Introduction

The NSW Branch of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to make this 2020-21 NSW Pre-budget Submission. In preparing this submission, we have drawn together the latest research evidence, data and information and consulted with our Psychiatry Fellows across NSW who are working on the frontline with NSW families and communities.

Throughout 2019 and 2020, the NSW and Australian governments have demonstrated their commitment to the mental health of Australians by funding a range of important initiatives in response to the COVID-19 pandemic and related recession, bushfires, floods and ongoing drought. Investments have largely focused on bolstering primary and secondary services for people in distress and who experience mild to moderate mental health issues.

There is now an opportunity for the NSW Government to target investment to the most vulnerable groups with the highest level of mental health need and who have the least access to specialist (tertiary) mental health services.

In a snapshot

We know that specialist mental health service demand has been consistently growing for children and adolescents under 18 years with moderate to severe mental health issues. We are acutely aware that demand currently outstrips supply in NSW.

Need is being further increased by the COVID-19 pandemic and related recession – the impact of which is likely to continue over many years. COVID-19 suicide prevention modelling1 shows that along with education and employment initiatives, expanding community-based specialist mental health services for young people is a key strategy to reducing mental health Emergency Department (ED) presentations, self-harm hospitalisations and suicide deaths in young people over the next five years.

A statewide long-term investment in community-based CAARTs which provide in-reach to hospitals and outreach to homes, schools and communities seeks to address what is perhaps the biggest service gap as well as the fastest growing demand on our NSW specialist mental health service system (see Model in a Snapshot).

Teams will provide multidisciplinary specialist mental health care and essential care coordination, helping young people and families navigate the system and access the care they need in the community.

Teams will bring the right care at the right time in the right place, to children and adolescents under 18 years with moderate to severe mental health issues and their families.

They will divert demand from inpatient beds and EDs, reduce demand on first responders, and offer young people and families more responsive, rapid and intensive specialist mental health services in homes, schools and communities.

Our recommendation

Invest $92 million over four years and $28 million recurrently to establish 25 Child and Adolescent Acute Response Teams (CAARTs) to provide urgently needed rapid, mobile, intensive and flexible short-term responses to young people in mental health crisis and their families.


2 Costing excludes Goods and Services, extended hours loading, some allowances, escalation, evaluation and statewide implementation support.
The Model in a Snapshot

25 Child and Adolescent Acute Response Teams (CAARTs) providing services to children and adolescents with moderate to severe mental health issues and their families/carers

The service

- Rapid, intensive, short-term acute response (average 6-8 weeks)
- Crisis assessment, specialist clinical care and short-term therapeutic interventions
- Face to face, telehealth and phone options
- Extended hours services/partnering closely with other 24/7 mental health services
- Appointments in community (including schools, homes) and hospital settings (EDs, wards)
- Step-up and step-down services to provide in-reach, short-term risk containment and connection with young people presenting to EDs
- Facilitated discharge of young people from hospital (EDs, paediatric wards etc) and assertive, intensive follow-up in the community (homes, schools etc.) until they are well enough to be transitioned to a community-based service
- Specialist short-term care coordination and system navigation - empowering children and families, linking them up with appropriate other services as needed, and liaising with relevant partners such as Education (public and private schools, TAFE), Department of Communities and Justice, GPs, private psychiatrists and other mental health providers (e.g. Headspace, private psychologists), NDIS providers, vocational supports, youth organisations, housing providers and other supports as needed
- Capacity building and improved access of health and partner agencies (e.g. schools) to specialist mental health consultation
- Integrating care through close partnerships with a range of service providers and first responders
Staffing model per core team (6 FTE)

- Consultant child and adolescent psychiatrist (24 hours per team per week – approx. 0.6 FTE)
- Registrar child and adolescent psychiatrist (1 FTE training place)
- Clinical Nurse Consultant/Nurse Practitioner (1 FTE)
- Allied Health professionals (1 FTE)
- Allied Health or Nursing (2.4 FTE)

