

The unmet need in mental health services for children and young people in care

Summary of the Report of the Case File Audit of Mental Health Services for Children and Young People in Care

From consultation in 2010, the Office of the Guardian heard often about unmet need for mental health services among children in care. However there was little evidence to support the claims and little clarity about where, when and for how long children were waiting.

To understand better the extent and nature of unmet need in mental health services for children and young people in care, in 2011 the Guardian's Office audited 60 case files from five Families SA offices. The audit did not attempt to examine the quality or outcomes of the intervention.

The audit showed that the majority of children and young people whose files were viewed received a service. However, needs were not being met for reasons which included:

- assessments that did not focus exclusively or primarily on the child's mental health;
- delays between assessment and provision of the service; and
- little integration of mental health issues and progress into case planning and annual reviews

Following is a summary of the findings.

Contact the Office of the Guardian on (08) 8226 8570

gcyp@gcyp.sa.gov.au

www.gcyp.sa.gov.au

[twitter](#)



**Government
of South Australia**

Office of the Guardian
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Assessment

Fifty four of the 60 children and young people had at least one mental health assessment completed.¹

Most of the assessments were to inform court order applications and judicial decisions. Recommendations covered matters such as access arrangements, placement options, the viability of reunification, parents' needs and children's emotional and behavioural needs. Assessors were often requested to provide addendum reports or case guidance.

The *Guardianship Health Standards* (2007) say that a psychological assessment should determine the child's social and emotional wellbeing, identify any psychological conditions needing attention, identify therapy goals, review periods and highlight any risks. The assessment should inform a case managers' case plan to ensure referrals to appropriate services, with formal case reviews at three and six monthly intervals. Many of the psychological assessments viewed did not achieve all of these objectives, as their primary focus was *not* the child's psychological needs but on the prospect of reunification including the parent's emotional capacity.

1. Assessment includes psychological assessment by Families SA; psychological/psychiatric assessment by a private provider or a Psycho Social/Psychological assessment by Child Protection Services.



Referral

The average time between the assessment recommendations and the first service appointment was seven months, with a median of five months. For 9 children of the 35 who were referred to a mental health service, there was a delay beyond three months in case workers completing service referrals following the assessment.

Fifty of the 54 children and young people who had mental health assessments, had recommendations that related to a referral to a mental health service, the best placement for a child or when the child's mental health should be reviewed. In five cases only some of the recommendations were carried out and there was no explanation on the file to explain omissions.

Of the 40 who needed a referral to a mental health service, 35 were referred. In an additional five cases, children or young people used a mental health service although this had not been identified through the assessment process.

The researcher observed that, from the case files and subsequent conversations with Families SA staff, offices preferred some mental health service providers over others based on that office's prior experience. One office chose to refer 11 of 13 children to one service.



Waiting times

Waiting times for first appointments were sometimes lengthy. Fifty two referrals to mental health services were made for 35 children and young people. On 32 occasions (62 per cent) an appointment was offered within three months of the referral. On 20 occasions (38 per cent) an appointment was offered between four and eleven months from the time of referral.

The average time for a child, young person or carer to remain *engaged* with a service was 11 months, with a median of 8.5 months.



Case planning and review

For 29 of the 50 children who required action on mental health needs (58 per cent), there were references in the case plans to the recommendations, providing a constant guide and reminder to case managers about the child's needs.

However, only 12 annual reviews (24 per cent) had considered the recommendations and there was no detail in these of the need for further assessment or referral. In some reviews, there was an observation that the child did not want counselling, but no remedy was provided about other options or how it may be pursued in the year ahead.

There was no documented evidence that therapists had been asked by Families SA to participate in annual reviews or contribute to case plans.

In cases where there was good communication between therapist and case manager, the purpose and progress of therapy was routinely reviewed. In approximately one third of the cases there was evidence of a collaborative relationship between Families SA and mental health services in frequent communication, involvement in case planning and meetings.



Carers

Policy and Practice guides say that carers should be involved in developing and implementing care plans associated with mental health, and receive support to do this. There were examples of carers engaging in therapy and, on occasions, sourcing therapy for children or themselves, following agreement with case managers.

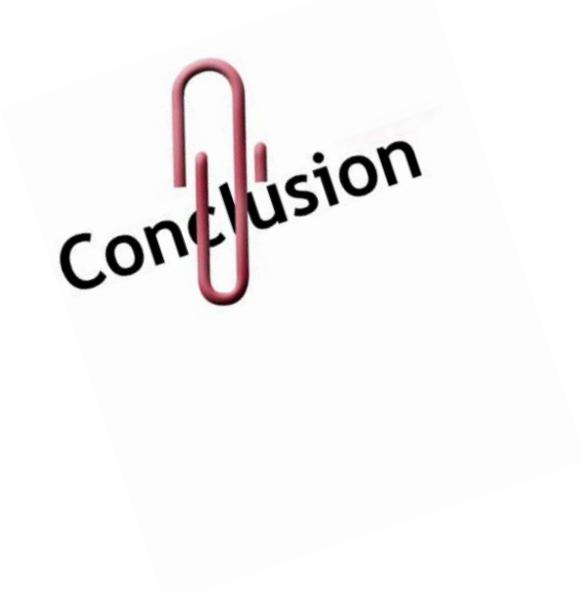
In four cases however, carers dismissed mental health care plans and actively obstructed children from accessing therapy.



For children and young people, establishing and maintaining a relationship with a practitioner is key to meeting their mental health needs.

There was documented evidence in 18 case files to suggest that there was good continuity of therapist. The therapist was able to reconnect with the child or carer when needed.

For 16 other children and young people there was evidence of discontinuity caused by changes in mental health practitioner. A child was returned to a waiting list after seeing a therapist who went on annual leave and another child was assessed as a low priority and not seen by a replacement therapist because the child was not going through court. In other cases, two young people wished to disengage from therapy when their therapist changed but did not, while one young person stopped attending when their therapist left the service.



Conclusion

Timeliness of response and continuity of care is important to anyone of any age who has serious mental health problems. For children and young people timeliness and continuity are particularly significant because of their developmental needs and for children and young people who have suffered trauma even more so.

The areas for improvement suggested by the audit are:

- More active management of mental health problems, including prompt referrals following assessment and regular joint child protection and mental health service reviews of progress on recommendations and referrals.
- Consideration, in case planning and review, to the adequacy of the original assessment in informing decisions about the child's needs and whether an assessment specific to the child is required.
- Active engagement and sharing of information between Families SA offices and the mental health service providers in their local area, to ensure misunderstandings are resolved promptly and delays in service provision are minimised.