ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

Held via Zoom

On Tuesday, 23 June 2020 at 2pm

Before: Ms Penny Armytage AM (Chair)
Professor Allan Fels AO
Dr Alex Cockram
Professor Bernadette McSherry

Counsel Assisting:
Mr Stephen O'Meara QC
Ms Georgina Coghlan
Ms Fiona Batten

1 THE CHAIR: Welcome to the Commission's panel discussion
2 on how to promote good mental health for infants and
3 children.
4
5 I'm Penny Armytage, the Chair of the Royal Commission
6 into Victoria's Mental Health System. I am joined by my
7 fellow Commissioners: Professor Allan Fels, Dr Alex Cockram,
8 and Professor Bernadette McSherry.
9
10 On behalf of the Commission I acknowledge the
11 traditional owners of the lands on which we meet and I pay
12 my respects to their Elders past, present and emerging.
13
14 Before we commence, I would like to thank Professor
15 David Coghill, Professor Harriet Hiscock and Professor
16 Louise Newman for taking the time to participate in today's
17 panel. I know a considerable amount of effort has gone
18 into the development of your witness statements and into
19 the preparations for today's discussions. We are
20 particularly mindful of the time you have afforded us in
21 the context of the current pandemic.
22
23 These panels are an opportunity to discuss and contest
24 ideas in an interactive way. One of the most powerful
25 aspects of our work so far has been engaging with people in
26 evidence in an interactive way through avenues such as our
27 community consultations and our 2019 public hearings.
28
29 In our current environment we are continuing to
30 creatively engage with people to ensure that this is not
31 lost, particularly with people with lived experience.
32
33 Today's discussion will focus on infant and child
34 mental health, including an examination of current service
35 responses in both the mental health and broader social
36 services sectors, along with ideas for reform and examples
37 of evidence-based and effective practices.
38
39 We have chosen to convene a panel on this particular
40 topic given its complexity, unique challenges and
41 opportunities, and intersections with areas that extend
42 beyond the mental health system.
43
44 We know that this life stage has considerable bearing
45 on an individual's opportunity to experience good mental
46 health throughout their lives but, for a multitude of
47 reasons, we have also heard that poor mental health in

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1 infants and children may go on unrecognised.
2
3 Whilst this may be reflective of service capacity, it
4 also points to the mental health literacy of parents,
5 families and people working in universal services, along
6 with stigma, and a raft of other issues which we will
7 discuss today.
8
9 For those who do seek help, we have been told about
10 how services often do not meet the needs of infants and
11 children and their families.
12
13 One parent, Erin, reflected on the inpatient unit her
14 young child, Matthew, was admitted to, saying that:
15
16 The inpatient unit felt like a horrible
17 place and its look made me feel terrible.
18 As soon as I walked in there I had a
19 feeling of fear. We felt like there was a
20 big black box that we were shoved in to be
21 processed without any consideration about
22 the individuals involved. Nothing was
23 tailored about our treatment.
24
25 Of course, we know that there are many tireless,
26 dedicated and kind professionals keeping this system afloat
27 and seeking to improve, if not at the least, the three
28 experts of you who are joining us here today.
29
30 We will be convening a separate panel on youth mental
31 health accounting for the different contexts, experiences,
32 challenges and service responses between infants and child
33 mental health compared with youth mental health, a theme we
34 will no doubt explore further today.
35
36 I and my fellow Commissioners have read with keen
37 interest your respective witness statements and it is
38 evident that you bring a wealth of experience and expertise
39 to this topic, along with thoughtful and progressive reform
40 ideas.
41
42 Across your statements there are areas of agreement:
43 broadly, the importance of recognising risk factors early
44 in an infant and child's life, the integral role of social
45 services in early identification and intervention, and the
46 critical role of parents, carers and the broader families.
47

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1 But there are also points of difference and I was
2 interested to read the varying emphases that you put
3 forward in your reform ideas and the local and
4 international examples of effective practice you
5 referenced.
6
7 The purpose of today is to contest your ideas,
8 highlight firm areas of agreement, and expand on areas of
9 reform you propose in your written witness statements.
10
11 I and my fellow Commissioners will largely play a
12 listening role today and Senior Counsel Assisting, Stephen
13 O'Meara QC, will facilitate the discussion.
14
15 Before I hand over to Stephen to outline the logistics
16 and parameters of today's panel discussion, I would like to
17 once again thank you for your time in assisting the
18 Commission with its deliberations.
19
20 Finally, I will leave you with the words of Erin and
21 her reflections on trying to seek support for her young
22 son:
23
24 We felt hopeless and angry. We could not
25 believe that this was the best that could
26 be done. We couldn't believe how
27 peripheral Matthew seemed to be to the
28 process. The services just continued doing
29 their thing regardless of whether or not it
30 was helping him.
31
32 We look forward to a robust and constructive panel
33 discussion this afternoon. Thank you, Stephen.
34
35 MR O'MEARA: Thank you, Chair.
36
37 May I commence by thanking you, Chair, for your
38 introductory remarks and I'd like to thank the Royal
39 Commissioners and the Commission staff for identifying the
40 very important topic, the subject of today's panel
41 discussion, which is entitled, "Supporting the next
42 generation through good infant and child mental health."
43
44 Today's topic grasps the critical importance of
45 supporting the mental health of those who are presently
46 infants and children in order that they and the entire
47 community may reap the benefits now and into the future.

1
2 I should, in broad terms, introduce some of the issues
3 that are likely to arise for consideration of today's panel
4 members; namely, the issue of identifying infants and
5 children at risk of mental illness and the kind of supports
6 that should be made available to them; the specialist
7 expertise that may or should be made available to service
8 providers supporting infants and children, their families
9 and carers; how the system of mental health and other
10 social services may be organised so as best to address the
11 mental health needs of infants and children; whether there
12 can or should be streaming of care of infants and children
13 within the system and, if so, how; whether the engagement
14 of families and carers of infants and children is important
15 and, if so, how that can be best facilitated; and finally,
16 the future requirements of the mental health workforce.
17
18 I should now briefly introduce our panel members and
19 commence by thanking them again, and in advance, for their
20 time, enthusiasm and generosity. Without the contributions
21 of witnesses and all of today's panel members the work of
22 the Royal Commission couldn't practically progress.
23
24 In no particular order, our first panel member is
25 Professor Harriet Hiscock. Professor Hiscock qualified as
26 a paediatrician in 2000, she works at the Royal Children's
27 Hospital Centre of Community Child Health. She is the
28 group leader of Health Service at the Murdock Children's
29 Research Institute. She is currently leading the Centre of
30 Research Excellence in Childhood Adversity and Mental
31 Health.
32
33 She has many other qualifications which will be
34 evident in her witness statement which will come to be
35 posted on the Commission's website in due course. The same
36 is true for all of our other panel members.
37
38 The second of whom is Professor Louise Newman AM.
39 Professor Newman is a Professor of Psychiatry at the
40 University of Melbourne and a Practising Perinatal and
41 Infant Clinician. In 2011, she was made a Member of the
42 Order of Australia for services to medicine in the fields
43 of perinatal, child and adolescent and mental health,
44 education and as an advocate for refugees and asylum
45 seekers.
46
47 Our final panel member is Professor David Coghill.

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1 Professor Coghill trained and practised extensively in the
2 United Kingdom and it's been our privilege to have had him
3 here in Australia for the last four years. He is employed
4 by the University of Melbourne and the Royal Children's
5 Hospital. He is the Financial Markets Foundation Chair of
6 Developmental Mental Health in the Departments of
7 Paediatrics and Psychiatry at the University of Melbourne.
8 At the Royal Children's Hospital he is a Professor of Child
9 and Adolescent Psychiatry and a Consultant Psychiatrist at
10 the Department of Mental Health. And, as if he isn't
11 involved in enough, he is also involved in research at the
12 Murdock Children's Research Institute.
13
14 On behalf of the Commission, may I extend a warm
15 welcome to each of our panel members today.
16
17 Each of our panel will now confirm that they will be
18 giving evidence today as if we'd been assembled at a
19 hearing face-to-face, and I might start first with
20 Professor Hiscock, if you could confirm that?
21
22 PROFESSOR HISCOCK: Yes, I confirm that, Stephen.
23
24 MR O'MEARA: Thank you, and Professor Newman?
25
26 PROFESSOR NEWMAN: Yes, I confirm.
27
28 MR O'MEARA: And, Professor Coghill?
29
30 PROFESSOR COGHILL: Yes, I confirm that.
31
32 MR O'MEARA: Thank you all.
33
34 To deal with, and the Chair's already referred to
35 areas of identified agreement with you, and to make it
36 clear for the purposes of this hearing, there was a witness
37 and panel member conclave some time ago and in the course
38 of that conclave the three of you broadly agreed and, as
39 the Chair identified, relatively firmly, upon some
40 particular observations and principles.
41
42 And, I might read them out in order that they are just
43 established as areas of agreement, and I'll read out a few
44 of them at a time and then ask one of you to confirm as the
45 case may be.
46
47 The first three are these: that there's been a lack of

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1 overall leadership and strategic thinking to date in
2 respect of the system of mental health pertaining to
3 infants and children.
4
5 Secondly, that there's been an underinvestment in the
6 workforce and support for the mental health of infants and
7 children and such services, as there presently are, tend to
8 be siloed in the sense that they're insufficiently
9 integrated with other areas of the system or, for that
10 matter, outside the mental health system.
11
12 In this sense, and this is the third point, there has
13 to date been insufficient prioritisation given to the
14 mental health of infants and children, and I might just ask
15 for the confirmation concerning those three matters from
16 Professor Hiscock.
17
18 PROFESSOR HISCOCK: Yes, I confirm that, that we've agreed
19 upon that.
20
21 MR O'MEARA: Then the next group and areas of agreement
22 are that, fourthly, if you like, that there's presently no
23 Australian evidence-based guidelines for the prevention and
24 treatment of mental illness in infants and children. There
25 are some international guidelines that could be adapted for
26 the Australian context.
27
28 The next is that there's presently a deficiency in the
29 education and training of the health workforce in respect
30 to the mental health of infants and children.
31
32 The next is that there's a significant actual need for
33 mental health support to or treatment of infants and
34 children that's presently poorly served.
35
36 The next is that it's necessary to develop and provide
37 evidence-based care, and the next is that there's a need to
38 identify and intervene early in the mental health care of
39 infants and children. And I might ask, perhaps Professor
40 Newman, if you could confirm those?
41
42 PROFESSOR NEWMAN: Yes, I confirm those.
43
44 MR O'MEARA: Thank you. And lastly, and I'll come to you
45 for these, Professor Coghill, but the third-last is that
46 the health, allied health and non-health workforce relating
47 with infants and children requires specialist support for

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1 the identification and treatment of mental health.
2
3 The second-last is that it's necessary to develop
4 evidence-based guidelines for the prevention and treatment
5 of mental illness in infants and children, and the final
6 area of agreement is that, in order for such guidelines to
7 operate, there must be clinical pathways established for
8 prevention and treatment, and this time I'll come to you,
9 Professor Coghill.
10
11 PROFESSOR COGHILL: Yes, I agree, we agreed on these.
12
13 MR O'MEARA: Thank you very much. That brings us then to
14 the discussion of a number of the issues that were
15 identified in your very invigorating conclave that I've
16 referred to earlier.
17
18 I might start perhaps with one area that came up
19 several times in the course of that discussion and that is
20 what the risk factors that can affect the mental health of
21 infants and children, and in the context of that there was
22 reference both to areas of genetics and to social
23 determinants. In order that we can really establish these
24 early on, if I could ask Professor Coghill to identify what
25 those social determinants are that can bear upon infants
26 and children before we get to who infants and children are.
27
28 PROFESSOR COGHILL: Yeah. There are many factors, many
29 social determinants of health that really impact not just
30 on the prevalence but on the severity and the impact of
31 mental health disorders in infants and children, and in no
32 particular order I would list these as poverty, living away
33 from home, so children who are received into care, being
34 Aboriginal or a Torres Strait Islander, all other forms of
35 marginalisation, whether it be by culture, ethnicity,
36 colour, sexuality and/or language; those who are or have
37 suffered from abuse, neglect or other significant traumas,
38 those with refugee backgrounds.
39
40 And these are the more social side. There are other
41 factors. Would you like me to go on with those, Stephen?
42
43 MR O'MEARA: Certainly, go for it.
44
45 PROFESSOR COGHILL: Which I see as more constitutional:
46 intellectual impairment, parental mental health problems,
47 obviously an environmental factor for the child, but also

1 an indicator of potential genetic transmission of mental
2 health problems; physical health problems, a family history
3 of mental health problems, and having another mental health
4 disorder yourself increases the likelihood that you will
5 suffer from a subsequent and other mental health problem.
6
7 MR O'MEARA: Thank you. Accepting that, and I'll take it
8 that that's broadly an area of agreement between our expert
9 witnesses today, but that then brings us to an issue of who
10 infants and children are.
11
12 PROFESSOR HISCOCK: Sorry, I'll just add parenting as
13 another very important modifiable risk factor. I think
14 David is caught up in parent mental health but the actual
15 parenting style as well.
16
17 PROFESSOR COGHILL: I agree.
18
19 MR O'MEARA: Thank you, Professor Hiscock. While I've got
20 you, can I ask you to address the question of who or what,
21 if you like, infants and children are because there's
22 something of a definitional debate. If you can start by
23 addressing that definitional debate if you might and tell
24 us whether it really matters.
25
26 PROFESSOR HISCOCK: Sure, and I'm sure Professor Newman
27 will have expertise here to contribute, but infants would
28 broadly say from birth to the first year of life, but also
29 recognising that there are antecedents of infant mental
30 health that begin in pregnancy between the mother and the
31 father. So, really up to the first year of life for
32 infants, and then children certainly goes up to, depending
33 on your definition, up to the end of primary school as a
34 very practical definition, maybe 12 or 13 years of age,
35 although some of our colleagues in youth mental health
36 would say that adolescence begins at 10 years of age. I
37 think of infants and children up to the age of 12 years.
38
39 MR O'MEARA: Just before I move from you, Professor
40 Hiscock, and I'll go to Professor Newman in just a moment,
41 but what role and what are the significance of
42 developmental processes in those age ranges that you've
43 referred to, do they map to what are the developmental
44 processes and do they map to particular ages or is it --
45
46 PROFESSOR HISCOCK: Broadly they do. I mean, obviously
47 development follows a sequence of an infant's learning to

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talk and walk and develop social and emotional regulation, attachment to primary caregivers is incredibly important and protective for their mental health.

When we go into the primary school age, think of the toddlers, the tantrums, all of those things you see, the extreme shyness and inhibition; so again, an infant's learning to work out their own autonomy but needs the caregiver there.

Into primary school age we start to see maybe different things there, issues with forming and maintaining relationships, peer relationships, the sort of emergence clearly or even earlier of autism spectrum disorder, attention deficit hyperactivity disorder becomes more pronounced in these age groups. Also these children, their frontal lobes are developing, focus, concentration, planning is starting to develop. Self-regulation again is emerging in these children and that's really then taking them up into the end of primary school where we certainly see children in primary school with signs of anxiety and depression as well as ADHD being the three most common mental health disorders of this age group.

MR O'MEARA: So, children would go up to a developmental period after the age of 12. You're a paediatrician, paediatricians would treat --

PROFESSOR HISCOCK: Up to 18 years.

