

# Partnerships to Better Outcomes; Supporting the Mental Health of Children and Young people

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THE UNIVERSITY  
OF QUEENSLAND

# The Age

Peter Ellingsen, August 21, 2005

- Victoria
- **Child mental health service in 'crisis'**
- “THE system responsible for Victoria's mentally ill children is in crisis and should be replaced by a new arrangement that would allow more young people to recover, experts say.
- Melbourne University psychology professor, Margot Prior, formerly director of psychology at the Royal Children's Hospital, and Ric Pawsey, a 25-year veteran of mental health, say the Child and Adolescent Mental Health Service (CAMHS) is a mess that fails to treat most of the vulnerable under-18s seeking its help.
- "It's a basket case," Professor Prior said. "Because I'm now out of it, I can be honest."

# A PERSONAL CONTEXT

- London 1968-9
  - Analytic psychotherapy (Irving Kreeger, Gordon Stuart Prince)
  - Hypnosis (Marcuse)
  - Behaviour Therapy (Marks and Gelder)
- Canterbury 1970-74
  - Child Psychotherapy (Ken Munro Fraser)
  - Structural Family Therapy (Minuchin)
  - 25 bed inpatient Unit

# A PERSONAL CONTEXT

- Adelaide 1974-82 (Children's Hospital)
  - Infant Observation
  - Child and Adolescent Psychotherapy
  - Transactional Analysis (Berne)
  - Gestalt therapy
  - Group therapy
  - Strategic Family Therapy (Gerard, Epstein, Haley)
  - Systemic Family Therapy (Palazzoli et al)

# A PERSONAL CONTEXT

- Private Practice 1982-86
  - Expert Family Therapy group 2 years
- Flinders Medical Centre 1986-2001
  - Cognitive Behavioural Therapy
  - Individual Therapy
  - Family Therapy (Screens and Teams)
  - Solution Focussed Therapy (de Shazer and Insoo Kim Berg 1990- )

# A Note about Private Practice

- Solid Clinical Work
- 10-12 hours per day, on the hour every hour
- 600 new cases in 4 years - ie about 3 new cases per week
- Some school visits
- Some supervision and Teaching of registrars
- Art classes one afternoon a week to preserve sanity

# Sustainable Service Development South Australia

- Southern CAMHS (Flinders Medical Centre - 15 years)
  - 2 teams to 6 teams
  - No rural service to 3 rural teams
  - 12 therapists to 40 therapists
  - No teaching to Masters level programs
  - No research to 22 programs including two longitudinal programs
  - CHASP Accreditation 1994
  - Gold Award THEMHS 1994

If you want effectiveness and efficiency in a service, there is no substitute for highly skilled, well supervised, experienced clinicians.

# Clinical Work

- Central to what we do
- Yet we can never be quite certain what goes on in the consulting room
- No measures, no online reporting, no audio can really tell you what goes on
- Current administrative attempts to find out are self serving and overwhelm the clinical process
- The best Risk Management is to have good clinicians

# On Entry to Clinical Service

- Orientation Program
- 16 week therapy training program in house
- Option to train with Malcolm Robinson or Michael White with service sharing the cost and the time cost.

# Clinical Expectations

- 1-2 new cases a week
  - ie 70-75 per annum on average (range 50-100)
  - For 30 therapists in a service you could manage about 2200 new cases
- 10± clinical follow-ups a week
  - ie about 500 follow-up per annum
  - For 30 therapists about 15,000 slots per annum

# Therapist Burnout

- Too little training
- Too little supervision
- Too little variety
- Too many cases
- Too much paperwork
  
- Important to provide enrichment - special project development, teaching, evaluation, research, publication

# Issues

- You must have staff who have energy to reach out
- You must avoid the ‘Exclusive Service’ mentality - “we exclude everyone who does not meet DSM4 criteria”

Every minute you take away  
from a clinician doing best  
quality clinical work wrecks any  
attempt to provide efficiency.

# Clinical Work

- Systematised interviewing (Eisen and Irwin)
- 4 sessions of assessment with an initial interview with the family, then two interviews with the child, then a family feedback session.
- The problem was that the mean number of sessions attended was only 3, with a mode of 1.

# Clinical Work

- We reviewed 200 clients to see what had happened to them.
- 50% had ‘got what they wanted’
- 20% felt the service had little to offer their problem

# Initial Consult System

- Single session
- Asked the patients what they wanted to achieve by the end of the session
- Listed problems and ranked them
- Discussed alternatives for change in the most pressing problems
- Psychoeducational approach
- Checked at the end of the session to see whether they had got what they wanted

Window Shopping is OK!

# Registration as Case

- Genuine issue here
- Do you register at the first session - even if they are never going to come back?
- Or do you wait until they commit to some specific course of therapy

# Sustainable Service Development Queensland

- RCH & District CYMHS
- Since 2001, Service to BYDC
- CYFOS Development
- MHATODS Team
- Reworking of CL Team
- EI Strategy - KOPING strategy
- Recent ACHS Accreditation, exceeding most standards
- Opening of Keperra CHC yesterday
- Publication

# Supervision

- Consultants in their first year
  - Anja (yesterday)
  - Jackie (the interview last week)
- The transfer to consultancy
- Management Skill
- I want them to be able to supervise others
- I want them to stay in the service
- Identification of gaps
- Not paid; no time allocation
- Mentoring

# Supervision

- Professional Hierarchical
- Cross professional for special purposes or on special request
- Peer group (cross team)
- Personal Appraisal (Service based)

# What is special about Child Psychiatry?

- Developmental Approach
- Systemic Context
- Analytic Themes Live
- We Play!

# Play and its Levels

May represent

- Just fun
- Real world
- Fantasy and new ideas
- Family Dynamics (Object Relations)
- Transference

# Michael aged 6

- An eclectic approach
- Intergenerational themes

# Developments in Psychotherapy

- Analytic (since 1967)
  - Virginia Axline ('Play Therapy', 'Dibs in Search of Self')
  - Melanie Klein, Anna Freud
  - Donald Woods Winnicott ('The Piggie', 'Therapeutic Consultations in Childhood')
  - Object Relations
- Behavioural Approaches (since 1967)
- Family Therapy Approaches (since 1974)
- Solution Focused Approaches

# Psychoeducation

✧ from RCT, educational materials play a significant role in improvement in depression

Robinson, Katon, Von Korff et al., 1997

# Cognitive Behaviour Therapy

∞ Dispute about unique effect

Murphy, Carney et al., 1995

∞ May reduce relapse

Fava, Grandi, Zielezny et al., 1996

∞ Therapist competency is vital

Scott, Tacchi, Jones & Scott, 1997

∞ Meta-analysis suggests effect size post-treatment

Reinecke, Ryan & DuBois, 1998

# De Shazer

- Solution focused
- Very task focused
- Demands 'Customer' Status over 'Visitor' or 'Complainant'
- Seeks 'Exceptions'

# Therapeutic Alliance

“Building the Therapeutic Alliance is a creative process, a central issue for all age groups, since in its absence, there can be no therapy”.

