Undergraduate Training in Child and Adolescent Mental Health: A Review

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Auckland
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Contents

Executive Summary 1

1.0. Background 4

2.0. Other work in progress by The Werry Centre 4

3.0. Aim of this report 4

4.0. Information gathering 5

5.0. Appreciation of participants 6

6.0. What is meant by “Child Development and Youth Mental Health?” 6

7.0. Interview findings 7

7.1. What does each group currently teach? 7
7.2. Nursing 8
7.3. Social Work 16
7.4. Occupational Therapy (OT) 21
7.5. Counselling 24
7.6. Community support work 26
7.7. Certified courses 28
7.8. Māori 29
7.9. Pacific People 32

8.0. General Issues raised by participants 34

8.1. Proliferation of mental health training programmes 34
8.2. Inclusion of the recovery approach 34
8.3. Science (clinical) versus art (personal experience + recovery) 34
8.4. The “medial model” versus theory or personal experience 34
8.5. Who does what? 35
8.6. “Publish or perish” 36
8.7. The clinical focus of The Werry Centre for Child and Adolescent Mental Health 36

9.0. Summary of findings 37

9.1. A major strength of all programme was the teaching staff themselves 37
9.2. What is taught about child and adolescent mental health 37
9.3. Gaps and barriers 37
10.0. How can the Werry Centre help?  39

11.0. The following recommendations are made-
The Werry Centre could:  40

References  41

Appendix 1: List of people/agencies consulted in alphabetical Order  42

Appendix 2: Content for child and youth mental health  44
Executive Summary

A sample of undergraduate training programmes was reviewed to see what was taught about child development and adolescent mental health, the barriers to such training, and ideas that would increase the content in undergraduate degrees and attract students to work in this area.

- Forty-two people from 21 agencies were contacted and interviewed.
- The results showed undergraduate training in Nursing, Social Work and Occupational Therapy is necessarily broad-based and to varying degrees include some adult mental health content.
- Very few training programmes include child and adolescent mental health as part of their curriculum. Those that do generally focus on developmental issues for children and adolescents and/or adolescent suicide and child protection/abuse issues.
- Occupational Therapy appeared to have the most mental health and child and adolescent content.
- A strength of all programmes was seen to be the teaching staff themselves:
  - In some programmes there were very experienced staff who were passionate about mental health in general (primarily adult mental health issues);
  - In all programmes staff were very willing to enhance the content of child development and adolescent mental health and to look at innovative ways to attract students and staff into this area;
  - Staff were also willing to express their own need to learn more about this area and to discuss ways to do this.
- In adult mental health content, people were finding ways to incorporate recovery approach into curricula and steps were being taken to include consumers in the design or delivery of some training programmes. This was not as evident for child and adolescent mental health.
- The main barriers to increasing content in this area were reported as:
  - The lack of value placed by universities and polytechnics on child and adolescent mental health as a subject area;
  - Mental health in general is viewed as a “soft” option (as compared with “real science”) both by new students and some non-mental health teaching staff;
  - Lack of access to lecturers/tutors with child and adolescent experience
Few child and adolescent-specific resources;
- Lack of access to senior workers practising in the field for supervision or mentoring of students on placement.

All agencies were interested in enhancing the child and adolescent content of their training programmes and as a result had many innovative ideas for resources and processes to attract and maintain student interest. Some people noted the need for inclusion of Māori, Pacific People and consumer/family input. Ideas included:

Other national agencies could:
- Develop clear national requirement/direction for inclusion of child and adolescent content in curricula;
- Establish new and innovative incentives for universities and polytechnics to undertake teaching in child and adolescent issues;
- Lobby national professional agencies (e.g. Nursing Council) to strengthen the provision of child and adolescent content as a requirement for registration.

Educational institutions could:
- Develop a close association with The Werry Centre for Child and Adolescent Mental Health;
- Obtain financial assistance to help students obtain supervision on child and adolescent mental health services placements.

The Werry Centre could:
- Develop child and adolescent mental health-specific teaching materials that could be used by each discipline as a trigger to discuss their professions possible contribution to the issues presented (i.e. a “toolkit” of materials: videos of basic child/adolescent mental health assessments, family engagement, Māori and Pacific People information, case studies, possible exam questions, etc.);
- In a future project, ask consumers what they think is important for clinical and community staff to be taught;
- Establish a “Train the Trainers” workshop for tutors and lecturers to up-skill them in child and adolescent mental health;
- Lead training in specialist communication skills for people working with children, adolescents and their families;
- Establish a national list of child and adolescent mental health “experts” available to teach as required;
- Review the needs (or advocate the need for) Pacific child and adolescent information/training.

- Both Māori and Pacific People wish training to be relevant to their respective cultures and to be involved in the design of materials relevant for their cultures. Basic Counselling training is seen as useful for Māori and Pacific staff working with children and adolescents.

- Counselling training is seen as useful in providing the emphasis on communication and engagement needed. Although the focus at undergraduate level is on adults, there is developmental content as well as basic mental health problems experienced by children and adolescents.

- The National Certificate in Mental Health Support Work is a qualification based on the recovery approach. It has been very successful in attracting Māori and Pacific People into support work. However, the content of the certificate includes very little about mental illness per se, and includes no child and adolescent mental health content. The new qualification being developed will include both areas.

- Several Certificate Courses are available that focus on child and adolescent issues. They are generally pitched as “precursors” to Social Work or other training and include some content on mental health issues.
1.0. Background

The University of Auckland and the Ministry of Health (MoH) have a contract to develop part of the mental health workforce strategy signalled in the Health Funding Authority's Tuutahitia te wero, Meeting the Challenges: Mental Health Workforce Development Plan 2000-2005. It was anticipated that the initiatives described in the agreement would promote the child and adolescent sector as a positive place in which to work and provide essential training for employees.

The Werry Centre was established in 2002 within the Department of Psychiatry, University of Auckland. The aim of The Werry Centre is to improve the mental health of children and adolescents in New Zealand by:

- Providing or facilitating first-class training and support to the workforce nationally
- Promoting research of a high quality into child and youth mental health
- Advocating for the mental health needs of children and adolescents
- Supporting the child and adolescent mental health workforce to provide high quality care.

The workforce development project undertaken by The Werry Centre is one of a number of initiatives that would provide a focus for a range of activities to support the education and training of the specialist child/tamati and youth/rangatahi mental health workforce including:

- An analysis of relevant workforce needs
- The determination of appropriate education and training goals, modalities and materials
- The delivery, or arranging for delivery, of education and training
- Monitoring and evaluation of the impact of training and unmet training needs.

2.0. Other work in progress at The Werry Centre

The Centre is currently funding several other projects that focus on workforce development in child and adolescent mental health. Among these is an analysis of the Psychology workforce.

Future work will be carried out to supplement Te Rau Matatini’s work in child and adolescent mental health workforce issues, and a separate project will be undertaken for Pacific People.

3.0. Aim of this report

This report is one of the specific initiatives undertaken within the first year of The Werry Centre’s operation. It is a brief summary of undergraduate training in child development and adolescent mental health currently undertaken among educational agencies in New Zealand. The aim is to examine current training undertaken in child development and adolescent mental health in a sample of tertiary institutions (i.e. degrees from universities and technical institutes) to develop appropriate training and/or resources for the future.
It is hoped this Centre will enhance the mental health workforce and ultimately improve service delivery to children and adolescents. The brief was to:

- Examine what (if anything) is taught about child and adolescent mental health in undergraduate training of Nursing, Social Work, and Occupational Therapy? The National Community Support Work Certificate and a counseling programme were also briefly examined.

- Include relevant Māori and Pacific issues will also be included by seeking advice from Māori and Pacific people working in the area as to what is important to include in undergraduate training.

