Child and youth mental health: Integrated health care using contemporary competency-based teams

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Mental health teams have long been the foundation for mental health services provided to children and youth. Changes in professional practices, the emergence of evidence-based care, the importance of integrating mental health into primary health care delivery, the decrease in professional 'ownership' of mental health care competencies and other factors now challenge the traditional structure and function of these teams. New and novel frameworks will be needed to address mental health care needs for problems that do not require 'traditional' mental health service interventions, to enable integration of mental health care into usual health services, to promote specialist mental health care delivery for those in need, and to facilitate the development and translation of mental health research into practice. In all of these new team structures, the active participation of young people and their families will be necessary.

Key Words: *Child; Integrated health care; Mental health; Multidisciplinary teams; Youth*

La santé mentale des enfants et des adolescents : Des soins de santé intégrés grâce à des équipes fondées sur les compétences contemporaines

Les équipes de santé mentale ont longtemps constitué la base des services de santé mentale dispensés aux enfants et aux adolescents. Des modifications aux pratiques professionnelles, l'émergence de soins probants, l'importance d'intégrer la santé mentale à la prestation des soins primaires, la diminution de « l'appropriation » professionnelle des compétences de soins en santé mentale et d'autres facteurs remettent en question les structures et fonctions traditionnelles de ces équipes. Il faudra établir des cadres nouveaux et novateurs pour répondre aux besoins de santé mentale en cas de troubles qui n'exigent pas d'interventions liées aux services de santé mentale classiques, pour intégrer les soins de santé mentale aux services de santé habituels, pour promouvoir la prestation de soins de santé mentale spécialisés à ceux qui en ont besoin et pour favoriser le développement et le transfert des recherches en santé mentale dans la pratique. Dans toutes ces nouvelles structures d'équipes, il faudra compter sur la participation active des jeunes et de leur famille.

Mental disorders and substantive mental health problems in children and youth are complex phenomena in their pathoetiology, social and clinical expressions, and in the interventions that can ameliorate, modify or prevent their onset, effects or negative outcomes (1). Mental disorders are also the most prevalent illnesses affecting young people and is the largest single category to contribute disability-adjusted life years to the global burden of disease, accounting for almost three times the disability-adjusted life years attributable to cancer and heart disease in this age group (2). More than two-thirds of mental illnesses onset before 25 years of age, and these disorders are mostly chronic with substantial negative impact on multiple personal, interpersonal, social and physical health domains (3). Early identification and intervention can decrease both short- and long-term morbidity and may substantially improve outcomes (2,4).

Traditionally, the mental health care model for young people has centred on multidisciplinary mental health teams providing care, often geographically separated from primary health services. Many primary care practitioners are not well trained to meet child and youth mental health care, so referral to these mental health teams has been the usual practice. However, changes in professional practices, the decrease in professional 'ownership' of mental health care competencies, the importance of integrating mental health into primary health care delivery, the emergence of evidence-based mental health care and other factors now challenge this traditional mental health service model. A 21st century care model is needed to better meet the mental health needs of young people and their families. The present article provides a brief overview and rationale for proposed changes to improve mental health care services.

MENTAL HEALTH CARE COMPETENCIES, PROFESSIONAL IDENTITIES, AND CHANGES IN PROFESSIONAL PRACTICES

Mental health service teams consist of diverse individuals whose activities are primarily driven by a traditional professional scope of practice frameworks and presumed professional 'ownership' of specific practice competencies. For example, diagnosis was historically considered a medical act and was deemed to be the purview of physicians; psychological treatments the domain of psychologists and psychiatrists;

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TABLE 1
Disadvantages of the traditional mental and physical health service separated model

- Limits mental health care competencies to limited number of providers in limited locations
- Prevents access to mental health care because it is separated from physical health care
- Limits development of mental health competencies of physical health care providers, forcing much mental health care into specialty services
- Limits development of mental health provider competencies in physical health care with potential detriment for those only receiving mental health care, eg, physical medical consequences of obesity with depression
- Perpetuates the stigma that persons living with mental disorders are 'different' from those with physical disorders and need to be segregated
- Increases administrative and infrastructure costs of health care delivery

and the application of social integration activities the realm of social workers. Competency categories determined the roles and functions of mental health service teams.