MR O'MEARA: Up to 18. What's the thinking behind that?

PROFESSOR HISCOCK: I think it's been traditional more than anything, that that's how we emerged as a specialty workforce out of the adult workforce. So, legally you became an adult at 18, so we provided care up till that point. That means that paediatricians have a lot of exposure to adolescent, youth mental health issues and that's partly behind my - I know we'll come to this later on - but the streamlining of services by age group.

I think there's a danger that, if we break it up too much, then we lose that continuity of care for families and they can disengage with services as they're passed from one service to the next based on age rather than perhaps these developmental processes.

1 So, does that answer your question?
2
3 MR O'MEARA: That answers my question, thank you very
4 much. Professor Newman, can I ask you to address the
5 question of the developmental processes.
6
7 PROFESSOR NEWMAN: Thank you. Look, I think what we've
8 already touched upon is that there's something
9 fundamentally problematic about trying to be too definitive
10 about what age things occur.
11
12 From my perspective it's actually very helpful, as
13 Professor Hiscock was saying, to think more about
14 developmental changes and processes and what's needed in
15 specific developmental periods to promote healthy
16 psychological and social development.
17
18 I personally, and this shows us maybe some of the
19 problems, think that infancy, what I would call an infant,
20 is someone who's older than 12 months, but in the area of
21 infant mental health where I work people have different
22 views: some people say 2 years, 3 years, and some say 4.
23 If you look at mental health services they're very unclear
24 as well and there's considerable variation about what
25 constitutes an infant as opposed to early childhood.
26
27 If we move away from that and think about
28 developmental processes, I think that that's really much
29 more helpful because we can think then about in utero
30 development and prenatal risk factors, such as having a
31 parent who has high levels of stress is a risk factor for
32 the developing foetus. We know that having parents with
33 their own mental health problems, substance abuse issues,
34 women exposed to domestic violence during pregnancy, all
35 these factors contribute to neurological and ultimate
36 psychosocial development of that infant in their particular
37 family context.
38
39 If we break it down maybe and think about
40 developmental processes as those tasks and organisational
41 things that need to happen during particular periods, I
42 think it's much more helpful. So, for example, infancy, no
43 matter when we have an arbitrary cut-off point, is a period
44 of a child developing neurologically, biologically and
45 psychosocially some core things that are needed for later
46 mental health. That's probably, from my perspective, a
47 very important point when we think about intervention and

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1 prevention and better identification of risk.
2
3 So, are there factors contributing to or derailing that child's progress in terms of developing a sense of who they are, so a sense of identity, understanding relationships and how relationships work, beginning to understand how to regulate their own emotions and behaviour and so on. All of those things are fundamental in the first few years of life.
10
11 We then see transitions which might be the development of peer relationships in a slightly older child as Professor Hiscock mentioned, all very important, and we can see children in that age, namely the pre-school period, already showing some signs of difficulty if they've had a range of risk factors in terms of their functioning.
17
18 Developmental processes I think don't just stop in childhood. So, for many of us it's important to have a lifespan perspective on what development is. I mean, fortunately humans get lots of opportunities for developmental repair even if some things have been detrimental or difficult early on, so we think about major challenges.
25
26 Adolescence, obviously hugely significant in terms of forming relationships outside of the immediate family, self identity, and again, a whole range of challenges for adolescents and young people merging into young adulthood and so on.
31
32 So we have these very important developmental challenges and periods as opposed to saying, well, if you haven't done this by 18, I'm sorry even though I might be able to help you, you need to move on to another service, or this rather reductionist argument about, well, if you turn 11 or 12 depending on definitions, service X won't see you but service Y will.
39
40 And there's a big difference between someone who has major challenges who may be 12 or 13 in terms of someone who's 18 or 19 who has very different options.
43
44 So, I think in a nutshell that's why I argued for the importance of having a developmental framework as an overarching way of thinking about the needs of children, young people and families as opposed to a siloing or

1 potential fragmenting of our services and responses by
2 having artificial distinctions and breaking everything down
3 into rigid categories.
4
5 On the other hand, that being said, I think the
6 complexity that we all struggle with is that there are some
7 specific things that a young infant needs and certain
8 developmental problems that a young infant can have that
9 not all clinicians are necessarily going to be trained in.
10
11 So we still need to look at, even in this
12 developmental framework, what's actually needed in terms of
13 skills and understanding to work at different age ranges
14 with different developmental challenges.
15
16 So I don't expect everyone to be able to see, as I do
17 in my work, a four-week infant and be able to say that that
18 infant shows some developmental difficulties even at that
19 very early age, or those parents are struggling in their
20 capacity to manage and regulate a young baby, for example.
21
22 So, there are some specialist sort of skills that are
23 necessary, but I think what all the child and adolescent
24 mental health system requires is that developmental
25 framework.
26
27 MR O'MEARA: Thank you. Before I go to Professor Coghill,
28 might I just ask Professor Newman, what's the practical
29 (inaudible) periods that you've identified in terms of how
30 you go about providing support to clients in those
31 developmental spaces? Does it impact upon the kind of
32 supports that they need, does it impact upon the particular
33 learnings and skills that the workforce who service those
34 clients might need to have and for that matter the
35 families? What's the practical consequences that you see.
36
37 PROFESSOR NEWMAN: Well, the practicalities are very
38 complex because of the complexity and some would say a bit
39 of a, maybe fragmentation of the system that surrounds
40 children and families at different stages.
41
42 So, for example, I might see women with mental health
43 problems and other risk factors in pregnancy and, on the
44 basis of their experiences and the issues facing them I
45 might be able to raise concerns about them and want to
46 coordinate better support for them during pregnancy, the
47 early perinatal period, and then we have a challenge of

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1 looking at follow-up for their infants and so on.
2
3 So, a lot of this depends on point of entry into the
4 system, and parts of the system may vary in terms of their
5 expertise and understanding. So, for example, in a
6 maternity setting a focus might be on healthy pregnancy,
7 have the baby in the best way possible, all of which is
8 absolutely essential, but there's also a need to look at
9 the mothers' and families'/parents' psychosocial
10 functioning, any parenting challenges that they might face,
11 particularly parents who might have mental health or other
12 physical health issues or other social risk factors,
13 because we need to be able to think ahead for the child,
14 but that might be in some maternity settings not seen as a
15 priority.
16
17 So, I think what we face is these challenges about how
18 do we prioritise parental functioning, attachment for
19 between vulnerable parents and families and children,
20 better engagement with very vulnerable population groups
21 and vulnerable families who on the whole are not catered
22 for well, and how do we get these approaches integrated
23 into a system of care much earlier than we're doing now.
24
25 When there are, from my perspective, real
26 opportunities for better identification of risk
27 intervention and, importantly, engagement with families who
28 might have vulnerabilities in a way that makes it easier
29 for them to accept help and stay with services. So,
30 services need to be more fundamentally respectful of the
31 challenges that many people face in parenting,
32 non-alienating and addressing anxieties which are real
33 anxieties that some families face, particularly based on
34 histories of cultural difference, discrimination.
35
36 We look at just as one example, there are many
37 islander and Torres Strait Aboriginal families who might be
38 very reluctant to engage with some services of early
39 intervention and support for them as parents which they
40 might feel really are just taking potentially quite a harsh
41 view of their capacity with an aim/risk of child removal
42 and so on. So, I think we need to tackle some of those
43 particularly difficult issues.
44
45 Pragmatically, as your question is alluding to, it's
46 very difficult to organise that without a major, from my
47 perspective, re-orientation to clinical services which

1 fundamentally integrates a preventive and early
2 intervention model. I use those words, as you're no doubt
3 aware, quite contested words: I'm meaning early in life
4 intervention as opposed to later early intervention or
5 intervention early in the course of illness, all of which
6 is very important but for this discussion talking about the
7 earliest intervention that we can do, the earliest
8 identification of risk, how do we have systems of screening
9 and identification that do support people who might wish to
10 discuss vulnerabilities that they have as opposed to making
11 them feel anxious and alienated by that.
12
13 On the whole, there are some examples where that's
14 done, but it is an attitudinal issue across the workforce
15 in many ways and thinking about the best possible system
16 flagging and identification.
17
18 And then accessible services which are seen as
19 engaging parents in a real way with trusted
20 multidisciplinary workers. So, a lot of work that I
21 mention in my statement has been about work with other
22 professional groups who are very important in the lives of
23 infants and families with young children, such as the
24 general child health nurses, for example, who I think are a
25 very valuable resource in terms of thinking about both
26 identification but also intervention and could be used more
27 effectively than we have in the past, I would think; a very
28 valuable resource.
29
30 So I think the bigger picture, and I hope that's
31 clear, is about the challenge of integration, breaking down
32 silos, and then having clinicians who are wanting to and
33 willing to engage in that way with vulnerable families who
34 currently don't fit nicely into particular service blocks
35 as we have them.
36
37 MR O'MEARA: Yes. Two matters in particular that I'll
38 just come back to you about in a moment because I'll go to
39 Professor Coghill about a particular - about the issue of
40 infants and children immediately, but I'll come back to you
41 Professor Newman if that's okay about two things you
42 mentioned, and they are to do with the research concerning
43 prevention, and we'll open also the issue of screening
44 about which you've all got views.
45
46 So, Professor Coghill, if I can pass to you at this
47 point on the question of who infants and children are.

1 You've got experience of how a service has approached that
2 question in Scotland and you plainly have your own views as
3 well. What can you tell us about how this is to be
4 approached or should be approached?
5
6 PROFESSOR COGHILL: My answer, I guess, reflects in some
7 ways what Professor Hiscock was saying, that traditionally
8 child and adolescent mental health looks across the age
9 range from the earliest ages through to at least 18 and
10 possibly further than that.
11
12 I don't have a strong opinion on what is infancy. I
13 think that Professor Newman's discussion of the
14 developmental tasks of infancy and the processes that we
15 have really help us know that it's very difficult to define
16 anything by actual numbers and age.
17
18 What we find in development is that children and young
19 people develop at very different rates, and one of the
20 factors that influences that rate of development is the
21 presence or absence both of mental health problems which
22 can put a pause if it's an episode of depression, for
23 example, on development; or neurodevelopmental disorders,
24 the broader kind of mental health problems like ADHD and
25 autism.
26
27 My experience particularly is kids with ADHD who we
28 know are much slower to attain some of the developmental
29 milestones, if one can call them that, and overcome some of
30 the developmental challenges unless their problems are
31 recognised and particularly well supported.
32
33 The issue of age and services, I think again, is an
34 incredibly complex one for which there is no real answer.
35 I think a concrete cut-off saying it's zero to 12 and 12 to
36 25 is not sensible because I think it puts a lot of
37 children and adolescents at disadvantage.
38
39 We know, for example, that the youth mental health
40 services aren't very experienced or skilled in managing
41 neurodevelopmental disorders; they're much more common
42 practice for both paediatricians and the child part of
43 child psychiatry and mental health. And so, for example,
44 to treat someone for ADHD up until the age of 12 and then
45 hand them over to another service really does that person a
46 disadvantage, even handing them over later on at 15 and,
47 because we struggle to find adult services, actually all of

1 those transitions are problematic for disorders that
2 continue life long.
3
4 However, if you've got services for adolescents that
5 are especially designed and very effective at managing
6 severe depression, for example, and you have a younger
7 child who becomes severely depressed, if it were my child
8 I'd want them seen by the specialists, I'd want them seen
9 by the services who have pathways, so I think there are
10 alternative ways at looking at how we manage development
11 over time.
12
13 I think the last thing that I would say on that is
14 that development has a different look depending on which
15 viewpoint you take. I think the advantage that
16 paediatricians and child and adolescent psychiatrists have
17 through their training is to be able to look at development
18 from young through to old.
19
20 One of the problems that we have within our youth
21 mental health services, many of which are actually staffed
22 by adult psychiatrists who have come down the age scale, is
23 that they're often looking at development from above. So,
24 they're looking at it from a perspective of understanding
25 adults, but looking back at what would or should be
26 expected in development, and by doing that you miss an
27 awful lot of the important developmental work that needs to
28 be done.
29
30 And again, we know that many adolescents with mental
31 health problems really struggle with some of the very basic
32 tasks that you would have expected by their age for them to
33 have managed, and the same goes for the children with
34 neurodevelopmental disorders.
35
36 MR O'MEARA: Thank you. Professor Hiscock, have you got
37 anything to add to that general topic before I open up the
38 question of prevention with Professor Newman?
39
40 PROFESSOR HISCOCK: No, look, I think I'm in agreement
41 with David and we'll get onto it later, I think, about
42 models of care whereby specialists can help the primary and
43 secondary care workforces, but I see that as key to
44 increasing the scope of existing workforces in what they do
45 in mild-to-moderate illness and then as Dave - Professor
46 Coghill, sorry, we know each other well - Professor Coghill
47 was saying is, you know, having those really specialised

services for the more severe end of a specific illness makes a lot of sense to me.

MR O'MEARA: Yes, thank you. Professor Newman, what does the research tell us about whether mental illness can be prevented.

PROFESSOR NEWMAN: It tells us a lot and then very little, to summarise it. It is really obviously a huge problem that a lot of people and scientific research has been looking at to really try and see, firstly, if it's possible, and secondly what we base our preventive science on.

So the consensus would be that we need to look at what are the earliest risk factors for mental disorder as we've been discussing, but also which of those risk factors are things we can actually intervene in. So, for example, someone might have a genetic vulnerability to a particular illness. We're not likely at this current state of knowledge able to change their genetic vulnerability, though that might be something in terms of intervention that happens in the future.

What we do know about early risk factors for mental disorder, and these have become the main objects of study for prevention, are things like the quality of the child's care taking relationships, so essentially their attachment relationships, the broad social factors, the significance as a risk factor of early trauma, abuse and maltreatment, however we define that, and particularly what protective factors there might be; so, are there other people in that child's environment who might be supportive carers, what's the service response and so on.

So the science has focused in terms of early infancy, however we define it, infancy and early childhood, on this idea of really boosting protective factors in terms of supporting children in their psychosocial development and brain development, often through attachment-based interventions, but also having actual programs which are aimed at reducing risk, particularly severe risk like child abuse and neglect.

