

Issues Paper (January 2019):

“The Social and Economic Benefits of Improving Mental Health”

This private submission is based on my experience as the lead research investigator and program manager of the Multisystemic Therapy (MST) service operating within the Western Australia Department of Health since 2005. Dr Mark Porter.

It is important to engage high-risk children and adolescents with interventions likely to obtain sustained improvements in mental health and well-being that will enable development into productive and healthy adults. However within this country there is limited access to effective interventions for a large cohort of children and adolescents who are very high risk for developing adult mental illness, and various other high-cost and life-long problems. This particular service gap results in great harm and costs that can often be prevented, and has major ethical, economic, mental health and productivity consequences for the nation.

There is a large population (3 - 7%) of older children and adolescents (National Institute for Clinical Excellence, NICE, 2013) with severe behavioural problems (i.e. conduct disorders), who don't receive any effective help for these problems. Specialised parenting interventions for parents of children with conduct disorder can often be effective, however parenting interventions to better manage children aren't eligible under Medicare (MBS, Better Access) guidelines. Families must therefore rely on the few services provided by the state or NGO sector, or pay for private psychotherapeutic help. There is little evidence for effectiveness of pharmacological interventions for conduct disorders (NICE, 2013), although pharmacological interventions are often effectively utilised for concurrent problems when conduct disorder is comorbid with hyperkinetic (ADHD) disorder, or some mood disorders.

Without intervention, conduct disorders predict a range of very high-cost, negative outcomes: (NICE, 2013; Kim-Cohen, Avshalom, Moffitt, Harrington, Milne & Poulton, 2003; Fergusson, Horwood, & Ridder, 2007; Dolan, McEwan, Doley & Fritzon, 2011; Spas, Ramsey, Paiva & Stein, 2012; Costa, Kaestle, Walker, Curtis, Day, Toumbourou, & Miller, 2015). Conduct disorders have been implicated with school violence & expulsion, substance abuse, mental illness, family violence, chronic unemployment, teenage pregnancy, criminal activity, fire-lighting, incarceration, and premature death including suicide. Enormous improvement in family mental health and well-being, and significant cost savings for the state can be realised by effective intervention with these families.

Depending on young person's age and severity, conduct disorders often respond favourably to various evidence-based interventions (e.g. cognitive behavioural therapy or CBT, specific parenting interventions like Triple P, and outreach interventions like Multisystemic Therapy, or MST). However there is typically a large service provision gap relative to service need, because many families don't access, or unable to access, effective help for various reasons. Many families don't seek help due to stigma and shame of being perceived as poor parents, and/or fear of charges or child removal. Some families distrust services and/or have complex difficulties, including inter-generational trauma, family violence, mental illness and substance abuse complications they don't wish to discuss. Other families can't reliably access clinic-based services due to transport limitations, and/or logistic complications for parents with multiple young children they care for. There needs to be a range of evidence-based service options according to parent circumstances, age of the young person, and problem severity. These are not expensive options and should include on-line parenting help, group parenting, clinic-based CBT for the young person, and intensive outreach services like MST.

Despite international child and adolescent mental health prevalence studies showing conduct disorders affect a large group of young persons, a relatively small number access effective help before the young person comes to the attention of Police and Justice Services. Families with an older child or adolescent with more severe behavioural problems are high risk for Justice involvement, and usually require an intensive, home-based, outreach intervention like MST. However there are limited specialist outreach services for this population that often results in family violence resulting in Police intervention and presentations to hospitals. The limitation in specialist outreach services for higher risk conduct disorder population also contributes to escalating family, school and community violence, then substance use/abuse, mental illness, then chronic unemployment, teenage parenthood, incarceration, and suicide.

Several Australian states and the Northern Territory have experienced riots in their juvenile detention centres in recent years that typically result in considerable damage and enquiry. There is also the likelihood of Government juvenile detention centres facing litigation as has happened in the United States in recent decades. There is considerable international evidence juvenile detention should be avoided whenever possible and safe, because it is high cost and often doesn't result in the detained juveniles being deterred from a criminal pathway. There is considerable amount of published evidence that early intervention with this population is extremely cost-effective, and can result in improved mental health and well-being for the young person, their family, and the wider community.

Several international treatment guides describe MST as a leading multi-modal intervention for empowering parents with the skills to appropriately communicate and manage older children (12 - 16 years) with conduct disorder to reduce the likelihood of juvenile detention. There have been many random controlled trials evaluating MST as an effective intervention, including longitudinal studies demonstrating enduring positive results. One longitudinal study (Sawyer & Borduin, 2011) reported that youth completing the 4 - 5 month intensive MST intervention had significantly less periods of incarceration during the following 21 years, and were much less likely to have committed serious violent felonies.

Published, peer-reviewed studies from various countries (USA, UK, Sweden and Australia), demonstrate MST can be successfully introduced in different countries when the intervention is implemented and operationalised consistent with the model developer guidelines. Fidelity to the MST model has emerged as a critical factor for achieving successful youth outcomes. Some families may be helped with alternate interventions, including cognitive-behavioural therapy (CBT) for these children when this is accessible, and proven parenting interventions when families are able to reliably access them. The NICE (2013) guide for conduct disorders (see references) is comprehensive, and describes the evidence base and relative effectiveness of various interventions for this population, including interventions for different age groups.

Client longitudinal outcomes of the MST program operating within the W.A. Department of Health since 2005 were published several years ago (Porter & Nuntavisit, 2016), that hopefully inspires other mental health services to implement this specialised clinical model. MST has substantial proven ability of effectiveness (Multisystemic Therapy, 2018) to realise significant cost savings for a nation (Klietz, Borduin & Schaeffer, 2011). Cohen and Piquero (2009) demonstrate that saving just one high-risk 14 year old from a life of crime can save U.S. \$2.6 – \$5.3 million dollars in justice, social and health costs. Important social and mental health benefits will also be realised from diverting a marginalised population from poor life-long outcomes that will significantly contribute to improving the general mental health, and the safety and quality of community life for many Australians.

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