- Identify gaps and barriers to adequate training in child and adolescent mental health.

- Recommend ways in which current undergraduate training in child and adolescent mental health could be enhanced.

In addition, the overall strengths of programmes were also noted and key issues raised by interviewees were documented.

4.0. Information gathering

4.1. Agencies/people contacted

Forty-two people were contacted from 21 agencies. Most were interviewed in person. Some course materials and websites were also examined.

The agencies and people visited or contacted were chosen on the following basis:

- Some were recommended by the Director and Associate Director of the Centre;

- Some were recommended by other key stakeholders;

- The larger training programmes of each profession were selected on the basis that they had access to the most students;

- A rough spread of North and South Island agencies was required.

As can be seen in Appendix 1 (the list of people and agencies contacted) this is not an exhaustive nation-wide review, rather it is a sample of some of the larger training agencies.

For Māori and Pacific People, key people were contacted and ideas sought on undergraduate training. As Māori workforce issues are covered by other current projects (e.g. Te Rau Matatini) and future work is being planned for the Pacific workforce, such issues were not a key focus of this current project. However, as both Māori and Pacific issues are a key thread among all professions the issues raised they are covered in separate sections under the headings, teaching, content and resources.

The training under review was that of:
➢ Nursing.
➢ Social Work.
➢ Occupational Therapy.

In addition, Counselling and Community Support Work were briefly examined.

5.0. Appreciation of participants

The interviewer appreciated the time and wisdom provided by the participants. Collecting information and views can often add to an already busy workload so we thank the people who took part.

A copy of this report will be sent to all participants.

6.0. What is meant by “Child Development and Youth Mental Health”?

The Werry Centre is focused on the provision of clinical mental health services for children, adolescents and their families. Centre staff was asked to specify what areas needed to be covered in a comprehensive programme.

Appendix 2 shows examples of some of the broad areas considered useful.

It was not expected that undergraduate degrees would include such specialisation; however, this list serves as a general guide.
7.0. Interview findings

This section will examine the content and issues for each professional group and then discuss some general issues raised by participants.

7.1. What does each group currently teach?

It was originally hoped to present a spreadsheet of “what is being taught where”. However, it soon became apparent that such a spreadsheet would remain largely blank as little is being taught at the undergraduate level in terms of child development and adolescent mental health. Although adult mental health is better served, it must be stated that in one or two agencies staff stated that getting any mental health input into undergraduate training could be a struggle. Resistance was seen as a lack of value placed on the subject by the training agency and, in some cases, a lack of mental health expertise among staff. In one or two areas where strong mental health content was found, it was led by lecturers/tutors who had come from a primarily adult mental health background.

The following reports the information collected by each professional group. These are reported under the following headings:

- What the profession does - The “end product” of teaching (this was included as there appears to be some confusion around the work/roles undertaken by each of the professions);

- What is being taught about child and youth mental health;

- Gaps and barriers;

- Ideas to strengthen future training.
7.2. Nursing

7.2.1. What do Nurses do?

As quoted from one undergraduate nursing programme:

“... The new graduate will be able to:

• Comprehend, explain and apply foundation knowledge and skills, demonstrate attitudes which are the basis for nursing practice;
• Implement safe, effective, ethical and sensitive client care;
• Demonstrate effective and confident problem solving skills as an individual practitioner and as a member of a multi-professional health team;
• Apply basic management skills, prioritise goals, show an understanding of resource limitations, and analyses costs in relation to benefits;
• Competently and actively contribute to health promotion and education activities for individual clients and the wider community;
• Critically analyse client care regimens, be receptive to new knowledge and maintain the ability to learn throughout their professional career;
• Demonstrate culturally safe behaviour and an understanding of cultural, ethnic, and socio-economic differences and influences on clients and self;
• Demonstrate leadership in nursing and healthcare issues;
• Meet Nursing Council of New Zealand Competencies for Entry to the Register of Comprehensive Nurses.”

7.2.2. What is taught about child and youth mental health?

The Nursing Council who specifies the criteria for competencies sets the content of nursing. Comprehensive nursing is just that – it covers a very broad range of knowledge and skills. There is one competency for mental health. The criterion for this specifies 2 weeks mental health theory and 160 hours clinical experience in the undergraduate degree. This requirement is supported by documentation for assessment of the competencies. The focus is clearly on adult mental health issues. For example, in one 2-week mental health programme 1 hour was devoted to adolescent mental health.

It was reported that some submissions to a recent Nursing Council review of undergraduate training had argued unsuccessfully for a 4th year in which nurses could be given specialist mental health training the better to equip them for work in the mental health sector. This recommendation was not actioned by the Council.
In the seven programmes reviewed there was variation in the amount of child or adolescent mental health content, ranging from very little through having some more specific, primarily developmental, content to one newer programme that had significant mental health content and plans to establish a new child and adolescent teaching position. Most programmes clearly see the content of undergraduate degrees as necessarily being broad. Several programmes offer “Pre-entry to Nursing” courses to encourage mature Māori and Pacific People to demonstrate successful study and continue in a nursing career sense? It must be noted that some of the graduate programmes clearly have a strong focus on mental health, but few target child and adolescent mental health issues.

Those teachers who led programmes with the most adult mental health content had a passion for, and experience in, mental health. If this was not present, little attention was paid to mental health. In fact, it was reported that in some agencies there was “active resistance” to focus on mental health in the training of undergraduates. Another programme noted the emphasis in general on medical and surgical nursing within the agency with mental health given a lesser status.

It appeared few teaching staff had an interest in (or experience of) child and adolescent mental health. The following Table outlines areas taught.
<table>
<thead>
<tr>
<th>In curriculum</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult mental health content, e.g.</td>
<td>100% had some focus on adult mental health areas</td>
</tr>
<tr>
<td>• Nursing care plans</td>
<td></td>
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<tr>
<td>• Diagnoses (schizophrenia, personality disorder, depression, anxiety, PTSD, dementia, eating disorders, alcohol and other drug abuse)</td>
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<tr>
<td>• Recovery</td>
<td></td>
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<tr>
<td>• De-escalation techniques</td>
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<tr>
<td>• Risk management</td>
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<td>• Crisis assessment</td>
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<tr>
<td>• Māori and Pacific mental health approaches/issues</td>
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<td>• Refugee mental health, maternal mental health</td>
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<tr>
<td>• Stigma and discrimination</td>
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</tbody>
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<thead>
<tr>
<th>Child and adolescent content, e.g.</th>
<th>Mentioned by most but usually very few actual hours devoted to these areas. Average appeared to be 1-3 hours in the total undergraduate curricula, with one or two programmes having a little more.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Growth and development</td>
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<td>• Suicide</td>
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<td>• Sexuality</td>
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<td>• Eating disorders</td>
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<tr>
<td>• Child abuse/protection issues</td>
<td></td>
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<tr>
<td>• Drug and alcohol abuse</td>
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<tr>
<td>• “Heads assessment”</td>
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</tbody>
</table>

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<tr>
<th>Placements in child and adolescent mental health services</th>
<th>Most tried to obtain child and adolescent mental health placements. This was often restricted by limited access to services; translates to 1 or 2 students per year per programme.</th>
</tr>
</thead>
</table>

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<tr>
<th>Strong relationships with local child and adolescent providers</th>
<th>3/7 agencies stated they had excellent relationships with local mental health services or NGOs who served their population; others seen as good.</th>
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</table>

<table>
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<tr>
<th>Child and adolescent mental health-specific resources mentioned as being used</th>
<th>0/7.</th>
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<tr>
<th>Consumer involvement in teaching</th>
<th>2/7, with others possible in the future.</th>
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</table>

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<tr>
<th>Planned joint teaching position with child and adolescent mental health</th>
<th>1/7, with others possible in the future.</th>
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</table>
Two other examples showed how teachers could influence students’ future career choices. One experienced mental health nurse was leading an undergraduate programme and, although the programme was in its first few years of operation, one third of students had gone on to choose adult mental health as a career. On this basis she was planning to establish a child and adolescent mental health teaching position to encourage students into this area. Another example was a tutor’s personal commitment to foster any interest shown by students in child and adolescent issues. She was dedicated to finding placements for students interested in child and adolescent mental health, and committed to giving the students additional tutorials, reading and help to ensure they were able to hold their own in the child and adolescent mental health service. It was noteworthy that both students were offered positions in this service after training.

