

Stocktake of Child and Adolescent Mental Health Services in New Zealand 2005: A Workforce Development Summary



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Target and actual access rates

The need for more and better services was specified in the Ministry of Health report, *New Futures: A Strategic Framework for Specialist Mental Health Services for Children and Young People in New Zealand* (Ministry of Health, 1998). *The Blueprint for Mental Health Services in New Zealand: How Things Need to Be* (Mental Health Commission, 1998) established benchmark target access rates based on findings in *New Futures*. The benchmarks for access, over a six month period, for the age groups, 0-9 years, 10-14 years and 15-19 years are 1%, 3.9% and 5.5% of the population respectively.

However, service provision and workforce capability falls far short of this benchmark. For example, in the 2002-2003 year period, only 1.1% of young people under 20 years of age were seen at any funded mental health service. This compared to 2% for adults in most regions (Mental Health Commission, 2004b). It has also been acknowledged, both nationally and internationally (Fergusson, Poulton, Horwood, Milne, & Swain-Campbell, 2003; Waddell & Shepherd, 2002), that rates of disorders with clinically significant impairment in functioning associated with a mental health diagnosis in children and adolescents is 15%. Assuming this, current New Zealand service use figures for 2003 suggest that only 10% of young people who need to access a mental health service are accessing one (MHINC data). Furthermore, this prevalence rate is 1.5-2 times higher for Maori than non-Maori (Durie, 1994, 2003; Fergusson et al., 2003; Mental Health Commission, 2004a) making the gap between actual and optimum access rates even more significant for this group.

Consistent with *Blueprint* target rate progressions, in the Jan 2003 – June 2004 period, access to child and adolescent mental health services increased with age: 0-9 years (0.42%), 10-14 years (1.40%) and 15-19 years (2.07%). This is true across all the ethnic groups although access rates for Pacific and Maori were lower than for the rest of the population. Pacific rates were particularly low as they accessed services at about 25% of the 'Other' population for ages 0-14 years and at about 50% of the 'Other' population in the age 15-19 years category. Furthermore, overall access rates for the entire age range were lower for Maori (0.9%) and Pacific (0.3%) than the total child and adolescent population (1.3%).

In 2003, more males accessed and attended child and adolescent mental health services than females (59% versus 41%). Fifty four percent of all child and adolescent mental health services clients were in the 15-19 years age group making this the largest age group accessing services. This was true for all ethnicities. In this age group, males and females, as a percentage of the total under 20 years population, accessed services at similar rates. However, for 0-9 and 10-14 year olds, males accessed services at a rate of twice that of females. Overall, slightly more males (1.9%) accessed child and adolescent mental health services than females (1.4%). The ethnic split of those accessing services is 76% Other, 19% Maori, 2.9% Pacific and 1.6% Asian.

There are also significant regional differences within these statistics. The Northern access rate for 0-9 years is only 0.2% whereas the Central access rate for this age group is 0.7% (the *Blueprint* target is 1%). There are also notable DHB variations. For example, West Coast and Otago DHBs are almost reaching their *Blueprint* targets for the 0-9 years age group. In the 10-14 years age group, the Northern region has again significantly lower than average access rates whilst West Coast DHB is meeting the *Blueprint* targets for this age group. This is also true for the Northern region and West Coast DHB in

terms of their access rates in comparison to Blueprint targets for the 15-19 years age group. An important point to note is that, due to the large population in the area, the Northern region has significantly higher numbers of clients accessing child and adolescent mental health services compared with the other three regions which all have similar numbers.

However, the important point to take from all of these figures is that access to services across all ages, regions and ethnicities consistently sits at 35-40% of benchmark target access rates (for the 2004 population) which is a statistic that requires immediate attention.

