Implementing a primary mental health service for children:

Administrator and provider perspectives

Abstract

The Child Mental Health Service (CMHS) was an Australian primary care program introduced in July 2010 to provide mental healthcare to children who had, or were at risk of, developing psychological disorders. The Australian Government provided supports (e.g., training for mental health professionals), resources (e.g., funding for positions devoted to fostering inter-agency linkages or partnerships) and various flexibilities in service delivery. This study aimed to explore the processes used in the implementation of the CMHS in order to achieve its objectives of delivering a high quality standard of service, and forging linkages and support networks with other relevant health and non-health agencies. Structured interviews were conducted with 20 program administrators, six referring professionals and eight mental health professionals. Interviews were recorded, transcribed and analysed for themes using NVivo. The CMHS appears to have made good progress towards achieving its objectives by implementing processes that facilitated the delivery of a high quality service (e.g., engaging appropriately qualified, and encouraging additional training and clinical support for, mental health professionals; employing quality assurance mechanisms and clinical governance arrangements) and establishment of inter-agency linkages (e.g., devoting a professional role - Coordination and Liaison - to this purpose). Provider perspectives suggest that the CMHS has had a positive impact on children and their families. Comparable countries implementing primary mental health programs for children may benefit from considering similar additional supports (e.g., training for mental health professionals), resources (e.g., funding positions devoted to fostering service inter-agency linkages) and service delivery flexibilities as those available in the CMHS.

Key words: child health services; child mental health; child mental health services; primary healthcare;

Australia

Introduction

Childhood mental health is an important public health issue worldwide given the high prevalence of child mental disorders and the low treatment rates (Merikangas, Nakamura, & Kessler, 2009). A review of the epidemiology of mental disorders in children and adolescents from community surveys across the world found that approximately 25% of youth experience a mental disorder in each year, with about 33% doing so in their lifetime (Merikangas et al., 2009). Findings from the Global Burden of Disease 2013 Study indicate that depressive disorders are among the top 25 causes of Disability-Adjusted Life Years (DALYs) in youth (aged 0-19 years) and rose in rank from 25th in 1990 to 19th in 2013 (Kyu et al., 2016). Furthermore, less than half of youth with mental disorders receive mental health treatment (Merikangas et al., 2009). Early identification of children at risk of mental disorders creates opportunities for tailored interventions that can help to avert or ameliorate problems in later life (Kessler et al., 2007). Primary mental health services have an important role to play in recognising vulnerable children and offering appropriate care and support.

The Access to Allied Psychological Services (ATAPS) program was introduced by the Australian Government Department of Health in 2001 (Pirkis et al., 2004). ATAPS was implemented by primary care agencies known as Medicare Locals at the time of this study and currently as Primary Health Networks. ATAPS enabled people of all ages, and increasingly from hard-to-reach groups, to access psychological treatment from mental health professionals (including psychologists, and appropriately trained nurses, occupational therapists, social workers and Aboriginal and Torres Strait Islander health workers possessing competencies to deliver evidence-based mental health interventions) on referral typically by a general practitioner (GP) (Australian Government Department of Health and Ageing, 2012b). Service delivery models varied across ATAPS in order to suit the local context, with Medicare Locals either employing and/or commissioning mental health professionals or agencies to deliver the services (Morley et al., 2007). Although this paper focuses on program implementation issues from July 2010 to September 2013, developments beyond this date and looking forward are noteworthy. As a result of a major review of all Australian mental health services completed in 2014 (National Mental Health Commission, 2014), the mental health system is undergoing major reform and from July 2016, Primary Health Networks will receive a flexible funding pool to commission primary care psychological treatment (subsuming ATAPS amongst other programs) within a stepped-care approach according to local population mental health needs (Department of Health, 2014).

In July 2010, the Child Mental Health Service (CMHS) was introduced as an initiative of ATAPS to specifically target children aged 11 years or under who had, or were at risk of developing, a mental, behavioural or emotional disorder. Implementation of the CMHS became mandatory for all Medicare Locals in July 2012. The CMHS offered certain flexibilities in service delivery (Australian Government Department of Health and Ageing, 2012a) that were not available via the general ATAPS program (Australian Government Department of Health and Ageing, 2012b); these are summarised in Table 1 (Supplementary). For example, individuals needed to have a diagnosis of mental disorder in order to access general ATAPS but a diagnosis was not mandatory in order for children to be eligible for the CMHS. Referral to general ATAPS was made by GPs, psychiatrists and paediatricians; however, in order to expedite service access, the CMHS allowed for provisional referrals by non-medical professionals (e.g., school counsellors, school principals and directors of early childhood services) provided that this was followed by a formal referral by a GP as soon as was practical. Additional service delivery flexibilities available via the CMHS were the delivery of services to parents or the whole family with or without the child present, and the availability of up to three sessions to be used exclusively for the purpose of assessment. These flexibilities recognised the importance of prevention and early intervention, and the significant role of parents and families, in childhood mental health.

Medicare Locals were granted a three-month period to establish the CMHS and funding to fill a Coordination and Liaison role. This role was intended to develop and maintain effective linkages with community agencies and early childhood educational services; provide general advocacy and support to stakeholders and the public in navigating the CMHS and other related childhood service systems (clinical and non-clinical); and provide assistance to mental health professionals in the coordination and management of internal and external services (Australian Government Department of Health and Ageing, 2012a). The Australian Psychological Society was funded to develop online training for mental health professionals who needed up-skilling to meet the required skills and competencies to deliver the CMHS, and to provide a telephone-based clinical support service for mental health professionals delivering the CMHS.

The objectives of the CMHS as identified by the funding body, the Australian Government Department of Health, were to: (1) increase ATAPS service delivery provided for children with mental health and behavioural issues and their families; (2) provide a high quality standard of service that is clinically appropriate for children, including the provision of education and training resources to support service delivery; and (3) establish and maintain linkages and support networks with mental health service providers and community

workers. It has been shown elsewhere that the first objective has been met (Bassilios et al., 2014).

Specifically, preliminary data from the first three years of its operation, including the first year since it became mandatory, showed that the CMHS was off to a successful start, having delivered services to a substantial number of children/families (N = 7,850) resulting in pronounced increases in service delivery to children irrespective of socio-economic position and residence in regional and remote locations (Bassilios et al., 2014).

Literature on child mental health services tends to focus on the efficacy of certain types of interventions delivered and the outcomes produced using quantitative methods (Bower, Garralda, Kramer, Harrington, & Sibbald, 2001). Qualitative methods can help improve our understanding of reasons for outcomes, stakeholder perspectives and the complexities involved in implementing child mental health programs (Southam-Gerow & Dorsey, 2014). Previous studies of child mental health services have shown that implementation issues differ according to the type of stakeholder: providers and consumers are most affected by child symptoms, family stress and therapeutic alliance while service administrators are affected by broader system-level factors (e.g., funding and agency collaboration) (Rodríguez, Southam-Gerow, O'Connor, & Allin Jr, 2014). Other researchers have found that different stakeholders value different aspects of quality of primary mental health care, and that different indicators are more or less relevant at different levels of the mental health system interface (Shield et al., 2003). For example, practice level indicators include access, policies and procedures, information, and effectiveness of various aspects of care, while partnerships and linkages between relevant services, professional training and development, and monitoring are considered to be higher level or system indicators (Shield et al., 2003). Administrator and provider perspectives of service implementation and quality issues are important as they can guide and inform practice and policy, thereby improving service delivery and ultimately consumer outcomes.

