Mental Health for the Young and their Families

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This edition

MHYFVic Forum

60th Anniversary of the UN Declaration of the Rights of the Child.

How are we doing?

On 20 November, 1989, the Convention of the Rights of the Child was adopted by the UN General Assembly. On 20 November, 2019, we had the opportunity to celebrate thirty years of the Convention and sixty years of the Declaration and the opportunity to measure our success. We did this by hosting a forum on Wednesday 20th November at the Royal Children's Hospital to consider how we are shaping up in relation to the principles of the Convention.

There were presentations on a variety of topics, including legal rights in Australia, bio-ethics, infants, indigenous children, and out-of-home care. Responses were given by Liana Buchanan, the Commissioner for Children, and the Honourable Justice Nicholson, former Chief Justice of the Family Court of Australia.

It was a really fascinating forum, greatly appreciated by everyone present. We are hoping to obtain transcripts of the presentations for posting on our website although this is a challenging task and may take a while. We will report further in future newsletters.

Summary of Draft Report on Mental Health by the Productivity Commission

Australia's mental health: a generational shift is needed

- In any year, approximately one in five Australians experiences mental ill-health. While most people manage their health themselves, many who do seek treatment are not receiving the level of care necessary. As a result, too many people suffer additional preventable physical and mental distress, relationship breakdown, stigma, and loss of life satisfaction and opportunities.
- The treatment of mental illness has been tacked on to a health system that has been largely designed around the characteristics of physical illness. But in contrast to many physical health conditions
  - mental illness tends to first emerge in younger people (75% of those who develop mental illness, first experience mental ill-health before the age of 25 years) raising the importance of

identifying risk factors and treating illness early where possible.

  - there is less awareness of what constitutes mental ill-health, the types of help available or who can assist. This creates need for not only clear gateways into mental healthcare, but effective ways to find out about and navigate the range of services available to people.
  - the importance of non-health services and organisations in both preventing mental illness from developing and in facilitating a person's recovery are magnified, with key roles evident for — and a need for coordination between — psychosocial supports, housing services, the justice system, workplaces and social security.
  - adjustments made to facilitate people's active participation in the community, education and workplaces have, for the most part, lagged adjustments made for physical illnesses, with a need for more definitive guidance on what adjustments are necessary and what interventions are effective.

- The cost to the Australian economy of mental ill-health and suicide is, conservatively, in the order of $43 to $51 billion per year. Additional to this is an approximately $130 billion cost associated with diminished health and reduced life expectancy for those living with mental ill-health.

A path for maintainable long term reform

- Changes recommended are substantial but they would set Australia on a path for maintainable long term reform of its mental health system. Priority reforms are identified and a staged reform agenda is proposed.

Reform area 1: prevention and early intervention for mental illness and suicide attempts

- Consistent screening of social and emotional development should be included in existing early childhood physical development checks to enable early intervention.
- Much is already expected of schools in supporting children's social and emotional wellbeing, and they should be adequately equipped for this task through: inclusion of training on child social and emotional development in professional requirements for all teachers; proactive outreach services for students disengaged with school because of mental illness; and provision in all schools of an additional senior teacher dedicated to the mental health and wellbeing of students and maintaining links to mental health support services in the local community.
- There is no single measure that would prevent suicides but reducing known risks (for example, through follow-up of people after a suicide attempt) and becoming more systematic in prevention activity are ways forward.

Reform area 2: close critical gaps in healthcare services

- The availability and delivery of healthcare should be reformed to allow timely access by people with mental ill-health to the right treatment for their condition. Governments should work together to ensure ongoing funded provision of:
  - services for people experiencing a mental health crisis that operate for extended hours and which, subject to the individual's needs and circumstances, provide an alternative to hospital emergency departments
  - acute inpatient beds and specialised community mental health bed-based

care sufficient to meet assessed regional needs

  - access to moderate intensity care, face-to-face and through videoconference, for a duration commensurate with effective treatment for the mental illness
  - expanded low intensity clinician-supported on-line treatment and self-help resources, ensuring this is consistently available when people need it, regardless of the time of day, their locality, or the locality choices of providers.

Reform area 3: investment in services beyond health

- Investment is needed across Australia in long-term housing solutions for those people with severe mental illness who lack stable housing. Stable housing for this group would not only improve their mental health and inclusion within the community, but reduce their future need for higher cost mental health inpatient services.

Reform area 4: assistance for people with mental illness to get into work and enable early treatment of work-related mental illness

- Individual placement and support programs that reconnect people with mental illness into workplaces should be progressively rolled out, subject to periodic evaluation and ongoing monitoring, to improve workforce participation and reduce future reliance on income support.
- Mental health should be explicitly included in workplace health and safety, with codes of practice for employers developed and implemented.
- No-liability clinical treatment should be provided for mental health related workers compensation claims until the injured worker returns to work or up to six months.