Barriers to accessing child and adolescent mental health services:

- Lack of knowledge of services
- Lack of services and specialised staff
- Stigma of being referred to mental health services
- Restrictive criteria for referral/acceptance
- Lengthy delay in response to referrals
- Lengthy waiting times to get in to services
- Lengthy assessment processes
- Costs to clients (private providers, GPs, transport, time off work)

Cultural considerations

Significant barriers for Maori, Pacific and Asian clients accessing child and adolescent mental health services have been identified as the following:

- Lack of culturally appropriate mental health services and staff
- Lack of understanding about culture, value and belief systems

(Tse, Bhui, Thapliyal, Choy, & Bray, 2005)

Maori

Durie (1994; 2003), notes the need for mental health services that encapsulate holistic models of care, that is Whare Tapa Wha. As such, the *Blueprint* (Mental Health Commission, 1998) recognises the need for Maori to be provided with the resources to allow Kaupapa Maori services and culturally supportive mainstream services to provide culturally meaningful support and care for Maori clients. Furthermore, the *Blueprint* (Mental Health Commission, 1998) also notes that due to higher need, 6% of the Maori population is targeted for mental health funding rather than the 3% for other groups. Services in isolated rural areas are particularly required given that these areas often have a high proportion of Maori tamariki and rangatahi.

In spite of this government recognition of the high needs and unique requirements of Maori child and adolescent consumers, there continues to be a disparity in service provision for Maori. Per child spend data clearly shows that in regions where there are high numbers of Maori youth, the amount of money spent on mental health services per child is much lower than other regions (see Table 29 of The Stocktake). Furthermore, there is a lack of acknowledgement of Kaupapa Maori services and the valuable work that they do, resulting in a real funding disparity between mainstream and Kaupapa

Maori services. As a result, Maori providers are unable to afford skilled and experienced clinical staff, particularly Psychologists and Psychiatrists.

Another workforce development area of concern is the fact that although 23% of the total 0-19 years population in New Zealand are Maori, only 20.4% of the total child and adolescent mental health workforce are Maori, and only half hold clinical positions.

Pacific

Pacific people also hold holistic models of health (Pulotu-Endemann, Annandale, & Instone, 2004) and the *Blueprint* (Mental Health Commission, 1998) again recognises the need for culturally appropriate services, both mainstream and Pacific. Access for Pacific people might well be enhanced by attending to the alignment of services to Pacific needs; a wellness focus, holistic perspective, outreach, recognition of traditional diagnoses etc. Language differences and the need for interpreter services is an additional issue that needs to be addressed for Pacific people, and similarly for Asian peoples.

Forty eight percent of the total New Zealand Pacific population is aged under 20 years yet there are limited mental health services designed for Pacific children and adolescents. Only ten Pacific child and adolescent mental health services were identified in the Stocktake Report, which is a real concern given that Pacific mental health is a priority area for future service development (Minister of Health, 2005).

The *Blueprint* (Mental Health Commission, 1998) also notes that “there is a shortage of experienced Pacific clinicians in mental health and, given the youthful New Zealand Pacific population, demand for Pacific Staff will increase” (p. 35). This is clearly evident in the fact that although 8.5% of the total 0-19 years population in New Zealand are Pacific, only 4.9% of the total child and adolescent mental health workforce identified in the Stocktake were Pacific.

Asian

Most Asian children and adolescents live in the Northern region. Ho et al (2003) found that between 1991 and 2001 the number of people in New Zealand who identify as Asian doubled to 240,000 or 6.4% of the population. Furthermore, approximately 45% of recent immigrants were under 24 years of age in 2001. Mental health problems related to discrimination and other factors associated with re-settling in New Zealand are a significant issue. Add to this the fact that many refugees suffer from mental health issues related to trauma they experienced prior to arriving in New Zealand and it is clear that we need to look at how services need to be re-oriented to ensure this increasingly significant population, with special needs of their own, are catered for.

Access for Asian people might be enhanced by ready access to interpreters, translated information, and through the use of mature workers and flexible hours. Stigma remains an issue for Asian and Pacific communities in particular.

The commonality with all ethnic minority groups is the importance of ensuring that staff working with these groups are culturally competent, regardless of the setting and type of service provided. We need to be providing quality and appropriate services for each of these vulnerable cultural groups. There is international recognition of the danger of three-fold discriminatory practices relating to age, mental

health, and ethnicity when planning any workforce development strategies (World Health Organization, 2003). New Zealand health documents also note the importance of providing services that are equitable and accessible and where ethnicity, age, impairment or gender are not barriers to access (Ministry of Health, 2002).