*Dorothy M Marcus, 1998*

# Therapeutic Alliance

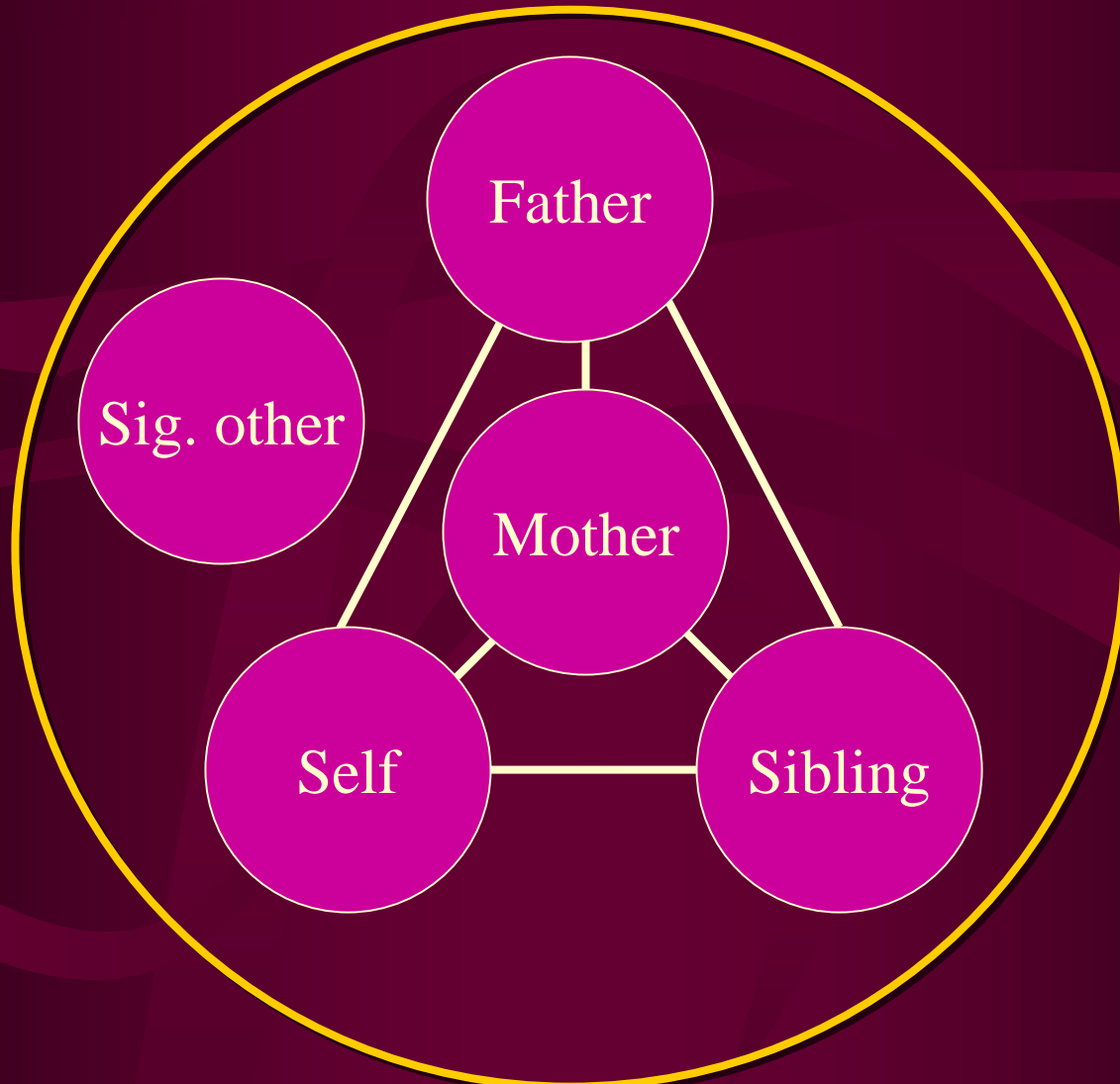
- The Working Alliance (Greenson, 1967)
  - Analytic
- The Treatment Alliance (Sandler et al, 1970)
  - Analytic
- Family Therapy Alliance (Pinsof and Catherall, 1986)
  - Systemic

# Therapeutic Alliance

- Set of Tasks
- Relationship Bond
- Toward a defined Goal

Bordin 1979

# The Family Context



# INFLUENCES ON THE CHILD

- Successful Ego Maturation
- Family Parameters
- Family Developmental Stage
- Gender and Same Sex Peers
- Education and Employment

# PARAMETERS OF FAMILY FUNCTIONING

after Epstein & Bishop (MCMMASTER)

- Roles
- Problem Solving
- Communication
- Affective Involvement
- Affective Responsiveness
- Behaviour Control
- General Functioning

# TRANSITION POINTS IN FAMILY DEVELOPMENT

After Barnhill and Longo, 1978

- Creation of the Couple  
(*Commitment*)
- Entry of the First Child  
(*Development of Parenting Roles*)
- First Child Development  
(*Acceptance of Child/New Marital Roles*)
- First Child enters the Wider World  
(*Accepting other institutions as responsible*)

# TRANSITION POINTS IN FAMILY DEVELOPMENT

- Adolescence  
*(Acceptance of changed physique, Sexuality, Social Roles toward leaving home)*
- First Child leaves the family  
*(Accepting/Permitting/Encouraging Independence)*
- Separation of Parents  
*(Continuation of Parenting without Marital Role)*

# TRANSITION POINTS IN FAMILY DEVELOPMENT

- Remarriage of Parent  
(*Acceptance of Extended Adoptive Family*)
- Last Child leaves the family  
(*Facing each other and the 'Empty Nest'*)
- Retirement  
(*Developing New Career/Grandparent Status*)
- Death of a Spouse  
(*Acceptance of Single Status*)

# Family Therapy Alliance

“that aspect of the relationship between the therapist system and the patient system that pertains to their capacity to mutually invest in, and collaborate on, the therapy”

Pinsof and Catherall, 1986

# Joining as an Issue

If you don't join with all members of the system early then therapy is doomed. The relationship between therapist and family can become so tenuous that early termination results.

# Overinvolvement

The therapist becomes so inducted into the family system they become ineffective as far as change is concerned.