Now, child abuse and neglect are one of those areas that are highly, it seems to me, always puzzling but it remains a contested area as to who does that work in child

1 abuse and neglect, despite the fact that we know that it's
2 a significant factor in producing and being associated with
3 the entire range of mental disorders diagnostically down
4 the lifespan. It is a huge risk factor and on that basis
5 should be one of the things that is a focus for services.
6
7 However, in my experience there are some mental health
8 services who say, well, that's a matter for Child
9 Protection Services solely and is not a mental health
10 issue. That's a good example of what I mean by a breakdown
11 of a developmental understanding and this siloing and
12 fragmentation of approach.
13
14 So, a lot of the work that I've been involved with,
15 and others, has really focused on how can we support the
16 development of attachment relationships, how do we support
17 vulnerable carers with a range of risk factors themselves,
18 how do we reduce rates of child abuse and neglect, as well
19 as the basic science work that's gone on about how
20 significant high levels of stress and trauma are in terms
21 of child development at a neurological and biological
22 level.
23
24 The challenge is, how do we have actual support within
25 systems and funding bodies for the implementation of these
26 sorts of programs? There's, you know, a reasonable amount
27 of clinical practice and some research about particular
28 programs that might be effective in improving those early
29 parameters of development; that's really difficult to get
30 funding for, but there is some very good work there.
31
32 The issue is, how do we get that translated into
33 service models. And, there have been various attempts to
34 do that over the years, but on the whole what's very
35 concerning I think is that we don't have an overall
36 strategy and coordinated response to the prevention of some
37 of the major risk factors that we know about.
38
39 We tend to maybe wait. Trauma is a very good example:
40 we know that early child abuse and trauma is associated
41 with a range of disorders, but particularly some adolescent
42 presentations who might not go into a trauma-informed
43 service; they might go to another service, and some youth
44 services vary, but some are not particularly trauma aware.
45 They might make other diagnoses, don't take a trauma focus
46 in terms of intervention, so in a sense a missed
47 opportunity for really stopping a developmental pathway to

1 enduring disorder.
2
3 The corollary of that is that we also see adults who
4 are survivors of very severe maltreatment and trauma in
5 infancy, largely women, who move between different aspects
6 of the mental health system who have not had opportunities
7 often for any trauma-focused intervention let alone
8 prevention. And we know in some cultural groups that
9 that's a major issue.
10
11 We then, in maternity services and related services,
12 will see that transgenerational impact where people who
13 have themselves experienced high levels of early adversity
14 in their own infancy and childhood attempt to parent the
15 next generation, and that in itself is a major public
16 health and social issue.
17
18 So, I'm using those examples really to make the point,
19 I think, that prevention - there are lots of preventive
20 opportunities. We have some basic understanding of the
21 science, we need a lot more research, support to actually
22 look at intervention programs.
23
24 I particularly advocate for those early parenting
25 programs for very vulnerable parents and population groups,
26 where we know there are risks for that transgenerational
27 transmission of trauma and adversity on the next
28 generation. And with the hope, I guess at the moment, with
29 the hope that we would institute that on a system-wide
30 basis, we might actually be able to intervene in a
31 preventative way in rates of childhood disorders, but
32 importantly lifespan trauma-related conditions.
33
34 So I think there is a gap between what we know and
35 what we do, which is a source of I think anxiety for those
36 of us who are working in that field. I think the science
37 is emerging, it's actually - maybe not in the terms of
38 longitudinal follow up studies, it's very difficult to get
39 funding for some of the longitudinal studies, but at least
40 in terms of shorter term intervention, that we can actually
41 improve infant developmental outcomes, parenting quality,
42 even for vulnerable parents, and engage them. I think very
43 appropriately, we need to focus on families' experiences of
44 coming to mental health and parenting services, but until
45 we get that integration it's going to be very difficult.
46
47 MR O'MEARA: Thank you. Can I ask you just one question

1 about care relationships which you referred to in the
2 course of your answer.
3
4 One feature of our community is that there's now a lot
5 of non-traditional family arrangements; is that an area -
6 or what does the research tell us about whether that's an
7 area of vulnerability? You've identified some other areas
8 of vulnerability, but is that something that needs to be
9 approached in any different way in parenting programs for
10 that matter by our clinicians once it gets into a clinical
11 setting?
12
13 PROFESSOR NEWMAN: Yes, depending - look, I think it's a
14 hugely important issue, one that is about obviously
15 equality in terms of access to support and services and
16 non-discrimination on the basis of whatever diversity
17 issues we're looking at.
18
19 In some hospitals, particularly in maternity settings,
20 that's still a problematic issue in some ways, some of it
21 might be on a clinician level, but the principles of what
22 children need for healthy development and prevention of
23 mental disorder and emotional problems is essentially to
24 support whoever's in a care taking relationship with that
25 child in terms of, from very early on that face-to-face
26 interaction, who helps that child, who supports that child.
27
28 So, parenting programs that I developed, we have had a
29 variety of carers who come to our programs; some are not
30 biologically related to the child in any sense, some are
31 other family members. That varies with culture, we have
32 same sex relationships, we have some very - you know,
33 non-traditional family configurations, and we have
34 consciously decided that it's very important that services
35 offer that.
36
37 There was some anxiety among some ethics committees
38 that maybe some others in traditional relationships may
39 find that difficult. I haven't found that to be an issue,
40 I think that's an attitudinal issue. I've found that most
41 people unite and share the common challenges of early
42 parenting and so on and want to be there to care for their
43 children.
44
45 The same applies to cultural diversity. I think there
46 is some logistic issues you have to be careful of, so if
47 I - I learned the hard way by working with some African

1 communities where I said, "Please, whoever's involved in
2 the care of this child please come to this particular
3 meeting", and I had about 15 people arrive because, for
4 them, all of these people were very important, which was
5 marvellous to see, but it makes, you know, with room sizes
6 and current issues it was very, very difficult.
7
8 So, I think there's some practicalities but I think
9 it's absolutely important that we break down this notion
10 that the - usually the mother - that the biological parent
11 has the sole right to treatment.
12
13 MR O'MEARA: Thank you. I think all of our theatres and
14 stadiums are empty at the moment, so you might find it
15 easier.
16
17 I tempted you by saying that I was going to ask you
18 about the question of screening, but I might go to
19 Professor Hiscock about that and come back to you, if
20 that's okay.
21
22 Professor Hiscock, Professor Newman's referred to one
23 form of intervention which is via early parenting programs
24 and that would be - and I said I'd come back to her and I
25 will - but that would be administered by clinicians and
26 professionals who are already administering that kind of
27 program.
28
29 Another area which is covered in the statements of
30 each of you is the value of intervening or knowing whether
31 to intervene via use of screening. Can I ask you to
32 introduce that topic and ask you to tell us what the
33 pitfalls or, for that matter, benefits of screening are
34 from your perspective?
35
36 PROFESSOR HISCOCK: Sure. So, the idea of screening
37 really comes out of physical health conditions rather than
38 mental health conditions, and I prefer the idea of
39 surveillance rather than screening.
40
41 So, the screening says you've got a really good single
42 or very brief measure that you can ask a series of
43 questions to families about their child or make
44 observations and on the basis of that you say the child is
45 or is not at risk of developing a mental health problem.
46 So, you've got to have a good measure that does that
47 reliably and doesn't give you a whole lot of what we call

1 false positives so that unnecessary stress happens for the
2 family or unnecessary resources which has a cost to them
3 are put into that family, or what we call false negatives,
4 saying, no, no, this child's actually okay, but actually
5 down the track they turn out not to be okay. So, you've
6 got to have a good measure and I don't think we've got a
7 really good measure in infants and young children to really
8 reliably do that at a single point in time.
9
10 Things change over time. So, whatever you do, you
11 can't just do it once and say, that's it I've sorted out
12 that family; you have to think about ongoing surveillance.
13
14 Then of course, you have to have the resources
15 available to be able to meet the needs of whatever you
16 find. So, the worst you can do is turn up a number of
17 issues and problems and not be able to address them and
18 say, "Sorry, we've identified that, but we can't meet your
19 needs for another 12 months because our waiting list is
20 12 months."
21
22 So, the Wilson and Jungner criteria, you know,
23 developed back in 1968, the year of my birth, and there's
24 criteria around when to screen and what you need to have in
25 place and they're some of the things. You've also got to
26 know the natural history of the underlying condition for
27 which you're screening.
28
29 So I think we should have, rather than screening, as
30 you know, one measure at a point in time, we should think
31 about ongoing surveillance of the mental health and
32 wellbeing of infants and children, and that can be done
33 through the sting workforces like maternity and child
34 health nurses and GPs and teachers and early childhood
35 educators. And there should be some warning signs that
36 then say, okay, we think this family may need some more
37 help, we need to ask them, do they want that extra help,
38 and then we need to have clearly identified pathways for
39 them to get care and support.
40
41 When Professor Newman was talking about parenting
42 programs which are so important, what we don't do though is
43 really - by and large a lot of the time those services
44 don't reach the lower socio-economic vulnerable families,
45 and I know my colleagues in New South Wales, instead of
46 waiting for families to come into their centres, they go
47 out and do supported play groups and they build into those

1 supported play groups assessments, they work out which kids
2 they're worried about and they start to deliver the
3 parenting interventions by going out into the population
4 rather than expecting the population to come in to us.
5
6 So, I think the concept of ongoing surveillance is a
7 great one. We've got the strengths and difficulties
8 questionnaire already embedded into primary school for
9 Government schools in Australia, but only at school entry,
10 in prep. Can we be doing something before that, and can we
11 be doing something throughout the primary school life: not
12 just have it at prep and go, right that kid is done and
13 dusted until high school, which is often not the case.
14
15 MR O'MEARA: Thank you. Professor Coghill, are there
16 difficulties relating to stigma or trust, or any other
17 difficulties that are provoked by the screening question
18 or, for that matter, the application of diagnoses to very
19 young children?
20
21 PROFESSOR COGHILL: Oh, that's a big question. Yes,
22 there are. Stigma is a huge issue within mental health,
23 but no less an issue within infant and child mental health
24 than it is across the board.
25
26 When we look at public surveys about mental illness we
27 see still high levels within our community, not just of
28 stigma, but of fear and misunderstanding. The RCH Child
29 Health Poll looking at child and adolescent mental health
30 showed us that the mental health literacy of parents is
31 still very poor and a lot of misconceptions and
32 misunderstandings there.
33
34 But our experience has been that it's not only at the
35 individual and population level, but there's still a lot of
36 stigma within health itself: within social work, within
37 education, and again, based often on misunderstandings and
38 misperceptions.
39
40 In my evidence, I cited an example which, as I said
41 there, unfortunately wasn't an isolated example of an
42 Ethics Committee asking us to take out the words "you're
43 child may be suffering from a mental health problem"
44 because it was felt that those words may cause fear, panic
45 and feelings of stigmatisation in the parents that we were
46 asking.
47

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1 What was important about this situation was that these
2 were families who had sought and already been accepted for
3 mental health care for their child, and these kind of
4 institutional aspects of stigmatisation are something that
5 come up very frequently.
6
7 What we do know about screening and screening
8 questionnaires is that asking the question, "Do you have
9 thoughts of harming yourself? Do you have worries? Has
10 your mood been low?", these kind of questions don't induce
11 problems. So, asking someone, for example, and it may be
12 the most extreme but "Have you been feeling suicidal?",
13 doesn't increase the risk that that person either will feel
14 suicidal or will act with a suicidal behaviour.
15
16 So, screening and asking the questions isn't the
17 issue. Professor Hiscock has really hit the nail on the
18 head: the problem isn't so much what we call specificity.
19 We have screening questionnaires that are quite specific
20 and pick up most cases, but they're also not - sorry,
21 sensitive and pick up most cases, but they're not specific
22 in the term that they often also pick up a lot of false
23 negatives, and that causes problems not just with
24 over-diagnosis but the potential treatment of children if
25 the subsequent assessment isn't actually of a high quality
26 and relies on the answers to the screening question to say,
27 ah, yes, we've got a case of depression or ADHD or anxiety,
28 then actually treating for something that isn't there or
29 treating the wrong problems.
30
31 Actually the best screens that we have are knowing the
32 right questions. We know that we can assess accurately,
33 sensitively and specifically childhood mental health
34 problems by asking the right diagnostic questions, the
35 right assessment questions, and the best people to do
36 screening are those people who see the child. And I think
37 here's an education perspective for us, that all of those
38 who are in constant - sorry, who are commonly in contact
39 with children should know how to ask these questions: they
40 should know what to look for from the behaviours, but the
41 behaviours on their own aren't often enough to let us know
42 whether something is a problem; they should increase their
43 sensitivity that there might be a problem, but then knowing
44 how to ask the questions.
45
46 And Professor Hiscock and I often debate this, about
47 whether people have time to ask those questions, whether

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1 people are given time to ask those questions, and I think
2 that depends on how important you see it as identifying
3 these types of very disabling mental health difficulties
4 that people have.
5
6 We ask a lot of other questions, we do a lot of
7 physical examinations when we see children within the
8 health setting, social workers and educationalists ask an
9 awful lot of questions, but making sure that we know and
10 that we can actually take time to understand whether
11 someone has a mental health problem is actually the best
12 screening, as well as, before that, screening for the risk
13 factors; those social determinants of health that we've
14 talked about are things that we can all recognise and put
15 someone in a higher risk category where we've got to be a
16 bit more sensitive, where we've got to open our eyes a bit
17 more to actually check whether or not someone's suffering
18 from a mental health problem.
19
20 MR O'MEARA: Could - I'm sorry.
21
22 PROFESSOR NEWMAN: If I may, about the issues of the very
23 young, where making a diagnosis of a baby or a young infant
24 is inherently problematic, and it's not as easy to define
25 disorder. I certainly do not use the language of "mental
26 illness" about someone who's a month old or a baby
27 (inaudible).
28
29 PROFESSOR COGHILL: Certainly I agree with you, Professor
30 Newman, but you also know the right questions to ask to
31 know whether there's a high possibility or probability, and
32 I'm sure when you work with the mental - sorry, with the
33 maternal and child health nurses, they also learn that
34 language, they learn how to recognise, not just from the
35 questions - an infant can't answer questions from you - but
36 to be able to look with a trained eye and a trained ear at
37 the signs that it's likely that someone has a mental health
38 problem. If I said "disorder" I apologise, but problems
39 that are associated with mental health.
40
41 So, I think that it is possible - if it wasn't
42 possible we'd all be really struggling - but actually the
43 literacy isn't out there, the understanding isn't out there
44 amongst all of those. I think it's getting better in some
45 settings but not in all to ask those right questions, be
46 they verbal questions or be they questions of looking and
47 observing.