Continuing development of the mental health workforce in relation to Maori, Pacific and Asian children and adolescents is essential to the healthy development of culturally appropriate services.

The Workforce (2004)

All 21 DHBs provide a child and adolescent mental health service. However, the composition and nature of services varies considerably across DHB regions, and NGO involvement within DHB regions also varies. For example, although 80 NGOs provide community based child and adolescent mental health services (2004/2005), five DHBs do not contract NGOs to provide services.

DHBs provide 80% of the clinical child and adolescent mental health services. Clinical services were predominantly provided by Mental Health Nurses, Psychologists, Social Workers and Psychiatrists (approximately 100 of each).

In terms of the NGO workforce, the bulk of clinical services were provided by Social Workers and Counsellors and non-clinical services were provided by Mental Health Support Workers (approximately 35-40 of each).

The total child and adolescent mental health workforce was reported to be 1129.69 actual FTEs with an additional 157.52 FTEs reported as vacant. The current DHB and NGO community clinical positions total 667 actual FTEs, however *Blueprint* benchmarks for 2004 total 1163.37 FTEs. Therefore a staffing increase of 74% is required in order to meet these benchmark figures.

Although nationwide vacancies exist in DHB child and adolescent mental health services, the Northern region has the most problematic level of vacancies. In particular, there is an acute shortage of inpatient mental health nurses in the Northern region.

Benchmark Workforce Numbers

The *Blueprint* (Mental Health Commission, 1998) states that there needs to be 28.6 community clinical child and adolescent mental health service FTEs per 100,000 children and adolescents (15.6 FTEs for 0-14 years and 13.0 for 15-19 years). Furthermore, WHO (2001) recommended 10 psychiatrists per 100,000 general population.

The current picture indicates that the DHB and NGO clinical workforce for 2004 would need to increase by 74% to meet the *Blueprint* target for appropriate workforce numbers. This disparity percentage is relatively consistent amongst the four regions though it is of interest to note that West Coast and Otago DHBs have met their *Blueprint* target in terms of workforce numbers, and West Coast DHB is also meeting *Blueprint* access targets. Counties Manukau, Taranaki, Whanganui and Southland DHBs have significantly lower workforce numbers against *Blueprint* benchmarks compared to the national and regional averages.

When DHB staffing is compared to McGeorge's (1995) recommendations for community mental health teams, these guidelines are currently met on a national basis for Psychologists, Nurses and

Social Workers but are not met for Psychotherapists, Occupational Therapists and Community/Cultural Workers. However, these recommendations were made in 1995 and it is unclear how relevant they are to current child and adolescent mental health services. In respect of WHO (2001) guidelines for numbers of Psychiatrists, the total Psychiatry workforce would need to increase by 103% to meet the WHO recommendations, although Capital and Coast DHB has reached these guidelines and Auckland and Otago DHBs are very close. Some DHBs have a significant disparity between target and actual numbers of Psychiatrists, including two (Nelson Marlborough and Southland) who have no Psychiatrists.

When we look at the occupational groups we can see that Maori staff hold mainly cultural appointments. Clinically, both Maori and Pacific staff hold Mental Health Nurse and Social Worker roles while Asian staff predominantly hold the clinical roles of Psychiatrist, Mental Health Nurse and Psychologist.

There appears to be regional consistency in terms of the Maori child and adolescent mental health services workforce while Pacific and Asian staff are predominantly located in the Northern region, with DHB CAMHS reporting the bulk of the Maori, Asian and Pacific workforce.

In 2004, 23.4% of the total 0-19 years population were Maori children and adolescents and the Maori child and adolescent mental health workforce only accounted for 20.4% of the total child and adolescent mental health workforce. Only in the Southern region did the Maori workforce accurately reflect the Maori child and youth population (14.1% and 13% respectively). The Central region had the largest disparity with only 17.3% of the workforce being Maori compared to 23.4% of the child and youth population identified as Maori.

In 2004, 8.5% of the total 0-19 years population were Pacific child and adolescents while Pacific staff only made up 4.9% of the total child and adolescent mental health workforce. Regionally, the Pacific workforce in the Midland and the Southern areas exceeded the percentage of the Pacific child and adolescent population for these regions. Of note is the significant disparity between the Pacific child and adolescent mental health workforce and the percentage of the Pacific child and adolescent population in the Northern region, which is where most of the Pacific child and adolescent population resides.

