Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF RICHARD HASLAM

I, Dr Richard Hugh Macnicol Haslam, Director, of 50 Flemington Road Parkville Victoria 3052, in the State of Victoria, say as follows:

1 I am authorised by The Royal Children's Hospital Melbourne (**RCH**) to make this statement on its behalf.

2 I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

BACKGROUND AND QUALIFICATIONS

Please explain your background and expertise.

3 I have the following qualifications:

(a) Bachelor of Medicine, Bachelor of Surgery;

(b) Certificate of Child Psychiatry (post-graduate); and

(c) Master of Science.

4 I have approximately 28 years of experience working in public mental health services, including child and adolescent mental health services (**CAMHS**), in Victoria. I joined RCH as Principal Consultant in 2007 and have been the Director of Mental Health of RCH since 2011.

5 Attached to this statement and marked **RH-1** is a copy of my curriculum vitae which provides further details on my background and expertise.

Are you associated with, employed by or do you receive funding from any entities other than the Royal Children's Hospital and the Murdoch Children's Research Institute?

6 I am not associated with, employed by nor do I receive funding from any entities other than the Royal Children's Hospital and the Murdoch Children's Research Institute.

SPECIALIST CHILD AND ADOLESCENT MENTAL HEALTH SERVICES IN VICTORIA

Please describe child and adolescent mental health services (CAMHS) in Victoria.

7 CAMHS are specialist, team-based services for children and adolescents up to 18 years old who have serious emotional and behavioural disturbances. They are modelled after

the longstanding CAMHS model in the United Kingdom and reflect a distinct specialty from adult mental health services.

8 CAMHS are led by child and adolescent psychiatrists and other child and adolescent specialists such as psychologists. They are configured in teams to reflect and respond to infants, children and adolescents and their families who have higher complexity and severity of mental health problems.

9 For a number of years the standard age groups dividing Victorian public mental health services (**MHS**) have been 0-18 (CAMHS), 16-64 (adult MHS) and >65 years old (aged MHS).

In principle, 16 to 18 year olds can be treated at adult mental health services (**AMHS**) but, in my experience, this has rarely happened in the last 20 years in Victoria, except in the specific situation where an older adolescent requires inpatient admission and there are no available adolescent (<18 years old) beds in Victoria.

What and where are these services?

10 There are 13 regionalised CAMHS in Victoria and all of them (except for RCH) are aligned with and governed by health services that also provide adult mental health services. Specialist mental health service policy and delivery in CAMHS are predicated on adult mental disorders; the use of catchment areas and the case management and recovery models at CAMHS have all been adopted from a model for managing adult mental disorders. It is not uncommon that policy initiatives, such as the Multiple and Complex Needs Initiative (MACNI) are introduced but for Victorians over 16 or 18 year olds only.

11 CAMHS provide services to 0 to 18 year olds, but there has been little attention to those aged 4 years and below until about 10 years ago. Even now, most patients at CAMHS are school-aged children, and there has been a general neglect of infants and pre-schoolers with mental illnesses, which reflects community reluctance to acknowledge that infants and pre-schoolers can suffer significant emotional stress and disorders. Relevantly, RCH is one of the world's leaders in infant mental healthcare for 0-4 year olds and has provided effective interventions for infants with congenital medical and developmental problems and medical trauma, and those who develop mental illnesses in the context of parent-infant relationship problems, parental mental illness or substance use and family violence. Infants born prematurely or requiring prolonged intensive care treatment can develop profound symptoms of traumatic stress, and their parents too experience ongoing traumatic stress symptoms. Assessment and diagnostic systems have been developed alongside effective interventions, which need to be delivered both in tertiary hospital settings and broadly across the community. Just like child and adolescent mental health as a whole, infant mental health needs a State-wide approach

to improve the reach and impact of training, monitoring of effectiveness and to increase the integration with paediatrics, child protection, early learning, adult mental health, family violence and forensic services.

12 Several Victorian CAMHS provide inpatient care but most mental health services for infants, children and adolescents are provided through community-based clinics which have a different range of services in each catchment.

13 The youth mental health model was implemented in Victoria from about 20 years ago, and represents a significant modification of adult models of psychiatric care. It aims, amongst other things, to provide greater access to services and "early intervention" for certain specific mental disorders (for example, psychosis). Most but not all people under 18 who are referred to mental health services for psychosis would be in their first episode of psychosis. This is discussed further in paragraphs 83 to 88 below.

How are they funded and monitored?

Funding

14 CAMHS receive block funding from the State government which consists of approximately 15 specified grants that are largely historical. Most of these grants do not have outcome-based key performance indicators (**KPIs**); if they do have KPIs, the KPIs are based on inputs, that is activity such as hours of contact/activity). The current set of KPIs is poor and reflects global functioning of a CAMHS service rather than accessibility (including by vulnerable groups) or individual clinical outcomes. Due to limitations to the State-wide RAPID/CMI (Client Management Interface) system and the complex overlapping age groups of the various metropolitan CAMHS/Child and Youth Mental Health Services (**CYMHS**), it is often impossible to benchmark inpatient or outpatient performance between services. For example, where a child and an adolescent ward operates from a single service, the adolescent ward performance cannot be compared with other adolescent wards (see the Victorian Auditor-General's Office's (**VAGO**) on Child and Youth Mental Health (June 2019) (**VAGO Report on CYMH**).

15 Importantly, as demonstrated by the VAGO Report on Access to Mental Health Services (March 2019) (**VAGO Report on Access**), funding is not related to population or prevalence and recent growth funding is intended to support treatment for 1.2% of the Victoria's population but 3.1% of the population have serious mental health illnesses (page 42). This is a key factor in the so-called 'treatment gap' in Victoria, which is seen worldwide in mental health, and leads to the current situation whereby about 27.5% of children with moderate or serious mental illnesses receive no treatment of any sort (Young Minds Matter survey). The VAGO Report on Access describes the partial funding of child, adolescent and adult inpatient beds relative to their true cost (page 10), with the

result that funding intended for community mental health is redirected to support inpatient costs.

