

Infant, Child and Adolescent Mental



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Who are we?

The **Melbourne Children's Campus** is the strategic and physical alignment of the Royal Children's Hospital (RCH) as the custodian of clinical care, the Murdoch Children's Research Institute (MCRI) as custodian of research and the University of Melbourne's Department of Paediatrics as custodian of education.

The RCH has been providing outstanding care for Victoria's children and their families for over 140 years. We are the major specialist paediatric hospital in Victoria and our care extends nationally and internationally.

The MCRI is Australia's leading child and adolescent health research organisation that creates and translates knowledge into effective prevention and treatment strategies across a range of disorders including mental health disorders.

The Department of Paediatrics is ideally placed to educate and train the next generation of mental health workers through the development of evidence-based guidelines, pathways, courses and educational resources. For example, the Department has developed and runs the Graduate Diploma in Adolescent Health and Wellbeing. This online Diploma provides the latest knowledge of adolescent health and development, prevention frameworks and skills to allow people to work more effectively with individuals and populations in schools and communities, and within health services. Mental health is a key focus.

The RCH Foundation has supported critical trials and research with the aim of improving mental health provision on the Campus.

The three institutions are co-located with the Royal Children's Hospital Foundation, in Parkville. Together, the Campus represents more than 6,000 health professionals committed to improving the mental health outcomes for infant, children and adolescents and their families, today and in the future.

Tuesday, 28 January 2020

Dear Commissioners,

Thank you for the opportunity to provide a submission on the Mental Health Productivity Commission Draft Report (October 2019). The Melbourne Children's Campus commends the Productivity Commission and Commissioners for the report and proactive recommendations to reform Australia's mental health system through sustainable, long term reforms.

The mental health of infants, children and adolescents differs from adult mental health, due to their immense physical, cognitive, social and emotional growth and developmental requirements. For this reason, if we are to improve the mental health and quality of life of Australian infants, children and adolescents and the adults they become, many of the Commission's findings and recommendations within its reform agenda should:

1. be considered and applied to the needs of infants, children and adolescents with mental health disorders or behavioural and emotional problems and their families;
2. necessarily focus on prevention and early intervention; and
3. result in the development of an evidence-based, accessible mental health system which is underpinned by ongoing monitoring of child and family outcomes and service effectiveness.

As such, we wish to bring the Commissioners' attention to these populations and in this submission we outline two key Campus recommendations, namely that:

- 1. the mental health care needs of infants, children and adolescents and their families are considered in future development of relevant recommendations/information requests; and**
- 2. data on effectiveness and cost-effectiveness of new or existing services should be routinely collected and reported.**

We then provide exemplars of work the Campus conducts to inform the Commission's reform agenda.

The Campus is extremely well positioned to work with the Commission, policy makers and the community and regional providers to lead the re-development of an evidence-based and accessible mental health system for infants, children, adolescents and their families that is focussed on prevention and care.

We welcome advice from the Commission as to how the Campus can effectively support the alignment and implementation of the recommendations to improve Australia's mental health system for infants, children, adolescents and their families.

Yours sincerely,

Jane Miller

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Evidence and key recommendations underpinning this submission

While the Productivity Commission's (the Commission) report highlights some issues and recommendations specifically related to infants, children and adolescents, the Melbourne Children's Campus (the Campus) considers that their unique developmental and family requirements need to be considered more broadly.

Evidence and key recommendations underpinning this submission

Campus experts wish to convey the following key recommendations to the Commission. *If we are to improve the mental health and quality of life of Australian children and the adults they become, many of the Commission's findings and recommendations within its reform agenda should:*

1. be considered and applied to the needs of infants, children and adolescents with mental health disorders or behavioural and emotional problems and their families;
2. necessarily focus on prevention and early intervention; and
3. result in the development of an evidence-based, accessible mental health system which is underpinned by ongoing monitoring of child and family outcomes and service effectiveness.

Our submission is supported by the following evidence:

- **50% of all mental health disorders begin before the age of 14 years** with many beginning in young children (Kessler et al, 2005)
- **Child mental health disorders are the single strongest longitudinal predictor of later mental health disorders** (Bosquet et al, 2006; Bor et al, 2001)
- In the national face-to-face household survey of 6310 parents and carers of 4- to 17-year-olds (Young Minds Matter), **one in seven Australian children met criteria for a mental health disorder** (Lawrence et al, 2015)
- Of these children, **only 56% got mental health services** in the previous 12 months
- Caregivers reported that **less than half of the children (35%) had their mental health care needs fully met** (Sawyer et al, 2018)
- **Most children received services in community** (not hospital) settings, primarily through GPs (35.0%), psychologists (23.9%), paediatricians (21.0%) and counsellors or family therapists (20.7%). Only 7.1% of children saw a psychiatrist (Johnson et al, 2016)
- The Australian system is beset by **difficulties accessing appropriate care**, with families and health providers reporting delays and difficulties identifying a clear path to management (Hiscock et al, unpublished data from NHMRC Project grant 1129957)
- Caregivers report not knowing if their child needs help or where to get help, and that the long wait times and **high out-of-pocket costs** are barriers to accessing care (Hiscock et al, unpublished data from NHMRC Project grant 1129957)
- Due to a lack of community services, more and **more children are presenting to Emergency Departments** (Hiscock et al, unpublished data from NHMRC Project grant 1129957).