7.2.3. Gaps and barriers

The lack of child and adolescent mental health content in training is evident and people had many opinions on barriers.

- One agency noted that a key issue for undergraduate training appears to be the negative attitude many new nursing students have of mental health in general. First-year students will often say they do not want to work in mental health. (Paediatrics and surgical services appear to be the areas of choice). This may be because of the information about mental illness and mental health services they have picked up over the years.

  We know that there is stigma and discrimination in the community about people with mental illness - nursing students enter training with it, too.

- There also appears to be a general negative view of mental health from some medical or surgical teachers in some educational institutions. Comments such as “What a waste of a good nurse” (when a top student got a position in mental health), and “mental health is not real nursing” or “X is not such a good nurse, maybe she’ll find a niche in mental health” were reported by tutors at some agencies. Similarly, another undergraduate nursing programme noted the value placed within the agency on the end product, which was seen as “pushing the generic nurse out.”

- A couple of respondents suggested it would be interesting to follow nursing students through their training to see where in health they ended up and why they made the choice they did. It is thought that if a student really enjoys placement experience they are likely to go back to that service. Conversely, students have reported negative experiences in both acute mental health units and in community mental health settings, and this can deter them from mental health for good.

- In general health settings, nursing students are exposed to what was called by one participant a “signs and symptoms” model of care. Another participant described this as a “task and technology” focus. In mental health settings the environment is less structured and student nurses report finding it hard to find a role that is more than custodial. Students have also reported being frustrated at the difficulty in being able to see if they can make a difference in consumers’ lives. Whereas in general health a urine sample can help the nurse see progress in a person’s condition, the ways to measure
progress in mental health problems are not as straightforward and require effective people skills. Several people suggested communication/engagement skills could be strengthened in curricula.

- Similarly it has been suggested that inpatient mental health units and forensic services appear to value activities such as legal knowledge and risk assessment skills more than the people skills of rapport building, the ability to work well with other cultures and families, the recovery approach and “just plain talking with people”.

- A lack of resources was identified as a barrier to strengthening child and adolescent content. People believed their courses could include more child and adolescent content if they had access to:
  - An up-to-date website on child and adolescent mental health issues;
  - Easily accessible materials for teaching (e.g. videos, books);
  - Exam questions;
  - Culturally appropriate content of materials.

- One person stated that in Australia the Government had recently cut university fees for both nurses and teaching students to encourage people into these two professions. This person cited an article that stated the Australian Government was:

  To give financial inducements to regional universities to move out of research and expand into nursing training (Sydney Morning Herald, 5/4/03).

7.2.4. Ideas to strengthen future nursing training

- Agencies such as the Ministry of Health or the Werry Centre should give strong direction about the importance of child development and adolescent mental health content to Heads of Schools.

- Joint appointments between universities/polytechnics and child and adolescent mental health services were seen as effective ways to enhance undergraduate training, and one agency was planning such an appointment in the future.

- Strong representation on training agency advisory groups by clinical staff who work in child and adolescent services was also seen as a useful method to enhance content.

- The development of a close association with the Werry Centre was seen as advantageous.

- It was suggested that it might help if the Nursing Council:
  - Had child and adolescent mental health expertise represented on the Council itself;
  - Strengthened the mental health (and subsequently included child and adolescent mental health) components of the competencies.
• Participants agreed undergraduates were more likely to pursue a career in mental health if they:

  - Are taught with “passion, vision and a belief that this is a great area to work in”;
  - Experience good quality placements (e.g. good preceptorship/mentoring, good coordination of the placements, opportunity to learn how to engage consumers, supportive staff, good working environments, and the ability to see clearly how they can contribute to the team);
  - They can see a clear career pathway in mental health nursing (e.g. to be able to progress to ‘Nurse Practitioner – Child and Adolescent Mental Health’).

• It appeared few teachers had a background in this area. Thus it may be useful to enhance existing staffs’ skills by having a “Train the Trainers” approach. In addition, getting more input from child and adolescent mental health staff from services (both statutory and NGO) would be useful. These sessions could be held in at least Christchurch, Wellington and Dunedin. However, access for nursing programmes in the smaller cities was also seen as being important. It was suggested Heads of School should attend.

• A useful suggestion was that of a national “Mental Health Educators Forum”, which could focus solely on child and adolescent mental health (or have both adult and child and adolescent ‘streams’ in it). Such a forum could target all workers, include consumers, family members, and Māori and Pacific People, and could focus on successes, and the sharing of experiences and teaching resources. Some aspects could be generic; other parts might need to be profession-specific.

• A national list of child development and adolescent mental health “experts” was seen as a useful way of tapping into relevant skills and knowledge. Such expertise could be bought in as guest lecturers.

• The need for early teaching (i.e. in year one) on stigma and discrimination was recommended by several people to counteract both the students’ attitudes and possibly those of other teaching staff.

• An increase in the content of programmes on communication skills was necessary. Content needs to include more on boundary issues, stress and distress, group process, how to gain trust, develop empathy and rapport, and how to work effectively with families.

• The inclusion of basic child development and adolescent mental health content would be a major step forward. Examples of such content included childhood depression, anxiety, autism and ADHD, adolescent depression, offending and alcohol and drug misuse. It was suggested that such knowledge is needed as a foundation on which a strengths and recovery approach could then be built. Mental health promotion for young children was also noted as a gap (as the focus appears to be on adolescent).
If people can work effectively in the area of child and adolescent mental health with young people and families they will also be effective with adults. Often the perception is that ‘children are mini-adults’ but this is not the case.

- There is an urgent need for resource materials at the undergraduate level.

Suggestions were:

- The Mental Health Commission’s resources on assessment could be cut down and re-packaged to fit the undergraduate teaching level; for example, excerpts from the video could be shown as an example of a clinical assessment.

- In addition one person suggested the recent Mental Health Commission video (and accompanying workbook) “Service users discuss mental illness and recovery” would be useful in a child/adolescent version.

- Other useful resources included a package that could encompass a range of resources teachers could select. These could portray a recovery focus and include Māori, Pacific and Asian People, and show basic situations commonly encountered in the child and adolescent area:
  - Videos (e.g. assessment, teach communications skills with children, adolescent and families);
  - Student workbooks;
  - Role plays;
  - Good case studies.

- There is a larger group of mature nursing students than 10 years ago, and many have had some experience of mental health issues (either their own or friends/family members). Teaching processes and materials therefore need to cater for their needs as well as for those of younger students.
7.3. Social Work

The main focus of this section is Social Work. However, as some Schools also offer Counselling and Certificated courses a few of these were also briefly examined.

7.3.1. What do Social Workers do?

One training programme states:

Social Work involves working with individuals, families and groups

- Creating positive change in people’s lives;
- Developing people’s potential;
- Accessing support, resources and information;
- Advocacy for those whose voice is not always heard;
- Promoting the development of people’s power and control over their lives;
- Changing systems that have a negative impact on people’s lives;
- Seeking justice where there is injustice;
- Encouraging people to take collective action to improve the quality of their lives;
- Understanding social and political systems and how they impact on people;
- Supporting and befriending people in times of difficulty;
- Respecting cultures and beliefs.