Reform area 5: fundamental reform to care coordination, governance and funding arrangements

- Care pathways for people using the mental health system need to be clear and seamless with: single care plans for people receiving care from multiple providers; care coordination services for people with the most complex needs; and online navigation platforms for mental health referral pathways that extend beyond the health sector.
- Reforms to the governance arrangements that underpin Australia's mental health system are essential to inject genuine accountability, clarify responsibilities and ensure consumers and carers participate fully in the design of policies and programs that affect their lives.
  - Australian Government and State/Territory Government funding for mental health should be identified and pooled to both improve care continuity and create incentives for more efficient and effective use of taxpayer money. The preferred option is a fundamental rebuild of mental health funding arrangements with new States and Territory Regional Commissioning Authorities given responsibility for the pooled resources.
  - The National Mental Health Commission (NMHC) should be afforded statutory authority status to support it in evaluating significant mental health and suicide prevention programs. The NMHC should be tasked with annual monitoring and reporting on whole-of-government implementation of a new National Mental Health Strategy.

These changes should be underpinned by a new intergovernmental National Mental Health and Suicide Prevention Agreement.

A New Care Model for Youth Mental Health.

Professor Ian Hickie wrote the following editorial in the Medical Journal of Australia Vol 211, No 9, November 2019, as a summary of the series of papers he and his associates from the University of Sydney Brain and Mind Institute wrote in the Supplement accompanying that issue.

"Australia can rightly claim to lead the world in mental health awareness, especially for the mental health and wellbeing of young people. However, despite the development of designated primary care-style services (eg, headspace), we still do not deliver effective care, early in the course of illness, to most young people with anxiety depression, or alcohol or other substance misuse. Even when we do deliver care, the longer-term functional outcomes are often disappointing. The consequences of this failure remain large — personally, socially and economically.

While the Morrison Government is committed to expanding youth services and reducing youth suicide, practical questions remain to be answered. Specifically, do we have: a viable clinical model; the necessary multidisciplinary workforce and team-based funding structures; health system capability and integration of key acute and ongoing service settings; regional planning, governance and service commissioning capability; and health information technology infrastructure to enable personal and system-level data tracking and integration?

All of these elements are necessary for the delivery of the highly personalised and measurement-based care model we propose in the Supplement that accompanies this issue of the MJA. Although this novel, technology-enabled care model for youth mental health has many evidence-based components and has been co-designed with young people and their families, as seen in the Project Synergy trials, it remains to be demonstrated whether, compared with either existing child and adolescent or adult service models, it results in improved clinical and social outcomes. If this youth model of care is more effective, the challenge will be to deliver it at sufficient scale to have real population-level impacts in regions where specialist clinics are not available, so that it connects with populations who are at high risk or traditionally under-represented in care.

Substantive clinical innovations over the past decade have led to the concept of highly personalised and measurement-based care (Supporting Information). The highly personalised component is achieved through the integration of three core concepts: assessing multidimensional domains of morbidity and function; clinical staging; and mapping pathophysiological pathways across development, from childhood, through adolescence and into early adulthood, as well as illness trajectories. The measurement-based care components is achieved by linking individual care to the use of more sophisticated real-time health information technologies that can enhance immediate and continuous clinical decision-making (see Chapter 5 of the accompanying Supplement).

The first of these innovations is the development of a more sophisticated, multidimensional approach to clinical and functional assessment. This approach provides a more accurate basis for comprehensive treatment planning. It incorporates the domains of social and occupational function; self-harm, suicidal thoughts and behaviours; alcohol or other substance misuse; physical health; and progression of illness trajectories, and requires the development of

multidisciplinary teams that can deliver the range of interventions needed (see Chapter 4 of the accompanying Supplement).

The second innovation is the adoption of clinical staging. While this concept is well accepted in clinical medicine, evidence is now emerging for its utility in major mood and psychotic syndromes. Clinical staging has a strong emphasis on differentiating immediate treatments from secondary prevention strategies. While much of the substantive early work focused on emerging psychotic disorders, more recently it has focused on common anxiety and mood disorders, and in particular the centrality of gateway conditions in early adolescence, such as major depression or social anxiety.

The third innovation is to propose specific pathophysiological pathways that can underpin primary treatment selection and secondary prevention strategies. This approach also recognises that various pathophysiological mechanisms, which are not mutually exclusive, may be associated with different behavioural expressions at different stages along the developmental pathway. For example, excessive brain arousal and reactivity in response to environmental stimuli manifests as separation anxiety in childhood, mixed anxiety and depression in early adolescence, and depression and alcohol or other substance misuse in early adulthood. The other two common mechanisms (neurodevelopmental and circadian disruption) can be similarly tracked to differing age-dependent expressions at points along the developmental pathway from childhood risk to longer term adult disorder}. Other novel mechanisms, particularly engaging autoimmune, neuroimmune, hormonal (particularly with sex-specific implications) or metabolic paths, are progressing to novel clinical interventions and have broader relevance in mental health practice.

This process of assessment departs from the traditional child and adolescent or adult models where specific diagnoses, within their social or family context, often lead to a sequence of recommended interventions. Adoption of this new approach has major implications for revision of traditional teaching, future workforce training and investments in new models of care, and would require a radical revision of the generic national policy framework of stepped care for common mental disorders or the standard provision of undifferentiated and time-limited psychological services.