1
2 So, I wasn't meaning diagnose, I mean identifying
3 those who are at high risk who need to come and see someone
4 like yourself, need to come and see Professor Hiscock, need
5 to come and see me or other mental health specialists.
6
7 PROFESSOR NEWMAN: So in our approaching infant work is
8 precisely that, that we look at - we describe more
9 developmental difficulties and developmental risk, and the
10 ways of questioning around that and screening around that
11 can be quite specific and very useful.
12
13 So, for example, we do screening for particularly
14 maternal psychological problems like depression in
15 pregnancy. So, someone who's going into a maternity
16 service will actually be screened for depression and
17 anxiety, domestic violence, and their history of mental
18 health problems at their first booking in visit in many
19 hospitals currently in Victoria, which is very important,
20 and immediately helps us to be alert to those who might
21 have problems in parenting or the infant might have
22 problems in terms of their development.
23
24 The skills that David mentioned I think are very
25 important: observational skills, so maternal child health
26 nurses have excellent observational skills and can pick
27 quite accurately quite early signs that there may be
28 developmental problems for that child, and they're using
29 routine screening, so I think all those approaches are very
30 helpful in that whole idea of alerting us to those who are
31 already at an early age showing developmental problems and
32 problems in emotional and psychological development that
33 can develop into mental disorder.
34
35 PROFESSOR COGHILL: The one other thing I would like to
36 say, if I can is, I have a difficulty with we shouldn't
37 identify things unless we've got the capacity to manage
38 them immediately.
39
40 I think that we have treatments that are effective for
41 mental health problems; we don't always have the capacity
42 and sometimes at the moment people need to wait.
43
44 I'm uncomfortable though with, in a sense,
45 deliberately not looking for something because I'm worried
46 that the capacity isn't there. I acknowledge that that may
47 be controversial to a degree, but I think that what we need

1 to do is, by increasing our recognition - and let's not be
2 under any misunderstanding, mental health problems in
3 infancy, children and adolescents in Australia are
4 under-recognised, under-diagnosed and under-treated, but I
5 don't think we can be complacent about that just because
6 our services struggle.
7
8 I think opportunities like this - that the
9 Commissioners are looking at how we can reform, how we can
10 remodel, how we can bolster our services - we need to be
11 truly aware of what the capacity needs are. And, it's not
12 just about extra funding, it's about being smarter with the
13 way that we use our resources, it's about being smarter
14 about the ways that we work together.
15
16 But I think that the argument that we have a capacity
17 issue, therefore, we shouldn't look to uncover again these
18 very disabling conditions, problems and disorders that our
19 children and young people have.
20
21 MR O'MEARA: Thank you. Can I ask a follow-up question,
22 Professor Coghill which is, you've referred to, well, if
23 you go looking for something you might find it and, if you
24 find it, you might have to do something. You've said that
25 there are interventions that work and you've alluded to the
26 possibility that you might be able to use the features of
27 the system that you already have to address them. Can you
28 expand upon that a little bit further to say and give us -
29 or the Commissioners the benefit of your ideas about how
30 the system could better be organised to respond to the kind
31 of information that screening might reveal?
32
33 PROFESSOR COGHILL: Yeah. I think it was acknowledged at
34 the very beginning that one of the things that we in
35 Victoria and across Australia suffer from in this area is
36 that siloing and fragmentation of services. That leads to
37 a lot of duplication, it leads to a lot of extra work being
38 done, people being reassessed by several different
39 clinicians in several different services to have their
40 problems managed.
41
42 We also have a lot of clinicians who are working in
43 isolation. So, many of our private clinicians, be they
44 medical or psychology or allied health, work independently
45 and therefore can't make use of the multidisciplinary team,
46 and actually as a multidisciplinary team within child and
47 adolescent health with the flexibility to use team members

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1 together and separately to play to their skills is
2 something I think that's very important.
3
4 We know that most children with mental health problems
5 don't get seen, but also, we know that those that are seen
6 under MBS, for example, often receive quite transient care.
7 So, only a very small proportion of those with mental
8 health problems who are seen within the MBS funded sector
9 actually receive what we could consider to be minimally
10 adequate treatment, a paper that Professor Hiscock and I
11 have just recently published on that.
12
13 But also, if we look at the publicly funded specialist
14 mental health services, they see a large number of
15 children; it was just under 12,000 in the 2017/18 year.
16 And, unlike the MBS funded services, those 12,000 children
17 were seen on average 30 times each. Now, that's a huge
18 amount of time that's been spent, and what I see when I
19 work within a publicly funded mental health service is, a
20 lot of that time was spent on case management, on
21 supporting the social and educational needs of those
22 children, rather than actually providing specific
23 evidence-based therapies.
24
25 And, where evidence-based therapies are provided, then
26 again we often don't measure outcomes: we're not clear, we
27 don't have both an evidence-based and a measurement-based
28 culture that's been very clearly demonstrated across health
29 including in mental health and in our own work in Scotland
30 within child and adolescent mental health services,
31 actually reducing the number of contacts that you need to
32 have with an individual, whilst optimising and improving
33 the outcomes. So, there are a lot of missed opportunities
34 in the ways that we currently work.
35
36 I think a key will be bringing together the paediatric
37 workforce who carry out a lot of the mental health work at
38 the moment and the specialist child and adolescent mental
39 health work, and I'm talking specifically here about
40 children; the same could be said for adolescents. I
41 wouldn't want to comment on how best to organise infant
42 mental health care, Professor Newman understands that much
43 better than me.
44
45 I think the way that Professor Hiscock and I differ on
46 how we deliver more integrated services is, my experience
47 is that bringing paediatricians, bringing allied health

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1 professionals and actually bringing in primary care and
2 others from the community, bringing them into the child and
3 adolescent specialist mental space - not subsuming them,
4 but joining them together with that as a focus is something
5 that can provide more efficient care.
6
7 I think Professor Hiscock has a different view that
8 I'm sure, whilst we have very similar ideas on the need to
9 integrate, slightly different views on how that should be
10 done.
11
12 But my view of an infant and child mental health hub
13 would be one that actually conducts the work that's
14 currently carried out within the CAMHS and CYMHS services,
15 but also brings the paediatricians into the tent, into the
16 workforce, and probably primary health as well.
17
18 I think the one problem with all of this, and this is
19 really, I guess, a governmental issue both at the state and
20 Commonwealth Government, is how this is funded. Because
21 currently mental health services and paediatric services
22 are funded by completely different streams with completely
23 different emphasis, so bringing them together needs reform
24 not only in the way that we deliver services, but the way
25 that we reimburse services.
26
27 I think these are incredibly complex issues, I don't
28 think we can solve them in an afternoon, and my suggestion,
29 which we may come back to, for a collaborative centre for
30 infant and child mental health, similar to the one that the
31 Commissioners are proposing for adults, similar to what we
32 have in Orygen Youth Health, is where we need to develop
33 and test these ideas out, and then we need to be able
34 disseminate them, evaluate them and bring them out into the
35 community.
36
37 So, I think it's a very, very complex question.
38 Obviously, I could talk all afternoon on this, but we need
39 to share the discussion around.
40
41 MR O'MEARA: Thank you very much, Professor. You wouldn't
42 be able to do that because, if you did that, you'd be
43 making the same mistake that I made last time we had a
44 panel where I got so overexcited we forgot to take a break,
45 so we won't be doing that today because that got me into a
46 lot of trouble.
47

1 But, before we take our break, why don't I let you,
2 Professor Hiscock, identify the areas of discussion and
3 disagreement that there have been between you and Professor
4 Coghill, because we've been so tempted by his
5 identification of the fact that you have slightly different
6 views.
7
8 PROFESSOR HISCOCK: I don't think it's an either/or. So,
9 I agree with a lot of what Dave is saying. At the moment
10 only 10 per cent of children with - according to the Young
11 Minds Matter survey who met diagnostic criteria for a
12 mental health problem between the age of 4 and 17 years get
13 a CAMHS service. So, the remaining 90 per cent are seen by
14 the GP, the school counsellor, the paediatrician or the
15 psychologist.
16
17 So, I am very interested in different models and I
18 think Dave said we need to develop and test them, because
19 we don't have the evidence, we don't know the answer.
20 There may be a model which brings paediatricians and GPs
21 into CAMHS. That may sit alongside a model where we say,
22 we can't bring everyone into CAMHS because we simply don't
23 have the capacity, so how else do we support our GPs, our
24 maternal and child health nurses, our often private
25 practice psychologists and private practice paediatricians
26 who are doing the bulk of mental health care for children
27 certainly, and for infants a lot of it, how do we support
28 them to do evidence-based care and care that we know can
29 make a difference?
30
31 And that's, I'm sure we'll talk about after the break,
32 things like telementoring. You know, we've all shifted to
33 telehealth with COVID-19 spectacularly well - not perfectly
34 for everything - but how do we get disciplines together in
35 a telementoring sort of Project Echo-type model, and I'm
36 thinking of bringing in social care and CRE and childhood
37 adversity in Wyndham; and in Marrickville we're going to
38 have GPs, maternal and child health nurses, paediatricians,
39 psychologists, social workers, financial counsellors and a
40 lawyer all in the same place, and we're going to look at
41 monthly telementoring support together; with that
42 telementoring actually being available to the childcare
43 centres around the centre, the antenatal, you know,
44 Werribee-Mercy Hospital, also to the school, so really
45 multidisciplinary telementoring.
46
47 And the Massachusetts Child Psychiatry Access Program

1 is another model that, you know, we don't know if it could
2 work in Victoria, but we need to bring these models, we
3 need to adapt them and we need to test them, we need to
4 look at their effectiveness and their cost-effectiveness.
5
6 So, it's not an either/or but I think there are
7 different ways to approach this problem, but we've got to
8 change what we're currently doing because, as Professor
9 Coghill said, most children under the age of 12 we have
10 shown do not get any care and, even if they do get care, it
11 would not be considered minimally adequate treatment based
12 on current best practice to change their mental health
13 trajectories.
14
15 MR O'MEARA: That's a good way to give us momentum for the
16 next five or so minutes while everybody catches their
17 breath and, subject to anything the Chair might say, why
18 don't I let you all have five minutes and I'll see you
19 then.
20
21 PROFESSOR NEWMAN: Thank you.
22
23 PROFESSOR HISCOCK: Thanks.
24
25 **SHORT ADJOURNMENT**
26
27 MR O'MEARA: Welcome back everyone, I think nearly
28 everyone is back. Yes, I can see a hand.
29
30 THE CHAIR: Yes, let's start going I think, we're all
31 here.
32
33 MR O'MEARA: Alright, thank you. Professor Hiscock, you
34 spoke so eloquently about your Wyndham project, and you
35 referred in various ways to the improvement of mental
36 health literacy in various people in the health and
37 non-health disciplines, I thought I might recompense by
38 asking you to speak a little further on that topic, both
39 about your Wyndham project and about steps that can be
40 taken to improve mental health literacy which might be at
41 the heart of the kind of where you're heading on this
42 topic, and then I'll ask Professor Newman about the same
43 issue.
44
45 PROFESSOR HISCOCK: Sure. So, the project in Wyndham is
46 part of a Centre for Research Excellence in Childhood
47 Adversity and Mental Health, it's half funded by Beyond

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1 Blue and half funded by the National Health and Medical
2 Research Council. Five year project, we're in year two.
3
4 Year one has actually been lead by Professor Tony Jorm
5 from Melbourne Uni and he's done an evidence synthesis of
6 what are the impacts of the various adverse childhood
7 experiences on children's anxiety, depression and suicide
8 risk, so he's actually quantified that.
9
10 And what's of interest I think to this panel is that
11 there's a variety of adverse - ACEs - adverse child
12 experiences, and none of them have a particularly worse
13 outcome, they're all equally bad for children in terms of
14 longer term mental health.
15
16 So, for example, physical abuse or sexual abuse is no
17 worse than neglect, so I think that's important when we
18 think about where we put resources.
19
20 He's now also done an evidence review of what works to
21 mitigate the effect of adverse childhood experiences on
22 children's mental health and there's 24 broad areas of
23 intervention, ranging from things that we've talked about
24 like parenting, things that build resilience in families,
25 peer to peer support, social support, housing support,
26 finance support, so all those really broad determinants
27 that we talked about.
28
29 What we're doing with that evidence now is, we're
30 taking it to experts across the country but also to
31 families experiencing these issues in Wyndham and to the
32 clinicians to say, that's what the evidence says but what
33 could work in your context.
34
35 Over the remainder of this year we're going to develop
36 the model of care that we're going to test at Wyndham to
37 integrate health, social and education sectors to deliver
38 evidence-based care to try and mitigate the effects of
39 adversity and we're going to explore how best to detect
40 adversity in those families either through a screening
41 process or less of a formal tick box screen which is a lot
42 of what happens in the US, because there are those concerns
43 we've talked about with screening. Then we'll be
44 evaluating next year what are the outcomes of this model of
45 care on children's mental health, the family's mental
46 health, quality of life and what are the cost-effectiveness
47 of the model as well.

1
2 We're also working with Health Justice Australia to
3 put a lawyer into those settings who will actually help
4 families with all the social determinants we've talked
5 about ranging from finance, housing and employment, to more
6 specific matters like family violence.
7
8 So, that's this area in childhood adversity and my
9 colleague, John Eastwood, is doing a similar model in
10 parallel in Marrickville in New South Wales, so we'll have
11 two sites from which to draw upon. And underpinning that
12 work we're looking at a framework for sustainability and
13 policy change, what needs to happen should this be
14 effective in terms of scaling this up, and we've chosen
15 community health centres deliberately because that's a
16 model of care that's available across Australia, it's not
17 state-specific or local government area-specific.
18
19 We're just in conversations now with Wyndham looking
20 at having a wellbeing coordinator who will have a role of
21 social prescribing for families as well as care navigation
22 for the families experiencing more complexity and severity
23 around their life circumstances and their child's mental
24 health and wellbeing.
25
26 So that's a bit of a watch this space and it's very
27 exciting and I can see it as a model for having child and
28 family hubs in the community, but as Professor Coghill
29 talked about, the funding of that's going to be really
30 interesting because a lot of the medical services there
31 would currently be funded through the GPs and
32 paediatricians by Medicare, whereas we have funding for a
33 CAMHS psychologist to come out and support case-based
34 discussions, telementoring, secondary consultation model
35 for the GPs, paediatricians and they're funded by the State
36 Government.
37
38 So, is that enough on the Wyndham model?
39
40 MR O'MEARA: Yes, absolutely. Go on.
41
42 PROFESSOR HISCOCK: And then the next question was around
43 mental health literacy.
44
45 MR O'MEARA: Literacy, yeah.
46
47 PROFESSOR HISCOCK: So, I think as Professor Coghill

1 alluded to, we know from the child mental health poll which
2 was 2,000 parents across Australia, that only a third of
3 parents said they could recognise when their child had a
4 mental health problem, two-thirds couldn't.
5
6 The interviews we've done with GPs last year about the
7 mental health system, they said we have real problems
8 knowing when a child's got a mental health problem or not
9 and knowing when to refer and when not to refer.
10
11 I know there is some work being done through Be You,
12 which is funded by the Federal Government, to develop
13 online training models and resources for early childhood
14 educators and teachers and GPs in this space. I think the
15 challenge will be getting them to take up those resources
16 and use them.
17
18 I also know that Mental Health First Aid, which is
19 borne out of Melbourne Uni, is now an international form of
20 training that's being delivered, they are now developing
21 mental health aid for primary school children and I'm
22 sitting on their advisory committee for that. So that's an
23 opportunity as well to better support teachers and
24 healthcare professionals in particular, not the mental
25 health care professionals, but everyone from the - you
26 know, the paediatrician or the GP in private land, to the
27 second year registrar in endocrinology at the Monash
28 Children's Hospital, whatever it might be, giving them some
29 basic mental health first aid training so they can
30 recognise the early signs of mental health problems in
31 children and know how to respond in the first instance.
32
33 So, they're going through the very rigorous process of
34 developing a mental health first aid course for primary
35 school-aged children.
36
37 MR O'MEARA: Thank you. Professor Newman, one area or one
38 discipline that Professor Hiscock didn't refer to but
39 you've referred to this area specifically and several times
40 is maternal and child health nurses. What about mental
41 health literacy support for those professionals,
42 particularly when it comes to infants?
43
44 PROFESSOR NEWMAN: (Inaudible).
45
46 MR O'MEARA: Yes, I can hear you.
47

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1 PROFESSOR NEWMAN: A very important workforce. I'm
2 interested in very similar ideas about integrated
3 multi-professional, multi-multidisciplinary hubs,
4 one-stop-shop models for vulnerable families to improve
5 access and equity of service.
6
7 So, I have some funding, philanthropic funding, from
8 Helen Macpherson Smith, to be running a trial of our
9 program, which is Melbourne University and Deakin
10 University called BEAR, as in teddy bear, building early
11 attachment and resilience which is an infant early
12 parenting approach for high risk, so-called high risk
13 families as opposed to generic parenting support, so that
14 covers parents with mental health issues, stressed
15 relationships and a lot of significant vulnerability.
16
17 The idea is, in the same way that Professor Hiscock
18 was talking about with her model, of trying to integrate
19 across primary care, paediatrics where that's necessary,
20 and a lot of our work is using maternal child health nurses
21 who have got that sort of, obviously, expertise in infant
22 observation who go into families and homes anyway, who are
23 a very trusted workforce and I think that's very important
24 for families, and the focus is on engaging these families
25 around being the best parents they can, promoting infant
26 development.
27
28 So we're trialling that as a model in Bendigo, Barwon
29 Health in Geelong in some very high risk demographic areas
30 like Corio where there are very high rates of quite
31 socially excluded families and a lot of drug and alcohol
32 issues and other social problems, very high rates of child
33 protection concerns in an area like that and high rates of
34 mental health problems, so a nice coalescence of all the
35 things we're talking about.
36
37 And we're also going to Mornington Peninsula, where
38 the services for the very young are largely run by maternal
39 child health nurses, very limited other services, and the
40 idea really is to build up capacity into these areas.
41
42 I absolutely agree with the point that Harriet made
43 earlier, that we don't want families with young babies to
44 have to feel like they have to keep coming back to a
45 hospital in a major metropolitan centre or a large town for
46 services which they should be able to access quickly and
47 effectively and in a better coordinated way in their area.