This study aimed to explore implementation processes used by Medicare Locals to achieve the CMHS objectives of assuring service quality (including education and training of mental health professionals) and establish inter-agency linkages and support networks. To do this we conducted a series of stakeholder telephone interviews with Medicare Local staff (service administrators) and providers (referrers and mental health professionals) that focused on their experiences of implementing the CMHS during its infancy stage (i.e., the first three years from its initial introduction, including the first year in which it became mandatory).

Method

Participants

Interviewees included 20 Medicare Local service administrator staff, six referring professionals and eight mental health professionals from 18 Medicare Local regions (representing 30% of all Medicare Locals). One quarter of administrator staff were employed in a role directly in the CMHS (Coordination and Liaison Officers) and others were in a range of executive, management and project officer roles. Referring professionals were two school psychologists, a general psychologist, an enhanced maternal and child health nurse, a GP and a paediatrician. Mental health professionals included five psychologists, two social workers and one mental health nurse. Table 1 displays the demographic characteristics of the three interviewee groups. The majority of interviewees were female and aged 45-54 years.

Table 1

Sampling was designed to reflect the range of states and territories across Australia (three Medicare Locals from each state and territory, apart from the Australian Capital Territory, Northern Territory and Tasmania, within each of which only one Medicare Local existed); level of uptake of the CMHS (both high and low); and remoteness (44% Medicare Locals in major cities, and 56% in regional and remote locations).

Administrators from nine Medicare Locals were asked to nominate one referring professional who might be willing to be interviewed for this study, and administrators from the other nine Medicare Locals were asked to nominate one mental health professional each and to act as intermediaries in the recruitment of both groups. Three Medicare Locals did not provide contact information for referrers, with this being attributable to not yet having received any referrals in one case and lack of response to three contact attempts in the other two cases; and one Medicare Local provided us with contact details for a mental health professional instead of a referrer. Two Medicare Locals did not provide contact information for mental health professionals; one explained that providers had high caseloads in the context of long waiting lists and did not have capacity to participate in an interview, and the other did not respond to three contacts.

All participants provided written consent to be interviewed and to have their interviews audio-recorded and professionally transcribed. Ethical clearance for the study was provided by the University of Melbourne's Human Ethics Committee (Ethics ID 1136812.2).

Procedure

This study was part of a larger mixed methods evaluation of the CMHS (Bassilios et al., 2014), the quantitative component of which examined uptake, and consumer and treatment characteristics. The evaluation of the CMHS was part of the broader evaluation of ATAPS conducted in Australia (Bassilios et al., 2013). Given the exploratory nature of the current study, we utilised a cross-sectional qualitative approach incorporating individual interviews as our data collection method in order to elicit in-depth program administrator and provider experiences (Moore et al., 2015). The value of participatory methods is that views of stakeholders, in this case administrators and providers, have the potential to improve the quality of health care through their influence on other stakeholders (Balbale, Locatelli, & LaVela, 2015).

Interviews were conducted by telephone over approximately six weeks in September and October 2013 by BB, AN and MF. Table 2 lists the two key objectives of the CMHS and the corresponding indicators (processes and a priori themes) under examination and data sources used to determine the extent to which each process had been met. We examined the processes rather than whether the objectives themselves were achieved because the latter requires more objective data sources and the CMHS was in its infancy stage at the time of data collection, and the former provides important insights about the processes that may impact on outcomes achieved.

Table 2

Interviews took an average of 35 minutes (SD = 11, range = 20-57 minutes) with Medicare Local administrators, 19 minutes (SD = 2.7, range = 11-19 minutes) with referring professionals and 22.4 minutes (SD = 5.8, range 15-30 minutes) with mental health professionals.

Measures

The interview questions - developed by BB, KK and AN - and tailored to each of the three interviewee groups, were generally aligned with the indicators (processes), focussing on implementation issues, quality assurance, linkage and referral pathways with other services, and factors that either facilitate or hinder service delivery. Examples of the types of questions asked of administrators include: "What clinical supervision arrangements are in place for mental health professionals delivering CMHS?" and "How has your Medicare Local developed and maintained referral and provisional referral pathways?". Examples of the types of

questions asked of mental health professional include: “How can the training and clinical support line be improved?” and “Overall have you found that being able to provide services under the CMHS has had positive or negative impacts for you?”. Examples of the types of questions asked of referrers include: “How have you found the process of making referrals to the CMHS?” and “Describe your experience of working with your Medicare Local on the CMHS”. The Supplementary Materials include copies of the interview schedules.

Data Analyses

NVivo version 10 software was used to manage and code qualitative data. BB, AN and MF coded the verbatim transcripts for content and themes using a theoretical semantic analysis approach, guided by our theoretical interest in the topic and the explicit surface meanings of the data (Braun & Clarke, 2006). A priori codes were based on the interview questions, which were directly aligned with the objectives and indicators shown in Table 2. Additional (inductive) codes were identified from the interview transcripts, which were ordered to produce a coding framework to organise themes into a coded hierarchy, whereby higher level themes were developed by aggregating the lower level inductive codes. The frequency of themes was calculated. Eight transcripts (four Medicare Local, two mental health professional and two referrer) were randomly selected and independently coded by BB, AN and MF in order to establish consistency of theme coding before all transcripts were then coded; the very few identified inconsistencies in allocating codes to data segments were discussed until consensus was reached.

Results

Interviewee responses should be interpreted in the context that the CMHS was in, or just beyond, its infancy stage for the Medicare Locals represented in the interviews; 17 had commenced service delivery between July 2012 and August 2013, and one had not yet commenced service delivery. The results have been organised according to the a priori coding framework shown in Table 2, with the key inductive themes and frequency counts presented in Table 3. Interviewee responses are summarised below, with theme counts in parentheses and illustrative quotes provided.

Table 3

Service quality

Mental health professionals' skills and competencies for working with children

Administrators from 14 Medicare Locals reported the number of mental health professionals providing the CMHS within their Medicare Local. Responses ranged from zero to 49, with a total of 147.

Qualifications and training

Administrators from the 18 Medicare Locals were not always able to specify their mental health professionals' exact qualifications and indicated that mental health professionals' level of education and experience for working with children may vary. For example, six interviewees stated that their providers had at least the necessary qualifications for registration in their profession (e.g., psychology, clinical psychology, mental health social work, mental health nursing), some with additional qualifications in the child or youth mental health field. A further six interviewees indicated that their providers were qualified but did not specify the formal qualifications, and a further three were unable to state the qualifications of their providers.

All eight mental health professionals who were interviewed reported holding qualifications that were relevant to the delivery of mental health services (e.g., postgraduate psychology and social work qualifications). Five mental health professionals indicated that they held specialised qualifications that were of specific relevance to working with children (e.g., postgraduate child psychology and Child and Adolescent Mental Health Service qualifications). Seven mental health professionals reported that their qualifications were complemented by previous experience providing services to children prior to their involvement in the CMHS.