Nichols, 1987

# Level of Alliance

- Level at the start of therapy predicts Outcome

Ryan and Cichetti, 1985

- Positive patient statements correlate with rated benefits

Luborsky et al, 1983

- Therapist's personal qualities correlate highly with Outcome

Luborsky et al, 1985

# Clinical Activity



# Therapist Qualities

## Better Outcomes from

- Engagement
- High Credibility
- Warm, empathic approach
- Accepting stance
- Liking the patient or family
- Specific targeted (or manualised) Programs

Lowen



We all have to  
pull together

# Why would you employ.....

- A psychiatrist

# Why would you employ.....

- A Psychologist?

# Why would you employ.....

- A Social Worker?

# Why would you employ.....

- A Speech Pathologist?

# Why would you employ.....

- A Psychiatric Nurse?

# Why would you employ.....

- An Occupational Therapist

# Prevention in Depression

David

A case of Conduct Disorder

**Case identification**

**Indicated**

# Prevention

## Issues

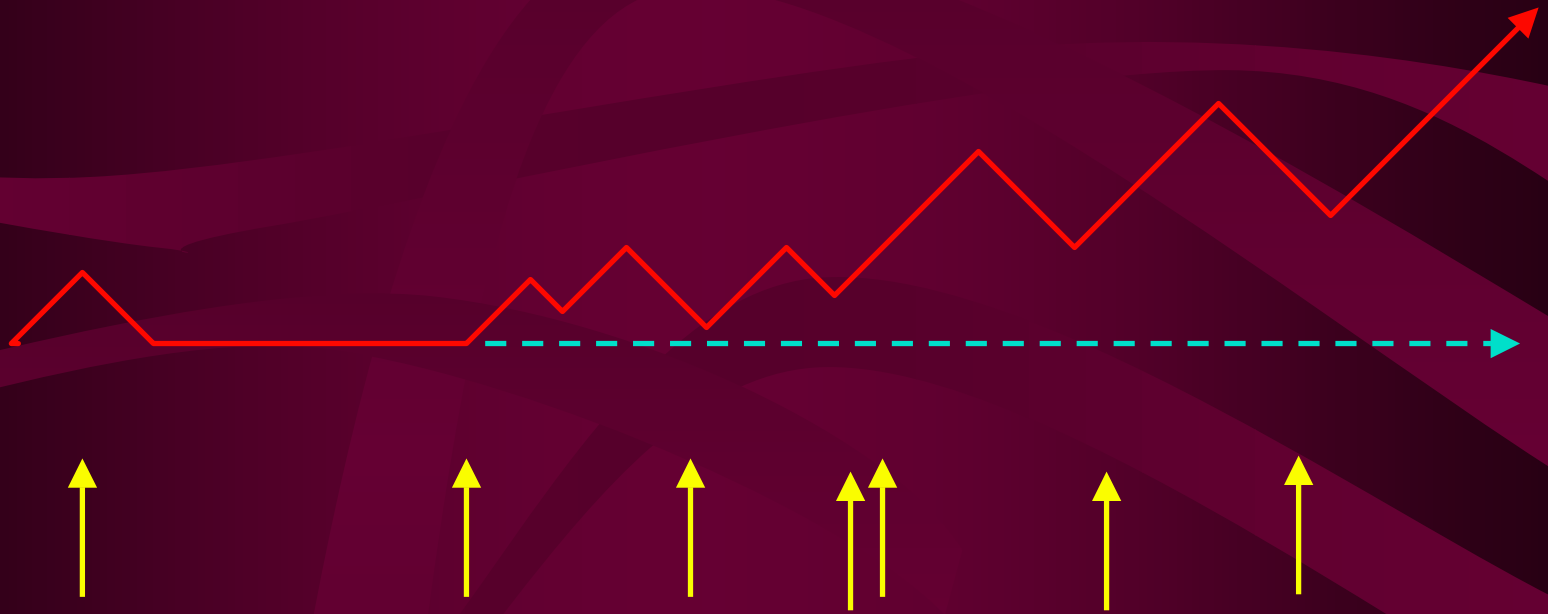
- Recognition of early symptoms;
- Knowledge of the pathway or trajectory;
- Available Interventions;
- Access to meaningful services;
- Multidisciplinary approach.

**Case identification**

**Indicated**

# Prevention

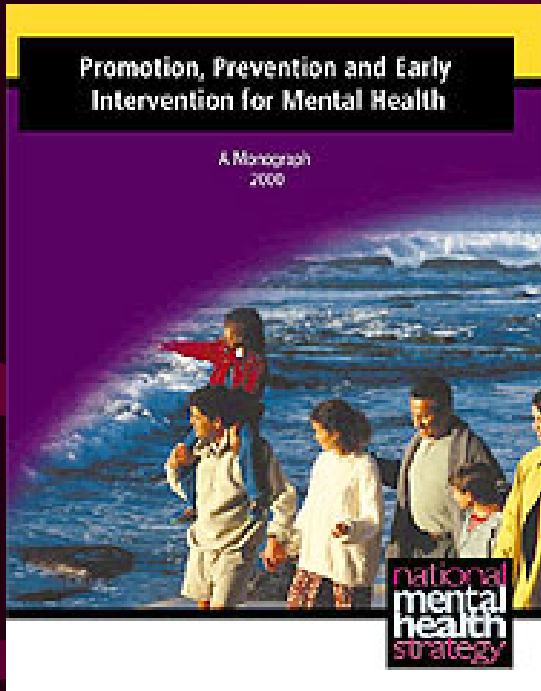
## The Trajectory



**Case identification**

**Indicated**

# The Spectrum of Prevention



**Mental Health Promotion**

**Rehabilitation**

**Maintenance**

**Standard treatment**

**Case identification**

**Indicated**

**Selective**

**Universal**

after Patricia Mrazek and Robert Haggerty, 1994

# Increasing burden of noncommunicable diseases and injuries

## change in rank order of DALYs for the 15 leading causes

(baseline scenario)

### 1999 Disease or Injury

1. Acute lower respiratory infections
2. HIV/AIDS
3. Perinatal conditions
4. Diarrhoeal diseases
5. Unipolar major depression
6. Ischaemic heart disease
7. Cerebrovascular disease
8. Malaria
9. Road traffic injuries
10. Chronic obstructive pulmonary disease
11. Congenital abnormalities
12. Tuberculosis
13. Falls
14. Measles
15. Anaemias

### 2020 Disease or Injury

1. Ischaemic heart disease
2. Unipolar major depression
3. Road traffic injuries
4. Cerebrovascular disease
5. Chronic obstructive pulmonary disease
6. Lower respiratory infections
7. Tuberculosis
8. War
9. Diarrhoeal diseases
10. HIV
11. Perinatal conditions
12. Violence
13. Congenital abnormalities
14. Self-inflicted injuries
15. Trachea, bronchus and lung cancers

