The Elephant leaves the room: An increased (and belated) focus upon policy and service reform in child mental health

The eleventh Winston S. Rickards Memorial Oration

Professor Frank Oberklaid AM, Melbourne, April 19'", 2021

Professor Winston Rickards 1920 — 2007

Child psychiatry at the time of Winston Rickards

- Focused on treatment of problems
- Psychodynamic as well as pragmatic
- Biological psychiatry in its infancy
- Minimal role of medications
- 'Environmental determinism'
    - — Autism ('refrigerator mother')
    - — Behavioural problems (parenting issues)
- Recognition of complexity — multidisciplinary department at RCH

Evolution of child psychiatry — a paediatrician's perspective

- Emergence of biological psychiatry
- Centrality of DSM and focus on diagnosis
- 'New' diagnoses and syndromes — ADHD, ASD
- Medications to address clinical symptoms
- Broader child and family lens
    - · Appreciation of environmental factors, including poverty
- Acknowledgement of multiple risk factors and pathways to increasingly complex presentations ('wicked problems')

Evolution of paediatrics

*· ‘Health is affected by environmental and social processes as well as by sociological factors. The community in which a child lives is a major determinant of his health. Although such statements are widely accepted intellectually today, they are not yet reflected in our health care institutions'.

(Haggerty 1975)

* A group of childhood difficulties that we have termed "the new morbidity’ is now gaining attention. Many of these difficulties lie beyond the boundaries of traditional medical care... a major shift in the orientation of training programs is required (Haggerty 1975)

*· Increased focus on prevention/early intervention, community, family centred practice, early child development and life course, adverse childhood events, disadvantage and vulnerability

The emergence of community child health

'A comprehensive system of health care, responsible for promoting the health and development of all children within the context of their family and community.’

Faculty of Community Child Health, Australian College of Paediatrics

(The clinical component of community child health is developmental/behavioural paediatrics — children with problems of development and behaviour).

Multi-sectoral and multidisciplinary:

- Public policy and health care delivery for children must extend beyond health
- Different governments agencies — health, welfare, education, housing, law, transport
- Different settings - hospitals, doctors, community nurses, kindergartens, schools, child care centres, pharmacies, etc

Paediatricians and mental health

• Oberklaid (1988) — national survey of paediatricians — increasing numbers of children with developmental/behavioural problems

• Hewson et al (1999)- audit of regional paediatric practice -1/3 children referred because of behavioural problems

• NMHW survey (2000) - children with mental health problems (especially younger children) see paediatrician more often than psychiatrist or psychologist

• Efron et al (2006)- specialty DB clinics and CAM HS at paediatric teaching hospital - comparable burden of emotional-behavioural problems

• Hiscock et al (2013) — almost 50% of new patients referred to paediatricians in community diagnosed with mental health problems

Introduction of mandatory training in community child health in 1992

• The Australian College of Paediatrics introduces a mandatory training period (minimum 6 months) training in community paediatrics

• Interpreted fairly loosely - can be in child psychiatry, child development, rehabilitation, community child health, DB paediatrics, etc

• Initial challenges - shortages of training positions (especially in community settings) and supervisors, but resolved over time.

First national survey provides important data on extent of problems

2000 · Sawyer MG et al. Mental Health of Young People in Australia (Child and Adolescent Component of the National Survey of Mental Health and Well-being - part of the National Mental Health Strategy

1. How many children and adolescents in Australia have mental health problems?

2. What is the nature of these problems?

3. What is the degree of disability associated with these problems?

4. What are the services used by children and adolescents with mental health problems?

Prevalence of problems

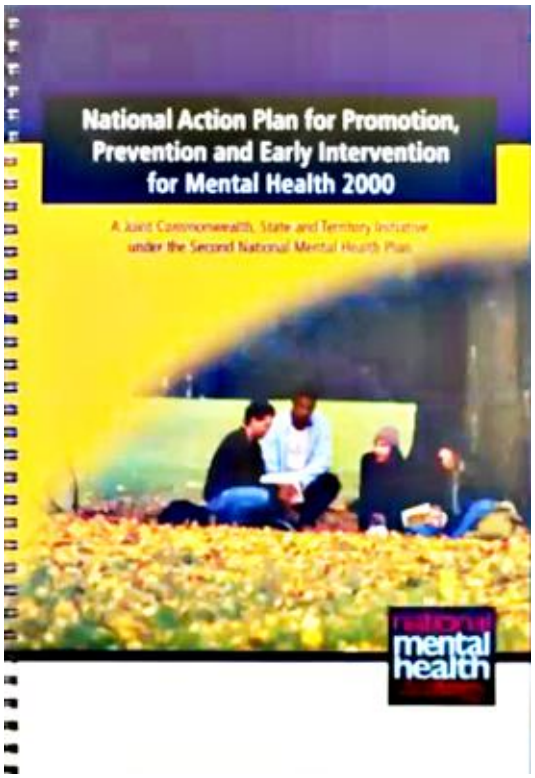
	Total problems (Percentage)	Total problems (Pop.estimate)
All children	**14.1%**	**521,886**
Males 4-12	15.0%	181,749
Males 13-17	13.4%	90,678
Females 4-12	14.4%	166,817
Females 13-17	12.8%	82,221

Use of professional services

- Only one in four receives help, usually from family doctors, school-based counsellors, and paediatricians.
- Children aged 4-12 years most frequently attended paediatricians and family doctors; adolescents most frequently attended school-based counselling services
- Only 50% of young people with the most severe mental health problems receive professional help

‘The relatively large number of young people with mental health problems stands in contrast to the limited number of trained clinicians available to help them. This disparity makes it unlikely that specialised programs based in secondary and tertiary treatment settings (*eg*. child and adolescent mental health services and departments of psychiatry in hospitals) will ever be able to provide direct care for all those with problems in Australia. As a result, there is a need to develop alternative approaches to reduce the prevalence of child and adolescent mental health problems .... experiment with alternative models of service delivery that combine direct care, consultation to primary health care or school-based services, and both universal and targeted prevention programs’.

— Sawyer et 0L 2000



'While much of the impetus may come from within the mental health sector, it needs to be recognised that other sectors also have a major and explicit interest in improving the emotional and social wellbeing of communities and individuals ...Partnerships need to extend across all sectors of the community including consumers; local communities and community groups; MCH nurses; education; welfare; GPs; lawyers ...’