1
2 We're also looking at these models of now using telehealth obviously to provide supervision and support and consultancy for (indistinct) in these areas, and we've rapidly, because of necessity but it has worked, been running our particular programs around early parenting using Zoom, which has been surprisingly effective as opposed to having people who are very isolated, have no service; I think that's - and we're evaluating that with some other funding.
11
12 I think what's important is that we evaluate these Models. We also have to cost them and look at the potential for upscaling these sorts of interventions.
15
16 But I absolutely agree that the principles are about improving access, acceptability, but also training and involving a range of service providers who need to be there for families.
20
21 Now, maternal child health nursing as a group in some of the Bear centres which I visited now in all of these areas before lockdown have actually been doing remarkable work in terms of coordinating care for vulnerable families to the extent of having clothing available for those with - you know, who have basic needs, clothing; food collection for some of those who run low on food, some of the basics of care with other local organisations and have seen themselves as offering that kind of coordination.
30
31 So often solo parents or very vulnerable parents or parents with mental illness will actually go there preferentially to other services, and in the absence of having mental health services, let alone child and adolescent mental health services, it's been absolutely Imperative. Mornington is a good example of that sort of provision.
38
39 Somewhere like Barwon Health is obviously better resourced but paediatricians there are very interested, they have a neurodevelopmental clinic for some of the very vulnerable infants and children of having a linked model of early parenting support.
44
45 And I think it's a creative process really in some ways at this stage of bringing together these sorts of elements. I think the very important issue is how we

1 evaluate and what sort of outcomes are we going to look at
2 developmentally in the very young and we engage in programs
3 and in parents and parents' capacity to deal with sometimes
4 the challenges of parenting and their own stress and so on
5 and that's what we're doing at the moment. Unfortunately
6 because of the pandemic things have been slowed down a bit
7 but we're hopeful that we'll be doing more via distance in
8 that sphere, so similar sort of models.
9
10 MR O'MEARA: Thank you. Professor Coghill, I think you
11 led the charge into the concept of discussing hubs, which
12 is a welcome one because it's a big topic. You have some
13 experience of hubs, but you've also spoken in your
14 statement of the importance of clinical guidelines and
15 pathways and, for that matter, some of your experience in
16 hubs has been, for example, to look at in a different way
17 or treat in a streamed way children presenting with
18 internalising disorders as opposed to externalising
19 disorders and so on.
20
21 I'm raising there several different facets of this
22 area of discourse, but I wonder if you could speak first to
23 what you observed in services on Tayside, and also to your
24 ideas concerning clinical guidelines and how hubs would
25 function in Victoria and, for that matter, relate to the
26 CAMHS and CYMHS services.
27
28 PROFESSOR COGHILL: I think, the first thing I'd like to
29 say in that, is that, I agree with all of the discussion
30 we've had on prevention, but it is very important to
31 recognise that even with the best prevention there are
32 still going to be mental health problems in children.
33
34 One statistic that we often don't hear: we often hear
35 about three-quarters of mental health disorders that adults
36 suffer starting in adolescence; we often don't hear that
37 50 per cent of those started in childhood, so before the
38 age of 14. So, we need preventative work but we also
39 need - and that's really where I'll focus in this answer -
40 we need to be able to assess and treat those who present
41 with existing and continuing mental health disorders.
42
43 It's timely actually that you ask this question,
44 because Professor Newman was talking about the maternal and
45 child health nurses, and one of the biggest differences I
46 found when I moved from the UK, or from Scotland to
47 Victoria, was that in our service in Scotland, our CAMHS

1 service in Scotland, an awful lot - I would go as far as
2 saying most of the frontline face-to-face work was actually
3 conducted by nurses. We had a combination of mental health
4 nurses and paediatric nurses that worked with us, and it
5 was absolutely fascinating to see how this developed over
6 time.
7
8 What we found was that, when we were trying to
9 implement evidence-based care - and we had evidence-based
10 protocols and I'll come back to them - it was the nurses,
11 not the doctors that actually implemented them very
12 efficiently.
13
14 So, you asked them to follow a plan and they followed
15 that plan, but they didn't follow it slavishly; they didn't
16 follow it with a sort of blind, I'm just going to do this
17 and that's my job and I'm finished. They followed it with
18 sensitivity, and they followed it up by saying, "I've done
19 the bit that I need to do, I've asked you the important
20 questions from my perspective, but is there anything else?
21 What are the other things that are troubling you?" They
22 did that and cared about the answers, so we got very
23 holistic care by including nurses.
24
25 I think there's been probably both a funding reason
26 why that hasn't happened in Australia, but possibly also a
27 structural reason, that nurses haven't been part of
28 services as they've moved forward. So, that's one thing
29 that I experienced.
30
31 The other was that we had, as I've suggested in my
32 submission in my evidence, we had a lot of
33 cross-pollination between paediatrics, primary care and
34 child and adolescent mental health specialists; with GPs,
35 we call them gypsies, GPs with special interest choosing to
36 spend time in the CAMHS service, learning how to assess,
37 how to manage more accurately the types of problems that we
38 see, and then going back out into their general practice.
39 They would maybe come one day a week and work in the
40 practice for the other four. Then going out and not just
41 practising what they learnt, but also training up the other
42 staff around them to work in a creative way with these
43 problems.
44
45 Likewise with paediatricians, we managed that in
46 several ways. We would go and join paediatricians in their
47 clinics and do kind of on-the-job, both consultation, case

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1 management and training with them. But also brought
2 paediatricians into the CAMHS service and had them as an
3 integral part, and that was an interesting experience.
4
5 I think one of the things we may come to is training,
6 what we recognised was that our paediatricians had many
7 skills, but they also hadn't had the opportunities to learn
8 how to deliver evidence-based assessments, how to deliver
9 evidence-based care.
10
11 But what they were able to do, and I think this is the
12 importance of having evidence-based guidelines and
13 evidence-based clinical pathways, they were able to pick up
14 on those and to see how important it was to practice in
15 that evidence-based way rather than not, and I think the
16 lack of evidence-based pathways in Australia is a real lack
17 for us.
18
19 There are, as Professor Hiscock said earlier, good
20 quality evidence-based pathways, I think particularly from
21 the UK but also from other countries. They can be adapted,
22 and certainly at the Melbourne Children's Campus, the Royal
23 Children's Hospital and MCRI and the university, we have as
24 part of our developing mental health strategy very clear
25 plans to adapt the existing evidence-based pathways to an
26 Australian health system which, of course, is somewhat
27 different with that balance between public and private
28 that's not there in the UK.
29
30 But I think I have no doubt that we'll be successful
31 in doing that as long as we can get the support to do it
32 and, from that, to develop much clearer pathways that will
33 manage a lot of the variability that we currently see.
34
35 One of the other things to come out of the project,
36 the NHMRC project that Professor Hiscock was leading and
37 that I joined shortly after arriving, was huge variability
38 in practice, and where there's variability, it's evidence
39 against there being a more evidence-based practice, and I
40 think that we can work on that but it's going to take time
41 and, as we heard earlier, change is difficult for people
42 and in order for that change to happen it's going to need
43 to be supported.
44
45 MR O'MEARA: Thank you. Can I ask you about one element
46 of what you observed in Scotland and that was the
47 difference between what you describe in your statement as

1 the externalising as opposed to internalising disorders and
2 how they might be approached in streaming generally.
3
4 PROFESSOR COGHILL: Thank you. Sorry, I'd forgotten you
5 asked that.
6
7 MR O'MEARA: It's a very long question.
8
9 PROFESSOR COGHILL: Externalising disorders are those
10 disorders like ADHD, like Oppositional Defiant Disorder,
11 like Conduct Disorder, that mainly manifest in abnormal
12 behaviours. The internalising disorders include the
13 anxiety disorders and depression, amongst others.
14
15 What we found within our service in the UK, and this
16 is a common problem, was that, because those adolescents -
17 we had a 0 to 18 service - because those adolescents who
18 were presenting with internalising disorders and also
19 eating disorders were often suicidal, often seen as high
20 risk, and often seen as needing immediate care, they were
21 prioritised, and their prioritisation meant that those with
22 externalising disorders, so those with neurodevelopmental
23 disorders and more behavioural problems, were always
24 shunted to the back of the list, to the bottom of the list.
25
26 What we did within our service, and I have to say this
27 was within a service, not a separate service for
28 internalising and externalising disorders because there
29 needs to be a cross-pollination of skills between these
30 streams of work, was that we streamed an internalising
31 disorder stream and an externalising disorder stream.
32
33 The externalising disorder stream was much more high
34 volume, it involved a lot more medication use, a lot more
35 long-term treatment for chronic problems like ADHD; whereas
36 the internalising stream involved a lot more psychological
37 therapies, a lot more emergency management of suicidality,
38 it required patients to come into inpatient settings.
39
40 But by separating these streams and by giving each of
41 them their own priority it meant that we were able to
42 allocate resources appropriately across the two streams
43 and, for those children with the neurodevelopmental
44 disorders whose impairments were actually very
45 considerable, often their problems were not seen as acute
46 but actually involved complete breakdown of schooling,
47 complete breakdown of families, substance misuse, criminal

1 behaviours. We were able to prioritise those within this
2 group of patients with the externalising disorders, whilst
3 those with suicidality and other more urgent needs within
4 the internalising group were also able to get prioritised.
5
6 And this worked extremely well and actually led to
7 really very much improved outcomes, but also a much
8 greater - more efficient - maybe not greater - a more
9 efficient use of our services than we'd had previously.
10
11 MR O'MEARA: Thank you. Professor Hiscock, you've
12 referred in your statement, or at least raised for
13 consideration in your statement the question whether it
14 might be possible to stream by severity. I wonder if you
15 could outline your views on that topic. You've certainly
16 said clearly there you couldn't stream by age, or you
17 wouldn't want to stream by age, so I don't want to restrict
18 you on the general topic of streaming --
19
20 PROFESSOR HISCOCK: Certainly.
21
22 MR O'MEARA: -- to age and why and possibly to severity and
23 why.
24
25 PROFESSOR HISCOCK: Yes. I said no to age really I guess
26 from my position and experience as a paediatrician where I
27 look after birth to 18 years and also from the feedback
28 from families in our qualitative interviews last year; we
29 spoke to 35 families about what's wrong with the mental
30 health system and how to fix it. And I time and time again
31 heard from families that having to go and tell your story
32 to yet another person or set of professionals was really
33 disruptive and they really valued continuity of care for
34 their child, and the child valued it as well; particularly,
35 they would actually disengage from going to yet another
36 service because of an age cut off, etcetera.
37
38 So that's really my feeling - and we don't make- kids
39 with diabetes from the age of 5 go to a different
40 endocrinologist and then kids with diabetes when they turn
41 12 go to another person for care of their diabetes, we just
42 don't do that.
43
44 So I think for the mild-to-moderate conditions these
45 should be managed across, you know, these zero to at least
46 12, I would say 18, within a service or within the same
47 person ideally. I think when it gets more severe and you

need the specialist expertise from a child and adolescent mental health service, then that's ideally when a child may go into that service but then they come back to the person that's holding them, whether that's the GP, the paediatrician or the psychologist would be the way to go forward.

So, I don't favour streaming by age but I do favour when things become severe and beyond the scope of the GP, paediatrician, psychologist, then you do need the specialist expertise and that's why I'm interested in models of care like the telementoring or like Professor Newman was talking about, or like the Massachusetts Child Psychiatry Access Program where we really try and upskill that existing workforce to manage the mild-to-moderate, which is still the bulk of by numbers, the number of children who are affected.

MR O'MEARA: Within the more severe or beyond moderate-to-severe presentations, do you see any benefit in what Professor Coghill suggests --

PROFESSOR HISCOCK: Yeah.

MR O'MEARA: -- in terms of separating and internalising and externalising.

PROFESSOR HISCOCK: As long as, and I think Professor Coghill actually said this, the clinicians managing those internalising/externalising streams are skilled in both, because up to 25 per cent of children will have comorbid internalising and externalising disorders at any one time. So, that's the child with ADHD and anxiety and a learning difficulty who's now suicidal because of X, Y and Z. So as long as that's not lost, which I don't think it was, then that makes sense.

MR O'MEARA: Professor Coghill, I'll go to you because I can see your hand, but Professor Newman I haven't forgotten you, I'm coming back.