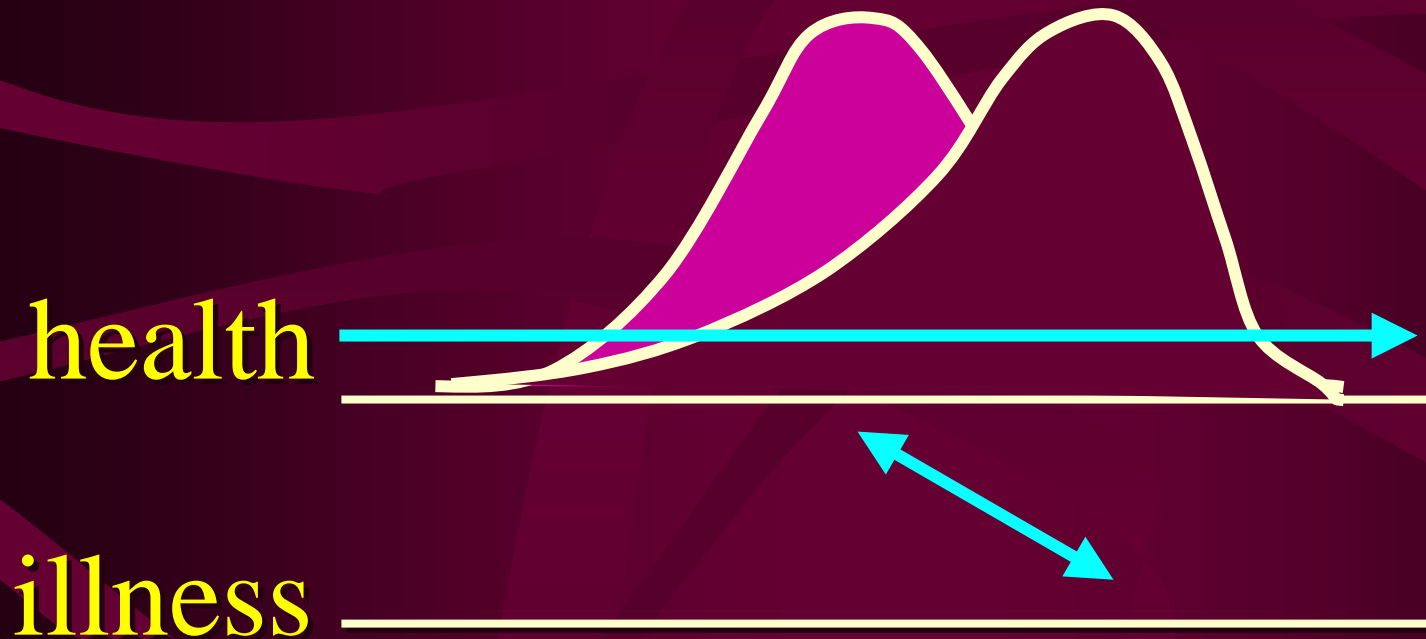
DALY = Disability-adjusted life year

Source: WHO, Evidence, Information and Policy, 2000

# WORLD HEALTH ORGANIZATION



# The Mental Health Continuum



# Resilience

“the ability to bounce back, recover from, or adjust to misfortune or change”

Burns, 1996

# Resilience facing Adversity

Fergusson and Lynskey, 1996

- ∞ intelligence
- ∞ problem solving ability
- ∞ female gender ??
- ∞ external interests/affiliations
- ∞ +ve parental attachment and bonding
- ∞ easy early temperament
- ∞ good peer relationships

# Profile of the Resilient Child

Benard 1991

## ❧ Social Competence

❧ responsiveness, flexibility, empathy, caring, communication skills, sense of humour;

## ❧ Problem Solving Skills

❧ critical thinking, generating alternatives, planning, produces change;

# Profile of the Resilient Child

Benard 1991

## Autonomy

✧ self-esteem, self-efficacy, internal locus of control, independence, adaptive/healthy distancing;

## Sense of Purpose and Future

✧ goal directedness, achievement orientation, high motivation, educational aspiration, persistence, **hopefulness**, coherence;

# The Protective Family

Benard 1991

## Caring and Support

✧ close relationship with one person, affection expressed physically and verbally;