Clinical supervision

Both administrators (n = 18) and mental health professionals (n = 8) were asked about clinical supervision arrangements. In this context, clinical supervision refers to a process in which a supervisor ensures the supervisee's clinical competency and professional development by providing professional support and encouraging critical reflection (Queensland Health, 2009). In Australia, clinical supervision is compulsory for the continuing registration of psychologists (Psychology Board of Australia, 2015) and other mental health professionals. Two broad themes emerged; supervision was the responsibility of the commissioned agency or professional, or was provided within the Medicare Local.

It was not uncommon for Medicare Locals to commission an agency to deliver the CMHS. Therefore, in terms of clinical supervision for mental health professionals, administrators most commonly indicated that the sub-contractor was responsible for the supervision arrangements (n = 7). Four administrators also stated that clinical supervision was mandated in the contract between the sub-contractor and the Medicare Local.

Other administrators reported that arranging clinical supervision was the responsibility of the mental health professionals (n = 6), most of whom stated that regular clinical supervision was a contractual requirement made of providers (n = 4). This is exemplified by the following quotation: "... because we're contracting them to deliver services, they do cover their own clinical supervision ... they will have their own individual clinical supervisors that ... support them through their private practice" (Administrator).

Five administrators stated that they provided regular supervision for their employed mental health professionals, making comments like:

Employed staff all have an individual supervisor ... and...the regularity of that depends on how much they work ... and it would vary probably from once a week to once every four weeks. There is currently a joint child and adolescent peer supervision group ... a range of people go to that, from very inexperienced to very experienced. (Administrator)

Seven of the eight interviewed mental health professionals indicated that they had clinical supervision arrangements in place; one professional reported that her employer was in the process of arranging internal supervision. The supervision arrangements in place (e.g., monthly peer; informal, regular by telephone within private practice; clinical with manager; monthly external) seemed clinically appropriate but were generally external to, and not funded by, the Medicare Locals.

Utilisation and experience of online training and clinical support line

Online training

In regard to the utilisation of the online training by mental health professionals, the themes that emerged from the responses of the 18 Medicare Local administrators varied. For example, seven stated that all of their mental health professionals had completed the online training; five indicated that some or most of their providers or sub-contractor agencies had completed the online training; two indicated that no providers had yet utilised the training and three were unaware of whether (or how many) professionals had completed it. Those who were familiar with the training rated their satisfaction with it in a favourable light overall; however, many also described the training as being too basic for clinicians who were experienced in working with children. To this end, at least two interviewees expressed the view that it would be ideal for providers to only complete the modules necessary as judged through recognition of prior learning.

Five of the eight interviewed mental health professionals reported having completed the online training, and generally being very satisfied with it. There were, however, some suggestions made in relation to improving the training, including increasing the level of challenge of the modules, enabling completion of the training across multiple sessions, simplifying the technical features, ensuring people could not complete the assessment having skipped the training material and making post-training webinars available online. The three mental health professionals who had not yet completed the training indicated an intention to do so in the future, with the main barriers cited including lack of time and untimely clarification from the training developer regarding the content of training (to ensure that it is sufficiently advanced in the context of extensive prior experience working with children).

Clinical support line

Four themes emerged in the responses of the 18 administrators regarding whether the clinical support line had been used: not known, promoted, not needed and used. Half of the administrators did not know whether their providers had accessed the clinical support line ($n = 9$), and two thirds explicitly stated that they had promoted it ($n = 12$). Six administrators indicated that the support line had not been used by their providers, generally due to the availability of strong internal support. One participant put it this way:

We have got a very strong internal support system where we talk to each other and they call each other and they discuss ... peer reviews and case conferences ... so I doubt whether they might have had a need for the phone support, but I will again make sure that they are all aware of it and that they can access it. (Administrator)

Only two administrators were aware that the clinical support line had been utilised by at least one of their staff, and they rated their satisfaction with the support line highly, indicating that it was comprehensive and provided prompt support.

Only one of the eight interviewed mental health professionals reported using, and being very satisfied with, the clinical support line. Half of the interviewed mental health professionals seemed to be unaware that the support line existed; however, they expressed a willingness to use the service as a result of the knowledge acquired during the interviews. These mental health professionals indicated that the existence of the support line ought to be promoted.

Quality assurance mechanisms/clinical governance arrangements

Findings in the above section are relevant to quality assurance and clinical governance because mental health professionals' skills and competencies are able to directly impact on the quality of the service delivered and are therefore relevant to clinical governance. When asked specifically what quality assurance and clinical governance arrangements they had in place to monitor service quality and ongoing service improvements, the majority of administrators indicated that they had implemented various strategies. Seven administrators reported having staff in roles directly responsible for overseeing clinical governance, including committees, reference groups and a Clinical Governance Director: "Our CMHS is just one of the fleet of services that we offer ... we've established a clinical governance sub-committee reporting to the board, consisting of three board members, myself and the CEO, and we meet on a monthly basis" (Administrator).

Six administrators reported that they had ensured commissioned agencies had good clinical governance arrangements. These administrators stated three means by which they ensured clinical governance used alone or in combination: (1) use as a specific criterion to assess agencies' tender submissions, (2) regular meetings and (3) workshops. Six administrators reported that file audits were used as a means to monitor service quality. Four

administrators noted that mental health professionals were supported by senior clinical staff in order to ensure service quality.

Perceived impact on consumers

Four of the six interviewed referrers indicated that the CMHS had benefited the children they had referred, as exemplified by the following quotation: “the outcomes have been really positive....a good sign that things are going well is that they’ll re-engage in learning” (Referrer). They noted generalised mental health benefits (e.g., reduced mental health symptoms, improved behaviours and learning abilities), and improvements in the child’s and family’s support networks and in the child’s relationships with peers, families and mental health professionals. They also perceived that linking children and families with expert services led to families learning new coping skills and developing their support networks. Two referrers stated they were not yet able to determine the impact of the service given its infancy.

All seven of the eight interviewed mental health professionals who had commenced service delivery indicated that the CMHS had had positive impacts for their clients, and this was frequently attributed to the ability to conduct sessions with parents or children or both parents and children. Positive outcomes were also occasionally attributed to offering a free service or to the ability to offer outreach. Some of the positive outcomes reported were finding a “better fit school” for one child, improved psychosocial functioning and children noticing self-improvement (e.g., one girl whose anxiety was managed was able to run for school captain, one boy was occasionally being awarded “student of the week”).

Linkages and support networks

Stakeholder engagement

The Coordination and Liaison role was emphasised by administrators as being particularly important in relation to stakeholder engagement. The availability of this role and strong stakeholder engagement, including having access to skilled providers to deliver the service, were considered to be key factors facilitating the success of the CMHS, as illustrated by comments like: “I wish all of our ATAPS programs had that role” (Administrator). All 18 Medicare Locals had either employed a person to fulfil this role or in a few cases,

subsumed the activities of this position within other roles. Coordination and Liaison personnel were from a range of professional backgrounds, most commonly psychology.