PROFESSOR COGHILL: I just wanted to comment on the severity issue. I think it can become quite complex because one of the things that we're trying to do, of course, is to treat and manage mental health problems and make them less severe. And, if you just select care by a severity, you can find people bouncing around between

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1 different professionals.
2
3 So that was really why I - or one of the reasons why I
4 prefer a hub that includes those who manage cases that are
5 currently mild-to-moderate as well as cases that are
6 severe, so that you can work within the same team to be
7 able to manage them appropriately.
8
9 Certainly, there's times when you will need a more
10 skilled professional to manage someone whose condition
11 worsens, but you want to minimise the movement between
12 different settings, and that really is a big reason I think
13 for bringing those settings together: so bringing the CAMHS
14 services and the paediatric services together within a hub.
15
16 MR O'MEARA: Just to be clear about that, your conception
17 of such an approach would be for the hub to include the
18 CAMHS or CYMHS service as well; is that correct?
19
20 PROFESSOR COGHILL: Yes. Yes, I think so.
21
22 MR O'MEARA: Professor Newman.
23
24 PROFESSOR NEWMAN: Thank you. Yes, I just wanted to
25 stress that I think the benefit of the hub approach, as
26 we're discussing now, is precisely that it shifts this
27 discussion about how should we design services from the
28 viewpoint only of the service provider to the viewpoint of
29 families and children who can actually access them, which I
30 think - maybe it's a philosophical point, but I think it's
31 very important, that we're actually talking about moving
32 away from artificial barriers of age, or you have to have
33 this number of symptoms to get in here, to really I think
34 shifting it to a discussion about streaming according to
35 need, and then your need on the basis of a comprehensive
36 assessment with the appropriate
37 multidisciplinary/multiprofessional approach should in and
38 of itself guide what sort of access to which services at
39 which level you would be supported by, and then that can be
40 a sort of a treatment plan that gets negotiated with
41 families and children as appropriate.
42
43 That's rather different in terms of how it might
44 function from the more siloed approach, and I think we all
45 probably agree that we're trying to move away from that.
46
47 Severity, in and of itself is obviously important. I

1 mean, even in the very young it might mean that a trauma
2 specialist needs to see a young child who's experienced
3 severe abuse and has post-traumatic stress disorder as an
4 example; that can be quite a specialised intervention,
5 might be very necessary, it's treatment for established
6 conditions and someone might be very young and have
7 post-traumatic stress disorder.
8
9 So, some severity needs specialist expertise no matter
10 what discipline that is, it's a matter of their children,
11 but there's still a whole raft of other people who might
12 help a family where there's been abuse of a child, for
13 example, looking at safety, maintaining safety of a child
14 and so on and dealing with a whole range of other
15 professionals. So I think, severity is one aspect of it
16 but I think refocussing the negotiation of treatment and
17 ongoing care of need from the family perspective and the
18 child perspective, I think, is very important.
19
20 MR O'MEARA: Thank you. Professor Hiscock, back to you.
21 An issue always with any kind of service, and let's accept
22 that a "hub" is a kind of service in its conception, is
23 always eligibility in order that the service is not
24 overrun, in order that its pathways function appropriately
25 and so on. How is that being approached in your Wyndham
26 service?
27
28 PROFESSOR HISCOCK: Well, we are deliberately putting our
29 hub into a disadvantaged area, so I think this would not be
30 a model that goes into every single part of the state. So,
31 we've chosen that approach. We're actually trying to have
32 a no wrong door approach so, if they do come to the hub
33 they're not turned away. We are still co-designing what
34 that might look like, but I think we are envisaging that
35 some - our hub is really about detecting adversity and
36 adverse childhood experiences and responding to them.
37
38 And we know that people might come in with a child
39 with mild problems, moderate problems, severe problems and
40 still have those adversities in the past or currently, so
41 we're not saying we're only taking severe cases, really it
42 is welcome to all, every one is able to come, and we're
43 really about referral pathways, both within the hub but to
44 existing services.
45
46 Because there are a lot of existing services across
47 communities, and we're looking closely with Wyndham Council

1 to map those existing services, but we also then need to do
2 some work to develop what we call those warm relationships,
3 so those disadvantaged families who might need support for
4 housing or might need support for parenting go to the top
5 of the list, not the bottom of the list, which is still an
6 issue I think.
7
8 So, we are not - our aim is to have, you know, it's an
9 open door, it's a one-stop-shop, and there won't be
10 criteria that they have to meet to get a service.
11
12 MR O'MEARA: Does it follow from what you've said, one of
13 the reasons for that is that some of the services are
14 actually outside your Wyndham?
15
16 PROFESSOR HISCOCK: Yes, exactly.
17
18 MR O'MEARA: And some of those services are other
19 state-based services, so it's child protection and so on;
20 is that correct?
21
22 PROFESSOR HISCOCK: Yes, and there's already an alliance
23 in that particular council of early childhood services and
24 family support services, we've presented to them, so they
25 already have mechanisms: you know, there's the not for
26 profit organisations and a number of programs, so they
27 already exist but they tend to work in silos, so it's about
28 getting them to work together and having agreed upon
29 referral pathways.
30
31 So I'm sure we're going to come up with those services
32 against some sort of triaging and severity criteria, but
33 then what we hope is that by being in the hub we can hold
34 those families until they get into that service, because
35 the hub's still got the GPs and maternal and child house
36 nurses and paediatricians who are getting monthly case
37 discussion and support from the CAMHS mental health
38 clinician who's coming out to the hubs to provide that
39 support.
40
41 So I think for some families there will be a holding
42 with their existing health professional before they get
43 into another service.
44
45 MR O'MEARA: Just also to be clear about it, it seems to
46 follow from what you said when you introduced this topic,
47 that the model that you have implemented or are

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1 implementing out at Wyndham is not a model that you'd be
2 proposing as to roll out across a state, this is very
3 specifically directed to that local community; am I right
4 to understand it in that way?
5
6 PROFESSOR HISCOCK: Yes, it's directed - we chose that
7 community because there was disadvantage, there's a lot of
8 cultural diversity, First Nations families, so I don't see
9 this as a child and family hub in every single suburb or
10 even local government area across Victoria, we would need
11 to go to the, you know, target the disadvantaged, low
12 socio-economic areas, and that's exactly what we've done.
13
14 And because of course this is a pilot and a study and
15 we're co-designing, we've gone in with a council who is
16 very engaged and very interested and have identified,
17 because they're a growth corridor, children and families as
18 a real need to support.
19
20 MR O'MEARA: Thank you. Professor Coghill, you mentioned
21 considerably earlier on the difficulties that can arise as
22 a consequence of case management in the system, and
23 Professor Hiscock has just referred to case management
24 necessarily being a part of the operation of a hub of this
25 kind, can you speak to some of the difficulties attaching
26 to case management?
27
28 PROFESSOR COGHILL: And I think they may reflect
29 differently on the different purposes. I think Professor
30 Hiscock was saying that the hub that she's got in Wyndham
31 is about managing childhood adversity, rather than
32 specifically about managing mental health problems.
33
34 My discussion in my evidence is an observation that
35 within child and adolescent, child and youth mental health
36 services, an awful lot of the work is taken up in providing
37 case management which takes away time from direct - both
38 assessment and treatment.
39
40 I think one of the reasons for this is that the
41 welfare systems within Australia are also extremely
42 fragmented, and so I was used to the social work services
43 again in the UK - which were always under pressure and were
44 certainly not optimised - but there was always one person:
45 if you had welfare concerns there was one person to go to;
46 if you had education concerns, there was one person to go
47 to, and a very clear system for who would manage that.

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1 That doesn't happen within the children that come to our
2 child and youth mental health services.
3
4 That case manager role is often the clinician, it's
5 not a role that they've actually been trained to do. They
6 are trained mental health professionals, they are trained
7 in assessment, they are trained in providing therapeutic
8 interventions, but they do - and they do take on these
9 roles of providing the other support that I think could be
10 managed elsewhere.
11
12 And I think that Professor Hiscock's idea of having
13 hubs that include not just health but also those who are
14 involved in welfare, those who are able to do the case
15 management, would be a real benefit because, as I say, so
16 much time is lost.
17
18 This work - I mean, I'm not suggesting that the case
19 management is not worthwhile, it's necessary - but I am
20 suggesting that you don't need to be a clinical
21 psychologist, or a trained nurse, or a doctor in training
22 for that matter to be able to provide this kind of support
23 to children and young people, particularly when that takes
24 away from your role of providing assessment, providing
25 intervention. So yeah, it's an observation and I think one
26 that's very tough to tackle.
27
28 I think the funding issue comes in again because it's
29 always very difficult, isn't it, to get the social work
30 departments to fund something that's going to give benefit
31 to health, or to get education to fund something that's
32 going to give benefits to health. But we need to break
33 down that, we need to see that the health and welfare of
34 our children are so integrated that we need that
35 cross-departmental support that I don't think we always
36 get.
37
38 But also, I don't know if there's any way to reduce
39 that fragmentation, but when I look at who are the right
40 agencies to provide support for a child's welfare need,
41 then there are usually multiple agencies rather than one
42 that we have to go to, and that duplicates work and also
43 costs an awful lot more.
44
45 MR O'MEARA: Thank you. Can I ask you about a
46 particularly intriguing observation in your statement,
47 Professor Coghill, which concerns the approach to the

1 diagnosis of autism, in particular neurodevelopmental
2 disorders in this country as opposed to elsewhere.
3
4 PROFESSOR COGHILL: Not just autism actually, I think
5 probably it may look like autism but it's actually the
6 broader neurodevelopmental disorders, and remembering that
7 ADHD is actually the most common neurodevelopmental
8 disorder, probably by five or seven times.
9
10 And it is, again, very different here from most other
11 countries, I think it's tradition, I think it's funding,
12 but also I think it's a lack of services provided by mental
13 health for neurodevelopmental disorders to be almost
14 completely the remit of paediatricians, with child and
15 adolescent mental health services having said for a long
16 time, and I think starting to say less now, thankfully, but
17 having said for a long time "these aren't our problems,
18 this is a paediatric problem."
19
20 The reason it's difficult is that, whilst
21 paediatricians have become very skilled at diagnosing ADHD
22 and diagnosing autism, not all of the same paediatricians
23 are as skilled at diagnosing the coexisting mental health
24 problems that go along with a neurodevelopmental disorder
25 or, when they assess them and diagnose them, not always
26 efficient at managing them.
27
28 Now, partly that's because, again, there's not access
29 to the multidisciplinary team. Whilst medication
30 treatments are the first line treatment for ADHD, ADHD care
31 needs to be integrated within a package of supports. And,
32 when you've got a coexisting anxiety disorder or depressive
33 disorder, as is extremely common, then actually it's
34 psychological therapies that are the primary treatment for
35 them, not medication.
36
37 Also, when you've got intellectual disability and
38 disruptive disorder, then actually a parenting approach or
39 parenting support and a behavioural approach,
40 non-pharmacological treatment, is the treatment of choice
41 there, again, supported by evidence-based guidelines
42 universally.
43
44 However, because a lot of the paediatricians find
45 themselves very isolated, they don't have easy access to
46 other mental health staff, it's not always easy either to
47 access psychology, although that can happen, and certainly

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1 it's not easy to work as part of that multidisciplinary
2 team. What I found is a lot more children being prescribed
3 medications for disorders where medication wouldn't be the
4 first line treatment.
5
6 On the other hand, because child and adolescent mental
7 health services have said, no, this is a paediatric
8 problem, not a child and adolescent mental health service,
9 one of the things I spend a lot of my time doing within our
10 service is working to help CAMHS clinicians and CYMHS
11 clinicians recognise treatable neurodevelopmental disorders
12 that they've mislabelled as naughty behaviours or as
13 intellectual difficulties, and so, the problems go both
14 ways.
15
16 In most other countries around the world there's a
17 much more even recognition and sharing of this workload.
18 Certainly paediatrics - and I'm not suggesting that
19 paediatricians shouldn't be involved in this work - and in
20 fact, I was reminded over the weekend of something that I
21 wrote a few years ago, saying that - let's see if I've
22 written it down here that:
23
24 The training, experience and availability
25 of professionals is more important than
26 their qualifications.
27
28 Unfortunately at the moment we don't have a balance of
29 training for paediatricians to deal with the broader mental
30 health problems, and for mental health specialists to deal
31 with the neurodevelopmental disorders, and we really need
32 to bring that together.
33
34 So it's not about, it should be one or the other, but
35 people I think, as Professor Hiscock said, should certainly
36 only be dealing with specialist cases if they've got the
37 specialist training, and at the moment that's not
38 available, at least adequately available either within the
39 mental health training or within the paediatric training in
40 my opinion.
41
42 MR O'MEARA: Thank you. Professor Hiscock, you're a
43 paediatrician, but more importantly you've had your hand
44 up.
45
46 PROFESSOR HISCOCK: Yeah. So, I'm just going to give a
47 paediatrician's perspective because I don't completely

1 agree with Professor Coghill. Certainly I've done national
2 audits of what do paediatricians see; the number one
3 diagnosis we see is autism, the number two is ADHD, the
4 number three is anxiety, the number four is learning
5 difficulties and I think coming in at number eight is
6 asthma, so we see a lot of mental health.
7
8 I agree that there's been an increase in prescribing
9 of anti-anxiety medications, because I've actually done the
10 audits and looked at that by paediatricians, but as a
11 paediatrician I can tell you that one of the reasons why is
12 that, when we try and find a psychologist we can't get one.
13
14 Dave will know, we did a secret shopper study last
15 year where we rang 185 psychiatrists, psychologists and
16 paediatricians pretending to be a parent of a child with
17 anxiety to get in to see, and one-third of clinicians had
18 closed their books for the year and that was last April.
19 So, already they said we're not accepting, or they didn't
20 see children under the age of 12 years. So, there's a huge
21 workforce issue for particularly psychological support for
22 things like anxiety in children with comorbid ADHD or
23 autism.
24
25 And, even if we can get a family in, the average
26 out-of-pocket cost for one consultation with a psychologist
27 is $84, that's the average, so there's a big range, and
28 many families - that's after the Medicare rebate. So, many
29 families will come to me and say, I can't keep seeing the
30 psychologist fortnightly for my child, I know they need
31 that. The school counsellor will give us three sessions,
32 that's it. I've had my five or six sessions Medicare
33 refunded but the $84 out-of-pocket cost is stopping me
34 going any further. So that's a big problem, and then for
35 paediatricians then to turn around and prescribe
36 medications because they feel like there's no alternative
37 available, and we can't get them into the CAMHS services
38 because they're not severe enough.
39
40 MR O'MEARA: Thank you. Professor Coghill, back to you.
41
42 PROFESSOR COGHILL: Yes, I don't disagree with what
43 Professor Hiscock is saying, however my point really was
44 that professionals who are managing these cases, and they
45 certainly have the experience, that they often don't have
46 the training. Training and experience aren't the same
47 thing, you know, and there's a reason why it took five

1 years to train to be a child and adolescent mental health
2 or psychiatrist, and within that training there's an awful
3 lot that one learns.
4
5 I think that we don't give enough training, and it's
6 not because people don't want it, it's that we don't give
7 it. We don't give enough training to our paediatricians,
8 many of whom when they finish their training will say,
9 "Gosh, I've got to deal with all this mental health
10 problem, but no-one's trained me to do that. I never
11 received the training. I get lots of experience", and for
12 me that's a problem. It's about having the training as
13 well as the experience, and certainly Professor Hiscock's
14 100 per cent right when she talks about the availability.
15 It's not anyone - it's not the clinicians', who are seeing
16 these cases, problem that they can't find people, it's
17 because they aren't there.
18
19 But if we want - and I am very supportive of this - if
20 we want a paediatric workforce working in specialist mental
21 health, then we have to provide them the training. There
22 isn't a shortcut to that; just experience won't cut it and
23 I think that that's a very important point.
24
25 So, no criticism of paediatricians, it's just that
26 that's not the way things are structured at the moment.
27 People do six months within a CAMHS service or a
28 behavioural paediatric service, and then go out and manage
29 and struggle to manage because they're not supported.
30
31 So, I'm not critical of those paediatricians, I'm
32 critical of the fact that we don't offer that support and
33 training. And that's why I think the hub that links in
34 paediatric and specialist mental health services because
35 that's how you provide some of that education - you don't
36 need to work in it for five days a week, you can work in it
37 for a period of time to get that experience, get that
38 support and get that access to services, and then be able
39 to work in other settings more independently.
40
41 So, I don't think we really disagree, and it certainly
42 isn't a swipe at paediatricians, and also remembering that
43 I am also very critical of my own profession in not having
44 got itself the correct training for what it ought to be
45 doing in the neurodevelopmental disorders.
46
47 MR O'MEARA: Thank you. Professor Newman, at least on my

1 screen you've been positioned as if you were the net court
2 umpire while that rally's been going back and forth between
3 your colleagues. Can I move or ask you to introduce and
4 address a slightly different issue, which is, much of
5 what's been said so far today has addressed and identified
6 issues of fragmentation in the provision of services, both
7 clinical and other, and it's also identified the need for
8 integration which is a point that every witness has made at
9 different times.
10
11 You in your statement refer to the need for statewide
12 or state level planning; can I ask you to speak to that
13 issue.
14
15 PROFESSOR NEWMAN: Yes, certainly. Look, I think it's
16 fairly clear that we all agree about the problems of
17 fragmentation and a lack of a coherent framework for
18 thinking about service modelling, service development and
19 the related areas: training and education as has been
20 discussed, and research that we can actually start to
21 evaluate our models on and so on which is very important.
22
23 Currently we don't have a statewide planning process
24 even in the most rudimentary sense. I've not been in
25 Victoria for many years, but since I've been here I've seen
26 the dissolution, for reasons that I'm not privy to, of what
27 used to be the maternal and perinatal planning process,
28 much wider committees for looking at child and adolescent
29 service development.
30
31 We used to have, I guess, more of a presence of a
32 child psychiatrist in the centre for mental health in the
33 Department and so on, which maybe has just been the way
34 things have shifted over a relatively short period of time,
35 but it certainly hasn't helped in terms of having any
36 centralised meeting places really where we can have
37 creative discussion about some of these ideas in the way
38 that I think we can all benefit from, let alone translation
39 into policy approaches, development and evidence base and
40 outcome evaluation.
41
42 I think very importantly we need some centralised and
43 very comprehensive modelling of who's doing what to whom,
44 that sort of notion, and with what benefit to children and
45 families. And that's certainly the approach - you know, my
46 experience in the UK that's been very important there, that
47 you've had the development of - you know, and constant

review of different approaches.