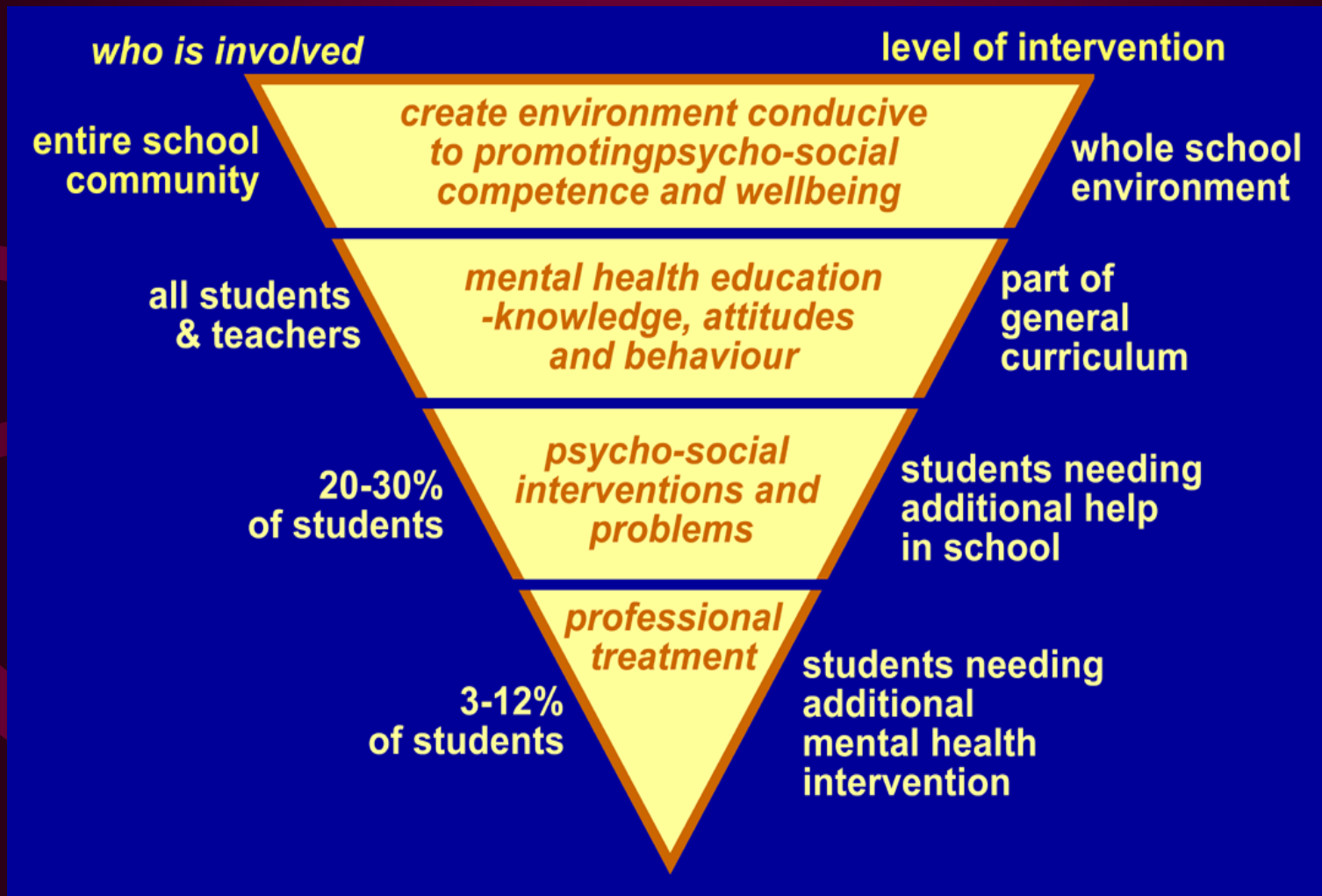
## High Expectations

✧ structure , order, discipline, values, explicit expectation, faith, hope for the future

## Participation

✧ valued participant, domestic responsibility, independence encouraged, autonomy respected

# WHO Framework for Comprehensive Mental Health Promotion in Schools



# Promoting Resilience in Australian Schools

- ✧ “Mind Matters” is a national program which follows a careful pilot program and evaluation
- ✧ High School
- ✧ Whole school approach
- ✧ Curriculum based
- ✧ National evaluation

# EVIDENCE

## SCHOOL AGE CHILDREN

- ✧ Increased resilience and connectedness to the school led to reduction in suicidal thinking

Resnikoff et al, 1997

# Who develops

- Early Intervention?
- Selective Programs?
- Universal Programs?

# Partnerships with the Community

- General Practitioners
- Young People
- Carers
- Non Government Groups
- Indigenous Communities

**RCT of Manualised Group  
Therapy for Self Harm  
in 12-18 year olds  
Collaborative with Newcastle and  
Logan CYMHS**

**‘Future Families’**

**Dr. Elisabeth Hoehn and colleagues**

# Bayside Ei Program - Partnership

- ‡ *Bayside District Health Service – Bayside Child and Youth Mental Health Service & Family Health & Rehabilitation Service*
- ‡ *Education Queensland- Bayside District*
- ‡ *Redlands College*
- ‡ *University of Queensland*
- ‡ *Bayside GP Division*
- ‡ *Department of Communities - Wynnum & Redlands*
- ‡ *Redland Community Centre Inc.*
- ‡ *Anglicare In-Sync*
- ‡ *Lifeline, Redlands*
- ‡ *Bayside Adolescent Boarding Inc., Wynnum*
- ‡ *Save the Children Fund*
- ‡ *Boystown Redlands*

# Bayside Ei Program

Six essential principles:

- ❧ Early Intervention at year 8 level
- ❧ Main target is DEPRESSION
- ❧ Skilled workforce to manage clinical problems
- ❧ Community Partnership
- ❧ Clear pathways for referral, BUT
- ❧ Protection of scarce therapy resources

# Bayside Ei Program

Tiered program

- ☞ Phase 1 - Universal
- ☞ Phase 2 - Selective Program
- ☞ Phase 3 - Indicated Program

**Indicated**

**Selective**

**Universal**

# Bayside Ei Program

## Universal Program

- ✧ 20 weeks (2 terms) of in school, class teacher managed, AUSSIE OPTIMISM
- ✧ (Dr. Clare Roberts, Curtin University provided direct training to all personnel)
- ✧ Program based on an Australianisation of the work of Seligman (Optimistic Child), and his team - Jaycox, Gillham et al.

# Bayside Ei Program - Instruments

- ✧ CES-D (a 20 item scale for depression now used frequently internationally with adolescents)
- ✧ Strengths and Difficulties Questionnaire (SDQ) (resolves into subscales for internalising, externalising, impact, peer influence)
- ✧ Both used prior to Aussie Optimism, and then again 20 weeks later

# Bayside Ei Program - Selective Process

- ✧ IF at the beginning a young person scores over 30 on the CES-D ( $>2SD$  greater than mean) and the SDQ also scores over 20 THEN
  - We discuss with school personnel and added intervention may or may not occur
- ✧ IF at the end a young person still scores over 30 on the CES-D and the SDQ also scores over 20 THEN
  - We discuss with school personnel and further assessment occurs with the DISC
- ✧ Group based or individual Cognitive Behavioural Intervention IN SCHOOL

# Bayside Ei Program - Selective Process

- ✧ At any time, with permission from the young person and their parents, members of the PARTNERSHIP may be involved to provide support
- ✧ IF the young person has multiple problems AND/OR is known to multiple agencies THEN discussion occurs with members of the PARTNERSHIP, and action occurs

# Bayside Ei Program - Indicated Process

- ✧ IF the combination of the CESD, the SDQ, discussion with school staff, and/or the results of the DISC suggest a clinical problem, THEN referral occurs to CYMHS or another agency for therapy
- ✧ At all times close liaison is maintained between the partners, and CYMHS provides ongoing support to school as required

# Bayside Ei Program - to date

- ☞ Staged program
- ☞ 3 of the planned 7 schools are active, one starting with last year's Yr 8s and now with this year's crop.
- ☞ Feedback to Wynnum North High School after initial CESD/SDQ scoring has just occurred.
- ☞ 8 young people discussed, 4 looking like they need fairly urgent further care.

If you want effectiveness and efficiency in a service, there is no substitute for highly skilled, well supervised, experienced clinicians.

# Depression in Young People

Major studies in USA, Canada, Dunedin and Christchurch all conclude that Major Depression occurs in 6-7% of 15 year olds and up to 15% by the age of 18 yrs.