7.3.2. What is taught about child and adolescent mental health?

Three Social Work programmes were examined. Social work training is offered in 2-, 3- and 4-year courses. Social Work is reported as a very broad degree that “is a mixture of sociological, psychological and cultural understandings”. It is a small allied health profession when compared with Nursing. As with other professions, it appears social work content is more likely to include mental health issues if the lecturer has a mental health background.

A report commissioned by the Mental Health Directorate of the Ministry of Health in 2002 investigated strengthening both Social Work and Occupational Therapy’s mental health workforce. It was recommended that a “new entrants programme” be developed to better support graduates in their first year of practice (Levack, Cromie, McNabb and Woodward, 2002). The report observed that child and adolescent mental health content was lacking in both programmes.
Teachers of social work maintain that a key strength of social work is the emphasis on strengths, social justice, human rights and empowerment of individuals, families and groups. Such an approach is in line with the recovery approach.

<table>
<thead>
<tr>
<th>In curriculum</th>
<th>Comment</th>
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<tbody>
<tr>
<td><strong>Adult mental health content, e.g.</strong></td>
<td>All programmes had adult content – a systems view is taken so focus is on policy and models of service delivery as well as practical Social Work roles.</td>
</tr>
<tr>
<td>• Mental health law</td>
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<td>• Mental health policy (e.g. the ‘Blueprint’)</td>
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<tr>
<td>• Family impact of child abuse, neglect and violence</td>
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<td>• Families in crisis</td>
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<td>• Major mental illness and the impact on the individual and family</td>
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<td>• Māori and Pacific issues</td>
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<td>• Professional ethics</td>
<td></td>
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<tr>
<td>• Recovery</td>
<td></td>
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<td>• Social work processes in mental health</td>
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<td>• Stigma and discrimination</td>
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<tr>
<td>• Counselling models and techniques.</td>
<td></td>
</tr>
<tr>
<td><strong>Child and adolescent content, e.g.</strong></td>
<td>There is little child and adolescent mental health content. Where it is present, the focus appears to be more on developmental issues, child protection, cultural issues, contextual factors and strengths, rather than mental health problems and interventions.</td>
</tr>
<tr>
<td>• Growth and development</td>
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<tr>
<td>• Social work role across “ages, stages and disorders”</td>
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<td>• Suicide</td>
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<tr>
<td>• Child abuse/protection issues</td>
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<tr>
<td>• Māori and Pacific perspectives on social and family issues.</td>
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<tr>
<td><strong>Placements in child and adolescent mental health services</strong></td>
<td>All 3 programmes place emphasis on placements in child and adolescent mental health services. These can be difficult to obtain.</td>
</tr>
<tr>
<td><strong>Strong relationships with local child and adolescent providers</strong></td>
<td>3/3 reported good relationships.</td>
</tr>
<tr>
<td><strong>Child and adolescent mental health-specific resources mentioned as being used</strong></td>
<td>Child Adolescent &amp; Family Services’ videos of “family group conferences” from different cultural perspectives were used.</td>
</tr>
<tr>
<td><strong>Consumer involvement in teaching</strong></td>
<td>Seen as important by all.</td>
</tr>
<tr>
<td><strong>Planned joint teaching position with Child and Adolescent Mental health</strong></td>
<td>Possible in the future.</td>
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A recent survey of nine District Health Boards mental health services in New Zealand found 31% of Social Workers worked in the child and adolescent services (McNabb, 2002), many coming to mental health from CYFS. One such service in Auckland, the Kari Centre, employs 10 Social Workers. Social Work students at the Kari Centre have access to the “Learning Objectives Manual”, developed by Social Work supervisors to assist their entry into services.

In addition, an analysis was undertaken by McNabb (unpublished report) of the contribution of Social Work to the New Zealand National Mental Health Strategy. This is a useful document other mental health workforce groups could emulate as it demonstrates the clear contributions of Social Work to mental health in line with the Government’s aims and objectives.

However, several of those interviewed noted that while students entered Social Work because it was a clear career path based on positive strengths-based and recovery values, these attributes need to be seen as valuable by staff in the mental health sector.

### 7.3.3. What are the gaps and barriers?

- One barrier was clearly seen as the lack of child and adolescent specific resources.

- Some parts of mental health services were very reluctant to give placements to Social Work students who did not already have mental health experience. This can lead to a Catch 22 situation in which the students lose out because they can never get the experience. Education of students was also not seen as a priority for some busy mental health services, therefore placements were hard to obtain.
• The language and values of clinicians bought in from mental health to teach on mental health issues was seen by some as an area in need of improvement. An example was given of a doctor who gave a guest lecture on mental illness:

The language used, the lack of cultural awareness and the attitude portrayed by this person only served to turn students off mental health.

• A couple of non-Social Workers expressed the view that in recent years there appears to have been a move from clinical skills to “social activism” and family therapy. In these people’s opinion, this has meant that few newly graduated Social Workers have a good clinical understanding of mental health/mental illnesses and interventions that work:

There is sometimes an anti-clinical attitude and a narrow focus on fixing the external environment (family, work, ‘system’) which may not be helpful when working with a person who has mental illness.

7.3.4. Ideas to strengthen future Social Work training

• It is important to remember “how to sell” an area. One person suggested that what is needed is:

Energetic, vibrant, passionate people who really know their area, who are clear about teaching objectives, who use a range of excellent media and resources (e.g. OHPS, video, group discussion, guest lecturers, rangatahi), and who have excellent relationships with local services – and the budget to pay for additional child and adolescent expertise).

• One participant interviewed said her Department takes the processes of attracting students very seriously. For example, all staff in that School take every contact or inquiry regarding study very seriously. Staff are required to take the time to attend fully to any query for information and follow up with further information. To attract students into the profession, promotional meetings at local high schools are carefully managed to ensure the content is “exceptional”.

• A national list of resource people with expertise in child and adolescent mental health (from policy, clinical and academic sectors) was seen as a potentially valuable tool. Guest lecturers could be drawn from this list.

• A focus on training programmes to strengthen the relationship between Social Work Departments and local child and adolescent mental health services may help encourage more placements. Many see clinical placements as a powerful way of recruiting future students. Placements need to provide good supervision and mentoring for the student and senior staff need to be able to value the student and assist with problem solving when needed. It would also be helpful if the service stated exactly what was expected of the student (in terms of mental health knowledge and skills). The training programme could then focus on that and ensure the student had adequate knowledge (e.g. basic knowledge of child development, mental illness and interventions, stigma and discrimination, recovery and strengths perspectives) before the placement.
• Several Social Workers and lecturers remarked that the process of attracting Social Workers used by Child, Adolescent and Family Services is seen as an excellent model that mental health could follow. CYFS offers 4th year BSW students:
  - $10,000 in a bonded position;
  - A textbook allowance;
  - And guarantee of a job with a starting salary of $35,000.

CYFS have also put much effort into building staff morale, retention and recruitment. CYFS also meet with Heads of Schools four times a year to work through issues. In a recent survey of CYFS staff the results were positive. A lecturer in one Social Work School noted that one quarter of the School's graduates enter Child, Adolescent and Family Services.

• With the increase in older students at training agencies there is a need to find whether they have different training needs to better cater for this student group.

• The “Te Rau Puawai” Bursary Scheme originally funded by the HFA was seen as a very successful, purposeful strategy. The aim was to have “100 Māori graduates in 5 years” from Social Work, Psychology, Nursing and Māori Studies. Although 2003 is the last year of this 5-year period, it is possible this may be extended. The scheme has meant teaching departments of agencies have needed to develop the skills to make it happen. An evaluation by Linda Nikora of the Psychology Department of Waikato University has demonstrated the scheme was very successful.