Below we emphasise two key Campus recommendations which apply across several of the Commission's requests and recommendations:

Key recommendation 1: That mental health care needs of infants, children and adolescents and their families are considered in the further development of the following recommendations/information requests:

- Recommendation 5.6—Practitioner online referral treatment service – PORTS
- Information request 6.1—Supported online treatment for culturally and linguistically diverse people
- Recommendation 7.1—Planning regional hospital and community mental health services
- Recommendation 10.3—Single care plans for some consumers
- Recommendation 11.1—The National Mental Health Workforce Strategy
- Recommendation 11.3—More specialist mental health nurses
- Recommendation 11.4—Strengthen the peer workforce. We believe caregivers should be part of a peer workforce.
- Recommendation 11.5—improved mental health training for doctors. Paediatricians prescribe the bulk of psychotropic medications to Australian children and as such be able to access training around psychotropic medication use and side effects.
- Recommendation 16.2—Mental healthcare standards in correctional facilities
- Recommendation 16.3—Mental healthcare in correctional facilities and on release
- Information request 16.1—Transition support for those with mental illness released from correctional facilities
- Information request 16.2—Appropriate treatment for forensic patients
- Recommendation 16.4—Incarcerated Aboriginal and Torres Strait Islander people
- Recommendation 20.1—National stigma reduction strategy
- Recommendation 21.2—Empower indigenous communities to prevent suicide
- Recommendation 22.1—A National Mental Health and Suicide Prevention Agreement
- Recommendation 22.2—A new whole-of-government mental health strategy
- Recommendation 22.3—Enhancing consumer and carer participation
- Recommendation 22.4—Establishing targets for outcomes
- Recommendation 22.5—Building a stronger evaluation culture
- Recommendation 25.2—Routine national surveys of mental health
- Information request 25.2—Proposed indicators to monitor progress against contributing life outcomes
- Information request 25.3—Data sharing mechanisms to support monitoring
- Recommendation 25.4—Strengthened monitoring and reporting
- Recommendation 25.5—Reporting service performance data by region
- Recommendation 25.6—Standardised regional reporting requirements

Key recommendation 2: That data on effectiveness and cost-effectiveness of new or existing services should be routinely collected and reported, including Patient Reported Outcomes (PROs) in the following:

- Recommendation 5.3—Ensuring headspace centres are matching consumers with the right level of care
- Information request 25.2—Proposed indicators to monitor progress against contributing life outcomes

- Information request 25.3—Data sharing mechanisms to support monitoring
- Recommendation 25.4—Strengthened monitoring and reporting
- Recommendation 25.5—Reporting service performance data by region
- Recommendation 25.9—A clinical trials network should be established – this *must* include trials in infant, child and adolescent mental health. The Campus has established the Melbourne Children’s Trial Centre with excellent processes we can share with the Commission.
- Recommendation 25.6—Standardised regional reporting requirements
- Recommendation 25.7—Principles for conducting program evaluations
- Recommendation 25.8—Requiring cost-effectiveness consideration

We believe measurement of outcomes is paramount to determine whether any given service is effective and cost-effective. A **common set of outcome measures** for infants, children and adolescents should be developed by clinicians, managers, families and policy makers, for use across services. This would allow for more meaningful comparisons of effectiveness between services. Caregiver mental health, wellbeing and workforce participation should be considered in a common measurement set.

PART I: Case for major reform

Information request 3.2 - out-of-pocket costs for mental healthcare

More information on the out-of-pocket costs of mental healthcare that carers incur

Research study: *How long and how much? - Wait times and costs for initial private child mental health specialist appointments (Mulraney et al, 2019)*

Rationale: Out-of-pocket costs for mental health care are a well-known inhibitor for people accessing mental health care, including children and young people. It sits alongside long wait times as the main reasons given by parents for not accessing services for children (Reardon et al., 2017). Despite this, the actual costs and wait times for child and adolescent mental health services in the private sector in Australia have not been quantified. This is despite the fact that the majority of child mental health care (>80%) is provided in the private sector. Researchers at MCRI sought greater understanding of these costs in its 'secret shopper' study conducted in 2019.

Study aims: identify the out-of-pocket costs and wait times for families attending private general paediatricians, child and adolescent psychiatrists and child and adolescent psychologists for initial mental health appointments.

What we did: A trained researcher posed as a parent seeking an appointment for their child, in one of two scenarios:

1. an 11-year-old girl with likely anxiety
2. a boy in Grade 2 with likely attention deficit hyperactivity disorder (ADHD)

A total of 317 private paediatrician, psychiatrist and psychologist practices were contacted by the 'secret shoppers' in Victoria and South Australia between 12 March and May 2019.

What we found:

- Average out-of-pocket costs for an **initial** appointment quoted to the 'secret shopper' were:

○ Psychiatrists: \$185	○ Paediatricians: \$122	○ Psychologists: \$82
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- Average wait times before an initial appointment and assessment were:

○ Psychiatrists: 51 days	○ Paediatricians: 44 days	○ Psychologists: 41 days
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- 25-31% of the 3 specialist types had closed their books because they had too many patients and 22-28% did not provide services to children under the age of 12 years.

In conclusion, parents face substantial out-of-pocket costs and wait times when seeking private mental health services for their child.

Recommendations:

- Increased funding for public services to reduce the backlog of patients in the public system (Victorian Auditor-General's Office 2019) that may be forcing families to seek help from the private sector.
- Shared care models whereby GPs work with child mental health specialists to co-manage children with mental health problems in order to reduce out-of-pocket costs and wait times.

PART II: Health services need to be re-oriented to consumers

Healthcare access

The Commission found that there is an inadequate range and quantity of treatment options that allow people timely access to culturally appropriate mental health care at the right level for their condition.