A key activity undertaken in the three-month establishment period and within the Coordination and Liaison role, as reported by administrators, was developing relationships with stakeholders relevant to implementation. The reported purposes of these engagement activities were to educate stakeholders about the CMHS, promote the service, understand the referral pathways from the CMHS into other services, and understand the needs of stakeholders when developing the service. The most commonly reported stakeholders engaged by the Coordination and Liaison staff were schools and GPs; other examples were early learning centres and the Department of Education (non-health stakeholders), health and mental health services and paediatricians (health stakeholders). The types of activities undertaken to engage stakeholders included contacts and meetings with individual stakeholders; attending group networks, forums, workshops, and other group activities with other child services; and other networking and relationship-building activities. For example, one respondent indicated, “We’ve networked with quite a lot of schools ... the lead school psychologists, and now I’m meeting with them individually ... and networking with other organisations that work with child and child health” (Administrator).

Seven administrators indicated that they had no difficulties establishing linkages with other child services. Examples of the nature of difficulties experienced by one or two administrators each were related to the requirement for a GP referral after provisional referral; accessing private psychiatrists, paediatricians, schools and non-government agencies; and the need to earn a good reputation before services are willing to engage.

Stakeholders’ experience

Stakeholders were asked about their experience of the CMHS using four a priori topics: the referral process, the availability of three assessment sessions, the ability of parents to attend sessions with or without the child and the impact on providers.

Referral process

Three referrers and four mental health professionals indicated that they experienced the referral process as satisfactory. Generally, mental health professionals considered the types of referrals received as being appropriate for the CMHS.

All six interviewed referrers reported that their experience of working with Medicare Locals and the communication received about the CMHS was positive. They experienced Medicare Locals as providers of information and ongoing sources of support, particularly in regard to the referral process, and the progress and outcome of the referral. Referrers stated that Medicare Locals provided information about the CMHS in a variety of ways: presentations by CMHS staff at other child services, supply of pamphlets or referral forms to referrers, and pamphlets for consumers. Referrers perceived that the receipt of information and support regarding the CMHS from Medicare Locals led to the formation of professional partnerships, the provision of interdisciplinary care, and improved coordination and integration of care for children and their families.

Two referrers, although positive about the process, reported lacking information about how to refer and whether they could make direct referrals. Two referrers were critical of the requirement that referrals had to go through GPs in the face of GP shortages, long waitlists and concerns that GPs would not follow-up on the provisional referrer's recommendations. One referrer experienced the bureaucratic aspects of the referral process as unnecessarily cumbersome. Referrers' recommendations for improving the process included streamlining the referral process, and in order to simplify the consumer's journey, enabling provisional referrers to directly refer to the service without requiring GP involvement. Additionally, referrers expressed a desire for receipt of written feedback regarding consumer outcomes.

Five mental health professionals suggested that there was a need to educate referrers about the CMHS processes: GPs about forms they need to complete and the difference between the CMHS and other mental health services, and schools about confidentiality. This sentiment is exemplified by the following quotation: "They [schools] sometimes thought that ... we will ... converse with them about the details of that client's therapy. So we've had to explain ... that it doesn't work quite like that" (Mental health professional). Two mental health professionals reported that there was also a need to educate parents, who are sometimes confused about the requirement for a GP referral. Consistent with referrers' views, mental health professionals were of the opinion that the requirement for a GP referral can be unnecessarily cumbersome for

parents and may sometimes result in parents of children with more complex presentations disengaging from the referral process, and therefore from available treatment.

Three assessment sessions

In terms of the allowance of up to three sessions to be used for assessment, service administrator views were mixed. Seven were unable to comment on whether this option was being used; six stated that the option was often used, with one indicating that this is “one of the really big bonuses” of the CMHS; and five reported that formal assessment frequently took fewer than three sessions.

Four mental health professionals indicated that they often utilised the full three sessions permitted for the purpose of assessment, three indicated that they occasionally did so, and one that s/he had not done so. One professional commented, “I think it’s really great that they have actually been explicit...in saying take that time to do a proper assessment.” By contrast, another view expressed was:

To divide therapy into assessment and then treatment is quite arbitrary, it doesn’t really, in practice ... work that way because throughout treatment you're assessing, and even in that first assessment session you're really treating ... I would certainly never use a full three sessions, which is just entirely focussed on assessment. (Mental health professional)

Parents attending sessions with or without the child

Fifteen administrators and all eight mental health professionals said that the inclusion of parents or carers in sessions in the presence or absence of the child was working well and was of great importance.

Eight administrators indicated that this option was essential to addressing the clinical needs of the child. Seven administrators stated it was often important to see the parent(s) or carer(s) without the child to deal with parenting difficulties affecting the child, with one participant commenting:

That part of the guideline is very crucial... It's certainly an effective way to work with children and families. It certainly is appropriate to not see children at every session and to do some parent work, and the team certainly like the fact that they have that flexibility with regards to their service delivery. (Administrator)

Mental health professionals' views supported those of the administrators, as demonstrated by the following quotations: "It's the single best thing about this service", "You really need to have the parent involved otherwise it's unlikely that any change that happens with the child is going to continue unless the parent is aware of ... how to continue that", and

A lot of the children's difficulties were around some of the... anxieties ... the parents were having... So being able to work with the parents and... empowering them to work with the children and provide the care for the children... see their confidence and therefore they have a capacity to be able to parent their ... children better. (Mental health professional)

Impact on providers

Fifteen administrators perceived that the responses to the CMHS from health (e.g., GPs, paediatricians) and non-health stakeholders (e.g., schools, early childhood services) were generally positive, with indications that stakeholders were of the view that the service was needed.

Referrers mainly reported positive benefits for children and their families, with possible flow-on benefits for the referrer and the service, noting that the CMHS was filling an important (early intervention) gap in the child and youth mental health sector. One referrer commented, "Keep it up. We need it and more. It [children] is the most important area to put mental health funding into and is the most cost-effective". They also described increased access to services and reduced waiting periods as a positive impact, which helped them to gain appropriate care for their consumers.

Seven mental health professionals reported that providing the CMHS had resulted in positive personal/professional impacts, with the eighth professional unable to comment due to not yet having commenced service delivery. The most frequently cited positive impact, reported by three professionals, was related to job satisfaction and a sense of doing something that is "worthwhile". The next most frequently cited positive impacts, each mentioned by two professionals, were related to "building relationships" with referring professionals, including the ability to implement a systems or "holistic" intervention approach, and improved social acceptability of children receiving mental health care. One professional mentioned self-development (i.e., learning about personal and professional qualities as a psychologist) as a positive impact, and another, the flexibility in service delivery (e.g., the ability to provide sessions to parents without children and to offer a free service). Several challenges were reported by mental health professionals, such as issues of

demand management, excess travel to provide services in remote towns, lack of attendance at appointments offered in schools at the end of term and 'teething issues' common with the start-up of any new program. However, they stated that the challenges were by far outweighed by the benefits.

Discussion

The purpose of our study was to investigate implementation processes used by administrators and providers to assure a high quality standard of service (including the provision of education and training resources to support service delivery) and establish linkages and networks with other relevant health and non-health agencies. Our qualitative interview data provide indications that, in the first year since it became mandatory, Medicare Locals implemented processes to facilitate the achievement of the CMHS objectives of delivering a high quality service and establishing linkages and networks.