16 The systemic underfunding of CAMHS/CYMHS is most acute in south and western Victoria (and possibly regional Victoria as a whole) – the VAGO Report on CYMH indicated that funding per young person (0-24 years old) in the south-western region of Victoria is substantially lower than that for all other areas of Victoria.

17 RCH was fortunate to receive growth funding in FY2016/17 and FY2017/18. Such funding was intended to allow RCH to begin to catch up with the population growth in our catchment area (to the extent possible), especially in the outer metropolitan regions. RCH was not directed how to deploy this funding and we decided to strategically deploy that funding to provide greater access to services by vulnerable groups (see paragraph 31 below). In my opinion, and despite endemic underfunding, there needs to be proper distribution of the available resources which reflects overall population but importantly the higher prevalence and lower access to mental health services in certain areas.

Monitoring

18 RAPID/CMI, the State-wide data system for mental health (first implemented in the 1980s) is a huge limitation for CAMHS/CYMHS, especially when we are in the era of electronic medical records. There are no current structures for information sharing between CAMHS/CYMHS. Importantly, the clinical interface between CAMHS/CYMHS is also not formally or effectively monitored with inevitable problems at the patient level resulting from different criteria for service provision or precedence given to providing care for a patient from a particular catchment area ahead of clinical urgency or need.

19 There is a focus on inpatient metrics and a lack of effective, State-wide governance. Individual CAMHS/CYMHS therefore lack central direction to balance the competing functions to mitigate risks, to treat psychiatric disorders or to provide social supports and case management. In this context, CAMHS/CYMHS seek to prioritise funding to address risks (predominantly suicide) which are more acute in older adolescents and young adults.

What mental health services does RCH provide?

Inpatient services

20 RCH only provides specialist mental health services to infants, children and adolescents (on average, about 1,500 patients in total).

21 RCH's Banksia Ward has 16 beds (out of 52 metropolitan beds in Victoria) for the provision of inpatient services to 13 to 18 year olds across the whole of north-western

Victoria and 3 districts of western Victoria. If our ward is full, we will seek to have patients admitted to one of the other three child and adolescent wards in Victoria.

22 About 70-80% of patients receiving our inpatient services are 'out of area' patients, in that they don't receive continuing care from RCH's community-based services. This creates communication difficulties as we have to liaise with other community-based services for the majority of our inpatients. It is also anomalous and problematic to provide inpatient care in a ward where the vast majority of patients receive different models of care for their core treatment from different community-based services. As inpatient care is in most cases a short period in a course of an outpatient care journey, it is vital for high quality care that communication at admission and discharge are clear between teams, and the models of care are congruent.

Outpatient community teams

23 RCH has three community teams based in Flemington, Sunshine and Hoppers Crossing to provide outpatient care to 0 to 15 year olds. While these teams treat 600-800 children and adolescents at any one time, they are insufficient to address the increased demand in other metropolitan areas (for example, Melton and Sunbury). We also have aging infrastructure for our community-based services which may not reflect community expectation for a setting in which recovery can be supported.

24 Outpatient care is the primary treatment for most mental health disorders and inpatients are invariably referred to community or outpatient care. Inpatient care is rarely the definitive treatment – the length of stay in our inpatient ward is a short period of (on average) about 6-7 days, whereas most psychiatric disorders requires weeks and months of treatment.

Hospital Consultation-Liaison Team

25 RCH has a Hospital Consultation-Liaison Team which provides psychiatric care to children and adolescents while they are in hospitals receiving other medical investigations or treatment or in Emergency Department (**EDs**), even though we are not specifically funded to provide such services. The massive increase in presentations by teenagers at EDs such as at RCH's ED, where there has been a 400% increase in after-hours mental health presentations over the last 7 years, has not been met with policy and funding initiatives to reduce this demand, develop appropriate infrastructure, or improve the timeliness or quality of care. In general, busy paediatric or adult EDs are not suitable environments for agitated, distressed children, adolescents and their families, whether this is their first contact with mental health services, or they are frequently returning in mental health crises.

Specialist clinics

26 RCH has a range of specialist clinics which offer mostly state-wide services, including:

(a) Infant Mental Health Team, which provides services to 0 to 4 year olds with a range of difficulties that may be impacting on their emotional wellbeing and development;

(b) Psychology and Neuropsychology Service, which offers clinical and neuropsychology services for 0 to 18 year olds;

(c) Eating Disorders Team, which collaborates with the Department of Adolescent Medicine to provide an integrated interdisciplinary assessment and interventions for 12 to 18 year olds with eating disorders and their families;

(d) Gender Service, which collaborates with the Department of Adolescent Medicine to provide 0 to 18 year olds with integrated, interdisciplinary assessment, treatment and support with concerns regarding their gender identity; and

(e) Specialist Autism Assessment Team, which provides an expert multidisciplinary autism assessment for children and adolescents in the RCH CAMHS catchment where commonly families are unable to afford or gain access to such assessment in the community. In a fee-for-service arrangement, an autism assessment and the associated reporting processes may take 2 hours each across three providers and cost well over $2,000 in total. Due to high demand, the waiting time for this service is about 2 years.

Intensive Mobile Youth Service (IMYOS) Team

27 RCH provides outreach services via the IMYOS Team to young people who have already been referred to RCH but have significant difficulty engaging with a clinic-based service and have a serious mental illness that needs intensive support. Such outreach services include frequent visits in the community to young peoples' homes, residential units, schools and community centres. There is significant unmet need in the community for mental health care for children, adolescents and families who cannot use clinic-based services.

In2School

28 RCH collaborates with the Melbourne Graduate School of Education and Travancore School to deliver the In2school intervention program. This successful program is for 11 to 14 year olds who have been school-refusing for between 3 months and 2 years and commonly have diagnoses of anxiety and/or mood disorders.

