



APPENDIX 3

RANZCP Victorian Faculty of Child and Adolescent Psychiatry

Submission to the Royal Commission into Victoria's Mental Health System

This paper is an attachment to the RANZCP Victorian Branch Submission. The purpose of a specific Faculty of Child and Adolescent Psychiatry (FCAP) submission is to highlight issues and challenges of particular importance to the mental health care of children and adolescents.

The FCAP highlights the following areas for the Royal Commission's consideration:

1. Managing the treatment gap between need and available resources
2. Appropriate models of service for child and adolescent mental health
3. Greater access to evidence-based psychotherapeutic and other psychosocial interventions
4. Prevention and early intervention
5. Workforce training and planning strategy
6. Co-production and involvement of consumers (including children) and carers
7. Subspecialist areas of child and adolescent mental health

1. Managing the treatment gap between need and available resources

There is the treatment gap between demographic/epidemiological need and resources to meet that need. This has been identified by the two surveys of Australian child and adolescent mental health.¹

There is also a treatment gap between demand need (those seeking treatment) and available resources. The most recent epidemiological survey suggests demand has increased.

There is a need for fairness and equity in availability of services according to demographic and epidemiological need. The current perception from the data suggests there is discrimination and lack of fairness against young children who are least able to speak for their need.

In running services there is a need to balance access for those seeking treatment with the need to provide a sufficient episode of treatment so as to meet the evidence base or to get a successful outcome.

The role of child and adolescent psychiatrists in delivering of services in public, private and non-governmental sector is crucial in ensuring services are informed by evidence

¹ Commonwealth of Australia. The Mental Health of Children and Adolescents. Report on the second Australian child and adolescent survey of mental health and wellbeing. Canberra, 2015.



APPENDIX 3

based practice and sound therapeutic frameworks. Child and adolescent psychiatrists in the public sector are limited due to low numbers of child and adolescent psychiatrists available to provide direct care and consultation.² Families, young people, and referrers are frequently finding it difficult have direct access to child and adolescent psychiatrists in line with other medical specialties.

2. Appropriate models of service for child and adolescent mental health

Child and Youth Mental Health Services (CYMHS) are a tier 3 service and have a role in managing the most serious and complex cases in their given catchment area. They are also used where tier 1 and 2 services are unable to effectively treat less serious illness for a variety of reasons such as parental mental illness / substance misuse, CALD, refugee, out of home care, and other priority areas. On top of this, they have leadership, training, consultation, supporting and up-skilling roles for tier 1 and 2 services. To do these latter roles effectively and maximize the influence of tier 3 expertise, adequate resources need to be ring-fenced to meet these community up-skilling and support roles. If this is not done, the pressure for direct work with patients and their families tends to take precedence.

Tier 2 services such as Headspace, Take 2 (DHHS), Aboriginal services (Koorie Kids), disability services, family support agencies, drug and alcohol services, and private practice clinicians require access to psychiatric expertise for those cases that are complex, but could be managed if supported by secondary consultations into their service where the case is expertly discussed, and primary consultations where the patient can be assessed and a treatment plan developed that tier 2 can implement.

There needs to be greater psychiatric presence in services like Headspace and Take 2 that are seeing complex cases that may require the availability of various bio-psycho-social treatment options, including the options of parent work, family therapy and expert medication management where it is appropriate. The Koorie Kids model of having a part-time embedded psychiatrist is a useful example of this in a tier 2 service.

There needs to be greater access to psychiatric input through primary consultations to other tier 1 and 2 services. Primary consultations could be increased by outpatient clinics, and able to be referred to by GPs, paediatricians or tier 2 clinicians. There could be neurodevelopmental / disability clinic as found at Monash Medical Centre, a behavioural clinic co-managed with the paediatric service as is found at Royal

² Royal Australian and New Zealand College of Psychiatrists (2019) *Child and adolescent psychiatry: meeting future workforce needs*. Melbourne, Australia: Royal Australian and New Zealand College of Psychiatrists. Available at: <https://www.ranzcp.org/news-policy/policy-submissions-reports> (accessed 25 June 2019).



APPENDIX 3

Children's Hospital, or an eating disorder clinic co-managed with paediatrics as is found at Austin Hospital.

There needs to be greater provision and utilisation of secondary consultations to assist tier 2 services and identified tier 1 services (such as specialist schools) to manage more complex mental health needs, and to help in the appropriate referral to tier 2 and 3 services.