**Case identification**



# *Out of the Blues* (OOTB) Primary Diagnosis

86.9%

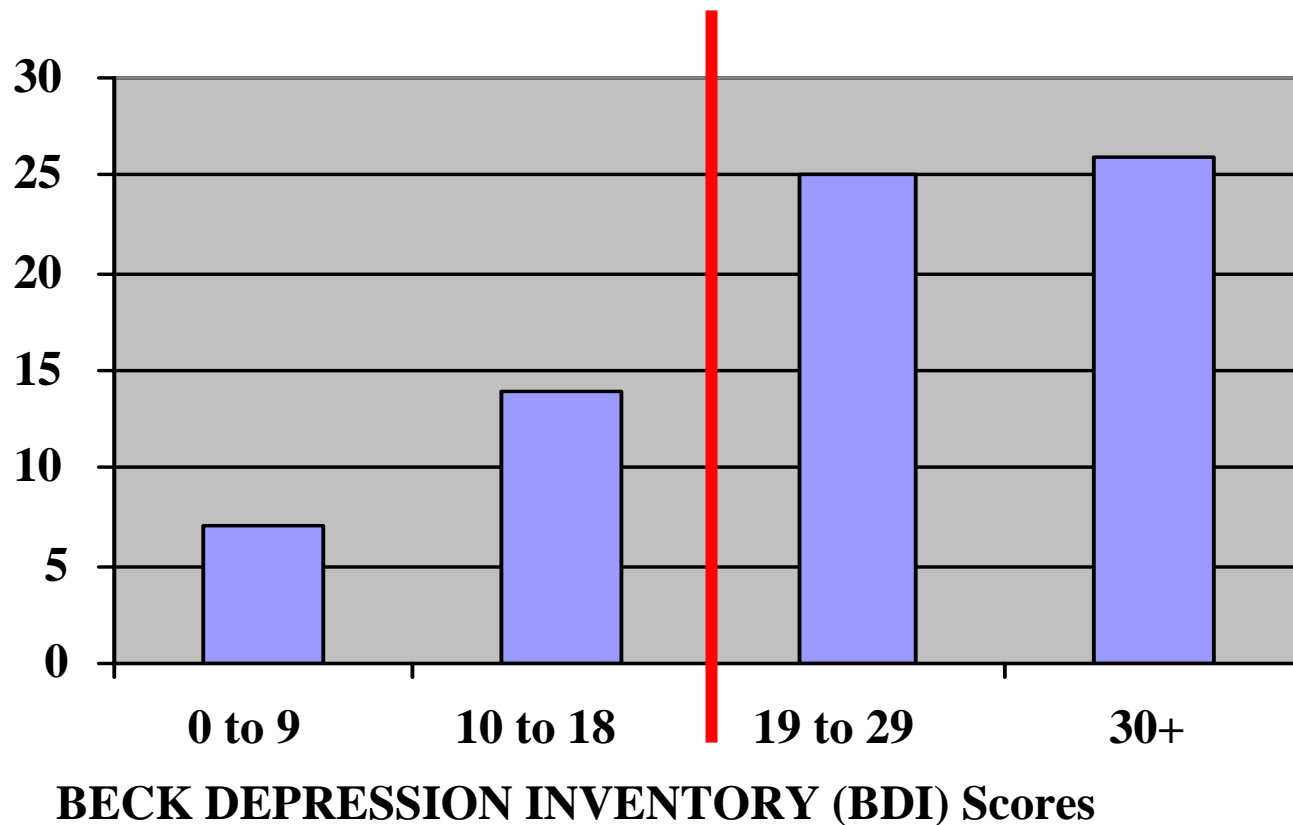
<b>MAJOR DEPRESSION</b>	<b>30 (39.5%)</b>
<b>DYSTHYMIA</b>	<b>18 (23.7%)</b>
<b>ADJUST. DIS. w. DEP. MOOD</b>	<b>13 (17.1%)</b>
<b>BIPOLAR DISORDER</b>	<b>5 (6.6%)</b>
<b>ANXIETY</b>	<b>4 (5.3%)</b>
<b>PTSD</b>	<b>2 (2.6%)</b>
<b>ADHD</b>	<b>2 (2.6%)</b>
<b>BEREAVEMENT</b>	<b>1 (1.3%)</b>
<b>DRUG -INDUCED PSYCHOSIS</b>	<b>1 (1.3%)</b>

**Case identification**



# Beck Depression Inventory Scores at Time 1

**LEVELS OF DEPRESSION Time 1.**





# OOTB Suicidal Behaviours

- 26 (36%) scores in  $>10$  on the ASQ-R;
- 37 denied an attempt;
- 34 attempters:

