the gap between adult and child centred services
* It was felt that Logan should be a high priority for the allocation of resources
* EXTREME lack of resources- Given limited staff, liaison always takes a back seat to service delivery
* Current services deal with acute problems only- No preventative work is done.
* The southern part of the region seems to miss out on services which are inner city based eg: Aids Council
* Transport is a major problem

Non-Region Specific Group

* Mental health intersectoral group should be established regionally (already operating on the Sunshine Coast)
* Placement of mental health-trained personnel in existing youth services.
* Placement of child and adolescent nurses in education institutions (West Moreton region)
* Placement of social workers in education institutions
* Define services (boundaries/limits)
* Need for drug and alcohol detoxification units
* Multi disciplinary services
* Health co-ordination for young people in each region.

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