CASEA

29 RCH's CAMHS and Schools Early Action (**CASEA**) is a State-funded, early intervention program for young children in Prep to Year 3 with challenging behaviours and emerging conduct disorders. This program uses evidence-based practices to work with parents and schools to help address conduct disorders early in life.

Mental health promotion

30 RCH conducts mental health promotion initiatives such as the Festival for Healthy Living, which over 20 years has built capacity in schools and communities (for example, those recovering from bushfires) for mental health promotion through the arts.

New collaborations

31 As a result of the growth funding in the past few years, we have initiated new collaborations to cater for vulnerable groups – for example, infants identified through maternal and child health nurses, and children and adolescents who have physical disabilities or development difficulties, are of indigenous heritage, are in out-of-home care or are refugees. It has been almost 2 years since we implemented these initiatives and we are due to evaluate them formally soon. The anecdotal reports from families and medical and child protection colleagues have, however, been very positive. Each of these innovative positions has an element of wider capacity-building with paediatric health or welfare colleagues.

Non-specialist mental health services

32 Mental health care is also provided through a large number of clinics through the Centre for Community Child Health, the Gatehouse Centre, Neurodevelopment and Disability and other parts of RCH. While mental illnesses and symptoms present with physical health concerns, a number of these clinical services address emotional and behavioural difficulties as a primary reason for referral, and can treat mental illnesses with a similar impact or severity to those addressed in the specialist mental health system.

Particular issues faced by RCH

33 In addition to the issues raised elsewhere in this statement, RCH's CAMHS has no inpatient beds for those under 13 year olds, and has no day program which could offer step-down care to consumers to spare the use of inpatient beds (which is offered by Monash Health's CAMHS). RCH has seen a sharp increase in presentations through the ED of children and adolescents with developmental disabilities such as Intellectual Disabilities or Autism Spectrum Disorders (**ASD**) along with aggressive or self-harming behaviours. The severity and chronicity of these challenging behaviours are exacerbated

by the dearth of therapeutic, respite and longer-term accommodation services for this group of younger Victorians. A suitable space in the ED for short-term assessment and interventions, as well as pathways for enhanced community-based interventions is missing. We have seen early success from our new Developmental Disability-Mental Health psychologist and IMYOS Developmental Disabilities outreach clinician (see paragraph 31 above) in responding to this important clinical problem.

When is mental health treatment for children and adolescents indicated?

34 I consider that there are three dimensions which represent the range of mental health problems for children and adolescents and therefore the needs of a service system:

(a) an age range from 0 to 18 years old – across these developmental stages, there are different settings therefore different challenges (for example, home, peers and schools), different needs and of course infants, children and adolescents have different degrees of independence, such that it is clearly simplistic to think of them as one homogenous group;

(b) a range of mental illnesses and symptoms – there is a wide range of illnesses (for example, conduct disorder, attention deficit hyperactivity disorder (**ADHD**), depression, anxiety disorders, eating disorders and phobias) and each illness may present differently depending on the age of the child (for example, anxiety presents differently for a 3-year-old as compared to a 16-year-old, and require different interventions); and

(c) a range of severity of mental illnesses and symptoms – there are wide ranges of severity for many mental disorders (for example, a child may be mildly impaired by anxiety about talking in front of a class, as compared to another child who refuses to go to school for 2 years due to severe and incapacitating anxiety).

35 In my view, the three dimensions above are a challenge to developing a 'service system' for mental disorders in isolation.

36 Designing an effective service system to meet these three dimensions must also reflect that the risk or impairment which dictates service level and intensity must be assessed through the report of the child or adolescent (for example, suicidal ideation) but can for some conditions be best informed by parents or guardians (for example, conduct problems) or educators (for example, concentration or social impairments).

37 The recent representative national Child Health Poll conducted by RCH highlighted the low levels of recognition of mental disorders in children by parents, which compounds the impact of stigma and shame which remain present despite recent media and public health campaigns.

38 It is the lack of attention to the child's voice, along with minimising of symptoms as 'part of growing up' or 'normal' that contribute to reduced help-seeking and the eventual escalation of symptoms of mental disorders. An effective mental health system will support children and adolescents to respond to their concerns where they are identified and offer appropriate information, support and interventions before the difficulties 'snowball' to affect school performance and social relationships and lead to behavioural disturbances, mood and anxiety and self-harming or suicidal behaviours.

IMPORTANCE OF MENTAL HEALTH SERVICES FOR CHILDREN AND ADOLESCENTS

What are the risk factors for mental health problems in childhood and adolescence?

39 The risk factors for mental health problems in childhood and adolescence include:

(a) social disadvantage;

(b) trauma, abuse, neglect;

(c) family violence;

(d) parents with mental illness;

(e) bullying;

(f) developmental disabilities (for example, ASD);

(g) out-of-home care;

(h) medical conditions; and

(i) indigenous heritage.

40 The prevalence of low to moderate severity mental illnesses has been fairly stable, but there is a clear rise in presentations of depression and anxiety in adolescents which is associated with increasing rates of self-harm and suicide (the decline in suicide rates since the mid-1990s for 15-19 year olds has ceased in the past ten years). The increase in depression and anxiety, and related presentations to EDs is contemporaneous with the arrival of the smartphone, which causes one to wonder about the impact of social media on mental health. There is no clear evidence that depression or anxiety in children has increased.

41 ASDs have also become far more common. About 20-30 years ago, about 1 in 10,000 people had autism – today the ratio is higher than 1 in 76 people.

42 It is, however, less stigmatising nowadays to have autism, depression or anxiety – this may be a factor in the increase in presentations of such disorders and well as increasing the identification of 'milder variants' or a 'spectrum' of illnesses.

What is the importance of providing mental health services when there are concerns about a child's or adolescent's mental health?

43 Mental disorders tend to be persistent or recurrent, and accumulative. There is a snowballing effect when mental disorders develop and accrete with other medical, mental health and social difficulties (for example, academic difficulties and family problems).

44 An effective mental health system will support the identification of infants, children and adolescents at risk of mental illnesses, offer evidence-based interventions likely to benefit those with early features and support collaboration with other service elements to step-up care where these measures are unsuccessful.