With time, team member roles and functions have evolved. Scopes of practice markedly changed, challenging traditional professionally framed competency 'exclusions'. For example, pharmacists in some jurisdictions will have the 'right' to prescribe medications, and nurses and child and youth care workers already deliver cognitive behavioural therapy.

In the past decade, the traditional mental health service team model has come under siege, driven, in part, by the changes in scope of practice within professional groups, in part by the increasing development of other professions (for example counsellors) and in part by scientific evidence demonstrating that unique professional qualifications are not key factors in therapeutic outcomes. For example, good outcomes may be found in cognitive behavioural therapy applied by psychiatrists, psychologists, nurses, social workers, counsellors or even computer-assisted therapy (5,6). Accordingly, there is a growing realization that mental health care competencies, not professional identification, should define roles and functions of mental health care team members.

MENTAL HEALTH SERVICE SILOS – INTEGRATING MENTAL HEALTH INTO PRIMARY HEALTH CARE

Historically, psychiatric/mental health services, including those for children and youth, have been relatively isolated from other health care services, ie, in silos (7). This has forced children, youth and their families to frequently obtain mental health care from a unique mental health care provider geographically distanced and distinct from their physical health care provider. This separation does not serve either recipients or providers well (Table 1). Removal of this silo model through the integration of mental health care with primary care is a necessary component of reforming mental health care for young people. The usual mental health care needs can and should be substantially met within primary care (8). This proposed change has profound implications for the mental health care team and the silo model.

A second silo, that of artificially created age limit care categories, also impedes the delivery of optimal mental health care. Although the majority of mental disorders onset before 25 years of age and need to be effectively and intensively addressed during this time, the current structural separation of child from adult health services occurring between 17 and 19 years of age creates an unnecessary and arguably toxic impediment to the continuity of care during this vulnerable period. Mental health care for young people must be continuous until the mid-20s and then appropriate transitional structures need to be provided for those who require 'adult' services. Primary care settings are ideally placed to dismantle this silo and provide a care continuum that can more appropriately meet the needs of young people and their families.

EVIDENCE-BASED MENTAL HEALTH CARE

Research has led to a remarkable evolution in the understanding of the complex interplay of genetics, epigenetics, neurodevelopment and the environment on the development and expression of mental health problems and disorders in children and youth (1). Although child and youth mental health practice has come late into the scientific arena, clinical therapeutic interventions are now moving from being theory driven to empirical assessment and validation using rigorous, appropriately designed clinical research strategies (1,9). Current practice is now expected to be informed by best available scientific evidence. Evidence-based clinical care guidelines are being developed using rigorous processes for assessment of evidence (10,11). Concurrently, clinical service and program evaluation has been moving from addressing process components to outcome indicators, also using best scientifically available methods of validation (12-15).

MENTAL HEALTH TEAM LEADERSHIP – RE-ENGINEERING TEAMS AND CARE

With the broadening of research and clinical enterprise has come a broadening of the managerial and operational functions of team members. The traditional professionally established hierarchies of 'knowledge' in which the psychiatrist or psychologist was 'understood' to be the single most authoritative repository is being challenged. Traditional team leadership based on professional identities (ie, psychiatrist, psychologist) is being replaced by management based on ability and competencies. The most competent and qualified individuals, regardless of professional identity, are increasingly undertaking therapeutic, leadership and operational roles.

This re-engineering of team member functions based on competencies rather than profession has important implications for the development and distribution of mental health care competencies into primary care. Now, all usual primary care providers can be enabled to provide mental health care consistent with their roles as long as they acquire the needed competencies. Primary care teams do not need to hire specific mental health professionals who may be in

short supply, but can instead hire individuals who have the skills needed to meet the mental health care needs of the children and youth they serve. Modifications in the delivery of continuing health education and appropriately enhancing the mental health training components of many different professional groups will be required to support this necessary shift in primary mental health care provision.

OTHER FACTORS PUSHING CHANGE

Mental disorders that onset in young people are now understood to frequently be long lasting and chronic – conditions requiring complex, coordinated and collaborative management over many years (1,16,17). Family members and the community are also now being recognized as having important roles in helping to address the care needs of children and youth living with a mental health disorder (18). These factors have important implications for the development of teams and the roles of patients, family members and communities alike.