Recommendation 5.2 — assessment and referral practices in line with consumer treatment needs

In the short term (in the next 2 years)

Commissioning agencies (PHNs or RCAs) should promote best-practice in initial assessment and referral for mental healthcare, to help GPs and other referrers match consumers with the level of care that most suits their treatment needs (as described in the stepped care model).

In the medium term (over 2 – 5 years)

Commissioning agencies (PHNs or RCAs) should establish mechanisms for monitoring the use of services that they fund to ensure that consumers are receiving the right level of care. If service use is not consistent with estimated service demand, commissioning agencies may need to make changes to initial assessment and referral systems (or work with providers to do so).

Recommendation 5.2 assumes that health professionals such as GPs know *how* to identify mental health problems in children and once identified, know *where* to send them. However, our research has shown this is not the case.

At MCRI, we have conducted a series of studies including analyses of the national child cohort Longitudinal Study of Australian Children (LSAC) with linked MBS data and a study asking caregivers and health practitioners about what is wrong with the current mental health system for children and how can we fix it. Below we outline the key findings from these studies.

Research study: *Use and predictors of health services among Australian children with mental health problems: A national prospective study (Hiscock et al. 2019b)*

Rationale: Up to 50% of children with mental health disorders in Australia have not accessed services in the prior 12 months. Studies to date have relied on retrospective, parent reports of service usage among children with mental health disorders. This is the first Australian study to document mental health service use by children with mental health problems *prospectively*, using linked Medicare Benefits Scheme (MBS) data.

Study aims: Use a national sample to determine which children receive care, from whom and who misses out.

What we did: Prospective analysis of linked MBS-rebated mental health service use in children aged 8–9, 10–11, and 12–13 years, from the Longitudinal Study of Australian Children K cohort (N = 4,983). Analyses were conducted for children with clinical levels of mental health symptoms as measured by the Strength and Difficulties Questionnaire (SDQ).

What we found: Only 9 to 27% of children with clinical levels of mental health symptoms accessed MBS rebated mental health services, typically from GPs, psychologists and paediatricians. Younger children, girls, children from more disadvantaged families or families speaking a language other than English were less likely to receive help.

In conclusion, most young Australian children with mental health problems are not getting care.

Recommendations:

- Training to support GPs to better recognise mental health problems in younger children.
- Include a diagnosis/reason for visit in MBS-rebated consultations to document what mental health problems are being managed by MBS-rebated services.
- Make service use data readily available for linkage across non-MBS funded services (e.g., CAMHS, ATAPS, headspace, and school services).

Research study: *Understanding clinician and caregiver views on the current mental health system for children and how to fix it. (Hiscock et al, NHMRC project grant, unpublished data)*

Rationale: The research undertaken by MCRI and others has painted a concerning picture about the prevalence of and the lack of care (Goodsell et al, 2017) for mental health conditions and behavioural concerns among infants, children and adolescents. We know some of the reasons why children could be missing out on care. Caregivers (Mulraney et al, 2019) have reported that they don't know if their child needs help or where to get help. The long wait times and high out-of-pocket costs are also barriers to accessing care for their child. However, little is known about what clinicians think.

Study aims: identify the thoughts of clinicians and caregivers of children and young people with mental health conditions about what is not working in the mental health system and potential solutions.

What we did: Between March 2018 and December 2018, MCRI researchers conducted 140 semi-structured phone interviews with clinicians (35 paediatricians, 35 child and adolescent psychiatrists, 35 psychologists and 35 general practitioners) from Victoria and South Australia. We also interviewed 28 parents of children with ADHD, anxiety, or depression (the most common mental health problems). We asked them:

- “What do you see as the challenges in the current system?”
- “In an ideal world, what would mental health services look like?” – question for clinicians
- “If you had a magic wand, how would you make things better?” – question for parents

What we found: We heard from caregivers that an accessible and co-designed online directory of services including information about entry criteria, waiting times, costs etc. MCRI researcher Dr Daniel Peyton has commenced his PhD research in Barwon to develop and test this approach.

We heard from the clinicians about long waiting lists, out of pocket costs, rules and restrictions applying to services, fragmented care, funding challenges, workforce and training issues as well as many other challenges.

Quotes from clinicians

“Clinicians don't talk to each other; there is a lack of child psychiatry expertise; and effective engagement with social, justice and education sectors is lacking.”

“There's no one to seek advice from really and there's huge waiting lists as well. So I've sort of made friends with the psychiatrist and I've text and emailed her. She's been kind enough to reply. And I've sent a few referrals on to her but, again, she's very expensive and she's private so not all my patients can see her.”

Recommendations:

- Additional supports for caregivers to assist them in how to help their child.
- Psychological support for the whole family including clinician sessions for parent education without the child in the room, funded (Medicare) family therapy, peer-to-peer support groups for parents and siblings and planned respite.
- Models of care to allow clinicians to access child psychiatry expertise e.g. via email/hotline/telepsychiatry etc.
- Greater involvement of trained non-specialist staff.
- Online, co-designed directory of services for parents and caregivers.

Research study: *Strengthening care for children: Pilot of an integrated GP-paediatrician model of primary care in Victoria. (Hiscock et al, in press)*

Rationale: MCRI piloted Strengthening Care for Children, an integrated paediatrician-GP model from the UK providing support to GPs in their care of children with developmental, mental and physical health problems.

Study aims: To assess the acceptability of a novel, integrated GP-paediatrician model of care, aiming to reduce referrals to hospitals and improve primary care quality.