Benefits for patients and families

- More services
- Closer to home
- Intensive
- Flexible
- Responsive
- Integrated

Benefits for the system

- Quick to implement and gets services to the community rapidly
- Diverts demand from EDs and inpatient beds
- Reduces pressure on first responders (police and ambulance)
- Increases system access to specialist mental health advice
- More attractive training places building the child and adolescent psychiatrist workforce
- More specialist CAMHS resources – 150 FTE in 4 years
  - 15 FTE consultant psychiatrists, 25 FTE psychiatry training positions
  - 25 FTE Clinical Nurse Consultants
  - 25 FTE Allied Health
  - 60 FTE Allied Health or Nursing

- Builds upon existing well-developed telehealth and community based CAMHS systems in NSW, with established infrastructure, evidence-based interventions and safety and quality processes

Cost

$92M over 4 years and $28M recurrent (see Footnote 2)
The challenge

We know that around one in seven (13.9%) young people aged 4-17 years have a mental disorder\(^3\). Conditions emerge early, with half starting by the age of 14 and 75% appearing before 25 years. We also know that the impacts of failing to treat psychological distress and mental illness in young people are extensive, long lasting and costly to individuals and society.

Without appropriate intervention, these young people are likely to have poor health and social outcomes and high ongoing service usage. Impacts include poor adult mental health, low school engagement and performance, high dependence on welfare, insecure housing, involvement with the child protection system, criminal activity, drug and alcohol dependency, and premature death\(^4\).

The recent Productivity Commission Inquiry Report noted that the mental health of children and families should be a priority and that this area is a good-value investment. Importantly, the Report identified a nation-wide pattern of under-resourcing of community based (ambulatory) mental health services, with the greatest gaps being in child and adolescent and older person’s mental health services.

These issues are reiterated in the recently released (December 2020) targeted review into Child and Adolescent Mental Health Services (CAMHS) following the death of a young person aged 13 years, commissioned by the Western Australian Government. The report highlights an escalation of serious mental health issues for children and young people, particularly the number who are self-harming. It recommends immediate investment in CAMHS including intensive, multidisciplinary emergency responses which provide assertive outreach over extended hours and support young people and families immediately following ED presentations and inpatient admissions.

Stephanie is 16 years old and has had many admissions to acute mental health inpatient units in crisis after self-harm. She has received multiple diagnoses and has been prescribed medication since childhood. The family are becoming increasingly desperate and frustrated in getting access to mental health services. On this occasion they contact the police and the PACER team respond and assess Stephanie at home.

Rather than take Stephanie to hospital they contact the CAART Stephanie and her family are seen in the family home within 24 hours by the Team who recommend that Stephanie and the family be seen daily in collaboration with the CAART staff until the acute crisis is resolved. During that time the Team focusses on engaging Stephanie and her family into treatment.

The Team organises for an urgent psychiatric review to confirm the diagnosis and review Stephanie’s medication and risk profile. The Team works with Stephanie and her family to develop a comprehensive care plan that includes coordinating with her school the range of supports that she needs in addition to support and psychoeducation for the family and individual dialectical behaviour therapy for Stephanie through CAMHS.

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\(^3\) The Mental Health of Children and Adolescents: Report of the Second Child and Adolescent Mental Health Survey of Mental Health and Wellbeing Australia (2015)

The NSW Mental Health Commission’s strategic plan for community recovery, wellbeing and mental health in NSW, *Living Well in Focus 2020 - 2024*, includes a focus on the impacts of COVID-19, bushfires, floods and drought on the mental health and distress of children and families, and the enduring impacts of trauma on children. The plan recommends enhancing public community mental health services to bring NSW up to the national average and scaling up and sustaining funding of integrated and evidence-based community mental health models to meet growing demand. It speaks to the importance of resourcing prevention and early intervention services to reduce the incidence of mental health issues arising in children, young people and their families and improving access for families across the state.