Traditional top down care provision needs to be replaced by models of care that involve appropriately shared decision making and responsibilities among providers, patients and families, with meaningful inclusion of young people and their families/caregivers into the care team. Furthermore, mental health literacy (and its essential partner – scientific literacy) must become essential components of health delivery, education and public service activities. Mental health literacy is arguably the least developed health literacy among the public, providers and policy makers alike (19-21). An immediate coordinated campaign led by a coalition of providers, patients, families, researchers and educators is needed to ensure that basic knowledge about mental disorders and effective interventions become commonly known and understood.

MENTAL HEALTH CARE IN THE PRIMARY HEALTH SETTING

Currently, most primary health care services are unable to efficiently and effectively address mental health care needs of young people. Many primary health care providers do not feel that they have the competencies needed to address mental disorders in children and youth, and in most cases, prefer to refer patients to a mental health care team. Furthermore, the physical design of many primary health care settings does not take into account the privacy or emotional/behavioural needs required by young people (and their families) with mental disorders. Thus, currently, early recognition and management of major child and youth mental health disorders in the primary health care setting is the exception not the rule. Hence, most mental health resources are currently directed toward the back end of the chronic disorders path, not upfront. Yet early case identification, diagnosis and the delivery of effective, efficient and recovery-driven care may be able to improve both short- and long-term outcomes for the individual, the family and the community. For example, although the pathoetiology of mental disorders is complex, the genetic component of most mental illnesses is well appreciated. Primary health care providers and not mental health teams are best placed to educate, monitor and intervene in the disorders that run in families. This change will require increased education of primary health care providers and families alike. Mental health monitoring needs to become a routine part of 'well baby' and 'well child' visits. These visits also provide an opportunity for mental health promotion as well as for screening for mental disorders. Primary health care delivery teams may need to be enhanced by health providers with the necessary early diagnostic and intervention competencies that can address mental health needs once identified, with referral to mental health care service teams only for unusual or intractable problems.

SO WHERE DO WE GO FROM HERE?

An understanding of how to best address mental health needs in children and youth requires us to rethink how we currently use mental health teams to best meet those needs, now and in the future. Mental health care needs to be fully integrated into comprehensive primary health services, possibly by restructuring primary health care teams to include mental health professionals (ie, psychologists, social workers, youth workers, counsellors, etc) or alternatively or concurrently, by enhancing the mental health competencies in primary health care providers (ie, physicians, nurses, etc) through education and mentoring. These approaches would enhance integration of mental health and physical health in primary care, improve the quality of chronic mental health care delivery, and build mental and physical health care competencies of all health providers. In addition, these integrated models may serve to decrease the current mental health stigma perpetuated by separating it from physical health care. These approaches would also encourage greater investment in mental health promotion, early identification and treatment of mental disorders, and the shared development and delivery of programs and activities designed to improve the mental health literacy of providers, patients, families, public and policy makers alike. One size will not fit all and the structure of mental health care will need to reflect the realities of different community needs and resources. Development will need thought, planning, consultation and trials of models to measure efficiency, effectiveness and outcomes. There will still need to be 'step up' referral programs for more detailed consultation and advice when needed – the tertiary network parallel to physical health care. In all cases, young people and their families/caregivers need to be viewed as an integral part of any mental health care team. Our models, policies and procedures must facilitate their full participation in each proposed type of mental health care team.

CONCLUSION

Current mental health teams are the product of history. Advances in scientific knowledge and clinical therapeutics, changes in social forces and the realization that convergence, not isolation, of professional identities is more appropriate for meeting the mental health care needs of young people and

their families led to a demand for new models of care. Primary health care teams may best provide early, effective, efficient and optimal recovery-based care by ensuring that the required mental health care competencies are available in each primary health care team and by ensuring that mental health and other types of health care are fully integrated. The development of a framework that can facilitate and support these changes is needed. Currently, the Child and Youth Advisory Committee of the Mental Health Commission of Canada has begun the first steps toward the development of such a framework – called Evergreen. Hopefully, its national and international consultation and transprofessional model of development will be able to assist us to move more effectively and appropriately in that direction.

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