What we did: The pilot ran from April 2018 to March 2019, with five GP clinics from Melbourne metropolitan and inner regional areas within the North Western Melbourne Primary Health Network (NWMPHN). Forty nine GPs and 896 families participated in the intervention, which included:

- weekly ½ day paediatrician-GP co-consultation sessions at the GP practice
- monthly 1-hour case study discussions
- weekday phone and email support for GPs

What we found: The study found that a GP-Paediatrician integrated model of care:

- is feasible and acceptable to GPs in Australia's primary healthcare system;
- improved GP confidence and quality of paediatric care;
- reduced paediatric referrals to emergency departments; and
- improved family confidence in, and preference for, GP care.

In conclusion this model could be tailored to focus on mental health in children, strengthening the primary care system to reduce hospital burden and improve access and quality in GP paediatric care, whilst potentially producing cost savings for families and the healthcare system.

Recommendations:

- We are now conducting a trial of Strengthening Care for Children across 22 GP practices in Victoria and NSW, with a focus on strengthening GP care for common mental health, behavioural and developmental problems.

Research study: *Take a Breath - treating parent psychological trauma with children who have a serious or life threatening illness or injury (Muscara et al, 2017; Rayner et al, 2016)*

Rationale: Take a Breath is a program of research committed to finding the best way to treat parent psychological trauma which is present in approximately 50% of families of children who have a serious or life threatening illness or injury. Discovering that a child has a serious illness or injury is distressing for parents. Along with the emotions and worries of having an ill child, spending time at the hospital for treatment also brings many changes to how the family functions day-to-day.

Study aims: Our program of research recruited parents of children admitted across four hospital departments at The Royal Children's Hospital and included parents of a child who:

- was admitted to the intensive care unit, for a stay longer than 48 hours
- had been diagnosed with a form of cancer
- had required heart surgery within a month after birth
- had been diagnosed with a serious neurological condition

What we did: A team of researchers, psychologists and mental health clinicians located at MCRI and The Royal Children's Hospital have been conducting a research program over a number of years, which consists of a number of different studies:

1. **Take a Breath Cohort study:** This was a longitudinal study in which parents completed a series of questionnaires over a two year period. We asked parents if they were experiencing psychological trauma or anxiety which was affecting their ability to provide a secure home environment for their child. This has helped us to better understand and identify families that may benefit from further psychosocial support. This work was completed in 2014.
2. **Take a Breath Pilot Studies:** The RCH/MCRI team developed the Take a Breath parent program, based on findings from our survey study. The program is delivered in a group setting and targets parent mental health and ways to manage trauma while still being a 'good' parent. A series of pilot studies was conducted to explore the feasibility, usability and usefulness of the program. Both face to face and videoconferencing modes of delivery were explored, and the videoconferencing platform was favoured as it allowed a greater number of parents across Australia to take part.
3. **Take a Breath Clinical Trial:** We evaluated the Take a Breath program in a large study across different hospital departments. In this trial, Take a Breath is being delivered online using videoconferencing so that the families in most need can take part from the comfort of their own home, anywhere in Australia.

What we found:

- Having a child with a serious illness or injury is associated with high levels of parent psychological trauma and injury.
- Parents, particularly fathers, valued the opportunity to receive psychological treatments in their homes and joining with other parents.
- Take a Breath led to a decrease in parent stress and anxiety, and an improvement in their ability to provide high quality parenting to their children.
- For chronic illness, where parents have lived with the stress of their child's illness for many years, more intense intervention is needed.

In conclusion, Take a Breath is an effective and feasible intervention for parents of very ill children.

Recommendations:

- Early recognition of parent trauma is recommended. This can be achieved through screening those at risk due to their child's illness. Where high levels of trauma are identified, treating parent mental health problems can provide an effective method of supporting the family.

Recommendation 6.1 — supported online treatment options should be integrated and expanded

The Australian Government should facilitate greater integration and use of supported online treatment, into the stepped care model as a low intensity service, for people living with mental ill-health with mild to moderate symptoms.

In the short term (in the next 2 years)

Funding should be expanded for services to accommodate up to 150,000 clients per year in supported online treatment.

- Supported online treatment programs offered should each have a strong evidence base for their efficacy and be offered to children, youth and adults.
- To aid integration of healthcare services, supported online treatment should have the option for outcomes data to be forwarded to a nominated GP or other treating health professional. Online service providers should annually publish summary output on use of their services, treatment provided, and other measurable outcomes.

In the long term (over 5 – 10 years)

A review of supported online treatment services as a low intensity option should be undertaken. This review should assess whether there are any barriers to take up, the effectiveness of the services contracted and future funding options

General response: There is a range of accessible tele-mental health methods including video-conferencing approaches to treatment (see Take a Breath above) and digital health tools (BlueIce, Beyond Now) and online Australian programs for specific child mental health disorders (eg anxiety - Cool Kids and BRAVE program). It is important to note that evidence shows that online treatments are not adequate for people with severe mental health conditions.

We agree with the Commission's recommendation that applying the stepped care model to the use of technology to provide mental health services. For example, online services are appropriate for people with mild mental health conditions, videoconference and telehealth for moderate or initial screening and face-to-face and inpatient services for people with severe mental health conditions.

Given that the mental health workforce who provide services to people with mild to moderate mental health conditions in the community is primarily non-medical, they are unlikely to have access to funded online services (telehealth etc). It will be important for consideration to be given for the inclusion of telehealth activities within Better Access to Mental Healthcare.

Recommendation 7.2 — psychiatry consultations by videoconference

In the short term (in the next 2 years)

The Australian Government should introduce a new suite of time-tiered items for videoconference consultations to regional and remote areas (RA2–5), as recommended by the MBS Review Psychiatry Clinical Committee, removing item 288 from the MBS.