There's still diversity of opinion and different approaches, but there was, if you like, a clearinghouse, much more of a clearinghouse sort of process that integrated early childhood right through. I'm referring there to Peter Fonagy's work, and others, which was very important in that context and really had that sort of expert consultancy role for Government in thinking about, well, how should we be modelling these services?

I think at the moment, to put it rather crudely, we have a sort of a bit of a gulf: there are, you know, those of us who are doing this sort of work, we're doing our own, trying to do research trying to feed into something, but it's not clear where we take the results and evidence to and how that gets translated in a policy context.

So, I think David raised the issue in previous discussions about how could we have a centralised or an approach which is a body to actually look at these crucial elements of service modelling and development, the development of clinical guidelines, collecting and monitoring evidence about infant, child and adolescent services in a way that some of the other mental health areas to different age groups are probably going to have.

So currently we don't have that. I also think it's, from my perspective, very important that we look at that in a broad way so that it does include providers, from my age group perspective, of all those who work with the very young and other components of the service system in the same way that we've been talking about the importance of primary care and paediatrics and so on to bring those bodies together and to actually talk about developing frameworks.

So there's a lot of thinking obviously that goes on into ideas about how things might be improved, but we don't actually have mechanisms other than at local levels to influence Government in that discussion.

MR O'MEARA: Thank you. Professor Coghill, I'll go to you on this topic and then I'll finish for my part with Professor Hiscock on this and any other topic.

But, Professor Coghill, you've referred to this need

1 for coordination in your own statement, and Professor
2 Newman's made reference to your views on this topic, could
3 you expand a little further, and also with observations
4 concerning the approach that's been taken in the UK that's
5 been referred to?
6
7 PROFESSOR COGHILL: I would have to say thank you to the
8 Commissioners for this, because I was really taken by and
9 impressed with your proposal for a Collaborative Centre for
10 Mental Health in the first part of your report.
11
12 When reading that, it really - and thinking about the
13 questions that we were asked, I think it's really necessary
14 that we have something similar that addresses the needs of
15 children.
16
17 I think the only question I have in my mind is how
18 many centres, collaborative centres, can one have. You've
19 highlighted one for adults. We already have Orygen who
20 serves this purpose for the youth mental health space, but
21 it's very clear to me that, with the best will in the
22 world, Orygen can't fill that space for the zero to 12s, so
23 I'm left with the conclusion that we do need one
24 specifically at this. I think the roles of that will be, I
25 think, ensuring participation and promoting co-design.
26
27 I love the proposal that you had for the Collaborative
28 Centre to be led jointly by an academic and someone with
29 lived experience. I guess we're not going to be asking
30 children to run this, but I think that involving those with
31 lived experience and consumers of mental health services is
32 really important; that we can get participation right, that
33 we can provide that strategic leadership that Professor
34 Newman is pointing out, and that the VIAGO report was very
35 clearly saying hasn't been there in child and adolescent
36 mental health.
37
38 To conduct research into new treatments, translational
39 research, to inform service delivery, to be able to
40 promote, design and test new models of care like the ones
41 that Professor Hiscock has alluded to, and also to be a
42 focus for education and training across the broad mental
43 health workforce. And I think, again, those two are
44 separate from each other, education and training, but we
45 would then need to be very strongly linked with the
46 Royal Colleges, with the other educational providers - we
47 have Mindful already - but I think at the moment again

1 that's a bit disparate, so I think that's something that
2 should be a key focus.
3
4 I've had the opportunity in the UK to work with
5 centres like the Institute of Psychiatry at King's College
6 which has a very strong academic centre for child and
7 adolescent mental health, but very clearly embedded into
8 the Maudsley Hospital.
9
10 Likewise my colleagues, again very close colleagues
11 that I've worked with at the Central Institute For Mental
12 Health in Mannheim in Germany: a big, very strong academic
13 mental health presence but embedded within, or with a
14 clinical service embedded around it. We don't really have
15 that model here yet. We don't have the strength. We have
16 good researchers, we have good clinicians, but often not
17 working together as effectively.
18
19 And likewise, the Donders Institute, and Karakter and
20 Nijmegen in the Netherlands, exactly that same model:
21 integrating academia with clinical work.
22
23 What they don't do as well and what I think we have
24 the opportunity to be, I guess, world-leading on would be
25 to have that but also have that effective participation
26 from a very early stage and at all levels of consumers, of
27 users, and be able to get that voice in much more clearly.
28
29 So really, I was spurred on in thinking about this by
30 your recommendations for the adult Collaborative Centre,
31 but I think it's hugely important if we're really going to
32 take child and infant mental health seriously that we have
33 something like this.
34
35 I think our campus may have already written to the
36 Commissioners to say that it would be very interested in
37 either taking a lead or very much being a part in that, and
38 I think that's very sensible, but I think it's something
39 that would need to very clearly be thought through and
40 worked through in a clear and equitable way that made sure
41 that it was representative and that it was excellent,
42 because that needs to be excellent.
43
44 MR O'MEARA: Professor Hiscock, I'm as good as my word,
45 can I finish off by asking you for your thoughts concerning
46 how best issues of fragmentation and integration and
47 planning, and also the translational research might best be

1 addressed in order to make the system work for infants and
2 children in Victoria.
3
4 PROFESSOR HISCOCK: Small question, thank you. Look, I
5 think this --
6
7 MR O'MEARA: And you've only got three minutes, so see how
8 you go.
9
10 PROFESSOR HISCOCK: Great. I think this Collaborative
11 Centre is essential and I think Professor Newman talking
12 about translation into policy is key, as well as what
13 Professor Coghill has said, otherwise we just risk on the
14 status quo, which is, good pockets of excellent research
15 and practice happening in silos, duplication, left hand
16 doesn't know what the right hand is doing, some excellent
17 things come out but they don't land on fertile ground
18 because there's no Government lever to make it happen.
19
20 I see hubs as the way to go that address children and
21 families and social determinants that bring together that
22 specialist mental health care to that primary and secondary
23 care workforce, but I think this idea of an overarching
24 collaborative centre that really has strategic overview and
25 leadership, is truly multidisciplinary, brings in the lived
26 experience, sets the priorities and framework for the next
27 five, 10 years for this state.
28
29 It's a really exciting opportunity to take the
30 fragmentation and silo that we have now and just turn it
31 into something fabulous. And, as Professor Coghill alluded
32 to, we're doing a microcosm of this with a five-year campus
33 mental health strategy that I'm leading, so all of this
34 just sounds like what I've been living and breathing for
35 the last four or five or six months, but to do this at a
36 statewide scale would place Victoria streets ahead of the
37 other states in the country as well, and really
38 internationally leading potentially.
39
40 MR O'MEARA: Thank you, and thank you to all of you for
41 your contribution so far. Now, Commissioners have sat very
42 patiently and quietly listening so far, but they have
43 questions I assure you, so at this point I can invite the
44 Chair perhaps to take the reins, but I'd like to thank each
45 of you for your contribution so far.
46
47 THE CHAIR: Likewise, thank you all very much, it was a

1 fabulous session to participate in and hear what gives
2 extra impetus in terms of your witness statements and the
3 details that you each individually had in them to hear what
4 your collective thoughts are, and there are many, many
5 issues that this conversation has raised for me and I'm
6 sure all of the other Commissioners.
7
8 There's one question I would just follow up with
9 Professor Newman which went to - you talked in your witness
10 statement about the fact that there's an impact on women
11 and infants by the fact that the Royal Women's Hospital has
12 not been gazetted as a recognised mental health service
13 under the Act.
14
15 What do you think are the implications for that and
16 what opportunities are there for us to make reform in
17 relation to the role it might play in terms of infant and
18 maternal health?
19
20 PROFESSOR NEWMAN: Yes, look, it certainly is a
21 significant issue, in that, although the hospital does a
22 reasonable amount of both acute and ongoing mental health
23 work and all the things that I raised about the
24 opportunities for early risk identification, prevention and
25 early intervention are really all there, but because of the
26 lack of constitution of that service as a mental health
27 service there's really under - maybe under-recognition, and
28 certainly that diminishes the actual capacity for service
29 provision, although there is a mental health team there.
30
31 I should say that I've recently resigned from that
32 position so I can't comment on what developments will be
33 there in the future, but I think in general the maternity
34 hospitals, not just the Women's, but all the hospitals are
35 in an ideal position to be doing some of this work.
36
37 And importantly for the women who are having mental
38 health problems either during pregnancy or post-delivery,
39 the whole implication of having to move women out of the
40 maternity setting into another environment can be very
41 disruptive to care, it's not necessarily in their best
42 interests and it sets up all sorts of major demarcation
43 issues between mental health services and maternity
44 services, and that's a constant issue.
45
46 So, on one level it's a governance issue, but on the
47 other level I think my personal view is that it's very - it

1 diminishes the importance of women's mental health and
2 where we should be providing that. I think it's not only
3 maternity, but that's an ideal place to be providing that
4 level of care, so a source of disappointment that that
5 hasn't been addressed.
6
7 THE CHAIR: Thank you. Just one other question. I was
8 particularly struck by that data that you gave, Professor
9 Coghill, about the fact that the 12,000 children seen by
10 CAMHS had, on average, 30 episodes or incidents of care,
11 but very little of that was directed towards evidence-based
12 therapies.
13
14 I guess I was pretty struck by that and I want to be
15 clear on whether the evidence-based therapies are
16 available, who should deliver them, and where, in your
17 view, are we best placed trying to address that going
18 forward.
19
20 PROFESSOR COGHILL: So, the data relates to the numbers of
21 individuals seen. It's my observation, not within the
22 VIAGO data, that much of that time is spent in case
23 management rather than in the delivery of evidence-based
24 care.
25
26 Evidence-based care is available but not structured.
27
28 So, across Victoria we have very little in the way of
29 ensuring that the care that is delivered is delivered in an
30 evidence-based way. We don't measure meaningful outcomes
31 to look at both how care is delivered, but also what the
32 outcomes of that care are. The reality is though that it
33 gets crowded out by this case management that has to be
34 done, and when you talk to staff within the services, and
35 you ask them why is it not possible to provide cognitive
36 behavioural therapy, for example, for this young person,
37 it's because their life is too chaotic and I have to spend
38 all my time actually managing their expectations and the
39 family's expectations.
40
41 Having said that, whilst evidence-based care is
42 available, the training in evidence-based care isn't
43 prioritised, particularly for psychological therapies.
44 Again, most staff will need to pay - or many staff will
45 need to pay for their own training in psychological
46 therapies. Psychologists are trained, that's part of their
47 training. Psychiatrists receive some training and some

psychiatrists top that up and receive a lot more. I was very fortunate to have received training across a range of psychological therapies, but many staff don't, and there's not funding within the budgets to provide that specific training, and that again is where I see the collaborative centre as being hugely, hugely important.

The other problem hidden within the services, I have mentioned it in my evidence, is that apart from the consultants, the medical consultants, most staff within CAMHS services work within generic roles. So, you'll find a psychologist whose job title isn't clinical psychologist, but mental health worker. You'll find a nurse who has exactly the same job title and is expected to do exactly the same work.

So, not everybody is trained in all of the therapies, and it then becomes very difficult to move patients between one caseworker and another in order to get them to the person who has that training. So, there are multiple causes for this happening. The casework is one, but there are other logistical issues that, again, are different here from my previous expectations. I think some of these are - should be easy to fix, but we need the leadership to do that, we need the direction to do that, and we need the services all pulling in the same direction, not working in isolation to very different strategies and strategic plans. I hope that answers your question.

THE CHAIR: It does, thank you very much. Can I just then ask finally, Professor Hiscock, do you think those sort of evidence-based therapies will be able to be delivered in your Wyndham pilot, for example?

PROFESSOR HISCOCK: Yeah, we're certainly hoping for that, and that's a part of what the evidence synthesis is about and then presenting that evidence synthesis back to the clinicians on the ground and to the families to say what version of this can we make work, so that's what we'll be aiming to do as part of our intervention along with the case discussions and the secondary consultation model and bringing all those different sectors together.

THE CHAIR: I know that Dr Cockram will have some issues, so Dr Cockram, do you want to put a question to the panel?