Modelling commissioned by the NSW Government under [Their Futures Matter](https://www.nsw.gov.au/their-futures-matter) confirmed that of all vulnerable groups in NSW, investment in children and young people under 18 years with mental health issues is one of the best-value choices in terms of improved outcomes for individuals and to society as a whole.

In line with this, we welcome the announcement of a significant expansion of the [Wellbeing and Health In-Reach Nurse (WHIN) program](https://www.nsw.gov.au/services/mental-health/wellbeing-health-in-reach-nurse-whin-program) across the state under the 2020-21 NSW Budget. It is anticipated that this program will lead to earlier identification of children with both psychological distress and moderate-severe psychiatric disorders. Growth in Headspace services has been steady and expected to continue, also leading to early identification and growth in case numbers.
A parallel investment in specialist mental health services is also urgently needed, to enable NSW Health to meet the consistently growing demand and respond to the anticipated increase in referrals of young people with higher level mental health needs from expanded primary and secondary services, including WHIN and Headspace. CAARTs will provide this specialist mental health response in a flexible, community-based way and work synergistically with these services. Anecdotal reports indicate that children and adolescents with complex presentations, particularly Intellectual Disability (ID) and Mental Health (MH) issues, often struggle to access specialist psychiatric services. The RANZCP welcomes the roll-out of the IDMH/NDIS Residual Functions program across the Local Health Districts (LHDs), as well as the development of the Sydney Children’s Hospitals Network (SCHN) MHID Hub. Synergies between these specialist services and enhanced CAMHS services would lead to better integration of care with primary and secondary health, and better outcomes. The RANZCP also welcomes the current scoping for specialist Statewide inpatient services for complex needs groups, such as those with ID/MH.

An investment in CAARTs will importantly deliver against the Premier’s Priorities Towards Zero Suicides (Target: Reduce the rate of suicide deaths in NSW by 20% by 2023), Improving outpatient and community care (Target: Reduce preventable visits to hospital by 5% through to 2023 by caring for people in the community) and Improving service levels in hospitals (Target: commencing ED treatment on time by triage category by 2023).

Enhancement of CAMHS is in line with the NSW Health Integrated Prevention and Response to Violence, Abuse and Neglect Framework which prioritises children, young people and those with mental health issues for attention and identifies CAMHS as important secondary response services. CAMHS investment also contributes to the objectives of the First 2000 Days Framework through supporting vulnerable parents/carers and families who have young people with significant mental health problems.

Chloe is an 11 year old girl who has struggled with emotional and behavioural difficulties since early childhood. She has been doing poorly at school and has been diagnosed with ADHD but she hasn’t received medication. She hasn’t really made any friends because she can be aggressive with other children and her siblings. Her school is concerned that she is not going to cope with high school. She has a history of early childhood trauma.

Lately she has seemed depressed and has talked about suicide. On this occasion she has been admitted for 24 hours following a presentation to the Emergency Department.

The CAART staff were called to meet with Chloe and her family on the inpatient unit. They map out a care plan with the family to provide intensive support in the community using attachment based family therapy and a thorough assessment including psychiatric review of the diagnoses and medication.
The case for investment

Meeting growing demand

We know that demand for NSW specialist mental health services for children and adolescents has been increasing disproportionately to other age groups over the last decade.

Demand can be measured in a range of ways and we offer examples of this through several data sources which reflect a trend of increasing need related to psychological distress, intentional self-harm and suicide in young people. Concerningly, some of the greatest increases are for our younger adolescents, aged 10 to 14 years.

We have also consistently heard from our Fellows working on the frontline about this growing demand, and CAMHS capacity limitations were again raised as a critical concern in a recent statewide Child and Adolescent Psychiatry RANZCP workforce survey (October 2020).