The intake / triage aspect of CYMHS is an obvious place where primary and secondary consultations could occur, as well as providing a consistent interface between tiers 1, 2 and 3. It could also provide brief interventions for those cases where short-term containment or expert assessment and treatment planning could be developed and passed on to tier 1 and 2 services. This would require a significant beefing up of most CYMHS triage services as they currently stand. With such an increased resourced service, perhaps a crisis assessment service with outreach could also be incorporated, for hard to engage youth or children who would not leave home.

There are clear significant gaps at most levels of care. There is insufficient capacity and resources at primary care. There is insufficient capacity at tertiary level care to meet the needs of those with severe and complex disorders. In particular there is a clear gap in services between primary care and tertiary level services despite the advent of greater private services through Medicare Better Access programs and the advent of headspace clinics (the effectiveness of both systems remaining unclear). The gaps in the service make running a stepped care system largely unworkable.

There are also gaps in the wider psychosocial support and disability sectors that impact on mental health provision.

There is a need to introduce more trauma competent or trauma informed care into the models of mental health provision.³

There needs to be education department run dedicated school refusal programs in each school to re-integrate students who are struggling to attend. This would require graded exposure programs, parent / family involvement, and dedicated mental health access within the program for those students with mental health reasons for their school refusal.

Case management needs to be returned to the disability sector for those families where more support is required to access and utilize appropriate services, particularly around maladaptive verbal, physical and sexual aggression. Such disability services need clear

³ Royal Commission into Institutional Responses to Child Sexual Abuse Final Report (2017) Available at: <https://www.childabuseroyalcommission.gov.au/final-report>



APPENDIX 3

processes to get primary and secondary consultations, and processes for when a transfer of case management to tier 2 or 3 mental health services is required.

Aggression in the community by under 18's is a difficulty facing many families. It is typically managed after a sudden crisis at home or school, and usually by school staff, police, emergency departments, and then referred to family support services when a serious mental illness is not the cause. Family violence services should be offered in all jurisdictions, and aimed not only at adults who are violent but also at violence by children / adolescents to family members.

Drug and alcohol services would benefit from an embedded psychiatrist on-site to help with the frequent mental health comorbidities and causes of substance misuse. There should also be provision of parent work for parents / guardians / carers to help them develop a confidence in knowing what they can and cannot do to help their loved ones, and develop clear boundaries around safety.

Mental health change requires the family involved to develop a therapeutic alliance with the mental health treatment service, and to have the resources to address the particular difficulties they are experiencing. Not all families are ready, are safe enough, or have the resources to use mental health treatment, and many require family support services to step in and help develop the basics required for change to be able to occur. Such basics include the importance of safety, basic needs, and strong, united consistent boundaries. These are the pre-requisites for change to be possible, and without them family based treatment by mental health services is rarely successful. So links between family support services (including DHHS) and mental health services need to be strong and flexible, with clear pathways to move between support and treatment services as the family strengthens or weakens, and clear sharing of expertise in both directions, and clear plans around getting both services involved as necessary to clarify who is responsible for what to help create change.

3. Greater access to evidence-based psychotherapeutic and other psychosocial interventions

The evidence base for child and adolescent mental health practice suggest much emphasis should be placed on psychotherapeutic and other psychosocial interventions. This is for most disorders. Yet, access to such psychotherapeutic and psychosocial interventions is severely limited such that most patients are not delivered an appropriate evidence-based treatment. It also leads to excessive use of psychotropic medications that can be both of limited effectiveness and place children at risk of adverse effects



APPENDIX 3

from medication.⁴ In part the excess use of medication occurs because there is inadequate access to appropriate evidence-based psychotherapeutic and psychosocial interventions, and the child is primarily seen as having problems that need to be solved. We would strongly advocate that any service involved in working with children should see them as people to be understood, rather than just as problems to be solved. As such, the bio-psycho-social framework of understanding and treating children holistically needs to be central to mental health services. This can only occur if the psychosocial aspect of assessment and treatment is available.

Such psychotherapeutic and psychosocial interventions require a skilled workforce and a commitment of services to develop and maintain such skills within their workforce. There could be many examples of this, but two examples are evidence-based family and individual psychotherapeutic interventions for anorexia nervosa and the evidence base for structured psychotherapies for young people with borderline personality disorder.

