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## Early intervention in youth mental health

David A Sholl

**TO THE EDITOR:** There are two fundamental flaws in the case for reform of youth mental health services outlined recently by McGorry and colleagues.<sup>1,2</sup> They argued that 18 years is an unnatural and inappropriate transition point between adolescent and adult services, and that Child and Adolescent Mental Health Services (CAMHSs) are somehow inherently ill equipped to deal with serious mental illness.

McGorry has long advocated a “youth model” catering for adolescents and young adults together. I believe this would be a disaster, particularly for adolescents. Adolescents and young adults need very different models of care, because of the differing degrees of responsibility and autonomy they can handle, the legal and moral responsibilities of families, carers, schools and health professionals, and the effectiveness of treatments.

McGorry's well deserved reputation and influence mean there is a real risk his opinions will be accepted as fact, especially as the opposing view is seldom heard.

People aged under 18 years (on average) are not expected, or permitted, to take full responsibility for their lives or their mistakes. Legally, they cannot vote, drink or buy cigarettes. They are generally still at school and living in the family home. Those aged under 16 years are not automatically entitled to grant or withhold consent to treatment.

Families thus have a central role in the management of illness in adolescents, in a way that is neither possible nor appropriate for adult patients.

Adolescent inpatient units need to be highly structured environments where adults would be out of place, with school-like rules, and careful control of group process and peer interactions. Otherwise, there is bullying, sexual exploitation, epidemics of self-harm, and the kind of competitive rebelliousness that leads to riots and fires. In adult units, adolescents are unacceptably vulnerable, not only from exploitative older patients, but from a lack of boundaries to their own behaviour.

McGorry made several perplexingly dismissive comments about CAMHSs. Two cannot go unanswered: that CAMHSs “struggle operationally and clinically with ... mood, psychotic, substance use, and

borderline personality disorders”;<sup>1</sup> and that “the capacity to skilfully and safely manage highly disturbed behaviour, and the more sophisticated psychopharmacological skills, are often lacking in ... CAMHSs”.<sup>1</sup>

The disorders described are, in fact, “bread-and-butter” work for CAMHSs. Further, there is powerful anecdotal evidence that CAMHSs manage them better, not worse, than others. Examination of data held by the Victorian Department of Human Services and the Office of the Chief Psychiatrist on seclusion (sole confinement) rates, consumer satisfaction and suicide rates will bear this out. Child psychiatrists all train as adult psychiatrists first and, in my experience, do not lack psychopharmaceutical sophistication.

It is hard to see what adolescents and their families have to gain from being incorporated into young adult services, nor why 30-year-olds should be excluded from specialist early psychosis services.

We need greater integration between the current tiers of service, and a more flexible approach to transition between them, not another separate tier of service.

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**Patrick D McGorry, Ian B Hickie,  
Anthony F Jorm and Rosemary Purcell**

**IN REPLY:** Sholl asserts that our case for reform of youth mental health services is based largely on personal opinion. In fact, as detailed in the Journal supplement,<sup>1</sup> it is based on hard epidemiological facts, the latest developmental perspectives and a growing evidence base. Consequently, it has been widely supported by young people, families, governments and the community.

The youth model ensures that developmental approaches appropriate to all stages of the process of transition from childhood to adulthood continue until the young person is genuinely independent. To design a health system around the transition age of 18 years, based on legal and educational precedents, is outmoded. Many more young people now pursue postsecondary educa-

tion and are financially and socially dependent on their families well into young adulthood.<sup>2</sup> The youth mental health paradigm involves families in a developmentally appropriate way from puberty to the mid-20s, and also recognises the increasing value of peer relationships. The key difference is that young people have increasing choice about the level and pattern of family engagement. Similarly, brain development continues actively up until the mid-20s.

We believe Sholl has misunderstood the fundamental issue of youth mental health reform. It is not a binary choice between current child-adolescent and adult service models. A new stream of care is required to respond to these “transition age youth” or “emerging adults”, as they were recently termed.<sup>2</sup> This stream borrows many of the features of adolescent psychiatry and extends these to around 25 years of age, complementing them with new evidence-based approaches, which have been difficult to create and nurture within a constrained and under-resourced Child and Adolescent Mental Health Services system. This step is crucial for the “graduates” of state care, who have appalling outcomes when care is withdrawn at 18 years (even though they can vote).<sup>3</sup>

We have successfully developed and provided such an adolescent-young adult service to a quarter of Melbourne for over a decade. Recently, we extended this to Sydney. The real-world impact of this approach has helped greatly to convince the community, including federal and state government leaders, of its wider value.