Early NSW data and anecdotal reports on the impact of the COVID-19 pandemic and recession also indicate that the mental health of children and young people is being disproportionately affected and service usage is up. Investment in supply of specialist mental health services has not yet kept up with increasing demand for this age group.
a) Psychological distress

There is a correlation between high levels of psychological distress and common mental health disorders. NSW health data (Table 1) shows that since 2010, a greater percentage of NSW young people aged 16-24 years (pale blue line) have reported levels of high or very high psychological distress than all other age groups. Table 1 also shows a notable increasing trend for this age group since 2013.

Table 1: High or very high psychological distress, persons aged 16 years and over, comparison by age, NSW 2013-2019

Young people under 16 years are experiencing a similar increase in psychological distress. A recent study of psychological distress among 13-year-old Australians 2007-2019 shows that psychological distress for 13-year-olds has been increasing to around one in five 5 females and one in ten males (Tables 2 to 4).

Table 2: Changes in psychological distress, 13-year-old Australians 2007 to 2019

Table 3: Changes in psychological distress, 13-year-old Australian males, 2007 to 2019

Table 4: Changes in psychological distress, 13-year-old Australian females 2007 to 2019

Source: NSW Population Health Survey (SAPHaRI), Centre for Epidemiology and Evidence, NSW Ministry of Health


b) Hospitalisation for intentional self-harm

Mental health disorders are known risk factors for intentional self-harm. Although most young people who think about suicide or engage in self-harm will not attempt suicide, suicidal thoughts and self-harm are strongly associated with suicide attempts.

We note there is a concerning trend of increasing rates of both intentional self-harm and suicide for NSW young people. Over the 10-year period from 2009-10 to 2018-19, NSW young people aged 15-19 years consistently had the highest rate of hospitalisation for intentional self-harm of all age groups (Table 5).

Table 5: Self-harm hospitalisations rate per 100,000 population, trend by age group and year 2009-2010 to 2018-2019

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<td>65-74</td>
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When examining the two time points at the beginning and end of this ten-year period (2009-10 and 2018-19), the age groups with the most dramatic increase in the rate of hospitalisations for self-harm are those aged 10-14 years (62% increase) and 15-19 years (42% increase) (Table 6). This correlates with what our Fellows have told us about a pattern of increasing psychological distress, self-harm and ED presentations for this younger age group.

Table 6: Change in rate of self-harm hospitalisations per 100,000 population, by age, between 2009-10 and 2018-19

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Rate Change</th>
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<tr>
<td>10-14</td>
<td>62%</td>
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<td>15-19</td>
<td>42%</td>
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<td>20-24</td>
<td>-11%</td>
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<td>25-34</td>
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<td>35-44</td>
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<td>45-64</td>
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<td>65-74</td>
<td>3%</td>
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<td>75+</td>
<td>-2%</td>
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Source: NSW Population Health Survey (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health

Some groups of children and young people have increased vulnerability to mental health issues including those who: have a parent with a mental illness; have experienced abuse and/or neglect; have a coexisting developmental disability; who identify as LGBTIQ; or are Aboriginal. In 2018-19, the rate of Aboriginal young people aged 15-24 years hospitalised for intentional self-harm was almost double that of non-Aboriginal young people (411 to 223 per 100,000 population).

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(9) NSW Strategic Framework and Workforce Plan for Mental Health 2018–2022 [p27]

(10) http://www.healthstats.nsw.gov.au/Indicator/men_suihos/men_suihos_Aboriginality?&topic=Mental%20health&topic1=topic_ men&code=men[_]%20bod_dementhos
c) Suicide

There is an association between mental health issues and deaths by suicide\(^\text{11}\). We know that suicide was the leading cause of death for young people aged 15-24 years in Australia between 2016-18 and the fifth leading cause of death for those aged 1-14 years\(^\text{12}\).

In 2018, 117 NSW young people aged 15-24 years were reported to die by suicide. The blue trend line in Table 7 shows the increasing rate. Between 2008 and 2018, the rate of suicide for young people aged 15-24 years nearly doubled, from 6 to 11.2 deaths per 100,000 population\(^\text{13}\).