This new model emphasises not simply early access to assessment but also rapid and ongoing provision of stage appropriate and effective, often multidisciplinary team-based, interventions. lt argues for the need to move beyond stepped care, where care typically proceeds from less intensive to more intensive, only after failure to respond to the initial offering, to staged care with the aim of delivering the right level of care, the first time. Consequently, workforce training needs to increase substantially the availability of health professionals who have more specialised skills to assess and intervene early and effectively. This is a major challenge currently in child and adolescent, youth and adult mental health services.

Implementation of this youth model of care also depends heavily on enhanced regional governance. For health services, this would specifically mean that providers commissioned by the Commonwealth-funded Primary Health Networks would need to work locally, and in complementary partnerships, with state-based acute care and other public systems.

Additionally, coordination with other family support, education and employment service providers is critical. These regionally based collaborative systems need to utilise predictive modelling techniques to assist with better service development, and be co-designed with young people and their families. If Primary Health Networks were resourced appropriately and able to access relevant modelling capabilities, health information technologies, information and clinical decision-making systems, and link these with genuine partnerships between young people and their families, it would then be possible to respond much more effectively to the agenda outlined by the Morrison Government."

HISTORY CORNER, 1917 (William)

When in New York in 2013, just prior to my Texan niece's wedding, we visited the Museum of Natural History. In the gift shop I spied a very attractive necktie with a hippopotamus motif. This was the famous piece from the tomb of the Nomarch of Senbi, which was donated to the museum by the Harkness family in 1917. This beautiful blue object about the size of a teddy bear, was covered with drawings of river creatures and plants. It was soon a favourite of the children who visited the museum and acquired the name of "William". This is still my favourite tie and certainly my favourite souvenir, as it brings together many themes in my professional life.

I am a child psychologist and family therapist (but work with children of all ages). I have been President of MHYF Vic for ten years. My PhD was into the processes and practices of referral and intake to child and adolescent mental health services (CAMHS) and one tangent this took me on was the beginnings of the child guidance movement. It was there that I encountered the Harkness family philanthropy through their Commonwealth Fund, which began in 1918. And I learnt about "William" and the funding of the Demonstration Projects in Child Guidance.

My colleagues are somewhat astonished about my interest in the history of our discipline. I am often curious as to why others do not take the history seriously, as it was formed by the pioneering work of William Healy and Augusta Fox Bronner, first at the Illinois Institute for Psychopathic Research and then at the Judge Baker Child Guidance clinic, in Boston. The team structure and the team-based approach remain at the core of contemporary CAMHS work.

The Commonwealth Fund

The Harkness family were one of eight owners of the oilfields of west Pennsylvania that were principally mined by the Rockefellers (Richardson, 1989). By the early 1900s they were extremely wealthy and the wife of one of the sons, Anna, advocated, that like the

Rockefellers, the Harkness family become philanthropists. The buying of *objets d'art* was one of the continuing legacies of the Harkness philanthropy, but for me it is their contribution to my profession, but really to the needs of children, that is the most precious legacy and deserves to be celebrated with the coming centenary of the funding of the Demonstration Projects in Child Guidance.

Seven projects were funded (Richardson, 1989), most of these were established at existing facilities, but involved the methodologies developed by Leahy and Bronner at the Judge Baker. Only one of these projects failed (Norfolk, Virginia) and all others are still in existence in some form. Nor were these the only child mental health initiatives of the early twentieth century. But the funding marks the beginning of a broad professional discipline that has been extended world-wide. The funding included a second wave of clinics in 1928 and clinics in London (Angel Islington) and Canada (Toronto). In 1935, Kanner published the first edition of his *Child Psychiatry* which announced the designation of a new professional discipline; this was the same year that the International Committee for Child Psychiatry was formed.

Following the Great Depression, funding of the clinics was returned to local government agencies and communities. Horn (1989) described three phases in the pre-Second World War of child guidance. The Commonwealth Fund supported the Demonstration Projects of 1922 to 1927. Movement building occurred between 1927 and 1933, with the establishment of the Institute of Child Guidance and the operation of some sixty clinics throughout the United States and the Islington Clinic in London in 1928 (Keir, 1952). Thereafter, the fund withdrew, and clinics became state or local authority funded. Professionals then ran the clinics autonomously.

Once the Demonstration Projects had demonstrated the value of the new set of interventions, the Commonwealth Fund turned its attention to new initiatives, but has always had an interest in health and medical innovation. For many years now, applications are drawn world-wide for Fellowships in medical innovations.

Celebrating the Commonwealth Fund's contribution to our discipline

MHYF Vic hope to be able to engage the surviving clinics in a trans-Pacific dialogue and presentation of history and current practice beginning in 2022. Information about each of the clinics will be supplied over the coming period.

References

Horn, M. (1989). *Before it's too late: the child guidance movement in the United States, 1922-1945.* Philadelphia, PA: Temple University Press.

Richardson, T. (1989). *The century of the child: the mental hygiene movement and social policy in the United States and Canada*. New York: SUNY Press.

Jo Grimwade

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