45 There are powerful economic reasons for the community to provide effective interventions for mental health problems and mental illnesses. These include the cost-effectiveness of intervening earlier, the long tail of economic impacts from disabling mental disorders through into adult life, and the impact for parents, carers and siblings of children and adolescents with mental disorders.

46 The impact on families of mental illnesses can be devastating and the effective provision of interventions offers a triple benefit for the child, for their family members and for the next generation as the future adult and parent has an improved opportunity to meet their potential and raise physically and mentally healthy children.

In your view, how easy or difficult is it for people to access child and adolescent mental health services when needed? Why?

47 It is often difficult for people to access child and adolescent mental health services when needed.

High prevalence of mental disorders

48 In the last national survey (The Mental Health of Children and Adolescents: Report on the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing (2015)), close to 15% of children and adolescents were found to have mental illnesses. These mental illnesses may be ADHD, conduct disorders, anxiety or eating disorders etc. In addition, as indicated in the VAGO Report on Access, specialist mental health services are funded to provide services to a little over 1/3 of those with even serious mental illnesses (page 42).

49 As such, the prevalence of mental illnesses is far too high for the thirteen CAMHS, and the waiting times for care at CAMHS are often more than 12 weeks. For example, at RCH, there is a waiting time of 12-18 weeks for a standard referral for assessment. This is concerning, considering that there is good evidence that the longer a consumer waits,

the lower the consumer's engagement and the lower the likelihood of success of treatment. In addition, CAMHS' working hours are generally from Monday to Friday, 9 am to 5 pm, which is likely to reduce accessibility for families and leaves EDs as the only gateway to mental health expertise outside these hours.

"Missing middle" of providers

50 CAMHS are specialist services and need to collaborate with a base of trained, financially-supported and available primary care providers (for example, allied health clinicians, psychologists, psychiatrists and general practitioners (**GPs**)) that can provide mental health care for high prevalence, low to moderate severity mental illnesses. There is a "missing middle' of such providers in Victoria.

51 In particular, there is a maldistribution of Commonwealth-funded services (through the Medicare Benefits Schedule (**MBS**)). There is an absence or paucity of primary care providers in areas with low socio-economic predominance (for example, parts of the north and west of Melbourne).

52 A related issue is that gap payments which are required in addition to the MBS subsidies are prohibitive for many families. For example, a consumer with moderately severe Obsessive Compulsive Disorder is likely to require at least 10 sessions with a psychologist, and the gap payment for each session could be about $100 dollars. The gap payments over 10-16 sessions are unaffordable for many people in Victoria. There are therefore regions of Victoria which have a higher prevalence of child and adolescent mental disorders, lower per-capita specialist mental health funding, fewer Commonwealth-funded providers and lower family financial capacity to seek interventions from those providers.

53 Even where there are primary care providers, many will refer children and adolescents facing mental health difficulties to CAMHS. For example, I am aware of paediatricians in parts of Victoria who have closed their books to children and adolescents referred with mental illnesses. This is because paediatricians and GPs:

(a) vary in seeing mental health as truly part of mainstream health and medical care and do not consistently acknowledge mental disorders as part of their core work;

(b) tend to feel ill-equipped to offer interventions for mild to moderate mental illnesses, as training in mental healthcare is limited in medical school and specialist training in paediatrics and general practice and there is a lack of supports for them to manage mental disorders; and

(c) experience a financial disincentive to accept children and adolescents with mental disorders for treatment, as assessment and treatment will involve both

parents and children/adolescents (often separately and together) and will require longer sessions to deliver than what is covered by MBS items; and

(d) find a lack of supports in private practice, such as the availability of timely specialist mental health consultation.

54 The result is an overburdened specialist CAMHS system that rations care by putting up barriers to access, and devotes considerable resources to triaging referrals of moderately-impaired children and adolescents. CAMHS have the capacity to see only a minority of infants, children and adolescents with even serious and impairing mental disorders. Consumers often do not satisfy the referral criteria for acceptance by CAMHS but are unable to access primary care providers. Another consequence of an overburdened CAMHS system is that staff morale is affected when staff are under pressure, feel their work is neglected or that they are not making much difference.

55 A related issue is that telehealth or telepsychiatry is not widely used – telepsychiatry, if available, allows primary care providers to consult child and adolescent psychiatrists, or allows services to be provided to children and families in their homes via videoconferencing. The latter service is available at RCH and from some private providers for regional consumers.

Recruitment and retention

56 I understand from my regional colleagues that recruitment and retention of the CAMHS workforce is considerably more difficult than in metropolitan Melbourne. An effective mental health system should seek to mitigate such a gradient from metropolitan to regional services.

Other issues affecting access

57 CAMHS are in general funded for inputs and not outcomes. Services themselves are not specifically funded to provide training in evidence-based assessments or interventions, or more recent innovations in collaborative care or digital health. Interventions are often not provided with a sufficient 'dose' to result in efficacy, due to staffing restrictions, or patient and family-related factors that impair engagement and participation in interventions. Given the co-occurrence of social, welfare and financial difficulties for many families seeking services from CAMHS, many consumers end their treatment prematurely, or rely on CAMHS for case management in efforts to bring other child and family services together.

58 Children and adolescents with intellectual disabilities can find services from CAMHS difficult to access, as symptoms of mental disorders can seem to overlap with behaviours associated with the disability and may not be identified as meeting referral criteria. Mental

health clinicians often do not have specific training in mental health and intellectual disability and may be less confident in offering or modifying their interventions.

What (other) issues prevent people from accessing help early?

59 As described above, recognition and stigma are limiting factors and may be more prevalent in some groups such as Culturally and Linguistically Diverse communities.

60 Parents have reported in the RCH National Child Health Poll that they do not know where to seek help for mental health problems in their children.

61 The availability of specialist or more general health services outside working hours is very restricted, leading to busy families being unable to use mental health services and at times, unnecessary use of Emergency Departments.

