Department of Health

Tasmanian Government

File No.:

DATE:	11 April 2022
Subject:	Commission of Inquiry; Request For Statement (RFS)
Prepared by:	Professor Brett McDermott
Position title:	Statewide Specialty Director
Organisation:	Child and Adolescent Mental Health Services Tasmanian Health Service
Address:	[redacted]
Telephone:	[redacted]
Email:	[redacted]

Question 1: Background

a) Relevant educational qualifications

Brett McDermott
B.Med.Sci., MBBS., Cert.Child.Psych.,
MD., FRANZCP

Statewide Specialty Director
Child and Adolescent Mental Health Service Tasmania

Professor of Psychiatry, James Cook University

Clinical Professor, University of Tasmania

By-Fellow, Churchill College Cambridge University

Foundation Director Hand-n-Hand Healthcare Peer Support

Education Background:

- Educated in Sydney (NSW) and Hobart (Tasmania), Australia.
- Graduated from the University of Tasmania with;
- Bachelor of Medical Science (B.Med.Sci.), 1982.
- Bachelor of Medicine (MB), 1984.
- Bachelor of Surgery (BS), 1984.
- Elected Fellow of the Royal Australian and New Zealand Colleague of Psychiatrists 1995.

- Completion Child and Adolescent Psychiatry training (CertChildPsych.) 1995
- Doctorate in Medicine (MD) 2005.

b) Relevant professional history

1985	Intern, Launceston General Hospital
1986	Resident Medical Officer, Royal Canberra Hospital
1987	Surgeon Lieutenant Royal Australian Navy,
1988	Ship's Medical Officer, HMAS Jervis Bay
1989	Ship's Medical Officer RAN Flagship, HMAS Stalwart
1990	Senior House Officer UK (Psychiatry)
1992	Psychiatry Registrar NSW
1993	Senior Registrar Mood Disorders Unit NSW
1993	NSW Training Fellow in Child and Adolescent Psychiatry
1995	Staff Specialist: Child and Adolescent Psychiatry (Newcastle, NSW)
1995	Senior Lecturer Child and Adolescent Psychiatry (UWA)
2000	Professor of Child and Adolescent Psychiatry (UWA)
2001	By-Fellow, Churchill College, Cambridge University, UK.
2002 – 2009	Director Mater Child and Youth Mental Health Service (Brisbane, QLD)
2002 – 2016	Director ADAWS: the Adolescent Drug and Alcohol Withdrawal Service
2002 – 2015	Associate Professor (University of Queensland)
2006 – 2016	Board Director BeyondBlue
2009 – 2014	Exec Director Mater Child and Youth Mental Health Service (Brisbane, QLD)
2011	Chair of the child and adolescent response to the Queensland Floods and Cyclones
2011-2015	Professorial Research Fellow; Mater Medical Research Institute
2013 – 2014	Director (0.4FTE) Mater Adolescent and Young Adult Centre (MAYAC)
2015	Professor of Psychiatry James Cook University (November)
2021	Statewide Director Child and Adolescent Mental Health, Tasmania

International Appointments:

- Guest Professor Shanxi University (2017-18)
- Invited Consultant Taiyuan Psychiatric Hospital: Child and Adolescent Mental Health Service Delivery. Shanxi Province China (2017)
- Faculty Member: Creating Futures – Mental health and the Developing World. Fiji (2017)
- InterPAR Collaboration: Low Intensity PTSD intervention. Sydney (2016-present)
- Visiting Professor (Universiti Kebangsaan Malaysia (UKM), Kuala Lumpa (2008).

- Scientific Convenor World Congress of the International Association for Child and Adolescent Psychiatry and Allied Professionals (2006).
- Appointee: By-Fellow, Churchill College, Cambridge University, UK (2001-present).
- Organising Committee Member: American Academy of Child and Adolescent psychiatry Annual Conference, Honolulu, Hawaii (2001).