In order to improve accountability and transparency, an Australian framework for the performance of mental health services has been developed, the indicators for which are the following: effectiveness, appropriateness, efficiency, responsiveness, accessibility, safety, continuity, capability and sustainability (Australian Institute of Health and Welfare, 2005). Similar quality indicators have been developed in other countries, such as the UK (Shield et al., 2003). The factors examined in the present study that were related to service quality included: mental health professionals' skills and competencies for working with children (capability); utilisation and experience of resources to support service delivery (capability); quality assurance mechanisms and clinical governance (all performance indicators); and perceived impact on consumers (accessibility, appropriateness, responsiveness and effectiveness).

Although not all CMHS administrators were able to specify the details of their providers' qualifications, the mental health professionals themselves self-reported adequate qualifications and experience in delivering mental health services to children. Although the majority of Medicare Locals included in this study reported actively working to support their mental health professionals and assure service quality and clinical governance, they could have further supported mental health professionals by ensuring that providers completed the online training, serving as a conduit to the training developer to relay suggestions for improvement of the online training (particularly in terms of recognition of previous provider training); better promoting the clinical support line; and providing clinical supervision internally or potentially funding external supervision. In terms of supervision arrangements, flexibility to suit the local context and differing service delivery models (e.g., employed versus contracted providers) is important. Lack of administrator knowledge about details of their providers' qualifications, and whether they had accessed the online training and clinical support line, is at least in part attributable to the fairly common use of a commissioning model. Under these

circumstances, ensuring that mental health professionals possess the required competencies and are adequately supported is the responsibility of the commissioned agency or individual, which was a theme that emerged from the data. Therefore, administrators possessing this knowledge in detail was not critical to the success of the program in this context. Nevertheless, it would appear important that commissioning primary health care agencies have ready access to sufficient information that will enable them to effectively monitor, adequately support and assure relevant aspects of service quality in the future.

Impact on consumers is the ultimate indicator of service quality. At the time of this study, there was insufficient objective outcome data from standardised measures being collected in the CMHS for statistical analyses (Bassilios et al., 2014); however referrers and mental health professionals indicated that the CMHS was having a positive impact on children and their families, with various flexibilities of the service (e.g., permission to use up to three sessions for assessment and the option to provide sessions to parents without children present) making a definite contribution to this impact.

Medicare Locals and providers successfully established linkages and support networks (i.e., partnerships and referral pathways) with various health and non-health stakeholders, mainly schools and GPs, through formal (e.g., meetings, group networks, forums and workshops) and informal contacts. The reported purposes of these linkage activities were service promotion, to educate stakeholders, understand the referral pathways from the CMHS into other services, and understand the needs of stakeholders when developing the CMHS. The factors examined in the present study in relation to establishing service linkages and networks were stakeholder (e.g., referring and mental health professional) engagement in, and experience of, the CMHS. Funding for a role dedicated to engaging stakeholders was considered to be vital and a key factor in facilitating the CMHS. In terms of overall experience of the CMHS, each of the stakeholder groups represented in this study appeared to be generally pleased with the CMHS and the service gap it filled. Providers reported a sense of participating in a worthwhile service, job satisfaction, and the formation of professional partnerships. Referrers appreciated the support that they received from Medicare Locals and immediate access to appropriate care for consumers. Suggestions were made for improving service access, the most notable of which was the removal of the requirement for a formal GP referral following a provisional referral from a school or other eligible referrer.

Our findings, regarding the delivery of child mental health care in the primary care sector, support previous research highlighting the significance of individual professional- and service-level linkages in mental

health care. For example, a narrative review of the effectiveness of service linkages in primary mental health care (which did not specifically focus on children) concluded that there is strong evidence for the effectiveness of collaborative primary mental health care for people with depression as demonstrated by clinical, service delivery and economic benefits (Fuller et al., 2011). Importantly, these benefits were specifically observed when linkages comprised 'direct collaborative activity' (e.g., co-location, consultation liaison, care management), 'agreed guidelines' (e.g., specific treatment protocols) and 'communication systems' (e.g., standardised letters, referrals and feedback reports; enhanced or expedited access), all of which are features of the CMHS. Similarly, a qualitative systematic review, which focused on severe and persistent mental illness, reported that system-level inter-sectoral linkages between the mental health and non-clinical support sectors can be variably established and are associated with positive clinical and non-clinical outcomes for services and consumers (Whiteford et al., 2014). One study, which specifically focused on child primary mental health care, reported that relationships and partnerships between paediatric primary care and mental health providers are associated with greater availability of consultation and communication, but not necessarily with improved assessment and treatment (Pidano, Honigfeld, Bar-Halpern, & Vivian, 2014).

There are some limitations to the validity of the data and methods used in this evaluation that must be taken into consideration when interpreting the findings. No consumers, not all Medicare Locals, and only a limited number of referrers and mental health professionals were interviewed for this research, and therefore not all views are represented in this study. However, by sampling a range of Medicare Locals in terms of their resident state or territory; representation of metropolitan, rural and remote areas; and variation in the stage of establishment and uptake of the CMHS sessions, we tried to gain a representative sample across the country. Furthermore, it can be argued that because our study aim was narrow and our sample possessed specific knowledge about the study's aims, our sample size had sufficient "information power" (Malterud, Siersma, & Guassora, 2015). In acting as intermediaries in the recruitment of referrers and providers, administrators may have been biased towards selecting professionals likely to present positive views. In addition, while participants were assured of the anonymity of their responses in reporting the interview outcomes, administrators and service providers might have felt compelled to present the best possible picture of their implementation of the CMHS. The expression of some negative views and description of the difficulties in implementation of the CMHS lend some support, however, to the validity of the interview findings, as does

the repetition of some of the themes found in earlier evaluations of other ATAPS initiatives (Reifels et al., 2013).

The Australian Government is currently in the process of changing the delivery of primary mental health services to Australians of all ages by awarding primary care organisations a flexible funding pool (which will subsume the CMHS) for commissioning of more flexible stepped-care services tailored to the local context. This change includes permitting initial referrals from sources wider than GPs, including self-referral from consumers. It will be interesting to observe the impact of this reform in Australia on program implementation, service reach and mental health outcomes. Future research will be necessary to integrate findings from objective outcome measurement with those regarding program implementation in order to determine whether variability in the latter affects access to services by, and outcomes achieved for, children and their families.

Conflict of interest

None.

Statement of human rights

All procedures performed in studies involving human participants were in accordance with the ethical standards of the University of Melbourne's Human Ethics Committee (Ethics ID 1136812.2) and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed consent

Informed consent was obtained from all individual participants included in the study.