62 The existing MBS items for paediatricians and psychologists do not support interventions directly with parents, although evidence-based interventions for several common disorders including parent interventions as first-line.

What are some of the consequences of being unable to access child and adolescent mental health services when needed?

What are examples of the short-term impacts?

63 The examples short-term impacts are:

(a) education: school non-attendance or exclusions;

(b) family: family conflict and violence;

(c) health: increased healthcare usage;

(d) worsening of symptoms, eg restricted eating, more severe depression;

(e) suicidal behaviour and deliberate self-harm: and

(f) escalation leading to crisis attendance at EDs.

What are examples of longer-term impacts?

64 Longer term impacts depend on the type of mental disorders; for example:

(a) Conduct disorders and ADHD: substance use, unemployment, criminal justice involvement (victim and perpetrator) and incarceration, teen pregnancy, death before age 30;

(b) anxiety: perpetuated disability and future depression as adolescent and adult, academic underachievement, deliberate self-harm and physical health disorders such as, being overweight, cardiovascular disorders and tobacco use.

EVIDENCE AND BEST PRACTICE

Are there examples of best practice in Australia and/or globally when it comes to systems of mental health care for children and adolescents? If so: (a) What impact has the approach had? (b) Why is it effective?

65 I have considered examples of best practice in other parts of this statement.

What evidence exists to show the effectiveness of specific interventions for children and young people?

66 Child and adolescent mental health is less researched than other fields due to the lack of funded academic positions in Victoria and more widely, and the practical barriers to conducting research on children such as ethical constraints.

67 Randomised controlled trials (**RCTs**) have been conducted and reported for common medications for anxiety, depression, ADHD and psychotic disorders, although typically not replicated in Australia.

68 Similarly, RCTs for psychological therapies have been conducted and reported especially parent management training for Conduct Problems, Cognitive Behavioural Therapy for Anxiety.

Are there any risks of these interventions; for example, risks of stigmatisation or pathologizing/medicating problems that might resolve naturally?

69 Given the prevalence of mental disorders, their impact and tendency not in fact to resolve, there are few risks from their identification that are not outweighed by the clear benefits. Screening for mental health symptoms should be – and is in many areas such as adolescent medicine – a routine part of physical health care for children and adolescents.

RECOMMENDATIONS

How can Victoria better identify and support children and adolescents and adults who need extra support for their mental health?

What key changes would you recommend to Victoria's mental health system?

Alignment with primary care system & building capacity in the "missing middle"

70 Victoria's child and adolescent mental health service system should be brought into alignment with the primary care system to enhance synergies across specialist mental health and with primary care. We need to take a long-term perspective and bring interventions upstream to the primary care system for the greatest benefits; that system needs to see mental health as part of general health.

71 I would strongly argue for GPs, paediatricians and schools to be at the frontline and be skilled to address mental health as a core part of general health, so that more children and adolescents can rely on primary care for addressing low to moderate severity mental health disorders. As mentioned above, almost 15% of children and adolescents have mental illnesses and it is neither possible nor appropriate for specialist CAMHS to address all of them (especially with the varying factors of age, type of disorder and severity). Given that we have a functioning primary care system with GPs and paediatricians, and most children are in school or in early learning centres etc, primary providers and schools need to be engaged to address the high prevalence of mental disorders (which may be coupled with other social problems) that is beyond the capacity of specialist CAMHS.

72 As such, in addition to addressing the issues relating to the MBS (see paragraphs 50 to 52 above), primary care providers (paediatricians and GPs) need to be supported to take up their role, be trained to provide information, accurate assessment and treatment for low to moderate severity mental illnesses, and be reimbursed through MBS items or salaried positions in community settings for treating mental illnesses just like any other physical illnesses.

73 Specialist CAMHS need to be tasked to build capacity in the "missing middle" of primary care providers by providing or contributing to professional development including formal postgraduate qualifications and direct clinical support, so that primary care providers feel equipped to offer interventions for mild to moderate severity mental illnesses. This can be done through programs like the Massachusetts Child Psychiatry Access Program (**MCPAP**) and HealthPathways Melbourne:

74 MCPAP aims to improve access to treatment for children with behavioural health needs and their families by making child psychiatry services accessible to primary care providers across Massachusetts. One of MCPAP's services is telepsychiatry, whereby a primary

care provider can request a telephone consultation with either a child and adolescent psychiatrist or a behavioural health clinician – this service has been successful and effective in enabling specialists to guide and support primary care providers to provide mental health care.

75 HealthPathways Melbourne is an online portal with information on the assessment and management of common clinical conditions, including referral guidance. It is designed for use during consultation by primary care providers and developed by clinicians (including hospital-based specialists). The model can be expanded to support primary care providers to provide child and adolescent mental health care.

Greater recognition of the special needs of child and adolescent mental health

76 There needs to be greater recognition in the public mental health system and in the community that the needs of children and adolescent mental health are different from those of adult mental health, and that children and adolescents are not 'little adults' – the nature of mental illnesses and the interventions available are different for them and they have different comorbidities, providers (for example, paediatricians and schools) and community supports. In addition, as most children and adolescent live with families, each child and their family must be at the centre of care provision and service design.

77 While the community may now better understand mental disorders for those aged between 15 to 18 years old as well as issues such as youth suicide and drug use, the impairment of mental illnesses occurring early in life are often minimised and misunderstood. For example, RCH's National Child Health Poll was conducted 12 months ago on a representative sample of Australian parents, and the poll results revealed that many parents feel that infants and children do not have mental illnesses and that even if their children do have mental illnesses, parents would not know where to turn for help. Parents also tend to think that their children will get better in time, or are afraid of their children being stigmatised, and so tend to neglect their children's voice, their distress and ensuing mental health difficulties. As most mental illnesses begin in childhood and adolescence, children with neglected mental disorders are likely to become adults and parents with mental illnesses. It is vitally important that the health, welfare and educational systems with which children and adolescents engage do not minimise or ignore the presence and impact of mental illnesses, and instead deliver the effective interventions that are available.