We want to see genuine reform, restructure and substantial investment in a new stream of care. How well this links, not only with existing child and adult specialist systems, but equally importantly with other key systems — notably education and employment, primary care, housing, justice and drug and alcohol services — will be critical to its success.

**Patrick D McGorry**, Professor of Youth Mental Health,<sup>1</sup> and Executive Director<sup>2</sup>

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## Why are community psychiatric services in Australia doing it so hard?

James D Hundertmark

**TO THE EDITOR:** Singh and Castle recently commented on the assumptions made in relation to the National Mental Health Policy.<sup>1</sup> One such assumption was that the cost of the community care service model could be constrained by limiting services to the “severely” mentally ill. The authors went on to describe the realities associated with making this and other assumptions on current mental health care delivery.

Many public wards have become the province of treatment-resistant consumers with limited insight who do not welcome the interventions provided by mental health workers. It may be that this type of inpatient population is influencing medical students’ views of psychiatry and contributing to low numbers in psychiatry training across the country. Students’ perceptions that psychiatry is a difficult and pressured work environment have been reported.<sup>2</sup>

Public services for consumers who have mental illnesses that do not involve psychosis are under severe pressure in the current paradigm. Despite the availability of effective treatments, anxiety and depressive disorders remain the principal cause of the disability produced by mental disorders, and half the people with such a disorder do not seek help, not realising how well they can become.<sup>3</sup> However, the public system appears to be retreating from providing services for such patients. There seems to be a view that all Australians with anxiety and depression can be treated in private practice or by general practitioners.

Does targeting low-prevalence disorders for treatment represent an acknowledgment by those in government of the power of mental health stigma? Is there misguided thinking that spending money on patients

with psychotic disorders will keep mental illness and violence off the streets? Doctors have an obligation to inform those in power that effective treatments need to be made available to the broadest range of Australians, not just those who are obviously mentally ill.

The difficulty of retaining psychiatrists in the public sector has been noted in many countries.<sup>4</sup> Health services need to provide variety in the work of clinicians to keep them within the public sector — a diet of chronic psychosis tends not to attract or sustain staff. I believe fostering specialist units dealing with high-prevalence disorders like anxiety and depression, and high-morbidity conditions like eating disorders, would encourage the training of new staff, contribute to research, and strengthen the future of psychiatry.

Revitalising public treatment services for high-prevalence psychiatric disorders could provide both symptom relief and a return to productivity for many thousands of Australians, and a more sustaining work environment for mental health clinicians. It is time for our governments to hear the call to provide mental health care for the many, not just the few.

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## Sternal fracture in an Australian Rules footballer

Robert J Douglas

**TO THE EDITOR:** A 20-year-old sub-elite Australian Rules football player presented with pain and tenderness in the lower third of the sternum. He had been involved in a moderate body collision with an opposing player about 3 weeks before presentation, and had continued to train and play despite sternal discomfort. He described no other symptoms.

On examination, there was no obvious sternal deformity. There was mild to moderate tenderness over the lower third of the sternum, and minimal sternal discomfort on lateral chest compression. Chest auscultation was clear. Plain chest and sternal x-rays were normal.

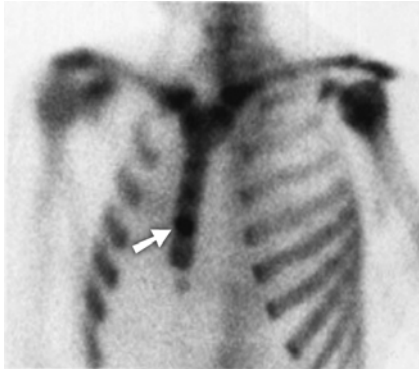
A technetium-99m HDP bone scan showed increased tracer uptake in the lower sternum, consistent with an undisplaced oblique sternal fracture (Box).

Management of the player’s injury and his fitness to train and play were discussed informally with medical and paramedical practitioners. Their opinions ranged from an immediate return to competition to 12 weeks of complete rest. After discussions within the player’s club, he was placed on a training regimen that avoided all upper body clashes and stresses, and he was rested from match play. He was regularly reassessed for symptoms and made an uneventful return to full competition 6 weeks after his initial injury. He remained asymptomatic and competitive for the remainder of the season and at 1-year review.