National Appointments:

- Member: NHMRC PTSD Guideline Editorial and Advisory Committee (2019-20)
- *Beyondblue* Clinical Advisor: National Bushfire Disaster (2019-20)
- Chair of Advisory Group: Building Resilience in Children, Australian Research Alliance for Children and Youth (2016-17)
- Director, *BeyondBlue* the Australian National Depression Initiative (2006-2016)
- Member of Advisory group: National Mental Health and Wellbeing Study of Police and Emergency Services (2016- ongoing)
- Member Rotary Mental Health Grant Committee (2015-ongoing)
- Member: FRANZCP Eating Disorders Clinical Practice Guidelines
- Member/appointee: National Mental health Service planning Framework Expert Panel (2016-17)
- Member/appointee: Federal Government Mental Health Expert Reference Group (2015)
- Chair: NHMRC-BeyondBlue Youth Depression Clinical Practice Guidelines Working Group (2010-12)
- Member: National Mental Health Working Group – Child and adolescent expert committee responding to natural disasters (ongoing)
- Chair: Child and Adolescent Mental Health National Outcome Measurement Experts Group (2005-2006)

State Appointments:

- Tasmania Government: Review of Child and Adolescent Mental Health Services (2019-20)
- Queensland Government (2011-13) Chair of the child and adolescent response to the Queensland Floods and Cyclones.
- Convenor; Australasian Conference on Child Trauma (2012), Gold Coast, Australia.
- 'Lead Clinician' (Child and Adolescent Mental Health) WA Department of Health (2000-2002)

Publications:

Over 100 journal articles and book chapters published on topics that include: mental service development, PTSD and stress, and adolescent depression.

For detailed information please refer to my CV, provided as **Attachment 1**.

c) Current role and responsibilities

Statewide Speciality Clinical Director of CAMHS - appointed in May 2021.

Responsibilities include leading joint CAMHS / Department of Education response to the Hillcrest Incident of December 2021.

- Professor of Psychiatry at James Cook University – since 2015
- Clinical Professor University of Tasmania – since 2021
- Founding member of *Hand n Hand* – a peer-related service for health professionals

Question 2: Child sexual abuse and harmful sexual behaviour

(a) The short, medium and long-term impacts of child sexual abuse on victim-survivors, including in relation to biology, brain development, executive function and psychology, including any specific impacts related to child sexual abuse that occurs in an Institutional Context.

The impacts of sexual abuse are variable, depending on factors such as the type of sexual abuse, its frequency, the age and gender of the child, and their relationship to the perpetrator. Impacts may also be buffered to some extent by factors such as strong family support and peer relationships.

Common presentations in victims-survivors of child sexual assault include depressive and anxiety symptoms and PTSD symptoms with prominent avoidance/numbing symptoms.

For example, a study by Garcia et al (2017) found that depression and anxiety symptoms in youth reported to child welfare in the US were 1.8 times more likely if they had experienced sexual abuse.

The Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder and Complex PTSD, of which I am a co-author, state that childhood sexual abuse can also lead to persistent self-regulation issues including:

- affect regulation and impulse control (self-harming, acting out sexually, engaging in dangerous activities)
- attention (regular dissociative episodes)
- self-perception (identity disturbance)
- relationships (attachment, sexual difficulties, parenting problems).

As further noted in the Guidelines, these self-regulation issues can lead to a range of diagnoses including personality disorders (e.g., borderline personality disorder) and attachment disorders. Substance use problems and eating disorders are also common. Comorbid presentations (multiple diagnoses, at the same point of time, for a given individual) are the norm for this group.

The Guidelines further note that ongoing sexual abuse, particularly during early childhood, can alter the child's developmental trajectory. Common symptoms include:

- nightmares
- sleeping difficulties
- withdrawn behaviour
- aggressive behaviour

In younger children, sexual abuse may be linked to sexual knowledge or behaviours that are inappropriate for the child's age (e.g., explicit drawings or simulations with toys or other children).

