



TUMBY BAY MENTAL HEALTH PROGRAM
28 November 1996

Mrs PENFOLD (Flinders): I move:

That this House commends the professional cooperation of the people of Tumby Bay and district who undertook a very successful strategy for mental health care and suicide prevention through an innovative preventive primary care program within their community.

Tumby Bay is 600 kilometres by road from Adelaide but only an hour by air. Unfortunately, almost all psychiatric and psychological services are based in Adelaide and are therefore completely inaccessible—logistically and financially—for the majority of people in the Tumby Bay district. The suicide of a 15 year old student gave general practitioner, Dr Graham Fleming, and others the resolve necessary to undertake the project. I stress the importance of suicide prevention, since males in their teens and twenties in rural areas are the single largest group in suicide statistics. After the suicide of this teenager it was obvious that unless the community attempted to solve the problem it was likely to grieve after more suicides. General practitioners, teachers, parents and mental health professionals at Tumby Bay cooperated to set up the Child and Adolescent Mental Health Project.

The local resources identified comprised medical and nursing staff who had some rudimentary training in mental illness and teachers who were professionally trained to deal with children and adolescents. A team approach using these people was decided upon as the best approach to tackle the problem. The team consisted of Dr Graham Fleming as director; teacher Gladys Fleming as project officer; the District School Supervisor, Kent Spangenberg; the acting school principal, Kim Mason; the deputy school principal, Helen Lovegrove; and the Director of Nursing, Pauline Kearns. Specialist resource people included a psychiatrist, Dr Carol Dorrington, and educational psychologist, Dr Gary Childs.

Dr Fleming spent eight weeks in the Department of Psychiatry at the Women's and Children's Hospital in Adelaide to confirm his understanding of the principles of child and adolescent psychiatry and to ensure that his practice of child and adolescent psychiatry was of a safe and satisfactory standard. He also attended the Smith Kline Beecham SOS program for prevention of adolescent suicide where he was asked to be a general practice moderator in future programs.

Information sessions were held with teachers to explain the nature of mental illness and the signs or symptoms which may be representative of some underlying problem. In fact, the team sought to identify any child or adolescent whose behaviour or learning was not consistent with a student of that age or level. Some teachers also became involved in the DECS Cornerstones program. Dr Childs spoke on learning difficulties. Mrs Kearns conducted educational programs herself or used the Adelaide Northern Child and Adolescent Mental Health team.

Through the Tumby Bay Hospital and health services Mrs Kearns also organised for a team of mental health nurse educators to give a series of lectures over two days to the community. These meetings were crowded with people coming from nearby towns and districts as well as Tumby Bay. This educational role was fundamental to the success of the project. Mrs Kearns was awarded the 1996 South Australian Nurse of the Year largely as a result of her part in the project. The school principal, deputy principal, a general practitioner and the project officer were the active team members who met at the school on a regular basis either weekly or fortnightly. The Director of Nursing joined the

team less often as she was not so directly involved in student teacher- parent interaction. However, she provided an interface with the community.

There was a free flow of information between members, but discussions remained confidential. Problems were categorised under four headings: social, behavioural, psychiatric and learning. Some included a combination of the four. All management programs were based on the premise of the school's behavioural management program which had been recently reviewed and updated. The children who could not be managed under this program were considered for assessment. An individual program was made for each of the students by the parents and class teachers. Initially teachers referred only the most difficult children because they were easily identified. However, the results were so encouraging and successful that an avalanche of children was referred as teachers became more experienced at recognising more subtle signs.

After 18 months the initial rush became more of a trickle as children and adolescents who had suffered problems for years were dealt with and only new cases had to be picked up. At the end of the project smaller numbers of children presented at much lower ages and year levels. Teachers were the main point of referral. However, some children were identified in general medical practice or by the police. Those students primarily identified by the doctor or brought to the doctor's surgery by their parents were, if suitable, and with the student's and parents' permission, entered into the program. Specialist services were used to verify the assessment of the team and were an important part of the evaluation strategy.

Once a child or adolescent was identified as possibly having a disability, they were observed by the team and, if the student's problems seemed significant, a formal assessment was made. A significant problem was diagnosed as frequent episodes in detention or deterioration in school work. Thus the selection for assessment was based on chronicity or severity of the presenting signs. Some children identified seemed to settle back into normal routine and made good progress, so no formal assessment was made in those cases. Once a student was considered for entry into the program the parents were contacted, the program was explained and permission was sought for the child to be included in the project. Parent permission was also sought for inter-agency discussion with normal confidentiality standards being maintained.

The project officer became the interface between senior teaching staff, teachers, the general practitioner, students and parents. The project officer was both a qualified teacher and counsellor but had also worked as a doctor's receptionist, and all these skills were used. The results of the project were encouraging. The number of children who were identified and assessed was consistent with the proportion found in general literature. The preponderance of male students—more than three times the number of female students—surprised, but again these figures were consistent with those in literature. Mr Deputy Speaker, I seek leave to insert in Hansard a table and graph.

The DEPUTY SPEAKER: Can the honourable member assure the House that the table is purely statistical?

Mrs PENFOLD: Yes, Sir.