• There is a need for resources appropriate not only for Māori and Pacific People, but also for the growing Asian population. For example, in the Christchurch region the Korean population is the fastest growing ethnic group. It was also suggested that it would be useful to have short videos about:
  - What child and adolescent mental health services staff actually do;
  - What a Social Worker can offer such services (i.e. the social work skills required);
  - An assessment of a child/adolescent person showing Māori and Pacific People, tangata whaiora and families;
  - Childhood depression and anxiety (from the point of view of child, parents, Social Worker, GP, school, etc.);
  - How recovery competencies might translate into Social Work practice.
  - Accompanying workbooks and use of the Internet would be useful in the teaching process.
7.4. Occupational Therapy (OT)

7.4.1. What do Occupational Therapists do?

A report entitled “The Occupational Therapists Role in Mental Health Services for Young People” notes that OT is “a profession that enables people to lead meaningful and satisfying lives through participation in occupation”. ‘Occupation’ is seen as “things people do”:

Everything people do to occupy themselves, including looking after themselves (self-care), enjoying life (leisure), and contributing to the social and economic fabric of their communities (productivity).

As described in one document, “Practice is client-centred and enables the individual to find health and well-being through participation in self-chosen and self-satisfying occupations”.

Skills include:

- Assessment of an individual’s occupational performance;
- Identifying people’s strengths and needs;
- Planning and use of selected activities;
- Activities analysis;
- Adoption of activity, environment or behaviour;
- Facilitating the individual to acquire and maintain skills;
- Incorporation of both individual and group interventions.

The outcome for consumers is seen as helping people craft a “life worth living.”

7.4.2. What is taught about child and adolescent mental health?

OT as a discipline originated from “mental hospitals” in the early 1900s when it was discovered that when “patients” were given meaningful structured activity symptoms decreased. Occupational Therapy in 2003 has perhaps the strongest focus on mental health compared with other undergraduate programmes. There are only two training programmes in New Zealand, both with a strong focus on interpersonal skills. One Head of School noted that from her programme 50% of staff had a mental health background and one third of graduates enter mental health.
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<tr>
<td><strong>Adult mental health content, e.g.</strong></td>
<td>Both programmes had significant adult content.</td>
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<td>• Introduction to mental health services</td>
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<td>• Abuse and neglect.</td>
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<tr>
<td><strong>Placements in child and adolescent mental health services</strong></td>
<td>2/2 Both programmes place emphasis on placements in child and adolescent mental health services. These can be difficult to obtain.</td>
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<tr>
<td><strong>Strong relationships with local child and adolescent providers</strong></td>
<td>2/2 Good relationships with services reported.</td>
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<tr>
<td><strong>Child and adolescent mental health-specific resources mentioned as being used</strong></td>
<td>0/2 None mentioned.</td>
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<tr>
<td><strong>Consumer involvement in teaching</strong></td>
<td>Yes. One programme noted &quot;lived experience&quot; was important for students to hear and contracts regular consumer input into teaching.</td>
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<tr>
<td><strong>Planned joint teaching position with child and adolescent mental health service</strong></td>
<td>Possible in future.</td>
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<td><strong>Planned p/t adolescent consumer teaching position</strong></td>
<td>Possible in the future.</td>
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</table>
7.4.3. What are the gaps and barriers?

- Obtaining placements in Child and Adolescent Mental Health Services is difficult as few OTs are employed in C & Y services; for example, while the Child and Adolescent Service in Dunedin does not employ an OT, OTs in Christchurch are employed in both the community service and the Child and Adolescent Inpatient Unit. This lack of access to supervision by a senior OT means very few students acquire Child and Adolescent Mental Health experience. In Auckland it is possible to find a very limited number of placements.

- As there is no graduate training for OTs that allows them to specialise in Child and Adolescent mental health it is difficult for graduates to see a clear career path.

7.4.4. Ideas to strengthen future Occupational Therapy training

It was suggested that teaching resources needed to raise debate and discussion generally but not be prescriptive. The following resources were identified as being useful additions:

- Information on attachment theory (as it relates to the New Zealand context);

- Child and adolescent case studies - where students could be given work on these and each discipline could then discuss their possible role (and that of other disciplines);

- Information on dual diagnosis for children and young people.

- Establishment of a Graduate degree specialising in Child and Adolescent Mental Health would help students see a clear career pathway. Students can currently choose to focus on specific areas (e.g., child and adolescent mental health) within graduate papers.

- To combat the problem of a lack of senior OT supervision in child and adolescent services it was suggested a different model of fieldwork be undertaken. For example, to ensure a greater number of students underwent child/adolescent mental health experience group supervision rather than 1:1 supervision could be implemented.
7.5. Counselling

7.5.1. What do Counsellors do?

As described by one programme:

Students who successfully complete the programme will:

- Be qualified to work as a Counsellor in the community
- Be eligible for applicant membership of the New Zealand Association of Counsellors (NZAC). (In order to apply for full membership graduates must complete a further 300 hours counselling practice);
- Articulate the theory and philosophy of counselling which informs their practice;
- Demonstrate the ability to counsel eclectically and appropriately;
- Demonstrate personal values and attributes appropriate for counselling;
- Practise counselling ethically, adhering to the NZAC Code of Ethics;
- Be able to explain how the Treaty of Waitangi impacts on their practice as a Counsellor.

Two training agencies were contacted. One Diploma in Counselling was a 3-year course part-time programme. Applicants were required to complete an assessed course in human growth and development from birth to death and Treaty of Waitangi awareness training. The other Diploma was a 1-year full-time course (which may be taken over 2 to 2 years) that required five prerequisite courses, the content of which included psychosocial development in children and adolescents, and problem behaviour (e.g., ADHD, conduct disorder, autism) and child abuse and protection.

Counselling uses a person-centred approach and the two programmes examined focus on adult issues. Content of both Diplomas included issues and processes such as stages and different modalities of counselling, trauma, grief and loss, emotions and their place in counselling process, sexuality, abnormal psychology, working with a range of clients, group processes and ethical and professional issues. The strengths of Counselling training are seen as strong emphasis is placed on the ability to engage effectively, to communicate with clients and to reflect appropriately on one's own emotional processes and responses are seen as strength of counselling training.

Although graduate Certificate and Degrees in working with children and adolescent are available, some participants noted students could complete an undergraduate degree (with a primarily adult focus) then be employed by a school as a counsellor without the requisite knowledge and experience. It was suggested schools should be educated about the need for specialist training and skills for Counsellors who work with children and adolescent.

The lack of access to Counselling staff trained in child and adolescent mental health was seen as the biggest barrier to increasing training in this area. In addition, payment for such
expertise was low (e.g., $55.00 for a session including marking) when Counsellors may get $100.00 per hour in private practice.

There was a need for the Ministry of Health to emphasise the importance of child and adolescent mental health curricula to Heads of Universities and Polytechnics. Resources used by Counsellors were few and made overseas. Resources suggested as helpful for Counselling programmes were:

- New Zealand-made video on child development;
- Basic “NZ-grown” information on mental health problems commonly experienced by children and adolescents (with possible interventions);
- NZ-made materials aimed at teaching children and adolescents an “emotional vocabulary.”
7.6. Community Support Work

7.6.1. What do Community Support Workers do?

As described by the Mental Health Support Work Advisory Group Report (2002), this group of workers aim to achieve the following outcomes:

- Assist consumers to find, get and keep their choice of accommodation, vocation, education and training, relationships;
- Maximise the health, well-being, social networks and finances of consumers;
- Increase/help/promote family/whanau support and education;
- Achieve positive and sustainable community development;
- De-stigmatise people with mental illness in the community.

These outcomes are undertaken through the following roles:

- Support needs assessment;
- Service co-ordination;
- Personal support.