In addition, the Australian Government should add new items for videoconference consultations mirroring existing items for psychiatric assessments (item 291) and reviews (item 293), that are available in major cities (RA1) as well as in regional and remote areas (RA2–5), and that are paid at the same rate as items 291 and 293

General response: The Campus agrees with this approach and would be extremely keen to see children and adolescents included, given our research (see Hiscock et al, page 11) with GPs, paediatricians, and child psychologists asking for this type of support and child and adolescent psychiatrists being willing to provide it.

We are submitting an MRFF Primary Care grant application (February 2020) to co-design and evaluate models of care that better support GPs to collaborate with specialist mental health providers for child mental health care. A new suite of time-tiered items for videoconference consultations to regional and remote areas would support such a model. Consideration must be given to what the GP or other healthcare provider (e.g. paediatrician, child psychologist) would be reimbursed to participate in video-conferencing.

Healthcare

Recommendation 8.1 — Improve emergency mental health service experiences

In the short term (in the next 2 years)

State and Territory Governments should provide more and improved alternatives to hospital emergency departments for people with acute mental illness, including peer- and clinician-led after-hours services and mobile crisis services.

State and Territory Governments should consider best practice approaches to providing paramedics with access to mental health resources when undertaking medical assessments in the field.

Public and private hospitals should take steps to improve the emergency department experience they provide for people with a mental illness. This could include providing separate spaces for people with mental illness, or otherwise creating an environment more suitable to their needs.

In the long term (over 5 – 10 years)

State and Territory Governments should, when building or renovating emergency departments, design them to take account of the needs of people with mental illness.

General response: The Campus wholeheartedly agrees with the Commission's recommendation to improve the emergency mental health service experiences. The huge growth in Emergency Department (ED) presentations of children and adolescents with challenging behaviours and mental health disorders must be addressed in mental health system redesign. We are fully prepared to

engage in government led determination of best practice emergency care for children and young people with mental health and behavioural concerns and their families.

It is inevitable that children and young people with mental health conditions will at times need to attend EDs as the most appropriate service to address their needs. These will include following episodes of significant self-harm, managing acute and severe deterioration in their mental health to the extent that hospital based care may be required, or to attend to unrelated physical complaints.

The RCH Emergency Department has seen a 400% increase in mental health presentations since 2012 (personal report 2020, Dr Lewena, Director RCH ED). Currently, 120 to 150 mental health related presentations attend ED every month. This demand continues to grow and exposes the deficiencies in the current facility to provide an appropriate environment to provide this care.

Whilst some of these presentations to EDs are appropriate, for many accessing alternate models of care would be preferred. For children and young people, there are 2 general populations for whom this is particularly relevant:

1. **Those who do not have an *emergent* need to be accessing care but are failing to be able to access any care in a reasonable timeframe in the community.** Presentations to EDs are then used as a last resort to engage or re-engage with mental health care. Affordable and accessible access to care in the community would remove this need to be presenting to EDs.
2. **A smaller group of high volume users of the service.** These are young people well known to and engaged with the system who have chronic and ongoing mental health and behavioural instability, often coexisting with intellectual disability. They are frequently transported to EDs by police or ambulance services due to periods of escalating behaviour in the community which may occur on a daily basis. They require de-escalation and distraction for their chronic behaviour dysregulation by people skilled in these techniques rather than repeated ED mental health assessments. An expansion of the adult PACER (Police, Ambulance and Clinical Early Response) programme to include those with specific paediatric mental health skills could provide a solution.

EDs are often noisy, chaotic, highly stimulating environments which can compromise the mood and behaviour of a young person with mental health concerns. It is imperative that EDs an environment and experience which addresses their needs without exacerbating their underlying mental health.

Analogous to our provision of purpose built spaces to care for acutely unwell or injured people in resuscitation rooms rather than trying to provide this care in the general ED, we need to provide purpose built spaces for children and young people with mental health and behavioural concerns and their families. A far cry from the historic padded room in the back of the ED, these spaces need to be welcoming, calm, accessible, and provide a sense of care and support, rather than seclusion and avoidance. Just like the staff who work in the resuscitation room, the emergency staff who work in the mental health space need to have specific high level skills and training to manage this unique population effectively, and without doing further harm.

Many EDs including our own at RCH are addressing these physical and staff training shortfalls, yet not enough to address the demands and scale of the problem. We are keen to work with relevant stakeholders to determine the most appropriate facility design to accommodate this vulnerable group when they require emergency healthcare.

Recommendations:

- Affordable and accessible access to care in the community would remove the need for children and young people with mental health issues and behavioural concerns to be presenting to EDs.
- We would be very supportive of a paediatric PACER trial, embedding paediatric mental health professionals in the police and ambulance community response.

- We are keen to work with relevant stakeholders to determine the most appropriate facility design to accommodate this vulnerable group when they require emergency healthcare.
- Emergency staff who work in the mental health space need to have specific high level skills and training to manage this unique population effectively, and without doing further harm.

Campus Research: MCRI has undertaken a number of studies to quantify these problems state wide and to further explore the challenges faced by children and young people with mental health and behavioural concerns in EDs as well as ED staff and environments. These are described below.

Research study: Paediatric mental and physical health presentations to emergency departments, Victoria, 2008-15 (Hiscock et al 2018)

Rationale: Mental health disorders in children and adolescents are common, but their impact on presentations to EDs is unknown and yet the number of children presenting to EDs with mental health problems is rising. The reasons for this increase should be determined so that mental health care for young people can be improved.