Tier 3 services are well aware of the evidence base and importance of parent work and family work, and are skilled in the selection and utilising of such treatments as appropriate. Tier 2 services can be less aware of and able to provide these services and look more at treating the individual child, even though their dependence and immaturity can make the usefulness of such interventions of questionable effect. For example in anxiety disorders, family-based CBT is more effective in the under 15's than individual based CBT. At a population level, parenting programs like "tuning into kids", "circle of security" and "PPP" are well researched and effective for mental health of developing children. However, the availability of such programs is hit and miss in many parts of Victoria, and where they exist the long waits for such programs can be an impediment.

Though a federal issue (through Medicare rebates) rather than a Victorian Government issue, a way of increasing the proportion of parent work provided by tier 2 private clinicians would be to advocate to the Medicare / Federal Government that when a dependent child is referred to a therapist, that their parent / guardian can be seen under the child's referral and receive the same Medicare rebate (at present it is a much lesser amount and thus a disincentive). Parent work and family work are powerful interventions that are cost-effective and extend out to other children in the family, help strengthen relationships and families, and provide ongoing benefits over the child's family's life span.

⁴ Australian Commission on Safety and Quality in Health Care (2018) *The Third Australian Atlas of Healthcare Variation*. Sydney, Australia: Australian Commission on Safety and Quality in Health Care. Available at: <https://www.safetyandquality.gov.au/our-work/healthcare-variation/atlas-2018#view-the-full-atlas> (accessed 2 July 2019).



APPENDIX 3

4. Prevention and early intervention

The development and implementation of early intervention and prevention strategies for the prevention of mental illness in infants, children and adolescents is imperative to addressing outcomes and preventing or reducing mental disorders in adulthood. Prevention and early intervention is defined as *'any activity which is aimed at identifying and/or treating risk factors for, or early symptoms of, emotional and behavioural disturbance that may lead to mental illness in childhood or adolescence.'*⁵ Psychiatrists have an important role in the early detection, assessment and treatment of mental disorders and problems in children and adolescents.

While prevention and early intervention strategies can be implemented throughout childhood and adolescence, there is particular relevance for issues and problems associated with infant mental health. There is a high community prevalence of infant mental health disorders. However, few infants and toddlers receive mental health interventions or early intervention to minimise the impact of trauma and emotional developmental difficulties.

The burden of infant mental health disorders frequently goes unrecognised by clinical services. Scarce resources are allocated to infant work with the bulk of child and adolescent mental health services directed at adolescents and perinatal mental health services focused on adults with severe illness

There is large range of evidenced-based and effective early interventions and child and child and family treatment options available. Early identification in the first few years of life of severe mental health problems such as autism and developmental disorders can lead to major improvement in child quality of life and overall family functioning and health. Mental health interventions for the most vulnerable infants can lead to significant relationship and developmental improvement.

Interventions need to be delivered both at a broad community level through universal services, and at a more specialised and intensive level for those infants and young children at severe risk. Key recommendations would include an improved trained clinical resource within Child and Adolescent Mental Health Services and CYMHS and increased community-based interventions.

There is a need to provide funding and an organisational structure to deliver appropriate prevention and early intervention. There is a very strong evidence base to support the

⁵ The Royal Australian and New Zealand College of Psychiatrists: Report from the Faculty of Child and Adolescent Psychiatry. *Prevention and early intervention of mental illness in infants, children and adolescents: Planning strategies for Australia and New Zealand*, 2010.



APPENDIX 3

benefit of early in life prevention and early intervention, but this is not currently delivered effectively or broadly.

There are questions about what a suite of preventive and early intervention strategies might look like. Many are educational and supportive in nature. There also needs to be relational interventions of a more therapeutic nature to the significant minority of very young children identified as at substantially high-risk of negative outcomes. The capacity to identify very young children at high risk is available to us. Access to the majority of these very young children at high risk is possible as most are already engaged in health services such as maternal child health nurse services et cetera.

Schools often find themselves dealing with the effects of poor mental health in their classrooms. Teachers describe themselves as poorly prepared for the emotional and behavioural challenges in the classroom, taking up to 30% of classroom time. The mainstreaming of children with disabilities adds to the challenges for teachers. “Calmer classrooms” is an excellent resource, but many teachers describe not knowing how to apply it in their classes. Each school should have an ongoing development program not just for teaching but also for managing complex emotions and behaviors in the school.