The overriding issue for the Community Support Work curriculum is that while this course is certificated nationally by NZQA, it focuses on adults and there is no child and adolescent mental health content designated within it. However, there are plans to include this area in a future Diploma that will focus more on rehabilitation. Other issues that are also relevant for child and adolescent are seen as:

- Consumers are increasingly involved in the design, delivery and evaluation of Community Support Work training.
- Community Support Work is seen as a very good option for Māori and Pacific people entering the mental health workforce. Existing clinical training may not be seen as “attractive” in terms of its cultural basis for some people.
- Although Community Social Workers are taught about recovery in theory, in practice the culture of those organisations in which they work does not support recovery. For example, the rise of specialist agencies means staff working in such an agency are more likely to consider themselves as “expert”, which is counter to the recovery philosophy (where the consumer is the expert).
- Although NGOs in general are often seen as being more “recovery-focused” than statutory services, it was suggested some NGOs have over time become “institutionalised and/or corporatised”, and thus less able to enact recovery.
• It was suggested that all clinical training should include how to work with the support workforce (and vice versa) in order that consumers are well served.

• As with nursing, it was suggested the following would increase the likelihood of CSW students pursuing/following/choosing a career in mental health:

  ▪ If they are taught with passion, vision and a belief that mental health is a satisfying and stimulating area to work in;

  ▪ Students are able to see a clear career pathway in mental health, which means graduate level degrees/training in CSW – at the moment CSW training is often used as a precursor to social work or counselling training;

  ▪ The opportunity to see that they CAN make a difference.

• Strengths of the current CSW training were seen by exponents to be the focus on recovery, people skills and home-based care. These could easily be replicated in child and adolescent training.
7.7. Certificated Courses

- A ‘Certificate in Youth Studies’ has been developed by one agency and offered for the first time in 2003. (A diploma Course will be offered in 2004 subject to final approval by NZQA). This Certificate is seen as a precursor to Teaching or Social Work or other social services. The content covers basic issues such as the impact of socio-cultural issues (e.g., gender, class, and ethnicity) on adolescent development, mental health problems for young people and on families; an introduction to teaching, and learning; and an introduction to communication, counselling, support and referral processes.

- A ‘Certificate in Social and Community Work’ is also offered by one agency. This Certificate is a 1-year course targeted at people who may have some experience in the social services area and who wish to work towards a qualification. Students generally study part-time and the course is an introduction to the possible skills required and places of employment required by, for example Social Work.

- A National Certificate in Youth Work was also offered at one institution. This 1-year course was seen as a precursor for Social Work or other training. Components of the content included policy, practical agency experience, health and safety, adolescent work skills, Treaty of Waitangi, and working with other cultures, supervision and other projects. Mental health issues were briefly touched on (e.g., depression, alcohol and drug use and suicide).
Key issues for Māori included the following:

**On teaching:**

- It was suggested that starting teaching early is important. Secondary school students should be targeted so they know that child and adolescent mental health is a career option. It also needs to be communicated as a “hip and positive” career option (much as adolescent work is now).

- One person noted, “A change in outcome requires a change in input”. That is, to improve training, and therefore the knowledge of issues for Māori, there must be changes in the way things are taught. For Māori content, the experts are Māori; however, being Māori does not always translate to being a good teacher. When you get both you will get the outcome you want. There is a need to train some Māori in teaching roles to be more effective.

- Effective delivery styles for Māori were described as:
  - Active involvement in learning;
  - Opinions of students sought often;
  - Group processes used;
  - Mentoring systems are very important.

- Credibility is important. It is no longer adequate to have non-Māori teaching Māori issues in terms of children and young People’ mental health issues. However, the lack of a Māori workforce is an issue. It may be most effective to ask the Māori community for the best person to teach child and adolescent issues. This could be a Kuia or other community member known for their wisdom.

- Māori could be contracted to teach in programmes from local Child and Adolescent mental health services. It is important that people get paid for their time (or at least the money goes back to their employing organisation). Good relationships with local Māori and Child and Adolescent mental health services must be established an maintained.

- Te Rau Matatini is seen by Māori stakeholders (as well as others contacted) to be an excellent initiative aimed at strengthening the Māori mental health workforce. This organisation aims to ensure tangata whaiora have access to a well-prepared and well-qualified Māori mental health workforce. As stated in one of their founding documents (Te Rau Matatini Projects, 2003), they will do this by:
  - Contributing to Māori mental health workforce policy development at national and regional levels;
  - Contributing to a Māori mental health workforce that subscribes to excellence in clinical and cultural practice;
  - Expanding and extending the Māori mental health workforce;
  - Promoting rewarding career opportunities in mental health for Māori.
Whananga (Māori tertiary training agencies) are moving into health-related areas and will have an impact on training for Māori.

On content taught:

- Good basic counselling and engagement skills are seen as important for any mental health worker working with Māori children and their families.
- Participants noted that Charles Waldegrave and colleagues at the Family Centre in Wellington have an approach to family issues called “cultural family systems”, which was seen as very useful for Māori families, given that discussing one single intervention might be inappropriate. As mental health problems for a Māori child or adolescent are often part of a complex array of issues (e.g., alcohol and other drug use, learning difficulties, poverty), a systemic approach culturally acceptable to Māori is required.
- Family systems for Māori may not be the same as for others. Multi-parenting can span generations within the contemporary urban structure, for example, two adult sisters may be living with their mother and bringing up their children collectively.
- One Kaumatua suggested it was important to tell students that it is a privilege to work with people; that the same depth of emotion with which a young person contemplates suicide is needed for a health professional to help that young person heal. He asked students “Are you really in the right game? Do you practice what you preach?” He noted that people who work with people need to be good at their own emotional, spiritual and physical self-management.
- Mason Durie’s “Te Whare Tapa Wha” model should be included in undergraduate teaching.
- The Ministry of Health’s “Cultural competencies” needed to be introduced in undergraduate teaching.
- Students should be informed of the role of Cultural Advisers/Consultants in mental health services. Such roles will increase in services, and students and clinical staff need to be able to work effectively within this framework. In addition, with an increasing number of Māori children attending Kohanga Reo, much more culturally appropriate health services will be necessary in future. In general Early Intervention for Psychosis Services are seen as providing a good model for how cultural issues should be taken into account.
- Placements for students in Kaupapa Māori services are seen as an important way to teach Māori processes.

On resources:

- Students need an understanding of how Māori think - their principles and values. Traditional Māori healing methods are important alongside modern mental health. Resources should reflect these issues.
• Māori need to be involved in the development of training resources as many clients of Child and Adolescent mental health services are Māori.

• It would be helpful if more information was available on child and adolescent mental health issues for Māori in New Zealand. For example, information on mental health problems experienced and what interventions are effective. There is a need for Māori to document or publish some of the work currently undertaken in child development and adolescent mental health to inform others and enthuse Māori.
7.9. Pacific People

Overall the Pacific equivalent of Te Rau Matatini is required.

On teaching:

- There was a clear message that Pacific students need to hear from Pacific teachers to increase the likelihood of students specialising in mental health. Pacific knowledge needs to be viewed broadly.

- It is not necessary for a Pacific nurse to teach nurses; a Pacific community worker who has the necessary knowledge is appropriate.

- Educational agencies need to contract in part-time Pacific people who can cover basic issues at the undergraduate level.

On content:

- The Fonofale Model was seen as an important foundation for Pacific mental health and as such needs to be incorporated into undergraduate teaching.

- As for Māori, Pacific people may present late to services, resulting in more enforced care, multi-agency involvement, and poorer outcomes. Reasons for such late presentation need to be taught.

- There are only two trained Pacific family therapists in New Zealand. This is an area that needs attention. Although there is no Pacific family therapy model per se, basic family therapy is helpful to understand the complex structures and values that constitute each Pacific Island family system. Issues such as:
  - Who lives at home?
  - Who makes the decisions at home?
  - Who disciplines the children?
  - What language does the family speak?
  - What church does the family attend?
  - Who in the family is New Zealand born and who is not?