The usual cause of sternal fracture is blunt anterior chest trauma, with about 90% of sternal fractures caused by trauma resulting from the forces associated with motor vehicle accidents.<sup>1</sup> Sternal fracture is rarely encountered in Australian Rules football and such a case has not previously been described in the literature. The Australian Football League Injury Report database revealed only four cases of sternal fracture over the period 1992–2006, accounting for a total of 18 missed games (range, 1–11 games) (John Orchard, Conjoint Senior Lecturer, Sports Medicine Program, University of New South Wales, personal communication, May 2007).

Patients suspected of suffering a sternal fracture should be investigated with appropriate chest x-rays. If these are inconclusive, it is now suggested the patient should

### Bone delay views from dynamic localised technetium-99m HDP bone scan



There is a band of low to moderate tracer uptake running in a slightly oblique line across the lower sternum (arrow), suggesting a sternal fracture. ◆

be further investigated with sternal ultrasound, which has recently been demonstrated to be superior to bone scan in identifying sternal fractures,<sup>2</sup> and without the associated radiation exposure. Patients with an acute suspected sternal fracture should also undergo electrocardiography. If the electrocardiogram is normal and there is no evidence of intrathoracic injury on radiological investigation, the patient can safely be discharged.<sup>3</sup>

Chest pain is the predominant persisting symptom after sternal fracture.<sup>4</sup> Conservative management with rest, analgesia and/or anti-inflammatories, and, if required, appropriate padding and taping<sup>5</sup> should result in full recovery and an uneventful return to competition.

**Acknowledgement:** I would like to thank Dr Tonia Mezzini for her assistance in preparing this letter.

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### Intervening early to reduce developmentally harmful substance use among youth populations

**Vania Modesto-Lowe, Nancy M Petry and Melissa McCartney**

**TO THE EDITOR:** According to a recent article in the Journal, the pervasive nature of under-age drinking underscores the need to develop prevention strategies to delay the onset of alcohol use and its adverse consequences.<sup>1</sup> In the United States, school-based prevention programs have played a prominent role in the alcohol-use prevention scene. Drug Abuse Resistance Education (DARE), the most widely recognised school-

based alcohol-use prevention effort, is an elementary school curriculum that focuses on the adverse effects of substances of misuse, and the development of skills to resist peer pressure to use. Despite its nationwide appeal, attempts to empirically evaluate the efficacy of DARE have failed to yield positive results.<sup>2</sup>

Subsequently, Mothers Against Drunk Driving developed a school-based alcohol-use prevention program called "Protecting You/Protecting Me" (PY/PM). PY/PM centres on instructing children about central nervous system development and the importance of protecting developing brains from substances of misuse. PY/PM appears to be effective in enhancing knowledge of alcohol toxicity and changing attitudes toward binge drinking,<sup>3</sup> but its efficacy in decreasing alcohol use remains to be established. Although the efficacy of school-based alcohol-use prevention strategies has been the subject of controversy, such programs have proliferated.

School-based multicomponent approaches have also emerged. Project Northland integrated school, neighbourhood, and family components in an effort to decrease alcohol use.<sup>4</sup> Project Northland consisted of classroom curricula, extracurricular activities, and parental involvement. Twenty-four school districts were randomly allocated to receive some or all of the prevention package or a control. At the end of 3 years, significantly fewer students in the intervention school districts reported the onset of alcohol use than students in control districts. Efforts to disentangle the impact of its various components show differential effects. While the classroom curricula proved moderately effective, the strongest effects in decreasing drinking were seen for those who participated in the

extracurricular activities and parent program components.<sup>4</sup>

The robust benefits noted from the parent program in Project Northland parallel effects of some other studies suggesting the utility of family-based approaches to alcohol-use prevention. In one study, the Iowa Strengthening Families Program significantly delayed the initiation of alcohol use.<sup>4</sup> This program, which is geared towards optimising parenting skills, showed persistence of positive effects on alcohol outcomes 4 years after the intervention.<sup>4</sup> These data suggest that parenting and family skills training may play a part in school-based alcohol-use prevention packages. Further evaluation of these programs in other countries is necessary, and may help to reduce the widespread adverse effects of early alcohol use among children.