The DEPUTY SPEAKER: With regard to the graph, members have been advised previously that diagrammatic and graphical material is not suitable for publication. Therefore, the graph cannot be included. Leave granted.

Year and Sex Distribution

Year	Male	Female	Total
1	2	0	2
2	1	1	2
3	4	1	5
4	6	1	7
5	6	2	8

6	2	1	3
7	4	0	4
8	4	1	5
9	3	0	3
10	0	1	1
11	1	1	3
12	5	2	7
Total	38	11	49

Mrs PENFOLD: It would be easy to postulate that boys are expected to be boisterous and girls quiet, or that girls learn to express themselves emotionally at an earlier age. However, the incidence of mental illness in the community is evenly divided, if not biased towards the female population. The team found it hard to believe that they were missing the girls and they felt that perhaps a screening instrument should be sought to see whether there was a discrepancy.

The team was exceedingly successful at assessing children with learning problems and only slightly less successful at identifying those students with psychiatric problems. These results were confirmed by senior educational psychologists and psychiatrists in their field. The strong correlation between learning problems, behavioural problems and psychiatric problems was a surprise. However, when the low standard of literacy among inmates of gaols is recalled, the correlation is perhaps not surprising. Children with evidence of psychiatric illness (for example, depression and conduct disorder) were referred to the general practitioner. Again, a plan of management was initiated with the student's and parents' permission. Students who were considered to have a significant psychiatric diagnosis, or where medication was begun, were referred to a senior specialist child and adolescent psychiatrist. The psychiatrist either continued management or referred the student back to the team or general practitioner.

Where the team considered that significant learning problems may be present, the student was either referred to school services officer provided by the Education Department or to an educational psychologist provided by the project. The educational psychologist was of immense benefit to the project. He made a comprehensive written assessment and offered helpful strategies to parents, students and more importantly teachers. Once serious learning problems were identified, the State schools system had little resources to deal with them. However, the professionalism of the teachers at Tumby Bay Area School was such that they could adapt teaching methods once they understood the nature of the problem.

Another plus was that the school was better able to target Learning Assistance Programs (LAP) to students' individual needs. Having freed up some of the school services officers' time, they were able to write special programs for the students. Evaluation was performed on several levels. The team's assessment was checked in this pilot study wherever possible so that the accuracy of the assessments could be professionally evaluated. Most of the evaluation was subjective because the cost of an objective screening process was beyond the finances of the project.

Parents, students, teachers and general practitioners were asked whether the program was helpful for an individual student, with each student being graded on seven possible levels of response. The team approach functioned efficiently, with meetings, lasting about an hour at lunch times, held two or three times a month. Informal interaction between team members occurred between meetings. Discussions were frank, covering students who were in the program and others who were being observed. Assessment, progress and management for each student on the working list was discussed.

Overall, the project exceeded everyone's highest expectations. Teachers found that difficult students were more manageable and they had another avenue of assisting students who were not progressing. Students themselves were greatly relieved to know that someone cared and understood their problems. In particular, children with learning

problems often felt a great weight was taken off their mind when they found they were not dumb and not programmed for failure. Parents were extremely grateful that someone was at last taking notice of their child's problems and almost universally were cooperative. Specialist services were grateful that their referrals were now well targeted and efficiently arranged. Of the 20 children assessed as having a significant learning problem, 19 were confirmed. Of the 26 children assessed with psychiatric disorders, 20 were confirmed and the remaining six had mild depressive illness or social and/or adjustment disorders.

The peak incidence of all problems occurred in three specific year groups: years 3 to 5, year 8 and years 11 and 12. The four different assessments of each student—that is, behavioural, psychiatric, learning and social—all had a similar year distribution. This correlates well with the three important development stages of the child and with administrative changes in the school—for instance, the change from primary to secondary school level. Also, 35 out of 49 students entered the program because they exhibited behaviour considered abnormal for their age and background. Psychiatric problems were often found secondary to behaviour and/or learning problems. Children who had proven significant learning difficulties were the second most common form of presentation. Some of the students were undiagnosed as late as year 10. Dyslexia had a high incidence but, as the figures are low, they are not statistically significant. It was difficult to know what was cause and effect in relation to behavioural and psychiatric problems.

In fact, it was found that 50 per cent of psychiatric problems had associated learning disabilities. The resources of the educational psychologists were crucial to the success of the project because learning disability had both a cause and effect to other problems. Social problems were strongly correlated with behaviour and psychiatric problems. Therefore, a child's assessment is not complete without an assessment of social behaviour. The Tumby Bay mental health project has shown that a team approach using teachers and GPs can provide efficient and effective primary mental health services as good as any available in the State. It can make reasonably accurate assessments and rapidly target those people who require more specialist services. Because of early intervention, it avoids the more difficult secondary behaviours and allows the child or adolescent to be managed locally, with resources that are readily available.

Economically, the project is relatively inexpensive with regard to both resources and finances. Most of the costs incurred were one-off for in-service training of the GP manager and to a lesser extent for the educational psychologist. Resources used were those found in most small country towns, that is, GPs and teachers. Usually one of the teachers has counselling skills, although others may be found in the general community.