In adolescents, it may be associated with indiscriminate sexual partnering, substance use and self-destructive/impulsive behaviours.

Behavioural difficulties and disorders (e.g., oppositional defiant disorder, engaging in risky behaviour) can also be associated with abuse, particularly in boys.

Long term impacts

For a comprehensive review of recent (up to 2013) Australian and international research on the long-term effects of child sexual abuse I refer the Commission to the work of Judy Cashmore and Rita Shackel published in the Commission to the Child Family Community Australia Paper No. 11 2013 The long-term effects of child sexual abuse (aifs.gov.au)

Research reviewed by Cashmore and Shackel, indicates a range of negative consequences for mental health, although not all victim-survivors experience these impacts equally.

Studies have shown significant links between child sexual abuse and drug and alcohol dependence and bulimia nervosa (Kendler et al), and major depression, panic disorder and alcohol dependence (Dinwiddle et al).

Studies have found a particularly strong association between child sexual abuse and post traumatic symptoms (Canton-Cortes & Canton, 2010; O'Leary & Gould, 2009; Ullman, Filipas, Townsend, & Starzynski, 2007).

Recent research has also associated child sexual abuse and psychotic disorders (Bendall, Jackson, Hulbert, & McGorry 2011; Lataster et al., 2006; Wurr & Partridge, 1996) and personality disorders.

A study by Cutajar et al (2010) on the reported mental health outcomes of individuals who were sexually abused, before 16 years of age, noted this was a major non-specific risk factor to an extensive range of adult mental health presentations from psychosis to anxiety, substance abuse and personality dysfunction. For some conditions there was a six-fold increase in the likelihood of that diagnosis over and above the non-abused group.

Studies have also found significant links between child sexual abuse and later suicidal behaviour or ideation (Dube, Anda, & Whitefield 2005; Fergusson et al., 2008; Molnar, Berkman, & Buka, 2001).

While there is increasing awareness of the continuing and long-term impact on those who were sexually abused as children or adolescents in societal institutions there is little research on how these impacts differ from the impacts of sexual abuse in other settings. Of key significant appears to be the relationship between the victim-survivor and perpetrator and the level of trust.

Adverse Childhood Experiences (ACE)

Sexual abuse is often accompanied by other types of abuse and/or neglect. This can make it difficult to single out the impact of child sexual abuse in isolation from the cumulative impact of multiple types of abuse or detrimental experiences.

A useful methodology for looking at extreme challenges to physical and emotional function, including experience of sexual abuse, is adverse childhood experiences (ACE).

The literature identifies10 ACES, comprising emotional, physical, or sexual abuse; emotional or physical neglect; witnessed household violence; household substance abuse or mental health issues; parental separation or divorce; and incarceration of a household member.

Studies have shown a linear relationship between the number of ACEs and depression. If a child had five or more ACES, their chance of depression in adulthood was five times higher, alcohol dependence approximately seven times, intravenous drug use more than nine times higher and suicide more than 11 times higher, than someone who has no ACEs (Chapman et al., 2007).

Biological Factors

Structural Brain abnormalities and abuse

When considering structural brain abnormalities, a statistically significant association has been established between childhood abuse and abnormalities across a wide range of brain regions (Tozzi et al., 2020). Including reductions in brain volume in areas involved in emotional regulation (De Brito et al., 2013), and frontal cortex in adults with major depression and a history of childhood trauma (Reynolds et al., 2014). The latter is important because of implications for executive functioning/decision making. Bick and colleagues reported structural brain changes in institutional cared for children exposed to early life neglect and related this to their ability to regulate emotions (2015). Similarly, childhood sexual abuse has been demonstrated to correlate with decreased brain grey matter volume with the duration of abuse before age 12 related to the degree of loss (Tomoda et al., 2009). This was replicated in a study of individuals with a psychotic disorder and a history of childhood sexual abuse (Sheffield et al., 2013), but was not replicated by Rinne-Albers and colleagues who studied adolescents with PTSD and history of sexual abuse (2020). There is also some emerging work investigating white matter tracks that form the connections between brain regions. Childhood trauma has been associated with reduction in global white matter connectivity and indeed in the study of Puetz and colleagues this was associated with placement instability for those in institutional care (2017).