References

- Australian Government Department of Health and Ageing. (2012a). Draft Operational Guidelines for the Access to Allied Psychological Services (ATAPS) program, Child Mental Health Service (CMHS), April 2012. Canberra, Australia: Department of Health and Ageing.
- Australian Government Department of Health and Ageing. (2012b). Operational Guidelines for the Access to Allied Psychological Services Initiative. Canberra, Australia: Mental Health Services Branch, Mental Health and Drug Treatment Division.
- Australian Institute of Health and Welfare. (2005). National Mental Health Performance Framework. Retrieved from <http://meteor.aihw.gov.au/content/index.phtml/itemId/584825>
- Balbale, S. N., Locatelli, S. M., & LaVela, S. L. (2015). Through their eyes: Lessons learned using participatory methods in health care quality improvement projects. *Qualitative Health Research*. doi: 10.1177/1049732315618386
- Bassilios, B., Nicholas, A., Fletcher, J., King, K., Reifels, L., Ftanou, M., . . . Pirkis, J. (2014). Evaluating the Access to Allied Psychological Services (ATAPS) component of the Better Outcomes in Mental Health Care (BOiMHC) program. Special Report: An evaluation of the ATAPS Child Mental Health Service. Melbourne, Australia: Centre for Health Policy, Programs and Economics, The University of Melbourne.
- Bassilios, B., Nicholas, A., Reifels, L., Machlin, A., Ftanou, M., King, K., . . . Pirkis, J. (2013). Evaluating the Access to Allied Psychological Services (ATAPS) program: Consolidated 10-year Report. Retrieved from https://ataps-mds.com/site/assets/files/1016/ten_year_ataps_report_final_acc.pdf
- Bower, P., Garralda, E., Kramer, T., Harrington, R., & Sibbald, B. (2001). The treatment of child and adolescent mental health problems in primary care: a systematic review. *Family Practice*, 18, 373-382.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77-101. doi: 10.1191/1478088706qp063oa
- Department of Health. (2014). Primary Health Networks Grant Programme Guidelines, V1.1. Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Program_Guidelines

- Fuller, J. D., Perkins, D., Parker, S., Holdsworth, L., Kelly, B., Roberts, R., . . . Fragar, L. (2011). Effectiveness of service linkages in primary mental health care: a narrative review part 1. *BMC Health Services Research*, 11, 72. doi: 10.1186/1472-6963-11-72
- Kessler, R. C., Angermeyer, M., Anthony, J. C., de Graaf, R., Demyttenaere, K., Gasquet, I., . . . Ustun, T. B. (2007). Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative. *World Psychiatry*, 6, 168-176.
- Kyu, H. H., Pinho, C., Wagner, J. A., Brown, J. C., Bertozzi-Villa, A., Charlson, F. J., . . . Ferrari, A. J. (2016). Global and national burden of diseases and injuries among children and adolescents between 1990 and 2013: Findings from the Global Burden of Disease 2013 Study. *JAMA Pediatrics*, 170, 267-287. doi: 10.1001/jamapediatrics.2015.4276
- Malterud, K., Siersma, V. D., & Guassora, A. D. (2015). Sample size in qualitative interview studies guided by information power. *Qualitative Health Research*. doi: 1049732315617444
- Merikangas, K. R., Nakamura, B. A., & Kessler, R. C. (2009). Epidemiology of mental disorders in children and adolescents. *Dialogues in Clinical Neuroscience*, 11, 7-20.
- Moore, G. F., Audrey, S., Barker, M., Bond, L., Bonell, C., Hardeman, W., . . . Wight, D. (2015). Process evaluation of complex interventions: Medical Research Council guidance. *British Medical Journal*, 350, h1258.
- Morley, B., Pirkis, J., Sanderson, K., Burgess, P., Kohn, F., Naccarella, L., & Blashki, G. (2007). Better outcomes in mental health care: The impact of different models of psychological service provision on consumer outcomes. *Australian and New Zealand Journal of Psychiatry*, 41, 142-149. doi: 10.1080/00048670601109915
- National Mental Health Commission. (2014). The national review of mental health programmes and services summary. Sydney, Australia: National Mental Health Commission.
- Pidano, A., Honigfeld, L., Bar-Halpern, M., & Vivian, J. (2014). Pediatric primary care providers' relationships with mental health care providers: Survey results. *Child and Youth Care Forum*, 43, 135-150. doi: 10.1007/s10566-013-9229-7
- Pirkis, J., Morley, B., Kohn, F., Blashki, G., Burgess, P., & Headey, A. (2004). Improving access to evidence-based mental health care: General practitioners and allied health professionals collaborate. *Primary Care Psychiatry*, 9, 125-130. doi: 10.1185/135525704X15048

- Psychology Board of Australia. (2015). Registration Standard: Continuing Professional Development. Melbourne, Australia: Psychology Board of Australia.
- Queensland Health. (2009). Clinical supervision guidelines for mental health services. Brisbane, Australia: Queensland Government.
- Reifels, L., Bassilios, B., King, K., Fletcher, J., Blashki, G., & Pirkis, J. (2013). Innovations in primary mental health care. *Australian Health Review*, 37, 312-317. doi: 10.1071/AH12203
- Rodríguez, A., Southam-Gerow, M. A., O'Connor, M. K., & Allin Jr, R. B. (2014). An analysis of stakeholder views on children's mental health services. *Journal of Clinical Child and Adolescent Psychology*, 43, 862-876. doi: 10.1080/15374416.2013.873982
- Shield, T., Campbell, S., Rogers, A., Worrall, A., Chew-Graham, C., & Gask, L. (2003). Quality indicators for primary care mental health services. *Quality and Safety in Health Care*, 12, 100-106. doi: 10.1136/qhc.12.2.100
- Southam-Gerow, M. A., & Dorsey, S. (2014). Qualitative and mixed methods research in dissemination and implementation science: Introduction to the special issue. *Journal of Clinical Child and Adolescent Psychology*, 43, 845-850. 10.1080/15374416.2014.930690
- Whiteford, H., McKeon, G., Harris, M., Diminic, S., Siskind, D., & Scheurer, R. (2014). System-level intersectoral linkages between the mental health and non-clinical support sectors: A qualitative systematic review. *Australian and New Zealand Journal of Psychiatry*, 48, 895-906. doi: 10.1177/0004867414541683

Table 1. Demographic characteristics of interviewees

Demographic characteristic	Medicare Local administrators (n = 20)	Referring professionals (n = 6)	Mental health professionals (n = 8)	Total (n = 34)
Gender				
Female	15	5	7	27
Male	3	1	1	5
Age				
20-24	2	0	0	2
25-29	3	1	0	4
30-34	2	0	2	4
35-39	0	0	1	1
40-44	1	3	0	4
45-49	4	1	2	7
50-54	4	0	2	6
55-59	2	0	0	2
60-64	0	1	1	2
Aboriginal	1	0	0	1
Torres Strait Islander	0	0	0	0
State/Territory				
Australian Capital Territory	1	0	0	1
New South Wales	3	1	1	5
Northern Territory	1	0	0	1
Queensland	3	1	2	6
South Australia	3	0	2	6
Tasmania	1	1	0	2
Victoria	3	1	2	6
Western Australia	3	2	1	6
Remoteness				
Major city	8	4	3	15
Inner regional	4	1	2	7
Outer regional	4	0	2	6
Remote	2	1	1	4
Very remote	0	0	0	0

Note. Frequency totals of less than 20 for Medicare Local service administrators and 34 for total interviewees are attributable to missing data.

Table 2. Objectives of the CMHS, indicators and data sources (a priori coding framework)

Objective	Indicator/process	Data source/interviewees
High quality of services, including the provision of education and training resources to support service delivery	ATAPS mental health professionals' skills and competencies for working with children:	Medicare Local administrators
	<ul style="list-style-type: none"> formal qualifications or other recognised training in the child and adolescent mental health field clinical supervision arrangements for mental health professionals 	Mental health professionals
	Utilisation and experience of online training resources and clinical support line	Medicare Local administrators
	Quality assurance mechanisms/clinical governance arrangements put in place by Medicare Locals for monitoring service quality and ongoing service improvements	Mental health professionals
	Impact on consumers	Medicare Locals administrators
Linkages and support networks established between mental health services providers and community workers	Stakeholder engagement	Referrers
	Stakeholders' experience	Mental health professionals
	<ul style="list-style-type: none"> referral process Three assessment sessions Parents attending sessions with or without the child Impact on providers 	Medicare Local administrators

Note. CMHS, Child Mental Health Service.