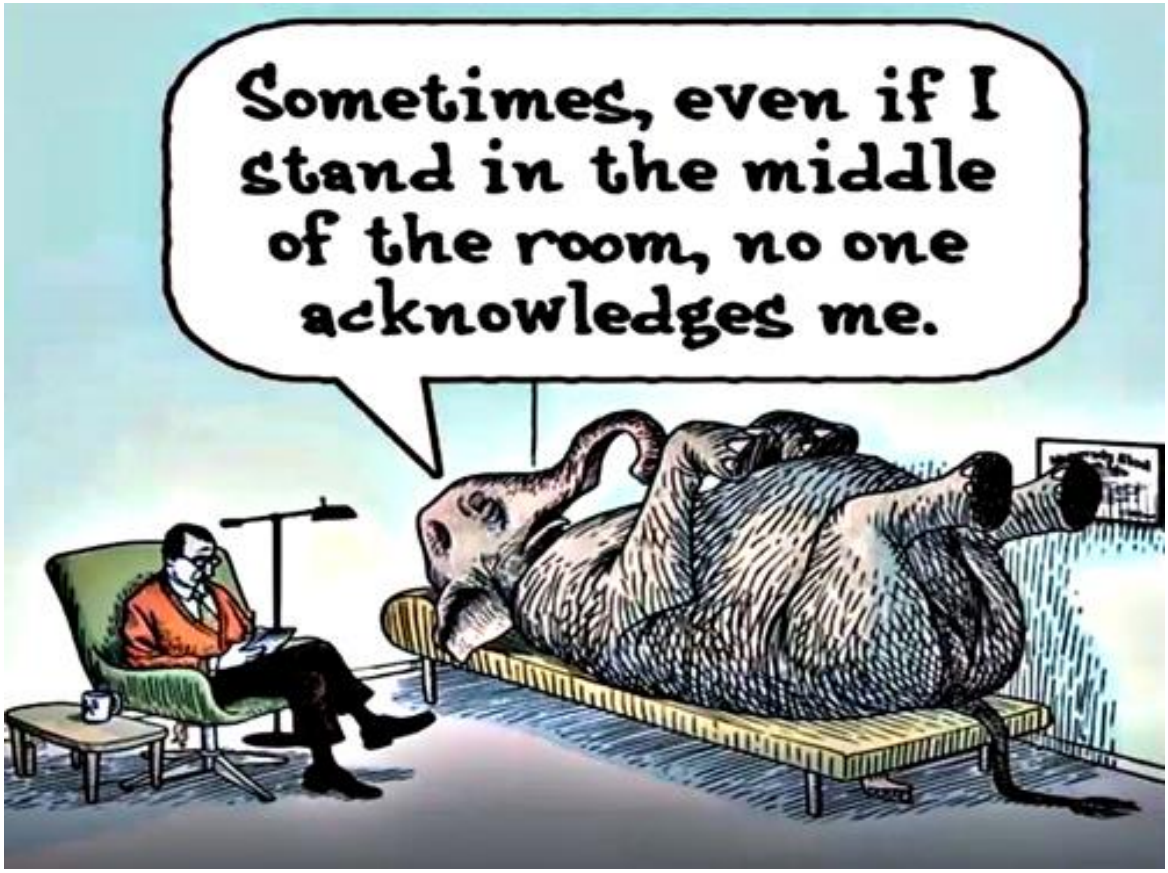
No mention of paediatricians!

Table 4: Key strategic sectors, settings and people for mental health partnerships Thirteen sectors: home; child care; education; health; welfare; housing; community; arts, sport and recreation; employment; financial; corrections; media; government.

(Still no mention of paediatricians!)

Table 5: Outcome indicators

1. Reduction of mental health problems...
2. increased mental health, wellbeing, quality of life and resilience
3. increased mental health literacy
4. Improved family functioning and parenting skills
5. Enhanced social support and community connectedness
6. Increased investment in evidence-based programs relevant to promoting mental health...



Why has advocacy for child mental health been so challenging?

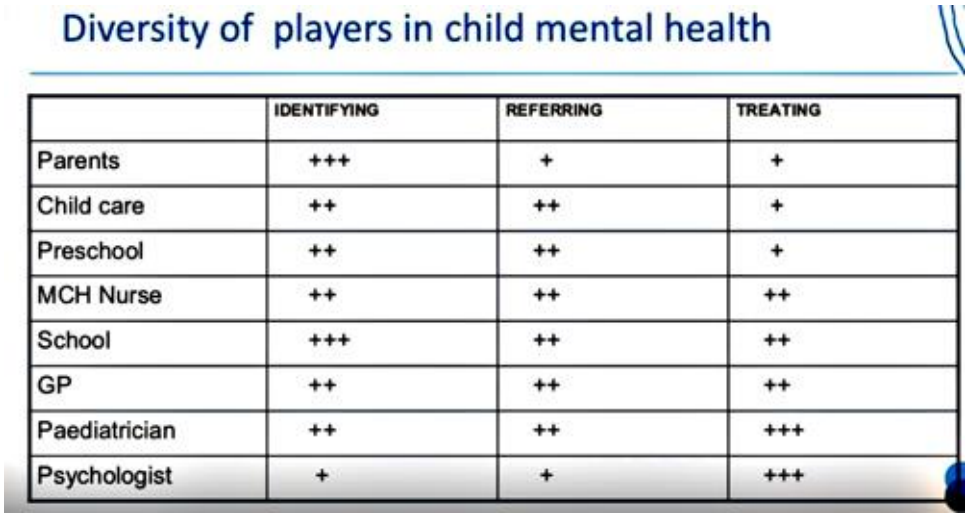
"Children's mental health problems reflect unique interactions between intra-individual difficulties and environmental conditions. Treatment must therefore address conditions in the family, school, and neighbourhood, as well as within the child. This requires a system with a diverse set of interventions and the capacity to coordinate multiple services'.

-Saxe L, American Psychoiogist1988

Children's mental health is a different country

- Children are dependent on others to seek support and treatment
- Developmental stages mean children's emotional and developmental needs and clinical symptoms vary with age.

- Foundations for lifelong health and wellbeing are established in the early years
- The universal systems — MCH nurses, child care, preschool, school- provide an infrastructure for promotion, prevention, early identification of emerging issues and early intervention
- But all this creates complexity



Diversity of players in child mental health

	IDENTIFYING	REFERRING	TREATING
Parents	+++	+	+
Child care	++	++	+
Preschool	++	++	+
MCH Nurse	++	++	++
School	+++	++	++
GP	++	++	++
Paediatrician	++	++	+++
Psychologist	+	+	+++

It is this complexity of child mental health issues that has contributed to the relative lack of policy attention when compared to adult and adolescent mental health.

"For every complex problem there is an answer that is clear, simple, and wrong".

— H L Mencken

- Governments do not like complexity
- Integrating policy across departments is challenging
- Fragmentation of policy and services -vertical and horizontal
- Plus prevention is a very hard sell!