78 As such, it is not effective to have CAMHS separated from child and adolescent services (schools, paediatrics, family services) and bolted onto a system designed for adults (with adult-oriented policies, practices, funding model, etc).

79 Greater recognition of the special needs of child and adolescent mental health will be achieved through changes such as amalgamating CAMHS into one single Infant, Child and Adolescent Mental Health Service with critical mass and singularity of purpose, resolving the issues relating to the insertion of the youth mental health model in the system, improving integration of paediatrics, schools and child and adolescent mental health, and implementing a centre for evidence-based interventions for children and adolescent mental health (each discussed below).

Amalgamation of CAMHS

80 We currently have a fragmented array of thirteen separate CAMHS which are mostly aligned with and governed by different health services (taking second place to adult and youth mental health services in policy and funding decisions), and each service lacks critical mass for efficient service improvement and workforce development. There are workforce recruitment and professional developments gaps across most CAMHS, especially regionally-based CAMHS. The thirteen CAMHS should be amalgamated into one single CAMHS for 0 to 16 or 18 years old in Victoria with common referral pathways, data, evidence-based clinical pathways, and support to primary care and paediatrics. A single CAMHS would have the critical mass to improve access and quality through sharing of information, increased efficiencies and opportunities for workforce development, and would support regionally-based CAMHS that face difficulties in recruitment and capacity. The benefits of having critical mass to enhance service quality and access can be seen in areas such as paediatric rehabilitation and children's cancer.

81 A single CAMHS with common evidence-based clinical pathways would also resolve the anomalous issue of the vast majority of patients in RCH's inpatient unit having received different models of care for their core treatment from different community-based services, and the alignment of models of care for regional consumers referred from local CAMHS to (metropolitan) inpatient wards. It would improve staff morale if CAMHS staff can see that they are making a difference and are working more effectively.

82 Relevantly, catchment areas do not serve any purpose for CAMHS – children in Mildura or Morwell have similar needs to children in metropolitan areas – and families in the outskirts of metropolitan Melbourne commonly prefer to travel into Melbourne for their care rather than out to the nearest regional centre. A single CAMHS without catchment areas would fit better with the primary care system in which GPs and paediatricians do not have catchment areas.

Resolving issues relating to insertion of youth mental health model

83 There is a need to resolve the issues relating to the insertion of the youth mental health model in the mental health system alongside the paediatric and adult models.

84 The youth mental health model has not been reconciled with paediatrics and exists in parallel with the paediatric model (which reflects specialist psychiatry training and the paediatric health system). The most obvious example of this is in north-western Melbourne, where the catchment area for CAMHS largely overlaps with that for youth mental health – RCH provides medical care to 0-18 year olds, community mental health care to 0 to 15 year olds and inpatient mental health care to 13 to 18 year olds, whereas Orygen Youth Health (**OYH**) provides community mental health care to 15 to 25 year olds and inpatient mental health care for 15 to 25 year olds.

85 A number of CAMHS have been converted to Child and Youth Mental Health Services (**CYMHS**) to provide services to 0 to 25 year olds – this is in the absence of a formal evaluation to weigh up the benefits of this or to reflect or quantify the unintended consequences for younger children in particular. This change may give improved access and better services to the older age group, but it is not clear whether there are improved or indeed fewer services for the younger children and adolescents. A significant and predictable outcome would be deployment of resources to the older age group who may present with higher immediate risks. At RCH, we have felt compelled to draw on resources for younger children (even though we can often intervene more effectively with the younger age group) to address the needs and risks of crisis presentations to the ED. I am not suggesting that the shift to CYMHS is necessarily wrong; instead, I raise the question of which problems this shift has addressed and which it has created. Transition from child and adolescent specialists to adult specialists is inevitable for many chronic health conditions and there is strong evidence from RCH for planned transitions for physical health conditions with clear clinical communication and flexible age arrangements. Single services for 0-25 years of age may reduce 'service transitions' although settings and providers will inevitably change. Reducing transitions, however, is but one part of care. Supporting effective models of care across all ages though parity of funding, policy guidance and monitoring is equally important for the community as a whole. It is a false economy and inequitable if services are expanded for older adolescents and young adults at the expense of children and younger adolescents.

86 Relevantly, there are contrasting approaches between paediatric and youth models. The paediatric model recognises that mental illnesses mostly begin during childhood or adolescence and typically present differently from mental illnesses in adults (such that treatment is not dependent on children and adolescents having persisting, adult mental disorders) and that these disorders are present alongside other mental health, physical health and social difficulties (for example, in school or with their families). For example, disorders such as psychotic disorders and Emotionally Unstable Personality Disorder 'crystallise' or are diagnosed from mid-late adolescence, but preceding these conditions is frequently a range of concurrent and interacting mental and physical health disorders and symptoms that are often unrecognised and untreated. The paediatric model

recognises that a vast majority of adolescents (including those above 15 years old) live with families, and that they are not fully independent adults making decisions about their healthcare even if they are developing autonomy and can make a range of decisions. Accordingly, the paediatric model takes a more holistic view and seeks an integrated approach with health providers, families, schools and other community supports.

87 Establishing consistency across Victoria in the eligibility criteria for assessment and treatment in specialist mental health services of children, adolescents and young people, and consistency in the interventions provided is an important goal in reforming the system as it currently operates.

88 I also note that there are a few contested terms relating to the youth mental health model which are sometimes misunderstood and misrepresented:

(a) the terms “youth” and “young people” are mostly used for 12 to 25 year olds, or 15 to 25 year olds, but can be used as if to include all people under 25 years old, which at a policy and funding level can allow for funding specifically for 15 to 25 year olds to appear to address and be sufficient for the needs of all younger people;

(b) the term "early intervention" has been co-opted to reflect early intervention for young adults for enduring mental disorders of adulthood, and not its true meaning of intervention before the development of mental disorders or early in their presentation (“early in life and early in episode”); and

(c) the term "serious" is also concerning from an early intervention perspective – when adult mental disorders are described as “serious mental illnesses” (principally psychosis and bipolar disorders), the result is to minimise the impact and effectiveness of treatment for major mental disorders in infants, children and adolescents.