Table 3. Selective content and frequency of inductive themes by stakeholder group interviewees

Indicator/ process	Medicare Local administrators (n = 20)	Mental health professionals (n = 8)	Referrers (n = 6)
Service quality (including resources to support service delivery)			
Mental health professionals' qualifications and training	<ul style="list-style-type: none"> Necessary qualifications necessary for professional registration (6) Qualified but not specified (6) Not known (3) 	<ul style="list-style-type: none"> Necessary qualifications necessary for professional registration (8) Specialised child mental health qualifications (5) Previous experience in provision of child mental health (7) 	
Clinical supervision of mental health professionals	<p>Externally provided</p> <ul style="list-style-type: none"> Responsibility of commissioned agency (7) Contractual requirement of commissioned agency (4) and/or mental health professionals (4) Responsibility of mental health professional (6) <p>Internally provided</p> <ul style="list-style-type: none"> Provided by Medicare Local to employed mental health professionals (5) 	<ul style="list-style-type: none"> Existing supervision arrangements (7) In process (1) Internally received (3) Externally received (5) 	
Completion of online training for mental health professionals	<ul style="list-style-type: none"> Completed by all mental health professionals (7) Completed by some/most mental health professionals/sub-contractor agencies (5) Not yet completed by any providers (2) Completion rate unknown (3) Viewed as 'basic' by experienced providers (2) 	<ul style="list-style-type: none"> Completed and favourably experienced (5) Intention to complete (3) 	
Use of clinical support line by mental health professionals	<ul style="list-style-type: none"> Unknown (9) Promoted (12) Not needed due to strong internal support (6) Used and favourably viewed (2) 	<ul style="list-style-type: none"> Used and favourably viewed (1) Unaware of existence (4) Willing to use in future (4) Promotion warranted (3) 	
Quality assurance/clinical governance	<ul style="list-style-type: none"> Staff in roles directly responsible for clinical governance (7) Ensure commissioned agencies have good clinical governance (6) File audits (6) Mental health professionals supported by senior clinical staff (4) 		
Perceived impact on consumers		<ul style="list-style-type: none"> Positive impacts (7) 	<ul style="list-style-type: none"> Mental health and other benefits (e.g., family support networks and relationships) (4) Not yet able to determine (2)
Linkages and support networks between mental health professionals and community workers			
Stakeholder engagement	<ul style="list-style-type: none"> Coordination and Liaison person employed (18) No difficulties establishing linkages with child services (7) 		
Stakeholder experience	<ul style="list-style-type: none"> Unable to comment on use of three assessment sessions (7) 	<ul style="list-style-type: none"> Satisfactory referral process (4) 	<ul style="list-style-type: none"> Satisfactory referral process (3)

	<ul style="list-style-type: none"> • Three assessment sessions often used (6) • Inclusion of parents/carers in sessions working well (15) • Positive responses from health and non-health stakeholders (15) 	<ul style="list-style-type: none"> • Need to educate referrers about CMHS processes (5) • Need to educate parents (2) • Often use three assessment sessions (4) • Occasionally use three assessment sessions (3) • Have not used three assessment sessions (1) • Inclusion of parents/carers in sessions working well (8) <ul style="list-style-type: none"> ○ Positive personal/professional impacts (7) ○ Job satisfaction (3) ○ Building relationships (2) ○ Improved social acceptability of children receiving mental health care (2) ○ Self-development (1) ○ Service flexibility (1) ○ Unable to comment due to not yet having commenced service delivery (1) 	<ul style="list-style-type: none"> • Positive experience working with, and communication about CMHS, from Medical Locals (6) • Lack of information about referral process (2) • Requirement for GP referral is a barrier (2) • Bureaucratic process of referral is a barrier (1) • Benefits for referrers in terms of availability of referral pathway and positive client outcomes (6)
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Note. CMHS, Child Mental Health Service. Inductive theme counts are in parenthesis and theme categories are not mutually exclusive.

Supplementary Materials

Table 1 (Supplementary). Key features of CMHS and the general ATAPS program (July 2001 – June 2016)

Key feature	General ATAPS	CMHS
Commencement year	July 2001	July 2010
Primary target group	Australians of all ages with high prevalence disorders of mild to moderate severity	Australian children aged under 12 years (but up to 15 years in exceptional circumstances) who have, or are at risk of developing, a mental, behavioural or emotional disorder
Mandatory initiative for Medicare Locals	Yes (since 2001)	Yes (since 2012)
Eligible referrers	GP Psychiatrist Paediatrician Mental health professional ^a	GP Psychiatrist Paediatrician Mental health professional ^a School counsellor ^a School principal ^a Director of early childhood service ^a
Annual session limit	6-12 (18 in exceptional circumstances) individual and 12 group sessions	6-12 (18 in exceptional circumstances) individual/parents/family and 12 group sessions
Other flexibilities	Low or no cost to client	Low or no cost to client Sessions can involve child alone, parents/family with or without child present Up to three sessions can be used for assessment Evidence-based interventions for working with children such as family-based interventions, parent training in behaviour management
Eligible providers	Mental health professionals with full or provisional registration	Mental health professionals with full or provisional registration

Note. ATAPS, Access to Allied Psychological Services. CMHS, Child Mental Health Service. Key features as of September 2015. ^a Provisional referrals required a GP- or psychiatrist-prepared mental health treatment plan ideally within two weeks of the first session, or as soon as practical.

Interview schedules

Medicare Local administrators

1. Name of Medicare Local:
2. Role of interviewee in CMHS:

Implementation

3. Thinking about the implementation of the CMHS:
 - a. Has your Medicare Local employed someone to perform the role of CMHS Coordination and Liaison?
 - b. If so, what is their profession?
 - c. If not, why not?
 - d. What types of activities are being/will be undertaken to fulfil the duties of this role?
 - e. The CMHS operational guidelines provided for a 3-month lead in to these services, what work did your Medicare Local undertake in this time to establish the CMHS?
 - f. Was the 3-month lead time long enough? If not, why not?
 - g. When did your Medicare Local commence delivering the CMHS?
 - h. What quality assurance mechanisms/clinical governance arrangements have you put in place for monitoring service quality and ongoing service improvements?

Providers

4. Thinking now about the mental health professionals (MHPs) delivering the CMHS:
 - a. How many MHPs deliver the CMHS?
 - b. How many of these MHPs have formal qualifications or other recognised training in the child and adolescent mental health field?
 - c. Are these MHPs employed directly, contracted, or do you use an agency? Or some other model?
 - d. Where are the MHPs based? (in Medicare Local's rooms, own rooms, GP rooms, elsewhere)
 - e. Were the MHPs existing or new ATAPS providers?
 - f. What clinical supervision arrangements are in place for MHPs delivering the CMHS?