Related research has further strengthened the case for children to be a major focus of public policy:

- Brain development and the importance of the early years in shaping lifelong health and wellbeing
- The importance of environment and central role of parents and caregivers
- The impact of stress and consequences of poverty and disadvantage
- Adverse childhood events and their negative effect on children' functioning

The neuroscience of brain development

- Brain architecture and skills are built in a hierarchical °bottom-up' sequence
- Foundations important — higher level circuits are built on lower level circuits
- Brain is changed by experiences - the early years of life can have significant impact life course and on long term outcomes
- Research clear about characteristics of environment that impact outcomes - parenting, family functioning, communities

- Plasticity of the brain decreases over time and brain circuits stabilise, so it is much harder to alter later
- It is biologically and economically far more efficient to get things right the first time — the scientific case for prevention and early intervention

Relationships influence brain development

- In high income countries the single most important determinant in the child's environment is the quality of the child's relationships with parents and caregivers
- Nurturing and responsive relationships build healthy brain architecture that provides a strong foundation for behaviour, learning, and health
- When protective relationships are not provided, levels of stress hormones increase - this impairs cell growth, interferes with formation of healthy neural circuits, and disrupts brain architecture
- Dysfunctional relationships major risk factor for mental health problems

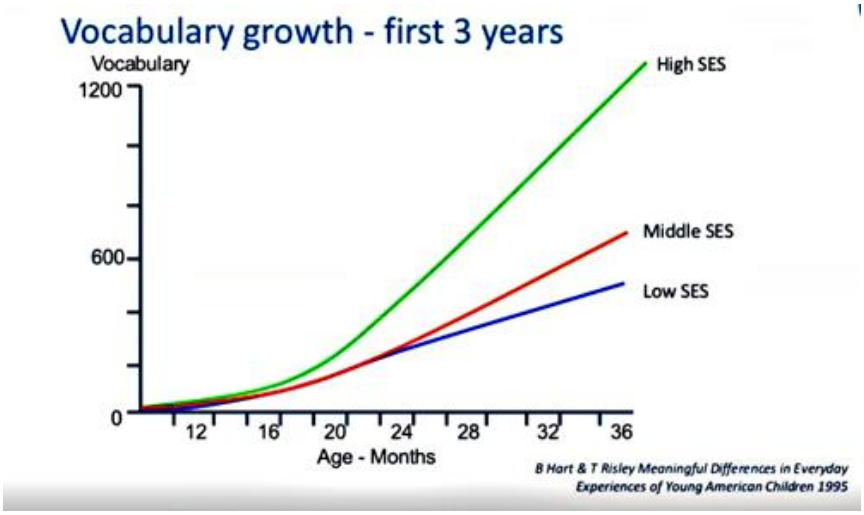
Adversity

- child abuse — physical, emotional, sexual · child neglect- physical or emotional
- poverty
- harsh or over-involved parenting · domestic violence
- serious physical illness
- parent mental illness
- parent substance misuse
- bullying etc. -Jorm and Mulder 2018

All more common in low SES groups.

<u>The impact of adversity and social inequality</u>

- Psychosocial factors impact on health because of association with high levels of stress
- Major impact in early years — affects developing brain and establishment of neural circuits, including executive functioning and self-regulation
- Chronic stress affects the body's physiological systems – including the cardiovascular and immune systems - increasing vulnerability to wide range of diseases and health conditions
- 'Double jeopardy' - have the least access to supports such as consistent health care, quality childcare and preschool, good schools, and family supports



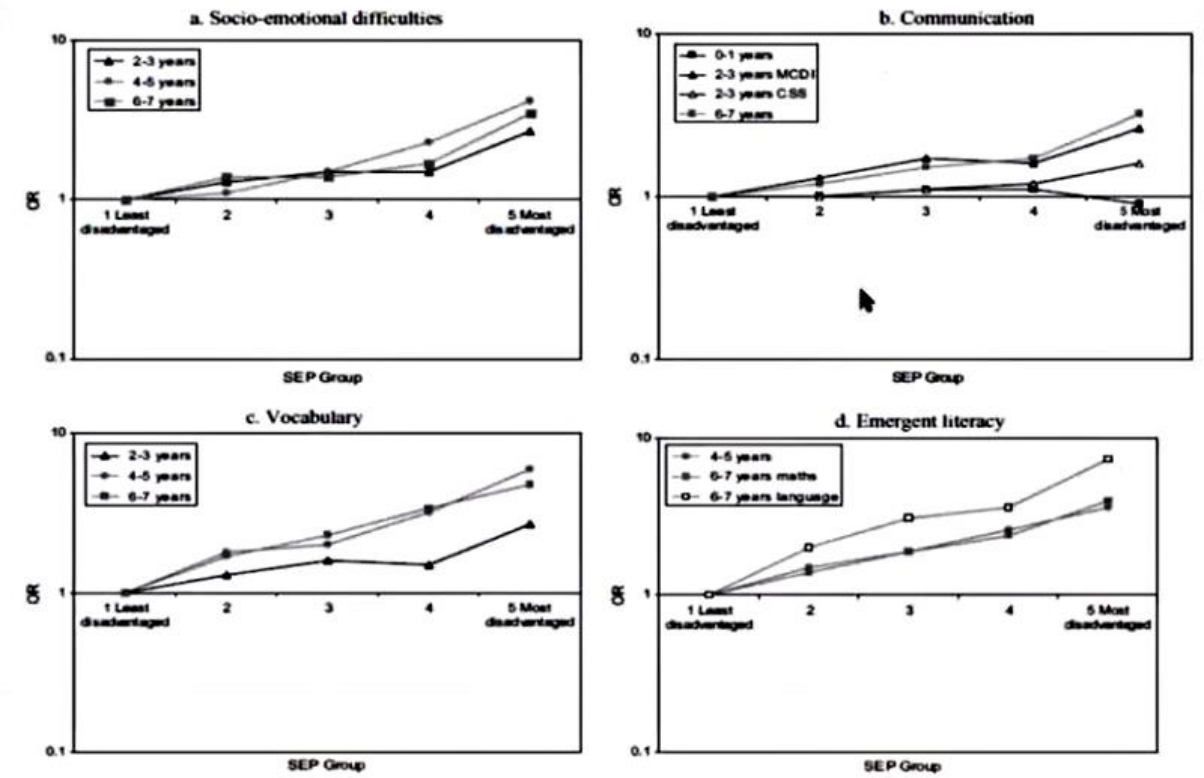


Figure 1 ORs (presented on a log scale) by socioeconomic position quintile for socio-emotional difficulties, and poor communication, vocabulary and emergent literacy skills. • *Nicholson et al, 2009*

Australian Early Development Census (AEDC)

A population-based measure which provides information about children's health and wellbeing:

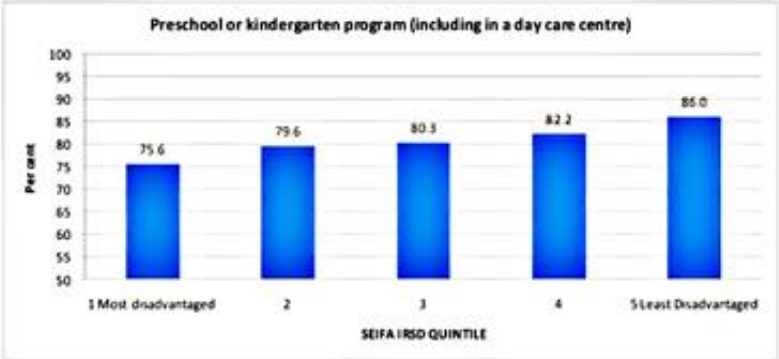
- 100+ questions covering five development domains — social competence; emotional maturity; language and cognitive development; physical health and wellbeing.
- Teachers complete the AEDC online for each child in their first year of full-time schooling
- Results are provided at the postcode, suburb or school level and not interpreted for individual analysis