Improved integration

89 There should be improved integration of paediatrics, schools and child and adolescent mental health given the clear overlaps and synergies.

90 In relation to schools, the CAMHS in the UK have undertaken considerable work to link with and meet children at schools. RCH provides ‘Opportunities To Consult’ (**OTC**) in various primary and secondary schools in north-western Melbourne to reach out and build capacity in schools. In OTC, we talk to school staff about what they can do to enhance child and adolescent mental health and what interventions they can implement to reduce the impact of symptoms of mental illnesses. We initially thought this initiative would lead to more referrals to RCH but it has in fact resulted in fewer referrals.

91 Inpatient mental health services should be as integrated as possible with the specialist mental health services they support. Age criteria for inpatient units should align with any age limits for the outpatient providers. Concerted effort should be made at a State level to streamline the age criteria for CAMHS, CYMHS and specialist youth MHS so that inpatient and outpatient care for individual consumers is consistent as much as possible.

92 With a standalone youth MHS in north-western Melbourne (OYH), there is a strong argument for inpatient capacity for OYH to be expanded to allow for treatment of OYH outpatient consumers by a youth inpatient service in a coordinated transition.

Evidence-Based Interventions in Child and Adolescent Mental Health

93 As described above, specialist CAMHS often deliver treatments for which there is only a weak evidence base, or deliver interventions in an insufficient 'dose' in terms of number of sessions. To maintain access for new referrals, brief assessments and interventions may be employed. Equally, CAMHS clinicians often find that the limits to child health and welfare services require that case management activities are given precedence over therapeutic interventions. In my opinion, a common CAMHS approach across Victoria that gives priority to evidence-based interventions over case management ensures that staff are suitably trained in evidence-based interventions and that outcomes are monitored to ensure the greatest effectiveness from the funding provided.

94 A centre for evidence-based interventions for child and adolescent mental health should be established (there is a new Centre for Mental Health Learning in Victoria but necessarily it is likely to be adult-centred). An example of such a centre is the Ontario Centre of Excellence for Child and Youth Mental Health (**Ontario CoE**); it is funded by the State government of Ontario, which has a population of almost 15 million. I have visited the Ontario CoE and found it an astonishingly impressive organisation – it sets standards for child and youth mental health, drives change, integrates data, conducts workforce training and grows evidence.

Funding based on outcomes and access

95 Funding (whether for MBS providers or for CAMHS) should be based on outcomes (including the use of evidence-based treatments and measurement scales to track progress) and access for vulnerable groups.

96 As funding is currently based on activity, CAMHS are not as effective as we should be. Centrally-determined funding allocations based on prevalence, access for vulnerable groups, the use of measurement and evidence-based interventions and outcomes offer the best means to improve mental health for children and adolescents with severe mental illnesses, and offer an approach to guide private providers to support children and adolescents with mild and moderate severity illnesses.

Data and monitoring and use of health technology

97 Along with a single CAMHS governance, delivered in partnership with public health services, accountability and transparency will be vastly improved with a commitment to develop a common set of measures for outpatient care to monitor access for vulnerable groups, reduce variability in waiting times across the State, and support effective evidence-based care and benchmarking.

98 CAMHS services invariably cover a wide geographic area and expansion of the use of internet-based conferencing should be supported.

Peer support

99 Adult and youth mental health services have successfully introduced funded peer support workforce. CAMHS trail in their use of peer support workers, who may be consumers or carers. Expanding the voice of the consumer is an important step in improving the quality and responsiveness of specialist mental health services for children and adolescents.

What key changes would you recommend to other service systems that support vulnerable children and adolescents; for example, schools and family welfare services?

Education and information

100 Parents and referrers (for example, teachers, sports clubs or anywhere else where children may present with stress and difficulties) need a 'road map' of services and should have accessible information on mental disorders and how to recognise them in children and adolescents. The services represented on the road map (which should include services other than CAMHS) would, however, need to have the capacity to respond – there is not much point referring to CAMHS if there is a long waiting list extending to 12-16 weeks and a certain level of severity is required to access the services. An example of a successful resource for parents is the Raising Children Network, of which RCH is a member organisation.

101 Older children and adolescents should also have access to information on mental health and avenues where they can get help (for example, online therapies may be effective for adolescents) through mobile devices. Awareness of the impact of poor mental health is rising amongst young Australians. When 28,000 young people were polled recently (Mission Australia 2018 Youth Survey), mental health was their key concern. Peers are an important resource in recognising and supporting children and adolescents to gain access to appropriate supports and interventions.

Community resources

102 An important missing part of the service system to support mental health and reduce mental disorders are community paediatricians and community hubs (similar to headspace) where children and adolescents and their families can visit to find out more about mental health problems, other health problems and other family difficulties. I do not consider that there should be a strict age cut-off (for example, only for children below 15 years old) for these hubs; even if adolescents are developing autonomy, the vast majority of them still live with families.

103 Community hubs with family, welfare, paediatric and child and adolescent mental health services should be piloted to emulate the 'no wrong door' philosophy of headspace, support for families and the position that mental health is a core part of general health.

104 Primary and secondary school should also have access to on-site mental health providers (for example, GPs and psychologists) and opportunities to consult mental health specialists.

105 To improve the effectiveness and focus of CAMHS, a collaborative engagement should be established with community and welfare providers to ensure that case management can be conducted at the community level beside, but separate from, the therapeutic service.

Group treatments

106 Group treatments are both cost-effective and effective for a range of low to moderately-severe mental disorders, but few providers are able to offer this. It would be a huge step forward if therapeutic interventions can be provided far more widely to groups of children and families in the community to allow early intervention for emotional and behavioural problems. An example is Tuning In To Kids, which is a fantastic group program for parents with children experiencing emotional and behavioural problems.