**Table 7: Suicide, comparison by age, NSW 2001-2018**

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Source: Mortality estimates for years up to 2005 are based on ABS death registration data. Data from 2006 onwards provided by Australian Coordinating Registry, Cause of Death Unit Record File; data for 2 most recent years are preliminary (SAPHaRI, CEE, NSW MoH)


\(^{13}\) [http://www.healthstats.nsw.gov.au/Indicator/men_suidth/men_suidth_age_trend](http://www.healthstats.nsw.gov.au/Indicator/men_suidth/men_suidth_age_trend)


d) COVID-19 pandemic and recession

In the context of the NSW COVID-19 pandemic and recession, there have been significant impacts on the mental health of the community. It appears that there is both an increase in prevalence of mental health issues among children and adolescents and an increase in those with a moderate to high severity of illness and associated high risks.

COVID funding enhancements have included a focus on increasing telehealth services, but we have heard that children and young people are less likely than adults to use these services and are more likely to present for face-to-face appointments. Families may also be disconnected from regular supports and seek assistance from in-person services. In line with this, our Fellows have observed a steep increase in demand across inpatient, ED and Community CAMHS.

The data and information available to the RANZCP NSW Committee for Child and Adolescent Psychiatry indicates there has been increased child and adolescent phone contact with crisis lines, youth disengagement with education and training, an ongoing increase in psychological distress as well as increased mental health related presentations to EDs across all LHDs. Of note, there have been increases in ED presentations for intentional self-harm across all LHDs, particularly for the 13-17 year-old age group.

Family stress is known to increase the risk for children and young people who are already vulnerable. Domestic violence (DV), already a common issue in Australia is known to increase in times of disaster. The volume of calls to DV helplines and internet searches for DV supports have grown significantly as a result of the COVID-19 pandemic14. Offering young people and their families options about how they safely access support is essential, and face to face appointments are key to clinicians being able to accurately assess child safety, wellbeing and other forms of risk.

The impact of recessions can be long lasting. Studies have found that it takes several years post-recession for employment to rebound and families to return to pre-recession income levels, with poorer families taking longer than those with higher pre-recession income levels; and impacts on children’s health can be lifelong15. The Mitchell Institute for Education and Health Policy at Victoria University16 estimates a significant increase in potentially vulnerable Australian children of around 130% as a result of COVID-19 related unemployment and underemployment.

The Institute notes that loss of employment and reduced income will place significant financial stress on many families, and this may compromise parental mental health, parenting capacity, family access to basic necessities and increase social isolation. This combined with other factors such COVID-related stress, anxiety and disengagement from supports such as through disrupted schooling are likely to have long term implications on children’s health, learning and employment outcomes.
William has never ‘fitted into’ a service in spite of repeated referrals because he is either ‘not sick enough’ or ‘too sick’. He is now 16 years old and has been diagnosed with Autism Spectrum Disorder (ASD) Level 1 and anxiety in addition to chronic physical illnesses. He has not been accepted for an NDIS package as his ASD is determined to be only Level 1. He does have a supportive GP. His mother is his full time carer and is feeling increasingly helpless about how to get help for William. His GP is concerned about William’s mother becoming burnt-out and the placement failing so he refers him to the new CAART.

The Team organise a comprehensive multidisciplinary and multiservice assessment. The psychological assessment confirms the diagnosis of ASD but also detects a range of learning difficulties. Assessment by a speech therapist and occupational therapist detect further communication and sensory difficulties impacting his functional level and it was determined that he has ASD Level 2. The psychiatric assessment confirms that he has an anxiety disorder and medication is commenced that will require close monitoring because of the potential for side-effects given William’s range of difficulties.

The Team reviews the range of diagnoses and disabilities that William has, contacts the LHD NDIS Coordinator and assists in proactively applying for an NDIS package. Regular monitoring of the medication by the GP was recommended.