Though the digital age has brought many benefits, schools should consider the gathering evidence of negative effects of phone and internet access on academic learning, socializing in school, cyberbullying, and the disengaging effect such potentially addictive technologies can have on a proportion of students. Urgent research is needed on the effect of technology on the mental health of developing young people, and in the meantime consider the banning of smart phones and unlimited internet access during school hours. If the research shows a strongly detrimental effect of digital technology on children, a public health campaign should be considered in a similar vein to that done for smoking, gambling, alcohol and other addictive activities.

5. Workforce training and planning strategy

Workforce planning and development is largely ad hoc. This often leaves large gaps in the capacity to provide a suitably trained and competent workforce at all levels of the system. A workforce strategy supporting a broad-based health and mental health system based on the evidence of epidemiology and demographic need should be the goal.

There needs to be recognition that the professional degrees provided by universities does not deliver clinically competent professionals to the workforce. Within services training and maintenance of clinical capacity needs to be undertaken. The above discussion about psychotherapeutic and psychosocial skills competence is one example.



APPENDIX 3

6. Co-production and involvement of consumers (including children) and carers

There should be a strategy to involve consumers and carers at all levels of mental health provision including in service design.

This should also involve developing strategies to include children not just older adolescents and young adults or their parents and carers.

Increase in workforce with lived experienced including family and peer workers would be vital in reducing barriers to accessing mental health service. Services and programmes need to be holistic, including attention to vocational and educational workforce, and physical health.

7. Specific areas of child and adolescent mental health

There are a number of specific areas of child and adolescent mental health characterised by unique needs and vulnerabilities.

These areas include:

1. Youth Justice
2. Children involved in the Child Protection System
3. Children whose parents have mental illness or drug and alcohol problems
4. Children with comorbid drug and alcohol problems
5. Children with dual disability with mental illness and intellectual difficulties and other neurodevelopmental problems
6. Aboriginal and Torres Strait Islander populations
7. Children of culturally and linguistically diverse populations.

In this paper we particularly wish to address issues associated with those children with a dual disability, mental illness and intellectual difficulties and other neurodevelopmental problems.

Neurodevelopmental/ Child Disability Psychiatry

A range of factors have seen the previously marginalised field of child disability psychiatry both expand dramatically and engage more effectively with mental health services over the last half-decade. Key factors in this change include the challenges associated with NDIS implementation, changes to what is considered acceptable practice in the use of restrictive interventions for people with disabilities, and changes in the expectations of families/carers regarding the burden of care associated with raising a child with a disability. The increasing tendency to medicalise emotional regulation difficulties and challenging behaviour may also play a role.



APPENDIX 3

This change places multiple and complex demands on existing services. Front line services are facing a crisis of highly disregulated children frequently presenting to emergency rooms and intake clinics, leading to high rates of restrictive interventions and pharmacological restraint. Child psychiatry has traditionally been focused on the treatment of high-prevalence disorders and adolescent suicidal risk. Developmental difficulties have been a more peripheral concern, previously redirected where possible to disability-specific services. Such services have had variable capacity. With the market-driven NDIS providing minimal incentive for providing services to high-needs complex children, a significant gap has emerged. Specialist disability services with expertise to manage complex problems need to be developed, and will require access and support from mental health services. This raises questions about the planning for education and training for disability-specific carers, clinicians and workers and the development of appropriate services. Access to Mental Health professionals with appropriate knowledge and skill in this area will be essential.

Within mental health programs some changes may need to be made. Redirection of young people with disabilities and complex social, emotional and behavioural problems is no longer appropriate. A balance needs to be struck between accessibility of services for young people with genuine dual diagnostic need on one hand, with resisting the medicalisation of any and all disruptive phenomena. Part of this is advocacy for the development of appropriate disability services, and providing mental health in-reach support for disability services. Part of this is also ensuring the skills and knowledge are present within the child and youth mental health workforce for identifying developmental disabilities and understanding their service needs. This may form part of Child and Youth psychiatry's early-intervention response; neuroatypical and developmentally delayed children are over-represented in cohorts that go on to develop psychotic illness. Improving emotional regulatory capacity and supporting the development of protective skills such socialisation and vocation may have broader benefits beyond the traditional disability psychiatry alone