Intersectorial Issues

There are clear gaps in the workforce needed to provide specialised services to children and young people in all associated government sectors, with a resultant lack of adequate care and protection services and health services for children and young people with significant mental health problems. For example, the sectors that address youth offending have identified the high cost of adult service provision if significant behavioural problems are not addressed through early intervention or prevention services for the young through workforce shortages. Put simply, gaps in one sector seriously impact on others.

Children, young people and their families who have mental health concerns often present with needs across a number of sectors including health, education, social welfare, justice and housing. Services therefore need to use holistic models of care including multi-systemic therapy approaches. The workforce needs to be competent in a wide range of skills, and the complexity of the work and relative caseloads need to be considered in order that quality services are provided and developed further (Ministry of Health, 1998).

This real need to work intersectorially is particularly evident when we look at the close relationship between clients of the Department of Child, Youth and Family and child and adolescent mental health services. For example “it is estimated that 12% of children and young people involved with CYF will have severe mental health problems...a further 35-75% are estimated to have clinically significant emotional and behavioural problems...almost half of those who complete suicide in the 14-16 year age group in the general population will have had contact with CYF” (Brown, 2000p. 95). Close intersectorial linkages between CYF and child and adolescent mental health services are therefore essential for the creation of a ‘team approach’ to support shared clients’ recovery.

Incarcerated young people under 18 years have high mental health needs, one study finding nearly two thirds of males and three quarters of females meeting diagnostic criteria other than conduct disorder (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002). This again highlights the need for strong collaborative models of practice between justice and child and adolescent mental health services.

The fact that Australian research suggests that school guidance counselling is one of the services most used by children and adolescents with mental health problems (Sawyer et al., 2001) also clearly indicates the need for effective training and strong relationships between schools and specialist child and adolescent mental health services.

Funding

An important financial point to note is the fact that although young people under 20 years make up around 30% of the total population, they received only 10.5% of the overall mental health funding expenditure in the year ending June 2003 (Gaudin, 2004). Furthermore, although all DHBs now provide child and adolescent mental health services, funding provided by MOH is not always utilised for the intended purpose. For example, 16.5% fewer staff were employed in CAMHS than were funded in the year ending June 2004 (Mental Health Commission, 2004a).

There needs to be recognition of the need for a focus on youth services that allow for early intervention. This is demonstrated by the results of research based around the Dunedin birth cohort, which showed that 74% of adult cases of mental illness had a diagnosis prior to age 18 and around 58% prior to age 15 (Kim-Cohen et al., 2003). Clearly, it is in all services interests to fund child and adolescent mental health services appropriately. If children and young people are unable to access mental health services their problems may be more complex and difficult to manage by adulthood.

Funding has, however, increased in recent years, resulting in an increase in the number of child and adolescent mental health teams providing services. Unfortunately though, the actual number of clients seen has remained relatively static (MHINC data). The Mental Health Commission (2004b) supports this access data by stating that “there was no growth in child and youth services. While the number of FTE positions funded continues to grow, there was a high vacancy rate across the country” (p. 32). Workforce issues have consistently been identified as a constraint on progress towards service provision for children, young people and their families and this recruitment and retention issue is an excellent example of how this is so.

Recommendations

- Workforce numbers need to increase significantly to meet Blueprint targets and beyond.
- Workforce planning should aim to increase the specialist workforce and increase the ethnic diversity of the DHB and NGO workforce.
- Workforce data should be collected annually on a consistent basis to identify trends and to support and monitor forward planning.
- NGO data should be collected and linked to MHINC data to properly estimate the number of clients who are accessing services and progress towards the Blueprint targets.
- There is a need for nationally co-ordinated strategic workforce planning with a linkage between this and strategic planning for service delivery.
- There is a need for inter-sectorial linkages around workforce development.
- We need to look at the service requirements for child and adolescent mental health services (E.g. Turner, 2002) and ensure that workforce development strategies are focussed on meeting these. Currently many of these requirements are not being met, particularly in relation to adequate numbers of Pacific and Maori staff to ensure appropriate service provision.

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