Although the most job and income losses are occurring in metropolitan regions which contain higher proportions of parents working in hospitality, retail and the arts, the report indicates that children from lower socioeconomic quartiles will generally be more severely affected.

Need exists across the state in regional, rural and metropolitan areas. A statewide approach is required in providing assertive, mobile and flexible specialist mental health services for vulnerable children and families, with targeted investment in regions of higher need.

The model we propose offers face to face as well as phone and telehealth consultations across a range of locations (home, school, community, hospital and clinic based) to give young people and families choice about how they access care in ways that support their privacy and safety, and allows clinicians to comprehensively assess risk and functioning. A long-term investment in this enhancement is required.
Building a sustainable workforce

There is a shortage of child and adolescent psychiatrists as well as a shortage of child and adolescent psychiatry training places in Australia to meet infant, child, adolescent and youth mental health needs. The October 2020 NSW RANZCP Child and Adolescent Psychiatry workforce survey (81 respondents) identified critical concerns with child and adolescent psychiatry resourcing and recommended increasing consultant positions as well as training places. This proposal offers a substantial increase in consultant psychiatrist as well as psychiatry training positions (15 FTE consultants, 25 FTE registrars). This innovative model with a strong component of multiple stakeholder liaison will provide trainees with broad experience across community-based (home, school and community), ED and inpatient settings.

Importantly, in terms of consultant psychiatry workforce resourcing for this proposal, just over half of RANZCP survey respondents said they would be willing to offer additional hours of child and adolescent psychiatry in a range of settings if adequate remuneration was offered. Of these, 36% said they would be willing to deliver additional outpatient services, 25% offered additional in-hours telehealth, 26% offered extra out-of-hours telehealth, and a smaller proportion said they would take on additional hours in ED (15%) or inpatient services (17%).

The model also grows the nursing and allied health mental health workforces in line with strategic priorities 2.3 and 2.4 of the NSW Strategic Framework and Workforce Plan for Mental Health 2018-2022.

What works?

It is essential that new NSW Government investment targets evidence-based alternatives to inpatient admission for young people with mental health issues so they can be provided effective, safe and timely care close to home and community. A systematic review in 2017 found promising indications that youth assertive community treatment (ACT) is effective in reducing the severity of psychiatric symptoms, improving general functioning, and

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reducing the duration and frequency of psychiatric hospital admissions\textsuperscript{18}. Components of the ACT models reviewed included home and community-based specialist mental health assessment, medication management, case management that supported transitions of young people from clinic-based services to home, family support, early intervention, and assistance for young people to reconnect with education and vocational activities. These ACT teams tended to carry low caseload numbers (under 10) and provided home and community-based outreach for hard-to-reach young people with severe mental illness and their families.

NSW Health trialled and evaluated an Assertive Community CAMHS pilot model that was implemented across three of the 15 LHDs in 2011. CAARTs are an advanced iteration of this model, and take into account learnings from the pilot, recent international evidence and accommodate for the increase and changes in scope of community mental health need.

Our recommended model

We recommend a best-buy model of 25 CAARTs that like ACT teams, will deliver rapid, mobile, intensive and flexible short-term outreach to young people in mental health crisis and their families across NSW (see Model in a snapshot page 2). The Teams would respond to young people in their schools, homes and communities and in hospital-based settings (EDs/Wards), through face to face, phone and telehealth appointments. This flexible model can be adapted to work across rural, regional and metropolitan locations and be tailored to meet local cultural and diversity needs.

Teams would be based in and complement existing CAMHS, facilitate integrated care with service partners (within and across LHDs) and build on recent NSW Government mental health enhancements including peer worker and suicide prevention initiatives. Teams will improve access for school nurses and counsellors from public and private schools to local specialist mental health advice and responses. Teams should provide and/or partner closely with extended hours mental health services to ensure a comprehensive 24/7 response to young people and families in crisis. Teams would be multidisciplinary and comprised of psychiatry, nursing and allied health professionals with the clinical expertise to deliver crisis assessment, specialist clinical care and short-term therapeutic interventions for young people with high and complex mental health needs and their families/carers. Teams would incorporate psychiatry registrar training positions which would grow a much-needed sustainable child and adolescent psychiatry workforce.