Key findings - 2018

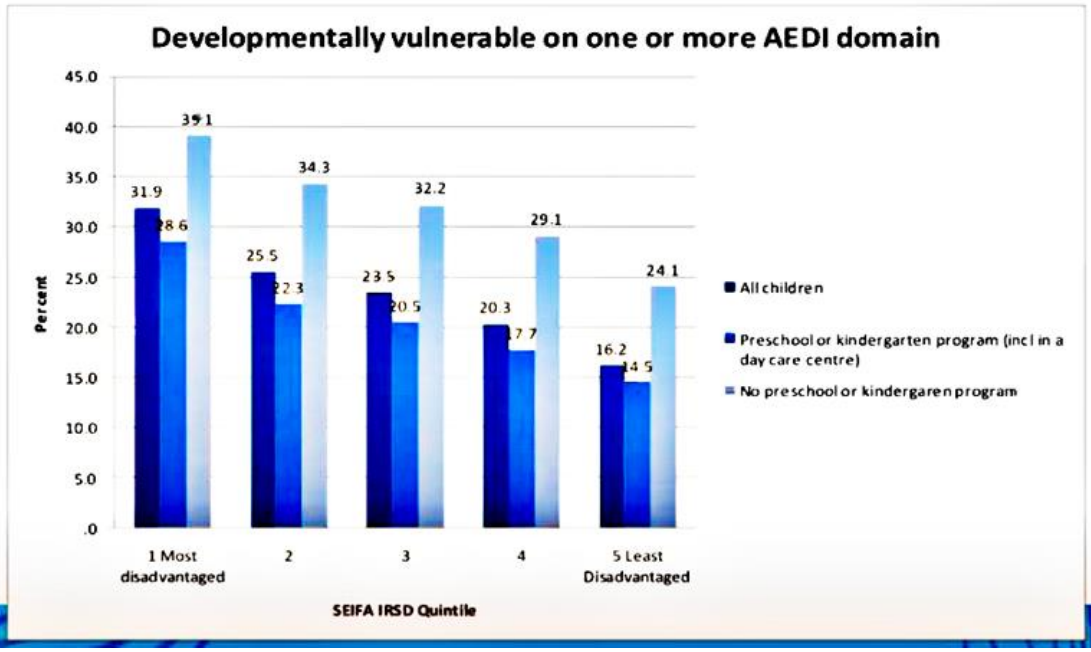
Percentage of children developmentally vulnerable (DV) across Australia by jurisdiction

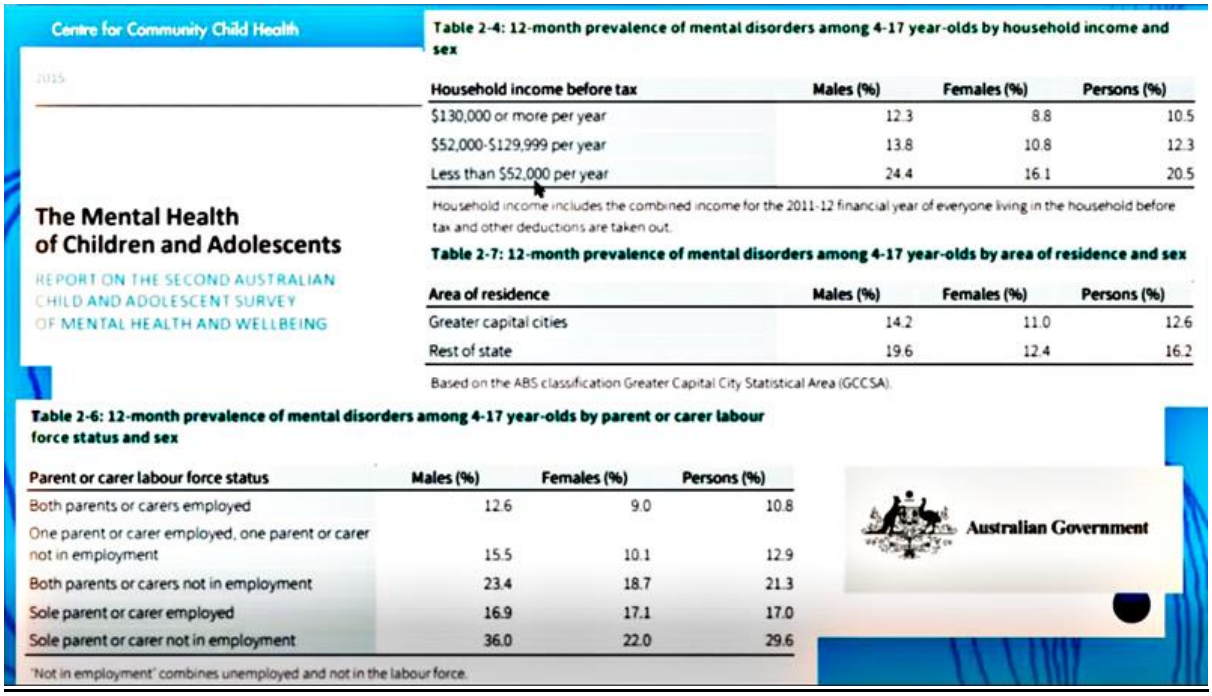
	DV ≥ 1 domains (%)	DV ≥ 2 domains (%)
Australia	**23.3**	**11.7**
New South Wales	21.2	10.2
Victoria	20.1	9.9
Queensland	29.2	15.6
Western Australia	24.3	12.0
South Australia	22.5	11.4
Tasmania	21.7	10.8
Northern Territory	36.3	22.1
Australian Capital Territory	21.9	10.8

Disadvantage and preschool participation



AEDC results and preschool participation





Centre for Community Child Health

2015

The Mental Health of Children and Adolescents

REPORT ON THE SECOND AUSTRALIAN CHILD AND ADOLESCENT SURVEY OF MENTAL HEALTH AND WELLBEING

Table 2-4: 12-month prevalence of mental disorders among 4-17 year-olds by household income and sex

Household income before tax	Males (%)	Females (%)	Persons (%)
$130,000 or more per year	12.3	8.8	10.5
$52,000-$129,999 per year	13.8	10.8	12.3
Less than $52,000 per year	24.4	16.1	20.5

Household income includes the combined income for the 2011-12 financial year of everyone living in the household before tax and other deductions are taken out.

Table 2-7: 12-month prevalence of mental disorders among 4-17 year-olds by area of residence and sex

Area of residence	Males (%)	Females (%)	Persons (%)
Greater capital cities	14.2	11.0	12.6
Rest of state	19.6	12.4	16.2

Based on the ABS classification Greater Capital City Statistical Area (GCCSA).

Table 2-6: 12-month prevalence of mental disorders among 4-17 year-olds by parent or carer labour force status and sex

Parent or carer labour force status	Males (%)	Females (%)	Persons (%)
Both parents or carers employed	12.6	9.0	10.8
One parent or carer employed, one parent or carer not in employment	15.5	10.1	12.9
Both parents or carers not in employment	23.4	18.7	21.3
Sole parent or carer employed	16.9	17.1	17.0
Sole parent or carer not in employment	36.0	22.0	29.6

'Not in employment' combines unemployed and not in the labour force.