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## Health technology assessment in Australia

**Brendon J Kearney** and **Stephen L Blamey**

**TO THE EDITOR:** We read with interest the recent editorial and articles on health technology assessment.<sup>1-4</sup> We are pleased that the Journal highlighted this important policy process that attempts to ensure that technologies that improve health gain or health care are supported and those that do not contribute to an improved outcome are not supported.

The description of HealthPACT in the editorial<sup>1</sup> is not quite accurate in that HealthPACT is a subcommittee of the Medical Services Advisory Committee (MSAC). Its funding comes through MSAC with some supplementation from the Australian Health Ministers' Advisory Committee. The techniques of early detection and horizon scanning have been developed, and the results of this work are available to the health community of Australia, be it jurisdictional, public, private or specialised. In particular, if promising health care technologies are identified through this process, they are referred to MSAC for a full health technology assessment, thus ensuring that appropriate technologies are identified as early as possible in the technology cycle and are assessed by MSAC for introduction into the health care system.

This horizon-scanning activity does not currently involve drugs or vaccines, and the Australian health care system could benefit from this process, just as the National Institute for Health and Clinical Excellence in the United Kingdom and the Canadian Agency for Drugs and Technologies in Health undertake comprehensive horizon scanning.

With respect to conflicts of interest, MSAC is very specific at all levels of its operation. At the commencement of every advisory panel and MSAC meeting, the Chair requests declaration of conflicts of interest. These are recorded in the minutes and appropriate decisions are made on the participation of the person declaring a conflict based on an assessment of the issue.

This is formal and explicit, and is on the public record. It is important to state this, as the article by Petherick and colleagues implies that MSAC does not record conflicts of interest.<sup>4</sup> In fact, MSAC places great importance on declaration of conflicts of interest.

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## Barrett's oesophagus and columnar metaplasia: saying what we mean

**Andrew A Thomson**

**TO THE EDITOR:** I wish Professor Carr the very best in his attempt to eliminate the somewhat confusing term "Barrett's oesophagus" from the literature.<sup>1</sup>

Changing well entrenched medical nomenclature is difficult, however. I tried to do this with "microscopic colitis" 10 years ago<sup>2</sup> but was not successful. After all, I argued, we do not speak of "microscopic bronchitis" or "microscopic salpingitis" — so why should we have the term microscopic colitis?

It is nonetheless pleasing to note that the definition of microscopic colitis has tightened up over the past 10 years,<sup>3</sup> and I think this may be a more realistic aim for Professor Carr with the term Barrett's oesophagus.

Admittedly, the two entities are not perfectly analogous, as, unlike microscopic colitis, Barrett's oesophagus is classically associated with abnormally coloured mucosa. However, in both entities, the endoscopist usually takes biopsies from endoscopically flat mucosa, specifically looking for the disease in question.

I am not sure I can see myself in 10 years' time looking down someone's oesophagus and saying, "I think there may be some columnar metaplasia down there. I wonder if there is some intestinal metaplasia as well?" Maybe this would be a good conversation opener in the halls of the pathology department, but certainly not in the endoscopy suite! I think I will still be saying, "That looks like Barrett's, but we will need to take biopsies to make sure".

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Norman J Carr

**IN REPLY:** I thank Dr Thomson for his kind comments. I sympathise with his attempts to eliminate the term “microscopic colitis”<sup>1,2</sup> and would happily join him in this campaign. I agree it is important to tighten up the definitions of ambiguous terms. For example, “indeterminate colitis” is another term that continues to be used in different ways, despite attempts to clarify its definition.<sup>3</sup>

However, in the case of Barrett’s oesophagus, there are precise definitions, but they are mutually exclusive. The British Society of Gastroenterology uses one definition (not requiring goblet cells), whereas other national bodies use another definition (requiring the demonstration of goblet cells histologically).<sup>4</sup> Therefore, when an endoscopist says “That looks like Barrett’s”, he or she could be saying either that the mucosa appears glandular or that a pathologist will find goblet cells in it. The two are not the same and we should not confuse them.

I believe we should not use “Barrett’s oesophagus” because it is defined differently by different people; confusion regarding the site of a particular biopsy can cause it to be applied inappropriately; and we have existing terminology that does the job.

I accept that a few lone voices are not going to change well entrenched terminology. However, we can hope that the national and international bodies that construct guidelines in this area will take heed, accept the challenge and deal with the problem.

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