Implementation considerations

A statewide rollout of CAARTs is needed. Teams must be appropriately resourced, the investment must be long-term, and the roll-out must be statewide in order to deliver the much-needed impacts for young people and their families.

Scale up: We recommend scaling up this model over three years, commencing with one team in each LHD (16 Teams in Year 1) and adding a further nine teams in areas of highest need in Year 3. Funding at this level recurrently is then required. Scale up at this rate is anticipated to be achievable in terms of workforce recruitment and establishment of training places.

Variation: We propose the SCHN (Westmead) receives one of the first 16 Teams although varied in arrangement. This would be to provide: increased services to young people in the ED; support for transitions of young people from SCHN inpatient services back to the care of LHD community CAMHS via a navigator function; and delivery of statewide psychiatry consultation (including extended hours) through enhancement to the existing Child and Adolescent Telemedicine Psychiatry Outreach Service (CAPTOS).

Allocations: Allocations should consider population need and unmet demand. Funding should enable mobile outreach (including cars, mobile phones and staffing arrangements), telehealth and innovative practices that improve access for young people to services.

Implementation planning should consider local factors requiring flexibility such as geographic location, availability of partner services, workforce factors and available infrastructure. Intersections and integration with existing mental health services, infrastructure and supports, and partnerships between new services should be considered to ensure efficiencies and avoid potential duplication.

Team composition: Teams require adequate staffing levels to support community visits and extended hours (where appropriate). A complement of 6 FTE for a ‘Core Team’ is recommended. Teams should be
multidisciplinary as indicated, with 2.4 FTE flexibly allocated to either nursing or allied health to assist recruitment in rural and more difficult to recruit to areas.

The Consultant Psychiatry time required is 24 hours per team per week, with flexible arrangements across teams as needed. This resource will ensure appropriate levels of supervision for trainees and provide clinical leadership and specialist psychiatry consultation for the team.

Staffing arrangements should consider the senior level of expertise require for this acute, intensive work and ensure appropriate supervision, organisational support and clinical governance arrangements to promote sustainability. Nurses who have training and expertise in mental health practice such as those who are credentialled by the Australian College of Mental Health Nursing or who hold formal qualifications in Mental Health Nursing and who have child and adolescent experience would therefore be recommended for these roles. Similarly, allied health who have mental health expertise and child and adolescent experience and an interest in short-term intensive work could be targeted.

Criteria for acceptance: Criteria for referral to teams should be based on age, appropriateness and moderate to severe mental health need rather than diagnosis-specific considerations or exclusions.

A consistent model: The evaluation of the Assertive Community CAMHS pilot recommended that explicit guidance about model operations should be developed centrally to guide implementation. A well-articulated model that still offers flexibility to meet local needs is advised to support a consistent, evidence-based approach and equitable access to similar, high quality services by families across the state. The RANZCP would be pleased to assist NSW Health in defining this model. Funding for model development and associated implementation resources and supports should be considered.

Evaluation: It is recommended that funding for an evaluation is included in the investment to ensure implementation success, make adjustments from early learnings and understand the longer-term benefits of the investment.

Conclusion

This proposal would quickly and efficiently bring urgently needed specialist help to young people and their families in mental health crisis. Although the enhancement is not expected to match demand, it provides a strong and appropriate response to address the most urgent pressure points in the NSW mental health system right now. We would appreciate the opportunity to participate in a future strategic planning process with NSW Health and other key partners to discuss additional options for a comprehensive response to the needs of children and adolescents under 18 years with mental health issues and their families.
Contact

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