- As sex is a taboo subject in Pacific cultures people are often loath to talk about sexual matters. But therapists need to be able to broach such areas sensitively. Such reactions are similar when discussing issues of violence, and staff must be clear about what is and is not acceptable (e.g., in disciplining children).

- An issue for staff working with Pacific elders and parents in that traditionally older people must be shown respect. On occasion, however, it is people of status who have been abusive and staff need to be able to deal with this in an appropriate way. Children’s personal safety is the prime issue (not the status of the abuser). Similarly, the church has a huge influence and some people interviewed noted that the pressure to give money is often on greatest on people who can least afford it, in which case the whole family may suffer.
• One programme also offered a Bachelor of Nursing (Pacific) to cater better for Pacific students and the needs of the Pacific community. The handbook from this course states:

This programme differs from the mainstream programme in that it has been designed specifically for Pacific students with a particular focus on the health needs of Pacific communities within the New Zealand context.

On resources:

• There is a need to document what works well for Pacific children and adolescent and their families. With a shortage of Pacific workers trained in this area ways of sharing information is important.

• Pacific people need to be involved in the designing of resources particularly when the resources relate to Pacific child and adolescent mental health issues.

• As Pacific people are a verbal people, role-plays are seen as a useful training tool.
8.0. General issues raised by participants

8.1. Proliferation of mental health training programmes

Students, employers, consumers and families find it confusing to understand the qualifications of the people with whom they work, given the proliferation of training in New Zealand. There appears to be little or no overall strategy for the mental health workforce, and no rationale for what is taught where. As one person noted, educational agencies now appear to operate in a business environment and seem say:

If there’s a hint of money – we’ll do it. Whether or not the expertise is there.

An example was given of a recent CTA tender asking for new entry training for Occupational Therapists and Social Work. The successful applicant was a nursing school that it appears will be contracted to provide training for Occupational Therapist’s and Social Workers. The rationale for such a decision was hard to find.

The Ministry of Health is currently funding an initiative whose aim is to co-ordinate many existing workforce development projects. The Project Manager Workforce Development, Robyn Shearer, is based at the HRC in Auckland. This initiative will help co-ordinate and rationalise most (but not all) existing projects.

8.2. Inclusion of the recovery approach

The recovery approach has not been taken up strongly in the child and adolescent mental health-training context. Read (2003) noted that an analysis of training standards for nurses and social workers by the Mental Health Commission in 2001 found that there was little or no reference to the recovery approach or to consumer participation. This current review undertaken in 2003 found this situation had changed, with recovery being cited among most training programmes on adult mental health issues. While a few areas now involved consumer participation in training, this was still mainly in the adult area.

8.3. Science (clinical) versus art (personal experience + recovery)

Several times during the course of this project the question arose as to the weight/acceptability of evidence versus opinion. Some participants maintained some professions pride themselves on being based on the scientific method (e.g., medicine, and to a large extent psychology, and a lesser extent nursing) as compared with others who are based more on theory (e.g., psychotherapy, social work). The consumer view argues that they in fact are the experts, having experience of mental illness.

8.4. The “medical model” versus theory or personal experience

One person interviewed argued that people do not understand what “the medical model” means and often use the term negatively. In his view, the medical model suggests that, through research, it is accepted that a problem (e.g., diabetes) is known to have certain
characteristics or prevalence, to take a particular course, and to have a specific outcome and treatments. There is no presumption of anything else behind this except the knowledge to date about diabetes. While this model is appropriate for certain mental illnesses, a multidimensional model is far better (i.e. the bio psychosocial/spiritual/cultural model). He said:

*W*e either have evidence that a treatment works, or we don't. Assertion, charisma and personal experience is [sic] valid - but not ‘the truth’ (i.e. generalisable to all people).

In addition he stated:

*Political correctness is a poor substitute for knowledge, and ‘believing’ does not make things true.*

The “recovery” approach is also viewed critically by an effective/important sector of mental health practitioners. Several of those interviewed alluded to the tension between the two approaches.

Some see both as incompatible (i.e. medical model = bad; recovery = good), when in fact they appear to be complementary. For example, a young person who experiences psychotic symptoms may find that a range of things works for him/her, e.g., support from other consumers, CSW support, assistance with work, therapy from a clinician and support from friends and family, and medication and support from a psychiatrist. There is a sense that areas of mental health training still reinforce this view. For example, in some areas it was suggested that Community Support Workers were still taught that clinical = medical = “bad”. What appears to be required is for each mental health discipline or worker to be taught exactly what other clinicians/workers contribute, and how they can best work together using their respective skills - for the benefit of the people they are trying to serve.

### 8.5. Who does what?

However, adding to the tension discussed above, there appears much overlap among the groups surveyed. It is no longer possible easy to differentiate specifically what each group offers over and above (or alongside) any other group. The statement, taken from a student brochure, *Seek to promote well-being and develop potential by working with individuals, families and groups to create positive change in People lives*, could have been lifted from any brochure of any of the groups interviewed. Positively, people are working for “the greater good of people”. Negatively, there may be confusion among workers about who is best placed to do what. In addition it is difficult for consumers to understand the difference between professions.

Social Work has recently taken a lead in this area with *The contribution of Social Work to Mental Health Services*. This document clearly ties the Social Work role to the National Mental Health Strategy, and discusses the contribution made by social workers at local and individual/family levels. It would be useful to have a similar document for the other professional groups.
8.6. “Publish or perish”

As the academic environment (particularly universities) appears to value publications above all other endeavours, little value is placed on disciplines that are not strongly research based. The main focus in all groups interviewed is on first providing quality training of students; research takes second place. Several people argued that as a result mental health professions are not valued in the academic context and therefore often largely ignored in terms of planning and university processes:

Universities are more interested in things that are measurable and researchable, like counting how many people die (than preventing them die).

According to some interviewed the result is a lack of incentive to put much time and effort into mental health training (particularly child and adolescent). It was argued that the best incentive for universities is money, and initiatives such as Te Rau Matatini demonstrate what can be achieved with this incentive in place.

8.7. The clinical focus of The Werry Centre for Child and Adolescent Mental Health

The Centre is contracted to enhance the workforce in clinical child and adolescent services. A couple of participants interviewed reported colleagues who had undertaken training led by the Centre found the strong “psychiatric” focus in training was somewhat off-putting for disciplines that embraced the recovery approach and a strengths/resilience model. This is an area the Centre could examine in the future.
9.0. Summary of findings

All people interviewed saw child and adolescent mental health workforce development as a critical area to enhance. As one person stated:

How can New Zealand have a ‘Knowledge Wave’ without attending to the mental health of children and adolescent – the adults of the future?

The following is an attempt to summarise training issues and to synthesise solutions offered by those interviewed.

9.1. A major strength of all programmes was the teaching staff themselves:

- Some programmes had very experienced staff who were passionate about mental health in general;
- In all programmes staff were very willing to enhance the content of child development and adolescent mental health and to look at innovative ways to attract students and staff into this area;
- People were also willing to express their own need to learn more about this area and to discuss ways to do this.

9.2. What is taught about child and adolescent mental health?

It is evident undergraduate training programmes include some adult mental health content. Several programmes teach some basic child and adolescent issues (e.g., child development, child protection, and/or suicide) but content is limited. More in-depth mental health content is taught by a few programmes (e.g., OT, a couple of nursing programmes and Social Work programmes).

To quote one participant:

Within all curricula mental health needs to be both ring-fenced, and integrated.

It appears most specific mental health content is taught at the graduate level, where there are programmes focusing on this area.