Specialist services for Developmental Disabilities and Mental Health

107 Recognition of mental health problems in children and adolescents with developmental disabilities is extremely low. Challenging behaviours, often associated with undiagnosed mood disorders or other neurodevelopmental disorders such as ADHD, can be very severe and impairing. The VAGO report on CYMHS identified numerous prolonged admissions to mental health wards by these consumers (and others) where extended periods of the admission are not clinically warranted, but the child or adolescent cannot be safely discharged to a community setting. In addition to arguing for accommodation services in the context of the NDIS, specialist mental health services need to recognise the needs of this group and their unique capacity to support interventions in the home

before and after emergency presentations that may occur. RCH has been trialling new models of outreach support for this important group of Victorians. A specialist service for children and adolescents with 'dual disability mental health' would be advantageous, similar to the Victorian Dual Disability Service for those above 16 years old.

sign here ▶ 

print name Richard Haslam

date 3 July 2019

Royal Commission into
Victoria's Mental Health System

ATTACHMENT RH-1

This is the attachment marked 'RH-1' referred to in the witness statement of Richard Haslam dated 3 July 2019.

Dr Ric Haslam

Curriculum Vitae

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Education and Training

2017	Master of Science; Associateship of King's College (King's College London)
2013	Senior Medical Leadership Development Program, RCH
2010	Australian Mental Health Leadership Program (University of Melbourne)
2004	Frontline Management Training: Learning and Organisational Development Unit, Austin Health
1997	Certificate of Child Psychiatry Victorian Postgraduate Child Psychiatry Training Program University of Melbourne
1989	Bachelor of Medicine, Bachelor of Surgery University of Melbourne

Fellowship

1997	Fellowship of the Royal Australasian College of Physicians

Membership

2008	Corresponding Member, American Academy of Child and Adolescent Psychiatry

Positions Held

2011-	Director of Mental Health, Royal Children's Hospital
2007-2011	Principal Consultant, RCH Integrated Mental Health Program
2002-2007	Consultant Paediatrician and Team Leader, Austin CAMHS
2001-2002	Consultant Paediatrician, Acting Team Leader, Austin CAMHS Melbourne
2000-2001	Consultant Paediatrician, Private Practice – Melbourne Children's Clinic, Kooyong
2000-2001	Consultant Paediatrician, Austin CAMHS
1998-1999	Senior Hospital Medical Officer, Austin CAMHS
1996-1997	Child Psychiatry Registrar, Austin CAMHS
1992-1996	Royal Children's Hospital/ Monash Medical Centre Combined Paediatric Training Program
1991	Hospital Medical Officer, Royal Melbourne Hospital and Royal Children's Hospital, Melbourne
1990	Intern, Royal Melbourne Hospital

Professional Memberships

Dr Ric Haslam

- Child and Adolescent Mortality and Morbidity Subcommittee of Consultative Council on Obstetric and Paediatric Mortality and Morbidity (Safer Care Victoria) 2019-
- RANZCP Victorian Branch Working Group on Family Violence 2014-16
- RACP Mental Health Working Group 2014 -16
- RCH Human Research Ethics Committee member 2009 - 2013
- Autism Victoria Professional Panel – inaugural medical representative and chair of Diagnosis and Assessment Reference Group, 2006 – 2010
- Ivanhoe Children's Community Cooperative – chair: 2013 - 16
- Banyule and Nillumbik Youth Services Network (BNYSN) - chair: 2003, member 2002-2006
- Further Education for Advanced Trainees (FEAT), RACP - Coordinating Committee 2001-2006
- Autism Secondary Consultation and Training Reference Group, Early Childhood Intervention Services (Department of Human Services)

Presentations

2013	World Psychiatric Congress: Meet the Expert Session: Common Mental Health Problems in Children: Assessment and Management
2007-2015	*mindful* Child Psychiatry Training Program Seminars; DPC Seminars
2004,2005, 2010,2015	Further Education for Advanced Trainees (RACP)
2004	Paediatric Update, Royal Children's Hospital
2002, 2003	Victorian Child Psychiatry Training Program Seminars
1995	"Influences of Age and Gender on Glycosylated Haemoglobin Levels Children and Adolescents with Insulin-Dependent Diabetes Mellitus" Australasian Paediatric Endocrine Group, Ballarat, Victoria

Publications

2013	K Milner, R Haslam "Social skills groups training for children with autism spectrum disorders" *Journal of Paediatrics and Child Health 2013; 49(7): 595-597*
2006	N Haslam, B Williams, M Prior, R Haslam, B Graetz, M Sawyer "The latent structure of attention-deficit/hyperactivity disorder: a taxometric analysis" *Australian and New Zealand Journal of Psychiatry 2006; 40: 639-647*
2001	RHM Haslam, DJ Borovnicar, DB Stroud, BJG Strauss, JE Bines "Correlates of Prepubertal Bone Mineral Density in Cystic Fibrosis" *Archives of Diseases in Childhood 2001; 85: 166-171*
2000	DJ Borovnicar, DB Stroud, JE Bines, RHM Haslam, BG Strauss "Comparison of total body chlorine, potassium, and water measurements in children with cystic fibrosis" *American Journal of Clinical Nutrition 2000; 71: 36-43*
1995	DJ Borovnicar, RHM Haslam, JE Bines, ML Wahlqvist, BJG Strauss, DB Stroud "Relationships between pulmonary status, total body nitrogen and potassium in children with cystic fibrosis" Abstract presented at the *International Symposium on Body Composition Studies, Malmo, Sweden*

Dr Ric Haslam

Research

2003-2005 An Open Label Safety Study of Methylphenidate Modified Release (Metadate CD®) in Children with Attention-Deficit/Hyperactivity Disorder (ADHD) – *principal investigator*

2002 A Multi-Centre, Double-Blind, Three Arm, Parallel Group Study Comparing the Efficacy of Immediate Release Methylphenidate (Ritalin®) and Modified Release Methylphenidate With Placebo in Children with ADHD – *principal investigator*

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