Australian Government

The Adverse Childhood Events (ACE) study

1995 - San Diego Kaiser — retrospective study of 17,000 adult patients

• Looked at the relationship between morbidity in adults and adverse events in childhood:

— Parental separation/divorce
— Parental mental health
— Parental alcohol or drug abuse
- Physical/sexual abuse/neglect
— Parent incarcerated

Child hood adversity and mental health

- Systematic review and meta-analysis of ACEs
- Individuals with at least four ACEs were at increased risk of all health outcomes compared with individuals with no ACEs.
    - — moderate for smoking, heavy alcohol use, poor self-rated health, cancer, heart disease, and respiratory disease (Odds Ratios of two to three)
    - — strong for sexual risk taking, mental ill health, and problematic alcohol use (0dds Ratios of more than three to six)
    - — strongest for problematic drug use and interpersonal and self-directed violence (0dds Ratios greater than seven).

Hughes K, et al. The Lancet Public Health. 2017.

‘Social climate change' and its impact

- Rapid social change - conditions under which families are raising children have changed (more complex)
- Divorce, single parents, blended families, shared custody arrangements I
- Working longer hours, part time/shift work, more casual work, Job insecurity
- Increase in poverty! health inequalities, and increased social gradient
- Poorly resourced families can be overwhelmed with challenges of daily life and parenting

· After Moore, CCCH

Modernity’s paradox

‘We are witness to dramatic expansion of market-based economies whose capacity for wealth generation is awesome...At the same time, there is a growing perception of substantial threats to the health and wellbeing of today’s children and youth in the very societies that benefit most from this abundance’. Keating & Hertzman (1999)

Developmental Health and the Wealth of Nations

‘It is not as if we have lost the knowledge of what has constituted a good childhood, but it seems more difficult to realise it in the context of rapid change. And we have limited ways of protecting, understanding, monitoring and controlling the impact of progress on children. Shared cultural, political and moral commitments to children are becoming confused, contested and weakened in the face of the unstoppable changes, disruptions and uncertainty.’

Green DM, 2013 (Discussion paper for the Berry Street Childhood institute)

- Only 35% of Australian parents are confident that they could identify the signs of social or emotional problems in their children
- Only 44% are confident they would know where to go for help if their child experienced social, emotional or behavioural issues
- 1/3 parents thought mental health issues were best left alone to work themselves out over time
- 1/3 parents were unaware that primary school aged children can experience depression
- 1/4 parents were unaware that mental health issues may present with physical symptoms (e.g. headaches and tummy aches)
- 1 in 3 parents did not recognise that persistent sadness or frequent tearfulness is not 'normal' in children

- 2015 results

Long wait times and high costs

- Secret shopper study (2019) - Called the practices of 81 paediatricians, 48 psychiatrists and 198 psychologists
- 8 year old boy with ?ADHD; 11 year old girl with ?anxiety
- Asked about: time to the first available appointment, total costs and out-of-pocket expenses after Medicare rebate for initial appointment

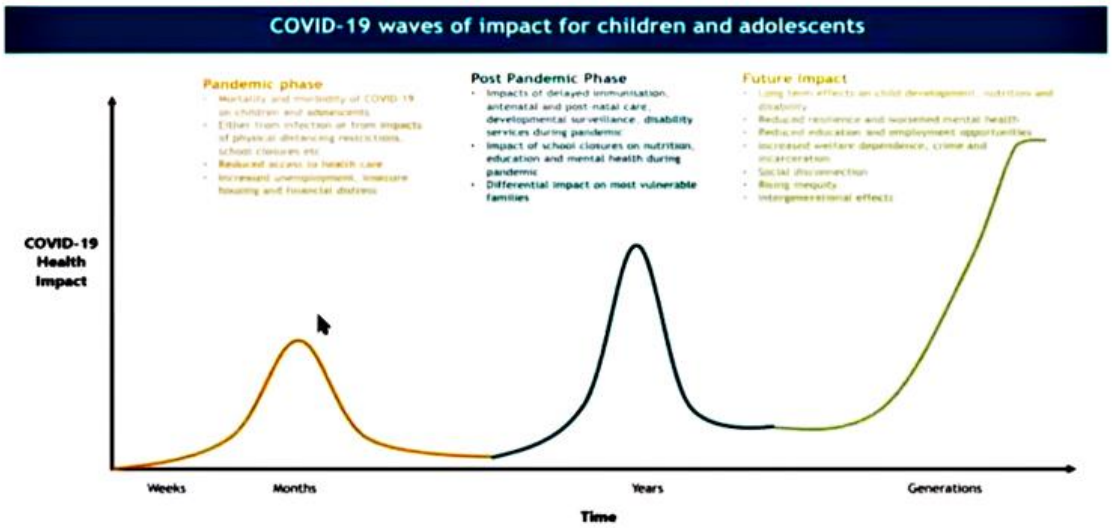
32% psychologists, 48% of psychiatrists, and 15% of paediatricians were unable to offer an appointment

	Mean wait time (days)	Out-of-pocket costs ($)
Paediatrician	58	122
Psychologist	40	82
Child & adolescent psychiatrist	51	184

<u>The Service System under severe pressure</u>

- Demand greater than services available - long waiting lists
- Focus on treatment of established problems
- Access and equity issues — especially in the secondary service system
- Fragmented - in Victoria 147 different *types* of services and programs
- Hard to navigate for professionals and families
- High thresholds for acceptance to CAMHS
- Some services dependent on child having diagnosis
- Services delivered in narrow disciplinary silos — mismatch with needs of many children and their families
- Geographic variability of service availability

COVID-19 waves of impact for children and adolescents.



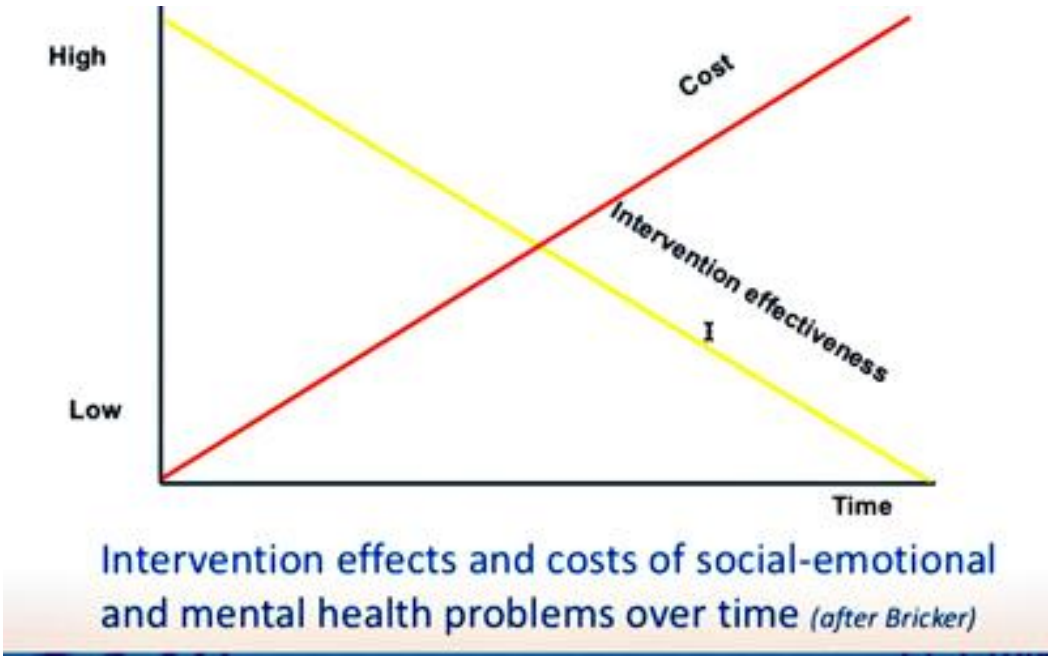
- Rosina Kyerematenge et al. 2020

Potential indirect impacts of the COVID-19 pandemic on children

Reducing risk factors for mental health problems

- Need major shift in public policy, focusing not just on treatment but also on promotion, prevention and early intervention (fence on top of cliff rather than more ambulances at the bottom)
- Treating established problems is difficult, expensive, and not sustainable at a population level
- Need to focus on family and community factors which have major impact on the development of young children - adversity, disadvantage, social equity