Resources for providers

5. Thinking about the Australian Psychological Society's resources for MHPs:
 - a. What measures has the Medicare Local taken to promote the CMHS online training or/and phone-based clinical support offered by the Australian Psychological Society?
 - b. How many MHPs have accessed the CMHS online training?
 - c. How many MHPs have accessed the phone-based clinical support?
 - d. Overall level of satisfaction with resources on a scale from 0 to 10 (0=not all, 10 =extremely):
 - i. Online training (rate from 0-10):
 - ii. Phone-based clinical support (rate from 0-10):
 - e. Any particular issues around accessing the CMHS online training and/or CMHS clinical support?
 - f. How could these resources be improved?

Referrals

6. Thinking now about the way in which referrals happen both to and from the CMHS:

- a. Does your Medicare Local accept referrals for clients aged between 12-15 years?
- b. How has your Medicare Local ensured appropriate referrals (from both new referrers and GPs)?
- c. How has your Medicare Local developed and maintained referral and provisional referral pathways (e.g., paediatricians, schools, early childhood services)?
- d. How do you ensure consumers are connected with the right service for them? [i.e. ATAPS vs state mental health vs other community services (i.e., parenting supports, other child-focussed services)]
- e. How has your Medicare Local developed and maintained linkages and referral pathways with other child based services providers (to facilitate cross referral)?
- f. Have you had difficulties establishing relationships with these services? If so, describe the difficulties and how they have been overcome.

Sessions

7. Thinking now about the sessions undertaken through the CMHS:

- a. The CMHS allows for parents to attend sessions (with or without the child); how well do you think this is going?
- b. The CMHS allows up to three sessions to be used for assessment; how often are the full three assessment sessions required?

General

8. Thinking now more generally about the CMHS:

- a. Do you think that the CMHS fills a service gap for your catchment area?
- b. How have health and non-health stakeholders responded to the expanded CMHS component of ATAPS?
- c. What factors have facilitated the effective implementation and operation of the CMHS?
- d. What factors have posed a barrier to the effective implementation and operation of the CMHS?
- e. Any further comments about the CMHS?

Mental health professionals

1. Medicare Local: (This will be confidential and not identified in the report).

2. What is your mental health profession?

3. When did you start delivering services via the CMHS?

4. Approximately how many clients have you seen who have been referred under the CMHS?

5. Approximately how many sessions have you delivered via the CMHS?

6. The CMHS allows for parents to attend sessions (with or without the child); how well do you think this is going?

7. The CMHS allows up to three sessions to be used for assessment; how often are the full three assessment sessions required?

8. Do you deliver other ATAPS services (e.g., Tier 1, other Tier 2)?

If yes: How long have you been delivering ATAPS services? (years, months)

If no: Were you recruited specifically for the CMHS?

9. Do you have formal qualifications or other recognised training in the child and adolescent mental health field?

If yes: What are the qualifications?

10. Have you had experience providing services to children with mental health issues prior to your participation in the CMHS?

11. Did you have concerns about providing services to children with mental health issues?

If yes: Describe these concerns:

12. Who has been the source of referrals for the clients that you have seen via the CMHS?

- ☐ GP
- ☐ Psychiatrist
- ☐ ATAPS mental health professional (psychologist/occupational therapist/social worker/mental health nurse/Aboriginal and Torres Strait Islander health worker)
- ☐ Paediatrician
- ☐ Medical Officer in non-government organisation
- ☐ School psychologist/counsellor
- ☐ Deputy Principal or Principal
- ☐ Director of early childhood service or equivalent

13. How have you found the referral process?

14. How appropriate have you found the referrals?

15. Have you used the CMHS online training resources developed by the Australian Psychological Society?

If yes: What is your overall level of satisfaction with the online training resources on a scale from 0 to 10 (0=not all, 10 =extremely)?

16. Have you used the CMHS phone-based clinical support line offered by the Australian Psychological Society?

If yes: What is your overall level of satisfaction with the clinical support line on a scale from 0 to 10 (0=not all, 10 =extremely)?

17. Describe any issues around accessing the CMHS online training and/or CMHS clinical support.

18. How can the training and clinical support line be improved?

19. Do you have other clinical supervision arrangements in place (within your own practice or from the Medicare Local)?

If yes: Please describe these arrangements

20a. Overall have you found that being able to provide services under the CMHS has had positive or negative impacts for you?

20b. What are the positive impacts for you?

20c. What are the negative impacts for you?

21a. Overall have you found that being able to provide services under the CHMS has had positive or negative impacts for your clients?

21b. What are the positive impacts for your clients?

21c. What were the negative impacts for your clients?

22. What arrangements, if any, do you have in place for providing services to children and their guardians who are from Culturally and Linguistically Diverse backgrounds?

23. Please provide any other comments you'd like to make about the CMHS.

Referring professionals / organisations

1. What type of service are you working in? (e.g., general practice, Child and Adolescent Mental Health Service, school)

- ☐ general practice
- ☐ private practice
- ☐ hospital
- ☐ non-government organisation
- ☐ school
- ☐ early childhood service
- ☐ child/youth mental health service
- ☐ other, please specify:

2. What is your profession?

- ☐ GP
- ☐ Psychiatrist
- ☐ Mental health professional (psychologist/occupational therapist/social worker/mental health nurse/Aboriginal and Torres Strait Islander health worker)
- ☐ Paediatrician
- ☐ Medical Officer in non-government organisation
- ☐ School psychologist/counsellor
- ☐ Deputy Principal or Principal
- ☐ Director of early childhood service or equivalent
- ☐ other, please specify: _____

3. What is your role in the service?

4. Via which Medicare Local have you been referring children to the CMHS? (This will be confidential and not identified).

5. When did you commence referring children to the CMHS?

6. On average, how many children per week does your service/do you refer to a mental health professional or other mental health service? (including the CMHS)

7a. Approximately how many children has your service referred to a mental health professional via the CMHS since you commenced referring to the service?

7b. If your organisation has not referred any children to the CMHS, please indicate why.

8a. If the CMHS was not available, what care would have been offered to these children?

8b. Would you have referred them elsewhere or provided the care yourself?

9. How have you found the process of making referrals to the CMHS?

10a. Overall, have you found that the ability to refer patients via the CMHS has had positive or negative impacts for you/your organisation?

10b. What are the positive impacts for you/your organisation?

10c. What are the negative impacts for you/your organisation?

11a. Overall, would you say that the ability to refer to mental health professionals via the CMHS has had positive or negative impacts for children whom you have referred?

11b. What are the positive impacts for consumers?

11c. What are the negative impacts for consumers?

12. Describe your (or your organisation's) experience of working with your Medicare Local on the CMHS?

13. What support did your Medicare Local provide to assist you to refer children via the CMHS?

14. Please provide any other comments you'd like to make about the CMHS.

Demographic questions (all interviewees)

Gender:

Are you:

- ☐ Aboriginal
- ☐ Torres Strait Islander
- ☐ Both
- ☐ Neither

Age range:

- ☐ 20-24
- ☐ 25-29
- ☐ 30-34
- ☐ 35-39
- ☐ 40-44
- ☐ 45-49
- ☐ 50-54
- ☐ 55-59
- ☐ 60-64
- ☐ 65-69
- ☐ 70-74
- ☐ 75-79

Interview duration: (minutes)

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