Study aims: identify trends in presentations to Victorian EDs by children and adolescents for mental and physical health problems.

What we did: We completed a secondary analysis of Victorian Emergency Minimum Dataset (VEMD) data for children and young people, aged 0-19 years, who presented to public EDs in Victoria, 2008-09 to 2014-15. In particular, we looked at the absolute numbers and proportions of mental and physical health presentations, the types of mental health diagnoses and patient and clinical characteristics associated with mental and physical health presentations.

What we found: Between 2008-09 and 2014-15, the number of mental health presentations increased by 6.5% per year, compared with that of physical health presentations (2.1% per year). Self-harm accounted for 22.5% of mental health presentations (11,770 presentations) and psychoactive substance use for 22.3% (11,694 presentations); stress-related, mood, and behavioural and emotional disorders together accounted for 40.3% (21,127 presentations). **The rates of presentations for self-harm, stress-related, mood, and behavioural and emotional disorders each increased markedly over the study period.**

In conclusion, we found that the number of children who presented to Victorian public hospital EDs for mental health problems increased during 2008-2015, particularly for self-harm, depression, and behavioural disorders.

Recommendations:

- public health campaigns to improve recognition by caregivers of the symptoms of mental health problems in children and awareness of where to seek help in the community
- providing GPs with skills and financial resources for managing social, emotional and behavioural problems during early childhood is also important; while Headspace provides mental health services for those aged 12-25 years, our data suggest that younger children need more help
- hubs of care for younger children should include clinicians who offer not only co-located services, but also outreach support to the community and schools to share their expertise and, ultimately, to reduce the number of children who present to EDs with mental health problems

Research study: *Understanding parent-reported factors that influence children and young people's anxiety and depression presentations to Emergency Departments: A multi-site study. (Hiscock et al 2019a)*

Rationale: The number of children and adolescents presenting to the emergency department (ED) with mental health problems is rising. Few studies have examined why children and young people with mental health problems present to the ED, and there have been no studies exploring parent-reported perceptions.

Study aims: to determine parent-reported factors contributing to these presentations.

What we did: Qualitative study with 72 parents of children and young people aged 0-19 years who attended one of four EDs across Victoria between October 2017 and September 2018 and received a primary diagnosis of anxiety or depression (excluding self-harm or suicide attempt).

What we found: The average age of children and young people was 14 years (SD 2.5) and two thirds identified as female (64%). Parents reported bringing their child to the ED for the following reasons:

- suggested by a trusted professional;
- desperation;
- a feeling of no alternative;
- respecting their child's need to feel safe; and
- Rule out a potentially serious medical condition.

Parents were hoping to get several things from the ED including admission to an inpatient unit, after hours help, reassurance for their child, or confirmation that their child did/did not have a serious medical illness.

In conclusion, parents' decisions to attend the ED were appropriate in the context of an overburdened, under-resourced child mental healthcare system.

Recommendations:

- Policy makers, managers and clinicians should work with parents to develop alternative approaches that allow families to recognise and manage anxiety and depression outside of the ED, particularly for younger children and after hours.

Healthcare workforce

Recommendation 5.1 — psychiatric advice to GPs

In the medium term (over 2 – 5 years)

The Australian Government should introduce an MBS item for psychiatrists to provide advice to a GP over the phone on diagnosis and management issues for a patient who is being managed by the GP. The effectiveness of the new item should be evaluated after several years.

General Response: We will submit an MRFF grant application (February 2020) to co-design and evaluate models of care that better support GPs to collaborate with specialist mental health providers for child mental health care. Whilst many models exist, many have failed to be taken up or sustained. We plan to co-design the 'best bet' model with GPs and child and adolescent psychiatrists and then test it with an eye on scalability and sustainability. We would be happy to discuss this further with the Commission.

We also strongly believe that for children's mental health, paediatricians and child psychologists must be able to access child psychiatry support in a manner such as this, given that they provide the bulk of care for children in the community (Johnson et al, 2016).

PART III: Re-orienting surrounding services to people

Care integration and coordination

Recommendation 10.2 — Online navigation platforms to support referral pathways

Commissioning agencies should ensure service providers have access to online navigation platforms offering information on pathways in the mental health system.

In the short term (in the next 2 years)

- All commissioning agencies (PHNs or RCAs) should, either individually or collaboratively, develop or maintain an online platform, including detailed mental health referral pathways. The HealthPathways portal model, which is already used by most PHNs, can be used to contain this information.
- Access to these platforms should be expanded beyond health, in particular to schools and psychosocial service providers. Each commissioning agency should also, either individually or collaboratively, fund a small dedicated team supporting the users of the online platform.

In the medium term (over 2 – 5 years)

All online navigation platforms should incorporate the ability to book consultations with service providers directly from the platform.

General response: The Campus research findings continue to highlight the challenges faced by both caregivers and staff in navigating the referral pathways within the mental health system. The Campus Mental Health Strategy 2020 – 2025 is considering options to overcome these challenges including a platform housing online care pathways for staff and stakeholders.

It is envisaged that the platform will be a single source of information about evidence-based care pathways and clinical practice guidelines. It will be an ideal platform to interface with HealthPathways for clinical care of common infant, child and adolescent mental health problems.

Prospective MCRI Research: MCRI research underway to trial the development and use of an app for parents to support their access to information about allied health providers in child and adolescent mental health care.

The development of an online navigation portal relies on three core components to ensure it improves mental health outcomes and the experience of consumers.