· The earlier we intervene the better - more leverage in younger years



Intervention effects and costs of social-emotional and mental health problems over time *(after Bricker)*

‘Organized abandonment"

Drucker calls for organized abandonment of products, services, markets or processes 'which were designed in the past and which were highly successful even to the present, but which would not be designed in the same way if we were starting afresh today, knowing the terrain ahead.'

- Peter Drucker “Leadership Challenges for the 21st Century”, Oxford, Butterworth/Heineman, 1990

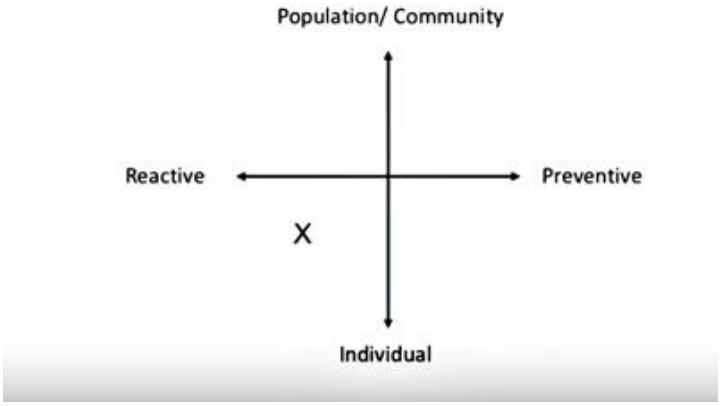
Old approach

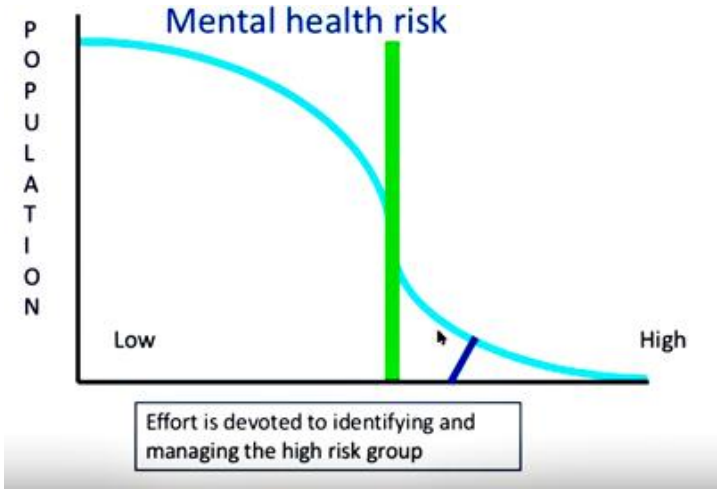
- The needs of the individual child are addressed in isolation
- Resources allocated only when problems become severe enough to warrant attention
- Policies are focused on fixing individual deficits
- Policy criteria - dollar amounts allocated
- Services delivered in narrow departmental silos

New approach

- Focus on populations - improve outcomes for all children
- Build on universal platforms
- Engage parents and all stakeholders
- Prevention and early intervention focus
- Whole of government approach - move away from departmental silos towards broadbanding of services
- Flexibility of services with accountability and responsibility at local level
- Community focus on improved coordination of services
- Innovative funding and accountability arrangements

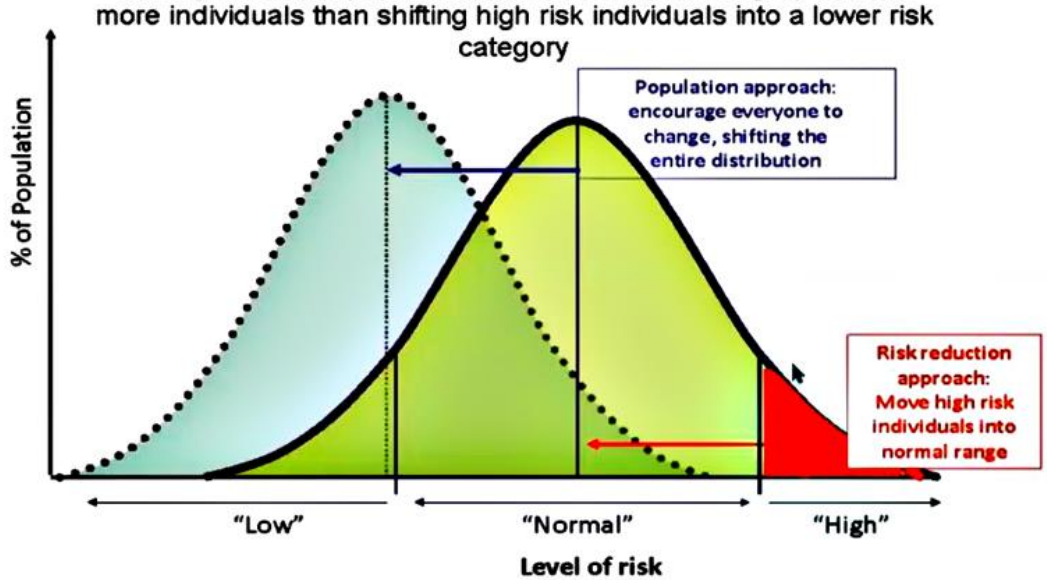
Where are our investments today?



