Specific issues for child and youth primary mental health care

This issues guide is linked to the vignette ‘Children should be seen and heard’

Consideration of Child and Youth mental health should be one of the most important elements of all your strategic thinking and planning. Some reasons for this are:

- The prevalence of child and youth mental health problems is high and underestimated.
- Recent developments in neurodevelopmental research highlight the importance of early psychological impacts on long term outcomes, both psychological and physical.
- There is a strong long term economic argument for investing in child and youth mental health in terms of future productivity.

Prevalence

The most prevalent childhood and adolescent mental disorders among young people in New Zealand are anxiety disorders, mood disorders, conduct disorder and substance abuse. Among 11-year-olds there is up to 18% 1-year prevalence, rising to 35%-40% in 18-year-olds. Childhood anxiety commonly precedes adolescent depression and studies comparing anxiety and depression have revealed a common genetic predisposition for these disorders. In the presence of both anxiety and depression, there is an increased risk of developing a co-morbid substance disorder.

Long term outcomes

Mental disorders in young people lead to emotional distress, impaired functioning, physical ill-health and increased suicide risk. They also carry a high risk of a pattern of recovery and recurrence (more likely in females) or unremitting persistence (more likely in males) into adult life.
Service delivery

Mental health problems in child and youth should be ‘core business’ for primary care and the young person with mild or moderate depression should typically be managed within primary care services. However young people often choose not to present mental health problems to GP’s, and many child and youth services are situated within education, social welfare or justice frameworks. Nearly all existing child and youth mental health services are situated within secondary care delivery frameworks.

Liaison and integration of health with other services is the key to successful development of child and youth mental health.

In adult mental health it is common to take a problem based approach. In child and youth care a strength-based approach should be used in combination with problem solving and risk reduction.

Use of technology

When planning services for child and youth, DHB’s and PHO’s should consider the most effective ways of communicating and disseminating information. The internet and mobile phone technology are becoming essential tools in the delivery of child and youth mental health services.

Appointments and follow ups are more likely to be successful using mobile phone and there is increasing interest in the use of web based information and therapy.

There are a number of useful websites for youth including www.thelowdown.co.nz for information, self-help strategies and support from peers.

Mental health problems in pre-school children and infants

There is a growing awareness of the importance of psychological issues in the ante and post natal periods and early childhood. This has important planning implications. DHB’s and PHO’s should promote and integrated team approach between all those
caring for pregnant women and the infant and young child. This will include midwives and Plunket. The active management of maternal mental health problems will help the infant as well as the mother.

Some recent studies indicate that mental health problems can be present in preschool children and infants. A Danish study reported a prevalence of mental health problems of 16 – 18% in children aged 1.5 years of age. The most common problems were emotional, behavioural and eating disorders. Psychosocial problems and parent-child disturbances appear to be risk factors for the development of a disorder in a very young child.

**A long term strategic view**

There is evidence that in health care, the best return on investment for future wellbeing is made between the years of 0 to 4 years. While it may be difficult for DHB’s and PHO’s to commit to a long term view, investment in early childhood is likely to provide the greatest gains in improving overall mental health outcomes.

Rates of return to investment in human capital as function of age when the investment was initiated. (Source: Knudsen et al. (2006) Economic, neurobiological, and behavioural perspectives on building America’s future workforce. PNAS 103 (27) 10155-10162)
‘Children should be seen and heard’

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At the regular planning meeting between the PHO and DHB a new member of the PHO planning and funding team asks how much of the overall DHB mental health allocation should be devoted to spending on mental health issues in children and young people. She recently attended a seminar on population investment models in which it was suggested that 80% of any health sector budget should be invested in children and young people to get the maximum return on overall investment in health care.

This sparks a number of different questions and discussion points:

**How much does the DHB currently spend on child and youth mental health services?**

The question may not be as easy to answer as some might think. There are significant resources devoted to child and youth services, but it is fragmented across a wide range of services – child and adolescent mental health (CAMHS), social welfare, CYFS and so on. Some of these inputs the DHB may have direct control over and for others the DHB has working links with other services or sectors.

Any decision about reallocation of resources must be made after considering current allocation, and an assessment of the effectiveness of current allocation models.

**Why does this DHB (and yours) allocate current resources in the way it does?**

In many aspects of health care children are ‘invisible’ and have no voice. Adult services tend to be given the largest share of resource because illness and disease are already well established and management of established problems is seen as a higher priority than the preventive and pre-emptive focus of childhood.

Reorienting allocation priorities will mean debating strongly held opinions and traditions.
Guides to specific issues

Why should your DHB consider reallocation towards child and youth?

The case for reallocation is strong. Firstly there is a growing appreciation of the high prevalence of illness and disorder in young people (18% of pre-adolescents with a ‘diagnosable disorder and 40% of those in late adolescence).

Secondly there is increasing evidence of the long term harm of not treating symptoms in young people. Established mental disorders do not suddenly develop de novo in people in their late 20’s. Tomorrow’s depression has its origins in the anxiety of late childhood.

How could our DHB start this process?

The first step is to discuss and answer the questions posed above in relation to your own local area and district. Having identified needs or gaps it is likely that the immediate challenge will be to identify the existing stakeholders and arrange a meeting to discuss these issues.

“Many of the things we need can wait. The child cannot. Right now is the time his bones are being formed, his blood is being made, and his senses are being developed. To him we cannot answer ‘Tomorrow,’ his name is today.”

Questions to consider

Work your way through the questions within the vignette.