More than a year ago = 5

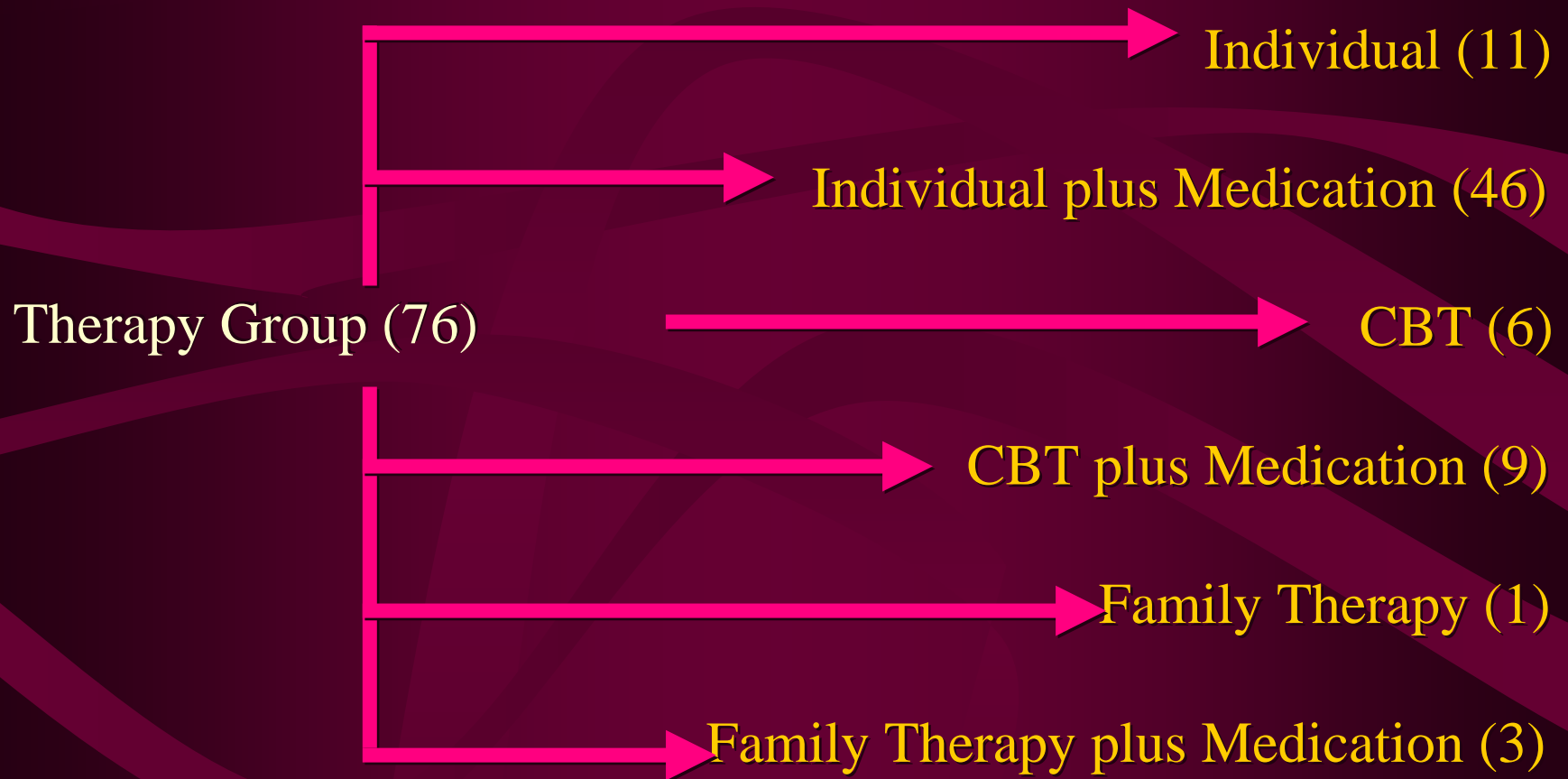
3-12 months ago = 10

1-3 months ago = 4

In last 1 month = 15



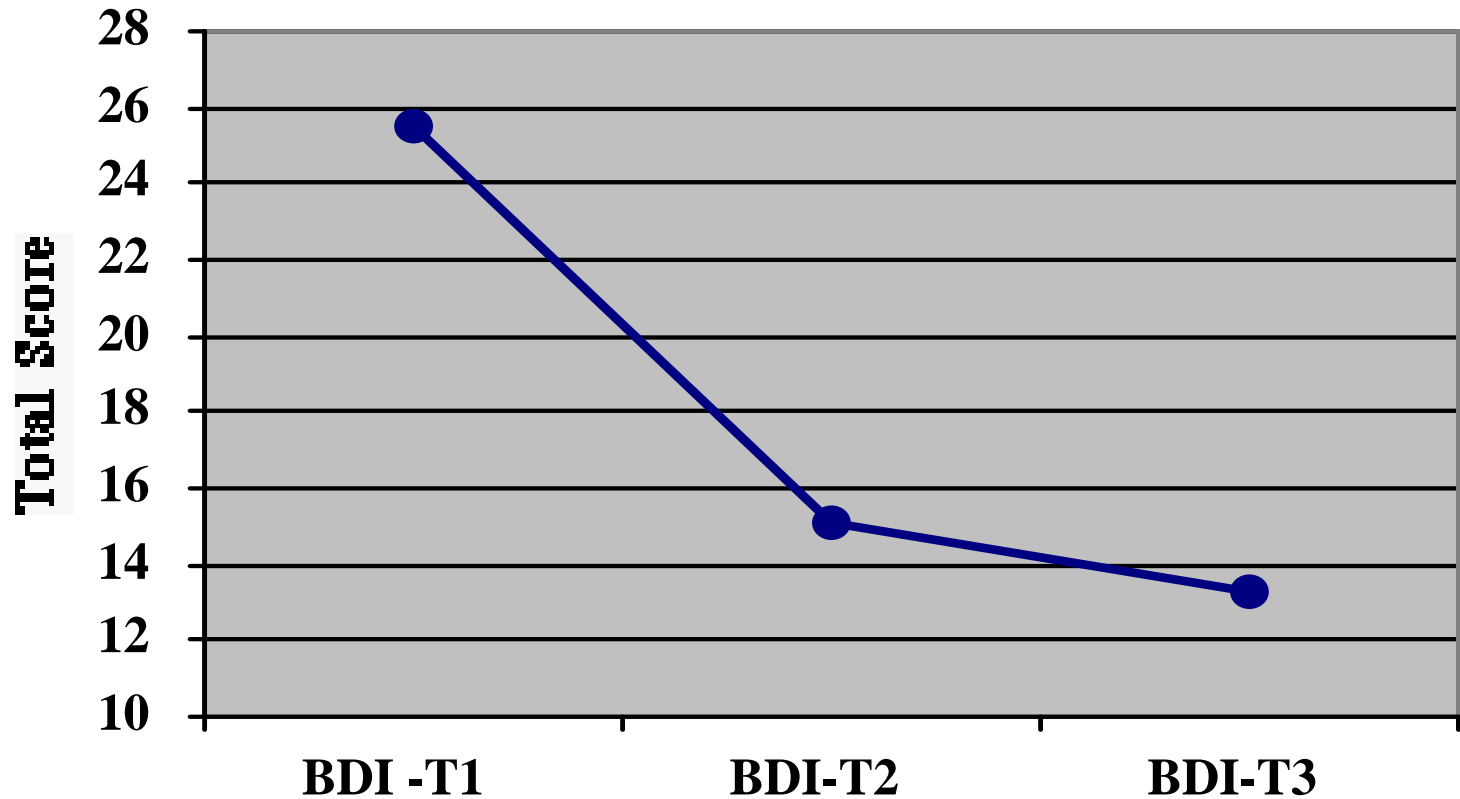
# Out of the Blues





# OOTB - BDI scores over time

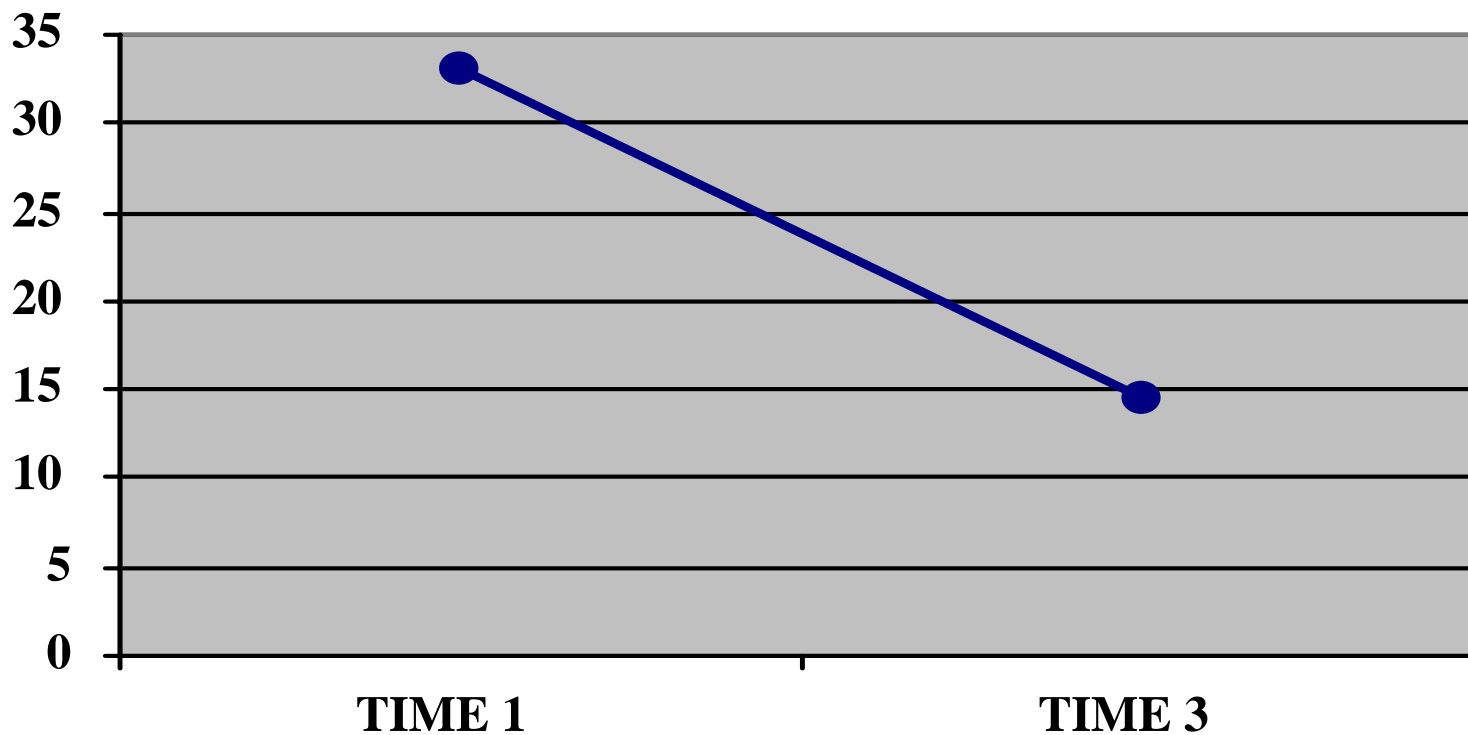
Depression from Time 1 to Time 3





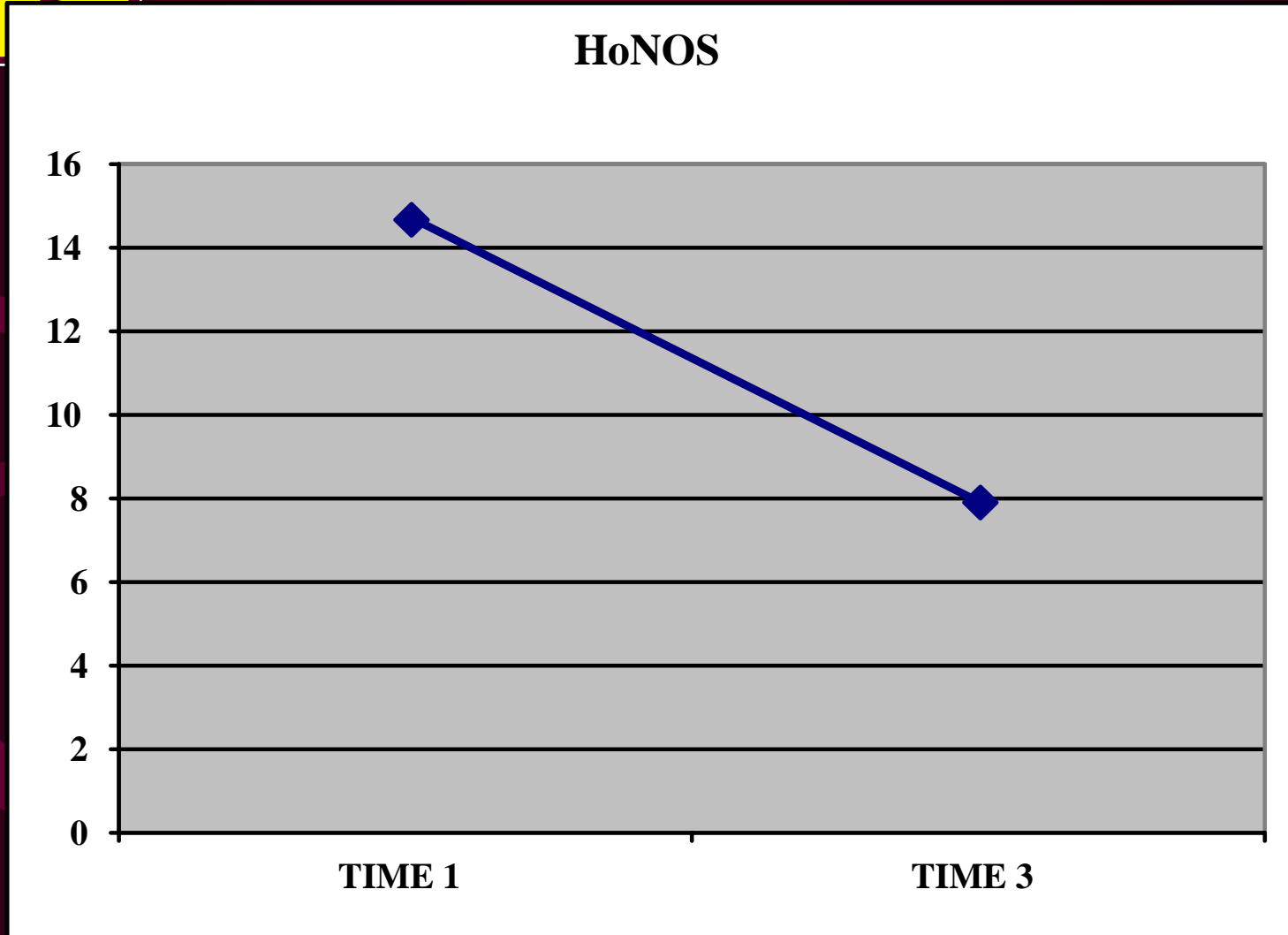
# OOTB - Ham-D scores

**HAMILTON DEPRESSION RATING  
SCALE - DEPRESSION**





# OOTB - HoNOS over time





# OOTB - Suicidal Behaviours

- 5 attempts between Time 1 and Time 2  
(2 medically serious)
- 3 attempts between Time 2 and Time 3  
(one a repeat attempt)  
(none medically serious)



# Access

## Referral Process

### INITIAL PHONE CALL

- initial management & safety issues
- interim supports
- appointment time no more than 2 weeks