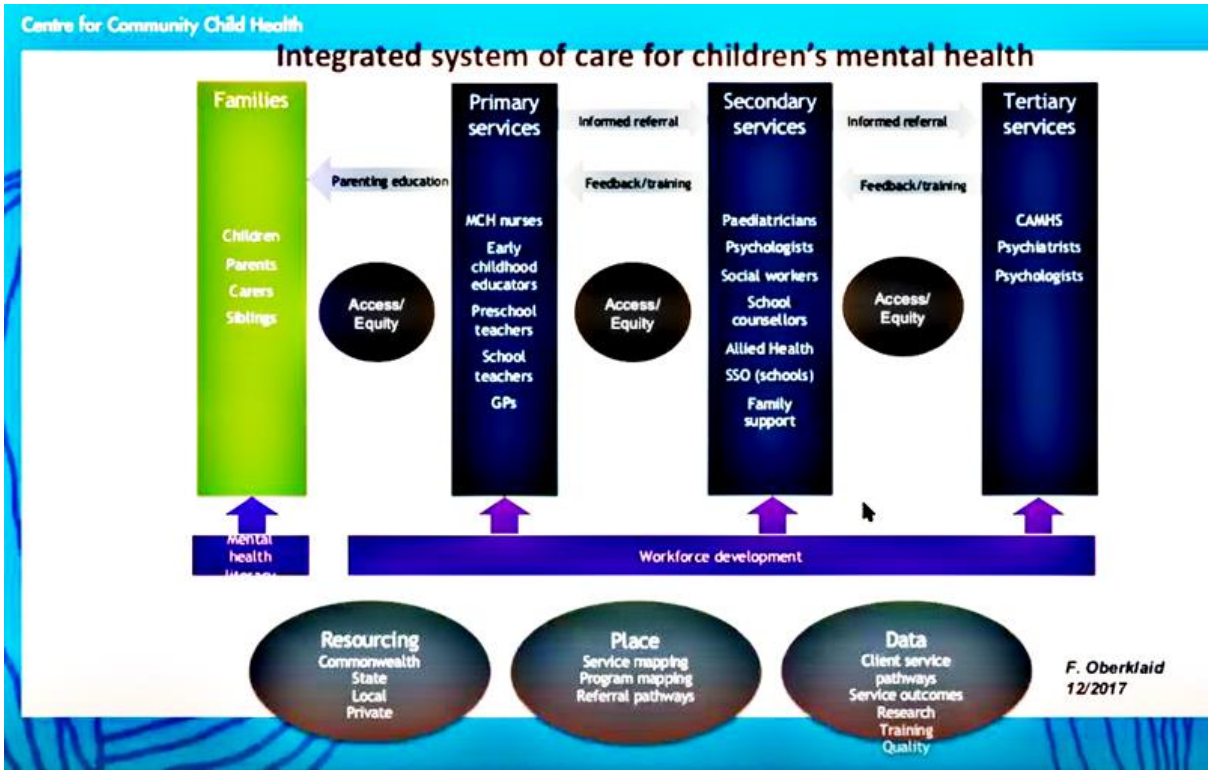


The Bell-Curve Shift in Populations

Shifting the whole population into a lower risk category benefits more individuals than shifting high risk individuals into a lower risk category



Source: Rose G. Sick Individuals and sick populations. *Int J Epidemiol.* 1985; 12:32-38.



New approaches ——— examples of work from CCCH

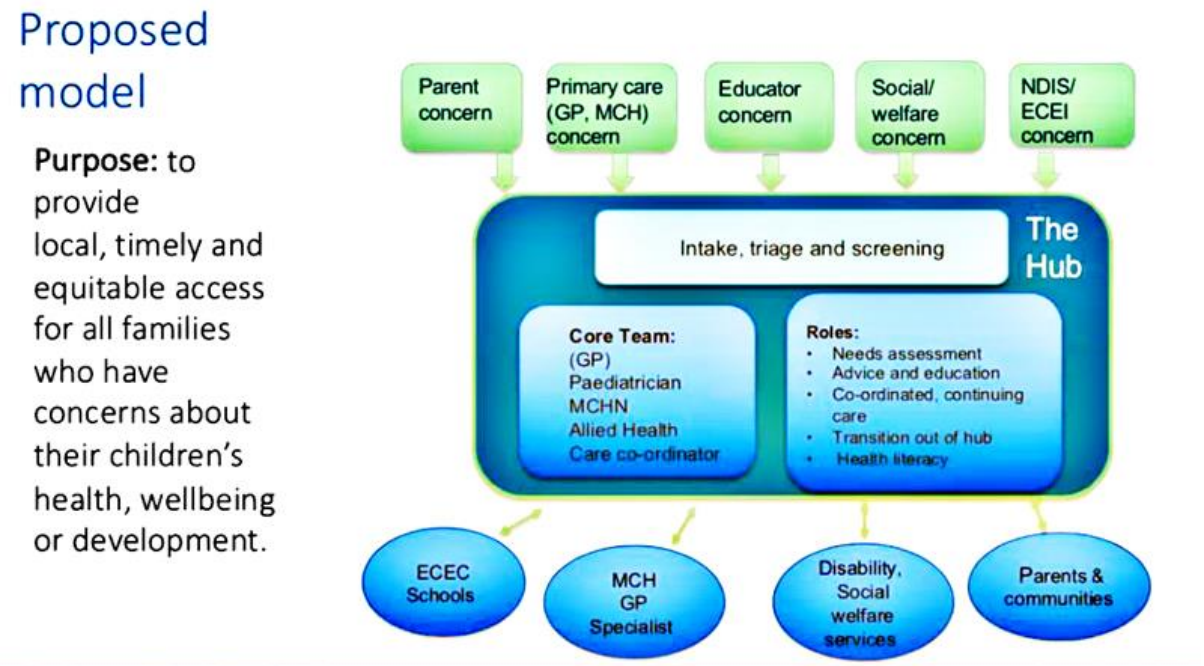
- Changing the language of child mental health
- Child and family centres
- Mental health in primary schools (MHiPS)
- Community of practice
- COMPASS — secondary psychiatric consultation for GPs and paediatricians

Changing the language

Child and family centres (hubs)- a new model of care

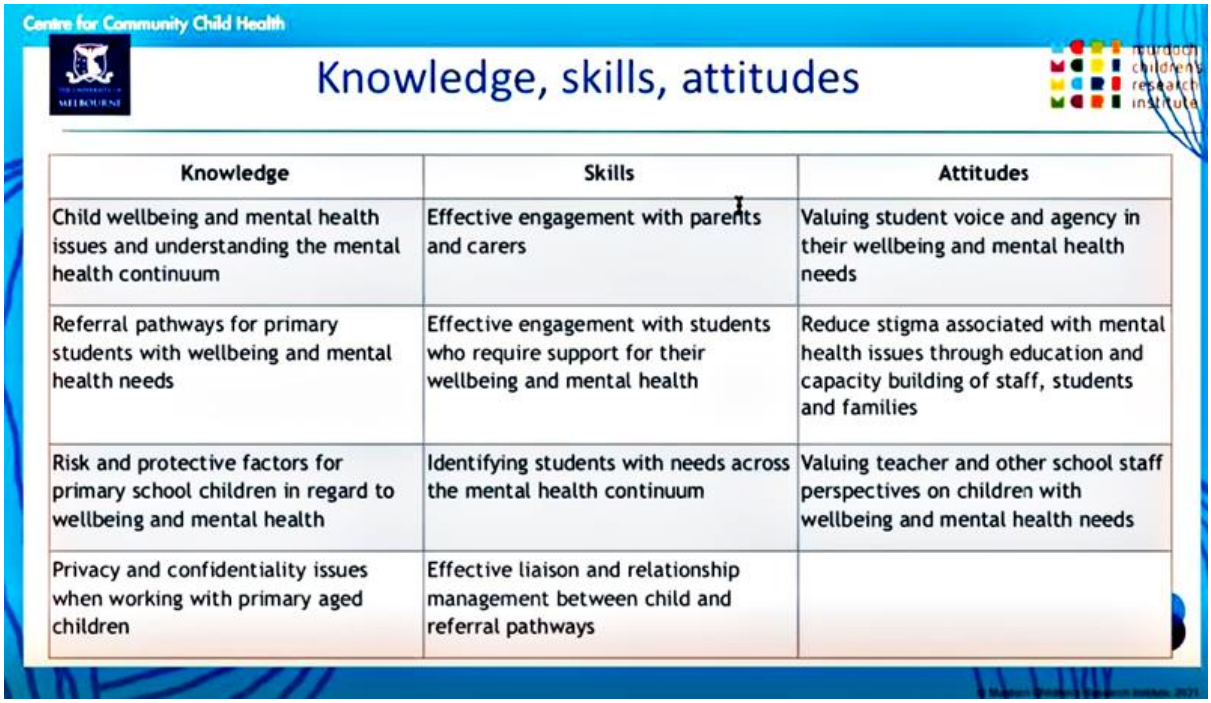
- A multidisciplinary core team
- Clear coordinated pathways from primary to secondary to tertiary integrated with existing community service system — built on local services
- Focus on equity and timely access
- Parent education and support