1. An accurate health services directory – the platform needs to provide a list, regularly maintained, of local and online services including key information valued by consumers (eg cost, availability, what the provider will do).
2. A usable platform – to encourage engagement and repeat use of the platform, the user experience of the platform must be *effective* (eg finding a service for the consumer's problem 95% of the time), *efficient* (finding that service within 60 seconds) and *satisfying* (clinicians would recommend the platform to others). For front line mental health workers, the platform will need to fit seamlessly within their respective workflows.
3. Efficacy – Use of the platform will result in a better experience for the consumer and improved mental health outcomes.

Researchers at the Murdoch Children's Research Institute are co-designing and testing such a platform for parents of children with behavioural/emotional problems aged 2-12 years. They will test this platform in Victoria's Barwon region where parents wait 6-12 months to access specialist support for their child.

Carers and families

Recommendation 13.3 — Family-focused and carer-inclusive practice

Family-focused and carer-inclusive care requires mental health services to consider family members' and carers' needs and their role in contributing to the mental health of consumers.

In the short term (in the next 2 years)

Where this is not already occurring, State and Territory Government mental health services should routinely collect responses to the Carer Experience Survey. The data collected should be sufficient for each Local Hospital Network to compare and assess the level of carer-inclusive practice across its services.

The Australian Institute of Health and Welfare should use the data to report publicly on survey take-up rates and survey results at the state and territory level.

In the medium term (over 2 – 5 years)

To improve outcomes for children of parents with mental illness, the National Mental Health Commission should commission a trial and evaluation of the efficacy of employing dedicated staff to facilitate family-focused practice in State and Territory Government mental health services.

The Australian Government should amend the MBS so that psychologists and other allied health professionals are subsidised:

- to provide family and couple therapy, where one or more members of the family/couple is experiencing mental illness. These sessions should count towards session limits for psychological therapy
- for consultations with carers and family members without the care recipient present. Consistent with existing items that are available to psychiatrists, there should be a limit of four subsidised consultations with carers and family members per 12 month period.

General response: The Campus agrees with the above recommendations which align with our caregiver interview study where caregivers wanted:

- Respite for them and the child's sibling/s
- Family therapy sessions
- Time with the health professional including paediatricians, child psychologists and other allied health professionals when the care recipient is not present. **This is particularly pertinent for young children with mental health problems where the most effective approaches are through moderating the parenting styles which necessarily requires one on one work with parents, not the child.**

PART IV: Early intervention and prevention

Early childhood

Recommendation 17.1 – Governments should take coordinated action to achieve universal screening for perinatal mental illness

In the short term (in the next 2 years)

The Australian Institute of Health and Welfare should expand the Perinatal National Minimum Data Set, to include indicators of mental health screening, outcomes and referrals. This data should be reported by State and Territory Governments.

State and Territory Governments should use the data to evaluate the effectiveness of health checks for infants and new parents, and adjust practice guidelines in accordance with outcomes.

In the long term (over 5 – 10 years)

The National Mental Health Commission should monitor and report on progress towards universal screening.

State and Territory Governments should put in place strategies to reach universal levels of screening for perinatal mental illness for new parents. Such strategies should be implemented primarily through existing maternal and child health services, and make use of a range of screening channels, including online screening and outreach services.

General response: Universal screening for Perinatal Mental Illness

The Campus is supportive of this recommendation, acknowledging that universal screening has a role to play in the identification of emerging and established perinatal mental illness with the following provisions:

- use of a robust quality screening tool within evidence-based, high quality care – it is not effective when used to compensate for the lack of quality relationship-based care
- Availability and accessibility of adequate services within clear pathways to care for referral of new parents identified with perinatal distress and mental illness.

In addition, the Campus advocates for the inclusion of alerts for assessment of the mental health and wellbeing of infants and children when perinatal mental illness has been identified. Ensuring there are adequate supports for the new parents and for the infant and children is vital to minimise the adverse impacts of perinatal mental illness.

General Response: First 1000 days

The Centre for Community Child Health, MCRI has led the way in bringing together key researchers and thinkers to build understanding of the 'upstream' influence on infant, child and adolescent mental health and wellbeing, the first 1000 days.

We are concerned that the Commission's report is silent on this very important component of system reform. This work must begin during a child's first 100 days - the earliest stage of human development during the period from conception to the end of a child's second year (Moore et al 2017).

One of the key concepts of the first 1000 days is the evidence for the biological, global, social, ecological, and individual factors that are reshaping our understanding of the first 1000 days.

First 1000 days

The evidence is now clear that the way humans develop is a result of the interaction between a variety of genetic, epigenetic, and environmental factors that operate as an integrated system. This means we are not predetermined by any single factor; but rather from a mix of what we inherit from our ancestors and the contexts in which our development takes place. This is an important message, because it can help us resist the illusion that we have no control over who and how we are. What we do ('we' being individuals, families, communities, services and governments) matters. (Moore et al, 2017)

Research is starting to uncover the mechanisms by which experiences during the early years affect outcomes. We know that experiences and environments can embed biological changes in children's bodily systems. And we are starting to appreciate how risks can escalate over time; with early adverse experiences and outcomes increasing the risk for later adverse experiences and outcomes.

Reducing health inequities and ensuring the best start to life for everyone, irrespective of socioeconomic status, race, or gender, must be an ethical and economic imperative for all governments. In addition to the immense personal and community costs, chronic diseases are also responsible for substantial economic burden given their collective impact on health-care costs and loss of productivity.

As a result, the Australian Research Alliance for Children & Youth (ARACY); Bupa Australia; the Bupa Health Foundation; the Centre for Community Child Health at the Murdoch Children's Research Institute (MCRI); and PwC Australia formed a partnership with the aim of growing a greater awareness of what happens during the first 1000 days and why it matters, and facilitating evidence-based action on policy, practice and parenting.