9.3. Gaps and barriers

For all groups these can be described in terms of:

Institutional barriers
Lack of value placed on mental health as an area in general by educational agencies;

Lack of value placed on training of students by services.

**Professional**

- Lack of allowance for child and adolescent content in professional requirements (e.g., nursing);
- Lack of general content around “how to work effectively with other professions/health workers”;
- Lack of value placed on child and adolescent mental health and of staff;
- Lack of value placed on mental health by some students and some non-mental health staff;
- Some mental health teaching staff not valued/supported by other colleagues.

**Resource and expertise**

- Lack of child development and adolescent mental health resource materials;
- Lack of access to Māori child and adolescent expertise;
- Lack of access to Pacific People expertise as above.

**Clinical placements**

- Few senior workers in child and adolescent mental health, thus a lack of supervision available;
- Services too busy to supervise students;
- In some cities several training programmes compete for access to the same child and adolescent services.

**Lack of analysis of consumer needs and subsequent workforce skills**

- There appears to be little current analysis of the skill-mix needed to effectively serve this population (which it is hoped will be helped by several recent initiatives by the Centre, Te Rau Matatini and the Mental Health Workforce Advisory Programme).
10.0. How can The Werry Centre help?

The ultimate aim is to enhance the Child and Adolescent workforce and thereby enhance the quality and quantity of services for children, young people and their families. The need for such enhancement was underscored by the recent report New Zealand Youth: a profile of their health and well-being (2003) by the Adolescent Health Research Group of the University of Auckland. The results of this survey of secondary school students showed that depression was a problem for 18.3% of female students and 9% of male students. Suicidal thoughts are also common among this population.

The writer believes it is important that projects such as this current review of undergraduate training are realistic in their recommended actions. Many excellent ideas have been reported above, some are outside the scope (and budget) of the Centre. Some are ideas that might be taken on board by each professional group, by educational agencies, or by child and adolescent mental health services. Some are already in place. For example, the Ministry of Health Mental Health Workforce Development Programme is looking at coordinating many mental health workforce activities. Te Rau Matatini is seen as a flagship initiative for Māori (with the need for a Pacific equivalent being suggested). Other Government initiatives (e.g., HWAC) could also positively impact upon child and adolescent mental health if this area is seen as a priority. The new Health Practitioners Competency Bill may lead to more clearly defined scopes of practice for each discipline working in this area (if this area is seen as a priority). Several people mentioned the need for clear public information from the Government on what mental health services (including child and adolescent services) actually do and how they work.

Professional agencies could include (or strengthen) child and adolescent expertise on national boards or councils. Training competencies need to include greater emphasis on child and adolescent mental health as a training focus. Some training agencies report having strong advisory groups to ensure effective relationships are maintained with clinical staff, and that content is relevant to services provision at the coalface. Other agencies could establish such groups. Strengthening alliances and joint initiatives with other agencies (e.g., Child, Adolescent and Family, District Health Boards) to establish “bonded” positions or “bursaries” were seen as ways to attract new graduates to the mental health area.

It goes without saying that actions need to include the participation of consumers, family members and Māori and Pacific People. In addition, the Recovery approach is gaining momentum in adult mental health and can be strengthened for this specialist area by thoughtful consideration of this approach in any area of action.
11.0 The Werry Centre could:

1. Distribute this report widely throughout educational agencies, professional groups, mental health services, Māori and Pacific child and adolescent mental health services/NGOs and to the Manager - Mental Health Workforce Development, Mental Health Commission, Ministry of Health and the Health Workforce Advisory Committee.

2. The Centre could also undertake some (or all) of the following:

   o Ask future consumers and family members what they would like clinical staff to be taught - what areas they see as being important.

   o Host a national “Mental Health Educators Forum”. This could either focus on mental health in general (with a child development and adolescent mental health “stream”) or target child and adolescent mental health specifically. It could include training and content issues for consumers, clinical staff, Māori, Pacific and Asian People, focusing on best practice - sharing successes, experiences and resources.

   o Co-ordinate the establishment of a national list of child development and adolescent mental health “experts” (including consumers) that might be available for teaching sessions (and their charge per hour - if any).

   o Lead training in specialist communication skills for staff/students working with children, adolescents and parents in the mental health context.

   o Develop child/adolescent-specific resource materials (e.g., a “toolkit” of materials each discipline could use as a trigger to examine how their profession might contribute to the issues displayed:

      ▪ A shortened version of the MHC assessment video;

      ▪ A child and adolescent version of the MHC recovery video with consumers;

      ▪ Demonstrating family systems approaches (i.e. by video and accompanying vignettes of common scenarios and case studies);

      ▪ Information on basic child development and adolescent mental health mental health problems and interventions;

      ▪ Basic information on Māori, Pacific and Asian People mental health issues for children, adolescents and parents.

3. Co-ordinate “Train the Trainers” forum, to teach existing tutors/lecturers about more in-depth child development and adolescent mental health issues. Some of this could be generic but could also have profession-specific streams.

4. As a precursor to a Pacific version of Te Rau Matatini, the Centre could undertake a formal review of Pacific child and adolescent mental health workforce needs and training (or lobby the Ministry of Health for this development for Pacific People).
References


Fee cut for nursing students. (2003, April 5). The Sydney Morning Herald.


Appendix 1: People and Agencies Consulted.

Carole Adamson  Massey University
Barry Afaaso    Auckland DHB
Dr Arini        Auckland College of Education
Marian Axtell   Manukau Institute of Technology
Kirsty Barber-Smith  Waikato Institute of Technology
Liz Beddoe     Auckland College of Education
Robyn Boladeras Waikato Institute of Technology
Tanya Cargo     University of Auckland
Mua’autoiia Tueipi Clarke Auckland Healthcare
Janice Clayton  Otago Polytechnic
Nicki Colemen  Canterbury DHB
Ken Daniels    University of Canterbury
Tony Farrow    Christchurch Polytechnic Institute of Technology
Sian Griffiths Otago Polytechnic
Reihana Haggie Auckland DHB
Helen Hamer    Auckland University
Pat Hickson    Massey University
Paul Hirini    Te Rau Matatini
Raylee Kane    Otago University
Angie Kennedy  Otago Polytechnic
Dr Ian Lambie  The Werry Centre
Kay Laracy     Whirireia Community Polytechnic
Dr Peter McGeorge Capital & Coast DHB
David McNabb   Auckland DHB
Cate Madison   UNITEC
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Appendix 2: Content for Child and Youth Mental Health

**What is “normal” child/youth development & what can go wrong?**

**Basic child development**

'Normal' child developmental processes and stages and Infant/Child mental health problems, e.g., sleep disorders, enuresis and encopresis, learning difficulties, autism, ADHD, fear/anxiety, substance use, physical disorders with psychological sequelae:

- DSM IV assessments: pros and cons of such an approach
- Wider assessment (strengths/resilience/environment)
- Therapies/interventions
  - empirically based
  - less tested
- Management techniques for parents
- Mental health promotion/prevention
- Māori - cultural issues
- Pacific People
- Other populations (e.g., Asian and refugee populations)

**Basic youth development**

'Normal' youth development processes and stages and Youth mental health problems, e.g., Alcohol and other drug abuse, mood disorders, eating disorders, psychosis, conduct disorder, suicide, physical disorders with psychological sequelae:

- DSM IV assessments: pros and cons of this approach
- Assessment (strengths/resilience/environment)
- Therapies/interventions
  - empirically based
  - less tested
- Parent strategies
- Mental health promotion/prevention
- Māori - cultural issues
- Pacific People
- Other populations (e.g., Asian and refugee populations).

**Other issues**

Child abuse, adoption, parental separation, grief, child and protection issues managed by Child, Youth and Family (would include foster care).

A recovery approach underpins all action.