- Build capacity and capability in workforce
- Strong links with child and family support services — child protection, housing, drug and alcohol, family violence, etc



<u>Mental Health in Primary Schools (MHiPS)</u>

- Schools are ideal non-stigmatizing platform - 99% of Australian children attend formal schooling
    - ~ 1000 hours per year in class
    - ~ 9 hours per year with a health professional
- Potential Intervention vehicle
    - Low intensity, universal
    - Screening and targeted intervention
- Goals of MHEPS:
    - Build capacity within schools to better detect and address mental health issues in the classroom through a trained Mental Health and Wellbeing Coordinator
    - Delineate a clear referral pathway for children requiring further assessment and intervention, both within the school and to external community agencies
    - Use these referral pathways to build bridges between the education and health sectors



Knowledge	Skills	Attitudes
Child wellbeing and mental health issues and understanding the mental health continuum	Effective engagement with parents and carers	Valuing student voice and agency in their wellbeing and mental health needs
Referral pathways for primary students with wellbeing and mental health needs	Effective engagement with students who require support for their wellbeing and mental health	Reduce stigma associated with mental health issues through education and capacity building of staff, students and families
Risk and protective factors for primary school children in regard to wellbeing and mental health	Identifying students with needs across the mental health continuum	Valuing teacher and other school staff perspectives on children with wellbeing and mental health needs
Privacy and confidentiality issues when working with primary aged children	Effective liaison and relationship management between child and referral pathways	

<u>Community of Practice (CoP) overview</u>

- GPs, paediatricians, psychologists (72 clinicians)
- Format: one-hour, didactic presentation by child psychiatrist followed by case discussion; resources/recording/slide decks collated and sent to participants at the end of each month
- Monthly sessions - topics:

- » Aggression/Challenging Behaviours
- » Anxiety
- » Depression
- » Eating Disorders
- » ASD / Complex cases

COMPASS — COnnecting Mental-health PAediatric Specialists and community Services

- 22 consults to psychiatrist across a two-week period
- GPs (N=5)
    - 5 secondary consultations
    - 5 phone calls I
    - Reason: all medication advice
- Paediatricians (N=17)
    - 13 primary consultations / 4 secondary consultations
    - Phone (4), email (3), clinic appointments (10)
    - Reason: Medication advice and diagnostic review
- Outcome: all sent back to referrer — avoiding CAM HS intake

Increased policy attention to child mental health

- Productivity Commission inquiry on the social and economic benefits of investing in mental health
- Royal Commission into Victorian Mental Health System
- The National Children's Mental Health and Wellbeing Strategy

Plus awareness of child mental health issues amplified by the COVID-19 pandemic

Productivity Commission (2020)

Focus on prevention and early help: early in life and early in illness

- The mental health of children and families should be a priority, starting from help for new parents and continuing through a child's life
- Schools should have a clearly defined role in supporting the social and emotional wellbeing of students, with effective pathways to care
- Provide seamless care, regardless of the level of government providing the funding or service

Gaps and barriers that need to be addressed

- A narrow view of people seeking support
- Underinvestment in prevention and early intervention
- Disproportionate focus on clinical services - overlooking other determinants of mental health
- Difficulties finding and accessing suitable support

- Supports that are below best practice — in part due to a lack of measurement and evaluation of what works
- Stigma and discrimination
- Dysfunctional approaches to the funding of services and supports
- A lack of clarity across the tiers of government about roles, responsibilities and funding — leading to (duplication)...and limited accountability

Priority reforms

- Prevention and early help for people
- Support the mental health of new parents
- Make the social and emotional development of school children a national priority
- National stigma reduction strategy
- Develop implementation plans for national strategies that integrate healthcare and other services
- Strengthen evaluation culture

Victorian Royal Commission

Data analysed by the Commission indicates that there is a substantial gap between demand and actual hours of community-based specialist mental health services delivered. In 2019-20, there was need for an estimated 539,000 hours of specialist mental health services for infants and children aged 0-11. Only 45,000 hours (less than 10 per cent of the estimated hours needed) was delivered by public mental health services in 2019-20.

Process for development of the Strategy

- Under auspices of Mental Health Commission — accountable to Board
- Co-Chairs — Frank Oberklaid and Christel Middeldorp
- Multidisciplinary Expert Advisory Group
- Two Working Groups (O-5; 5-12), and Aboriginal and Torres Strait Islander Reference Group
- National Steering Committee — including state governments
- Extensive stakeholder consultation with professionals — colleges, organisations, peak bodies.
- Consultation with vulnerable and at-risk groups — carers and those with lived experience

Eight principles to guide the strategy

1. Child centred
2. Strength based
3. Prevention focused
4. Equity and access
5. Universal system
6. Evidence informed
7. Early intervention
8. Needs based (not diagnosis driven)

Four focus areas

1. Family and community
2. The service system
3. Education settings
4. Evidence and evaluation

For each focus area

- Key objectives
- Actions
- Indicators of change

'...this Strategy proposes a number of actions that collectively represent a fundamental cultural shift in the way we think about mental health and wellbeing for children'

- a change in language - a wellbeing continuum that supports early intervention
- a change in status - to give child mental health parity with physical health
- a change to ensure access and equity in all systems with priority access given to children 0- 12 years of age
- a change towards needs-based access to services
- a change in the collective understanding of the roles of families, communities, services and educators.

'Nothing hard is ever easy"

- Don Berwick, 1998

Challenges in implementation of Strategy - some risks

- Success will be measured by the amount of new funding
- Focus on short term rather than a ten-year evolving plan
- Fragmentation — of funding, of policy, of implementation
- Federal/state differences on priorities
- Reform fatigue — challenge of ongoing system change
- Solutions too complex — will revert to funding new programs

- Child mental health seen through an adult mental health lens - diagnose and treat- rather than a child development and family perspective
- "Set and forget' - no evaluation
- Crowded out by adult and adolescent mental health

But there now exists a window of opportunity...

Carpe Diem!

‘It is the burden on good leadership to make the currently unthinkable thinkable, to question the obvious, to make the present systems unavailable as options for the future. The boundaries in our minds create fear about the consequences of crossing over to the undiscovered country.

But the possibilities we really need do not lie on this side of our mental fences. Once crossed, these fences will look as foolish in retrospect as the beliefs of other times now often look to us.'

— Don Berwick, 1998