Recommendation 17.6 — Data on child social and emotional wellbeing

Governments should expand the collection of data on child social and emotional wellbeing, and ensure data is used (and used consistently) in policy development and evaluation.

In the short term (in the next 2 years)

The Australian Government should fund the AIHW's work to finalise the development and implementation of an indicator of child social and emotional wellbeing. Where jurisdictions do not collect the required data, the AIHW should work with Departments of Health to implement data collection. Data should be collected and reported annually.

State and Territory departments of education should use existing school surveys to monitor the outcomes of wellbeing programs implemented in schools. These should be used to identify schools that require additional support to implement effective wellbeing programs.

In the long term (over 5 – 10 years)

The Australian Government should fund the creation of an education evidence base, including an evidence base on mental health and wellbeing. This should include funding networks of schools to trial and evaluate innovative approaches.

The Australian Government should fund the Australian Institute of Family Studies to establish new cohorts of the Longitudinal Study of Australian Children at regular intervals.

General Response: The Campus is very supportive of this recommendation, in particular the contribution of the indicators to policy development and investment.

The AIHW's Children's Headline Indicators '*high level, measureable indicators that identify the immediate environments as particularly important to children's health, development and wellbeing*' (Australian Institute of Health and Welfare, 2018).

The Social and Emotional Wellbeing Indicator focuses on the individual social and emotional strengths of children, rather than simply the absence of mental ill health. A key feature is the focus on the strengths of families, communities and the influence that these environments have on children's social and emotional wellbeing. Social and emotional wellbeing emphasises the experience of positive behaviours and emotions, as well as how the individual adapts and copes with daily challenges (through resilience and coping skills) while leading a fulfilling life. These skills are dynamic in that they form the social and emotional foundations of future behaviours, emotions, and abilities to adapt.

Source: <https://www.aihw.gov.au/reports/children-youth/childrens-headline-indicators/contents/18-social-emotional-wellbeing>

Suicide prevention

Recommendation 21.1 — Universal access to aftercare

In the short term (in the next 2 years)

Australian, State and Territory Governments should offer effective aftercare to anyone who presents to a hospital, GP or other government service following a suicide attempt. Aftercare should be directly provided or referred, and include support prior to discharge or leaving the service, as well as proactive follow-up support within the first day, week and three months of discharge, when the individual is most vulnerable

General response: The Campus is very supportive of this recommendation and advocates for the vital inclusion of prevention and aftercare for children and young people who self-harm and/or attempt suicide in this recommendation. The Campus is part of a national MRFF Million Minds grant (MRFF Million Minds Mission: The Kids are Not Okay: Emergency Department management of acute mental health crises in children and young people. 2019-2023) to determine the most effective way to offer effective aftercare to children and young people across multiple emergency departments.

Campus research initiatives to inform Commission recommendations

Below we highlight three important examples of our work and research findings that can be used to further inform the Commission's plans and specific recommendations. The Campus welcomes the opportunity to further discuss these major projects with the Commission so that future practice is informed by the best possible evidence.

1. Campus Mental Health Strategy 2020 – 2025

The Melbourne Children's Campus has initiated the development of a Campus wide Mental Health Strategy 2020 - 2025. The strategy is part of the Campus's state wide vision for infant, child and adolescent mental health and intersects with a range of government initiatives and community services. There are a range of drivers for the development of the strategy including 6 out of 10 child with chronic illness will have mental health symptoms, a 400% increase in presentations to our hospital's ED since 2012 and lack of clarity for families and community providers families as to where to seek help or how to navigate the system

The Campus Mental Health Strategy will include establishment of:

- clinical care pathways for common child mental health problems
- measurement based care with governance and oversight with the establishment of the Centre of Evidence-based Infant, Child and Adolescent Mental Health Care
- an Outcome Measurement Framework to ensure collection of outcome measures as part of usual care to audit efficacy of services– also to include Patient Reported Outcome measures
- a strong focus on collection and use of data in measuring and monitoring outcomes to inform service improvement – for example, *monitoring performance through the development of a Victorian dataset to support funding provisions and drive clinical improvement (RC rec28)*

2. Centre of Research Excellence in Childhood Adversity and Mental Health 2020 - 2024

The Centre of Research Excellence in Childhood Adversity and Mental Health is a five-year research program that has been co-funded by the National Health and Medical research Council and Beyond Blue. It aims to bring together people with lived experience and their families, practitioners, educators, researchers and policy makers from education, health and human services in a concerted effort to prevent the significant mental health morbidity load of depression, anxiety problems and suicidality experienced by children living in adversity and exposed to adverse childhood experiences.

We are completing an evidence review as to what works to mitigate the effects of adversity and adverse childhood experiences (ACEs) on children's mental health. We will then work in 2 sites (Wyndham, Victoria and Marrickville, NSW), to co-develop and deliver community-based programs that address the complex problems these children and their families face.

3. Generation Victoria

Generation Victoria aims to create large, parallel whole-of-state birth and parent cohorts for discovery and interventional research. It plans to recruit the cohorts across 2020-22 and link parents and their babies to existing health, education and social data.

It will enable researchers to explore the issues affecting Victoria's children and their families with greater speed and precision than we can today, allowing them to explore the critical links between environmental exposures, genome (genetics), physical characteristics and later outcomes across the life course including mental health and wellbeing. Generation Victoria will generate translatable evidence — including novel approaches to prediction, prevention, treatments, and services — to improve future wellbeing and reduce the future disease burden of all children and the adults they become.

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