COMMISSIONER COCKRAM: Yes, so many questions, and I'll

1 have to contain myself a little. I think I'm going to stay
2 on this hub discussion because I think you've raised a
3 significant thought process within the Commission.
4
5 So on one hand we've got Professor Hiscock
6 recommending or trialling a primary and secondary care
7 model with some embedding of the tertiary specialist system
8 within it, and on the other hand Professor Coghill's
9 talking about a more tertiary model with the embedding of
10 the primary and secondary up into the tertiary.
11
12 I guess, Professor Hiscock, I'm going to put the
13 question back to you. In your model you require a
14 specialist system because you've talked about the need to
15 have the CAMHS clinicians and other people coming to the
16 primary centre. Is there a model where both fit in; that
17 there is a regional specialist service that can embed
18 itself and maintain its own clinical practice and
19 specialisation whilst supporting these primary care
20 centres?
21
22 Because I don't think your system works without the
23 specialist, but if we don't consider the specialist then
24 where does it go?
25
26 PROFESSOR HISCOCK: Yeah.
27
28 COMMISSIONER COCKRAM: It becomes something that then
29 loses emphasis in the system and is at risk, so is there a
30 combination we're talking about here to keep that whole
31 ecosystem going?
32
33 PROFESSOR HISCOCK: Yes, and I think telehealth and
34 telementoring provides a way of doing that. I think
35 neither of these models has been fully trialled and tested
36 in Victoria, so you're getting opinion, not evidence, at
37 the moment which is very important to be aware of. I think
38 if we take any or both forward they need to be evaluated
39 for effectiveness and cost-effectiveness. So, that's my
40 first point - does that?
41
42 And then I think one of the big issues is, I've worked
43 quite a lot with GPs. Some GPs will be, as Professor
44 Coghill called them, gypsies and go into a tertiary centre
45 and get that experience. A lot of GPs, they are running
46 small businesses, they will not go in and participate in
47 day-long training, et cetera, in another area that takes

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1 them away from the practice they work in where they can
2 only bill a certain percent of what they see through
3 Medicare and they have to give the rest of the money to
4 operating the practice. So, we actually need to go out to
5 them, which is what can happen in a community health model
6 because the GPs are already co-located at the community
7 health centre.
8
9 COMMISSIONER COCKRAM: Just to confirm though, your model
10 does still require a specialist response, it's not a
11 primary care response?
12
13 PROFESSOR HISCOCK: Correct. So in the centre already are
14 GPs and maternal and child health nurses and
15 paediatricians, what we're trialling is bringing a CAMHS
16 psychologist out to the centre for, say, three or four
17 sessions per week to do some direct care but also some
18 secondary consultations with those GPs and paediatricians
19 and maternal and child health nurses to say, okay, tell us
20 about the patients you're having problems with and
21 difficulties with, let's work on how we can help and
22 support those families and help you to support those
23 families. So, RCH CAMHS, as part of their model, has
24 made - we've got funding to bring a psychologist out to
25 that centre, so they do a lot of outreach, as do many CAMHS
26 services already, reaching out into other community service
27 settings and this is an example of that, but bringing the
28 social care in and the lawyer in as well.
29
30 COMMISSIONER COCKRAM: Thank you. Penny, can I ask just
31 one more? It's again back to you, Professor Hiscock. You
32 mentioned that, the daunting 24 interventions that are
33 possible, and it's a biggish number, but you've actually
34 put it back to the local community in a place-based way to
35 say, what do the people of Wyndham and the clinicians of
36 Wyndham think will be most helpful.
37
38 Just talk a little bit more about that model where
39 you're getting - although you've got a kind of a potential
40 for a statewide scale, you're also requiring a local based
41 co-design approach, because I think that's also really
42 interesting.
43
44 PROFESSOR HISCOCK: Yeah, I think it's essential otherwise
45 you won't get uptake in implementation. If you just come
46 in and thrust in and say to people, "This is what you have
47 to do", it's not going to work.

1
2 So, this co-design process is happening towards the
3 end of this year - it's been delayed by COVID - and into
4 next year, so October, November, December is our co-design
5 process, and that's bringing in the Wyndham City Council,
6 the community health centre, which is IPC Health, who have
7 got number of community centres, we're going to Wyndham
8 Vale, the clinicians and the families with the lived
9 experience.
10
11 We have some fixed elements, we've got some ideas of
12 what we think should be in the model of care, but there
13 will be flexible elements that they can help with the
14 co-design, and they're also going to help co-design our
15 outcome measures for the hub as well.
16
17 And I think this just has to be place-based
18 considering the cultural diversity in certain areas. Rural
19 areas will have different needs to metropolitan areas,
20 et cetera, so we're adopting the co-design approach which
21 sits very well with IPC Health and the Wyndham City
22 Council, and I think that's going to maximise uptake of our
23 hub model.
24
25 COMMISSIONER COCKRAM: Thank you.
26
27 THE CHAIR: Thank you. Just one follow-on before I hand
28 over and ask Professor Fels and Professor McSherry for
29 their questions.
30
31 Just, in terms of co-design, Professor Hiscock, can
32 you ask children to have input into design, under the age
33 of 12?
34
35 PROFESSOR HISCOCK: Yep.
36
37 THE CHAIR: So, could you just speak to that issue,
38 because I think often people just presume it has to be the
39 families, the carers. What about the children themselves?
40
41 PROFESSOR HISCOCK: You can absolutely ask children
42 themselves. They will really, I think as young as 5 or 6,
43 have pretty clear ideas on what they have found helpful and
44 not helpful and what makes them feel welcomed and not
45 welcomed into a service, so there's some aspects around
46 that that they can certainly do.
47

1 I mean, I see children of all ages and, if a child of
2 mine has seen a psychologist I'll say, "So, what does she
3 talk to you about? What have you done? What have you
4 found helpful?" And they can pretty much tell me, "I
5 thought it was a waste of time", or, "She gave me all these
6 things like breathing exercises and things to do and, when
7 I get sick in my tummy, I start to use those and they
8 help". So, absolutely, they can inform co-design.
9
10 THE CHAIR: Thank you very much. Professor Fels.
11
12 COMMISSIONER FELS: Well, first of all, thank you all
13 three witnesses for your very excellent written statements
14 and also for today, it's been most informative and, I must
15 say, I've often been exposed to expositions about mental
16 health that put a huge emphasis on adolescence and we hear
17 much less about child and infant.
18
19 Incidentally, I would be interested if Professor
20 Coghill could send us that, was it, 50 per cent figure that
21 he quoted as a bit of a source of authority on the
22 importance of early childhood.
23
24 Now on my question, I just had a couple of general
25 questions, maybe to Professor Hiscock because as a - could
26 you tell us a little bit about family and carer
27 involvement. It seemed to me the sector is quite good at
28 that, and that's natural, but what are the real lessons,
29 secrets, methods, and I'm asking that because the rest of
30 the mental health system is not very good often at engaging
31 with families, so what can we learn?
32
33 Then my other question which I thought I'd ask is,
34 what are your big asks? I'll ask this of the three
35 witnesses, although Professor Hiscock, I think, was pretty
36 clear in her closing statement.
37
38 I mean, we've heard, you know, we need leadership,
39 strategic thinking, we need to deal with under-investment,
40 prevent siloing, more prioritisation, and I agree with all
41 that. And hopefully our Commission will try to give some
42 direction and priority to this area, and also I think
43 there's a fair bit of support for the Collaborative Centre
44 concept.
45
46 So, putting that to one side, what are the most urgent
47 things to spend money on? What are the most urgent asks,

1 most important asks, out of the big list, in our
2 resourced-constrained world?
3
4 And, as I said, we heard a fair bit from Professor
5 Hiscock in her wrapping up, so maybe particularly the other
6 two.
7
8 PROFESSOR HISCOCK: Thank you, Professor Fels. I'll start
9 with the issue about engaging families and how do that
10 well. I think that's part and parcel of the infant and
11 child mental health and health professionals who work with
12 families, that's sort of our core bread and butter because
13 we have to engage families to get anywhere with any of our
14 treatments and interventions, because it's mostly through
15 the parents that we and the caregivers or the extended
16 family who look after that child that we make most of our
17 difference.
18
19 So, I guess that depends, it comes back - there's
20 formal training programs in that, like the family
21 partnership training that comes out of the US, or versions
22 of that that are shorter because that's a five-day training
23 program. But the Centre for Community Child Health where I
24 work runs training in that for health professionals on how
25 to engage families, so that exists already.
26
27 I think we naturally will ask about what the parent's
28 expectations and goals are and how can we help them, you
29 know, those simple sort of questions to engage families.
30
31 However, in my interviews with families about what
32 they thought was missing was funded Medicare rebatable
33 family therapy. So, often they recognised that the child
34 came with a problem and that the parents were in conflict
35 about how to manage that and how to follow through on
36 therapy that was recommended and they realised that family
37 therapy was necessary. So, we don't have a lot of
38 publicly-funded family therapy available in Victoria at all
39 and that's a gap I think.
40
41 In terms of my big asks - sorry, I felt like I was
42 wrapping up an NHMRC Fellowship interview when I finished
43 off - but I think the big and urgent is, I do think we need
44 this Collaborative Centre that has - so, any of our work
45 has a place to land and some fertile soil to land on.
46
47 I think we do need to look at models that bring

1 together primary, secondary and tertiary healthcare and
2 social care. Now, that's not going to be done in a couple
3 of months, that's going to be done in some time, but I
4 think that's a big ask.
5
6 I think the clinical practice guidelines and care
7 pathways that Professor Coghill talked about are a big ask.
8 We have statewide guidelines out of the Royal Children's
9 Hospital for physical health problems. They're statewide,
10 they've been taken up by New South Wales and Queensland
11 because of their utility and need, but we have no
12 comparative statewide guidelines for children's mental
13 health or infant mental health, so that's a big ask I think
14 that we need as well.
15
16 So I think for me it's the integrated models, hub
17 models and development and testing of those. It's having a
18 place that we can - or an authorising environment where we
19 can bring our evidence into practice and policy, and that
20 really would be the Collaborative Centre that Government
21 listens to and responds to, and then the third thing would
22 be the clinical practice guidelines that then inform the
23 models of care.
24
25 COMMISSIONER FELS: Thank you.
26
27 THE CHAIR: Thank you, and I might - Professor McSherry,
28 if we hand over to you to ask your question and then, if
29 we've got time at the end, we might ask the other two panel
30 members what they would prioritise for the big spend. But,
31 Professor McSherry.
32
33 COMMISSIONER McSHERRY: Yes, thank you. This is for
34 Professor Newman, but I think Professor Hiscock might also
35 want to comment.
36
37 Professor Newman, you mentioned before the importance
38 of trust in services. We've heard from various community
39 groups, and in particular Aboriginal communities, about the
40 avoidance of going to mental health services for fear their
41 children will be taken away.
42
43 So, how would you go about building either
44 culturally-responsive services or culturally-specific
45 services? Is there a need for both?
46
47 PROFESSOR NEWMAN: There might well be a need for both,

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1 but I absolutely agree it's a huge issue, and particularly
2 in the sort of services that I've been involved with and in
3 maternity services, where you often get that limited access
4 to indigenous health workers, indigenous maternity
5 services.
6
7 Where those are in place - they're usually in regional
8 centres - they are actually utilised really well, but then,
9 if anyone has pregnancy or birth complications then they
10 come to a major hospital where they might not get access to
11 culturally specific and appropriate care, and I think that
12 immediately sets up poor relationships.
13
14 And people are, understandably, very reluctant to
15 engage in that way and we have some women self-discharging,
16 you know, against advice, these sort of adversarial type of
17 situations, and Child Protection Services are sometimes not
18 seen as being able to engage or talk about some of the
19 realities facing women in their particular context.
20
21 So, how do we unpack that and actually move towards
22 it? I think where we do have indigenous midwives and
23 indigenous trauma-informed services, they can be
24 particularly effective. So, I'm thinking of largely the
25 work that you may be familiar with that Cath Chamberlain
26 and others are doing, I'm involved in that, looking at
27 trauma-informed maternity and early childhood services in
28 indigenous centres, using indigenous health workers and
29 others on the ground to actually establish those
30 relationships.
31
32 Now, that's a long-term project, but I think it's
33 particularly important as a model. I think, just throwing
34 a couple of people in a maternity setting doesn't make much
35 difference to that.
36
37 COMMISSIONER McSHERRY: Thank you. And, Professor
38 Hiscock, I know you mentioned --
39
40 PROFESSOR HISCOCK: Yeah.
41
42 COMMISSIONER McSHERRY: -- culture and linguistically
43 diverse groups in your statement, and particularly in
44 relation to screening or surveillance, that might mean
45 different concepts to different groups. How do you go
46 about making sure that services are culturally responsive?
47

1 PROFESSOR HISCOCK: Well, I think - so I'm just thinking
2 of a couple of examples. At Monash Children's they have a
3 First Nations Child Health Clinic and what they found was,
4 kids weren't turning up. So, they had one of their
5 Aboriginal workers go out to families and do a home visit,
6 and after that first home visit their fail-to-attend rate
7 plummeted in the service. So, it's that initial warm
8 referral, you know, trusted health professional, someone
9 from their culture coming out.
10
11 Similarly at the Royal Children's we have Wadja, which
12 is - it was the Aboriginal Health Service. They make
13 contact with every - you know, First Nations family who
14 comes through the hospital and they do a lot of work around
15 mental health. They may not necessarily call it that, but
16 that's what they do, but that's philanthropically funded
17 and that's not funded out of any core operating hospital
18 funds, which I think is less than ideal.
19
20 And then I would just say, Dr Anita D'Aprano for her
21 PhD has done a cultural adaptation of some of the key
22 mental health screening tools for children.
23
24 So, there are some really good mental health measures
25 around for children that have been particularly adapted for
26 and tested in First Nations populations, so we do have some
27 of those tools available, and it is possible, and she's
28 doing that work through her PhD and found it to be feasible
29 and acceptable to administer to those sorts of screening
30 measures to Aboriginal families.
31
32 COMMISSIONER McSHERRY: Thank you.
33
34 PROFESSOR COGHILL: Also some very good work going on in
35 both Northern Territories and South Australia with outreach
36 into the very remote communities there, and I've certainly
37 seen feedback from that that looks very positive.
38
39 One of the problems we have, I think, with Aboriginal
40 and Torres Strait Islanders with mental health is actually
41 a very poor understanding of their understanding of what
42 poor mental health is and what it means.
43
44 I'm obviously very new to the country, but
45 understanding, for example, what ADHD means within an
46 indigenous community is something that we really just don't
47 have. So, I think alongside a lot of the great ideas and

1 work it is also very important that we commission research
2 to properly understand that cultural meaning.
3
4 Because there's often - my first involvement was where
5 there's a big culture clash between those disorders where
6 we recognise a strong genetic background with the cultural
7 beliefs and belief that many of the, if not all, of these
8 disorders are related to trauma and intergenerational
9 trauma, so actually squaring that circle of understanding I
10 think will be very important and that will take research
11 and funding.
12
13 THE CHAIR: So, thank you all very much for your time.
14 Professor Newman, is there anything you'd want to add to
15 that list of priorities?
16
17 PROFESSOR NEWMAN: I think the list we heard was a very
18 good list. I would only add one wish, that in all this
19 thinking that's going on is that we try as much as possible
20 to maintain a focus on prevention and early-in-life
21 intervention that's not - I mean, yes, we need to have the
22 leadership and the strategy and the input into policy to
23 actually develop things, but we need a philosophical, if
24 you like an overarching framework that allows us to think
25 developmentally, as we've all been discussing, to maintain
26 that as a way of looking at service development, but also
27 to look at integrating ideas about prevention and early
28 intervention, and that means from the beginning of life if
29 not before.
30
31 So, I think, rather than silo off infancy and
32 pregnancy care services, I'd be much more comfortable if we
33 could look at the overlap issues and actually really stick
34 to this idea of integration.
35
36 THE CHAIR: Fantastic (inaudible).
37
38 MR O'MEARA: You've --
39
40 THE CHAIR: Yeah, I've gone on mute.
41
42 Thank you all again very much for your time with us
43 today, and to Counsel Assisting most especially, thank you
44 for bringing so much depth to the discussion that we'd like
45 to ask. And, do you want to add a final word, Stephen,
46 before we finish up?
47

1 MR O'MEARA: I don't seem to be able to unmute this thing
2 very easily every time I go looking for it, but, I really
3 would like to thank everybody. The Commissioners have
4 undoubtedly, and they've said it, been tremendously
5 assisted by all of our panel members today, it's been a
6 thoroughly stimulating and enjoyable panel, and those who
7 get to view this on the Commission's website, I'm sure,
8 will be rewarded for the experience, so I'd like to thank
9 all of you.
10
11 THE CHAIR: Thank you very much.
12
13 PROFESSOR HISCOCK: Thanks for the opportunity.
14
15 THE CHAIR: We will give great thought to your input, so
16 thank you all very much for helping us in our task.
17 Goodbye.
18
19 PROFESSOR COGHILL: Thank you.
20
21 **AT 5.00PM THE COMMISSION ADJOURNED**
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