Gene-Environment Interactions

Another advance in the understanding of genetics is there are often more than one form of a gene that underpins a given biological function. For example, the serotonin promoter gene has a short 's' and a long 'l' form. Because there are 2 strands of any given chromosome the possible serotonin transporter genes are 2 x 's'; 2 x 'l' or 1 of each 'sl'. In Caspi and colleagues' (2010) demonstrated an increased risk of depression in adults abused as children if you had the 'ss' genes, not the 'll' or the 'sl' forms. An example of a gene form interacting with an environment (experience of abuse) to create a mental health outcome. Another example is early evidence of a relationship between one form (the C allele) of an important stress response gene (FK506 Binding Protein 5 gene /FKPB5), the experience of childhood abuse and significant brain connection abnormalities (Hart et al., 2017).

Epigenetics

Epigenetics is based on the recent understanding that gene function is not static rather the transmission speed of genes (how fast or slow the gene can transcribe information to messenger RNA, with the latter moving out of the cell nucleus into the body of the cell to program the creation of protein) can be altered by environmental influence. The way this occurs is by a chemical process – the most studied being methylation of DNA at specific sites alone the DNA strand.

An example of an epigenetic relationship is child maltreatment leading to methylation of the oxytocin receptor and reduced grey brain matter (Fujisawa et al. 2019). Related adverse mental health outcomes included insecure attachment, in the Fujisawa research, and general mental health symptoms in the work of Smearman and colleagues (2016). The epigenetic

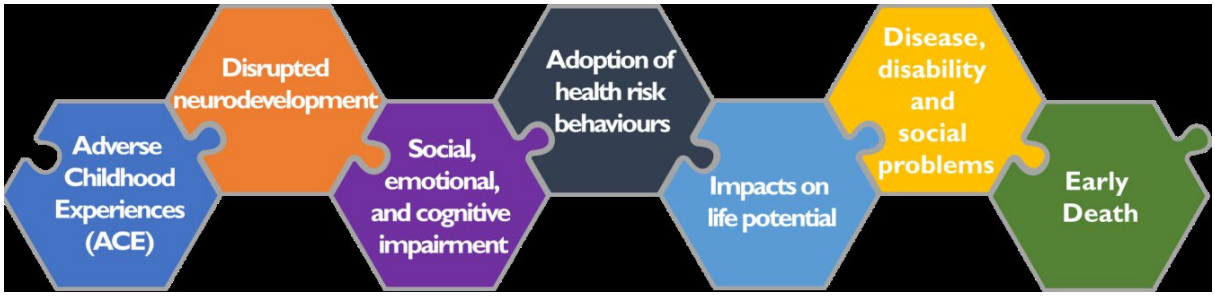
process of DNA methylation is a greater risk of occurring with earlier onset of abuse and in male children (Cicchetti et al., 2016). The emerging field of epigenetic change following adversity has implicated a range of other brain mechanisms including pathways that implicate both dopamine and serotonin neurotransmission.

(b) The ways in which the impacts on victim-survivors of child sexual abuse identified in your answer to paragraph (a) can manifest in negative psychosocial outcomes. Include reference to any studies or research that you consider to be part of your answer.

As noted above, childhood adversity, including the experience of sexual abuse, can significantly impact neurological and childhood development. This has been linked with a range of negative physical, health, and social outcomes (Currie, Spatz Widom, 2010; Lansford et al., 2002; Finlay et al., 2022).

I refer the Commission to my discussion of adverse childhood events (ACE) in 2 a) above. The importance of ACEs is depicted in Figure 1, which provides an understanding of the far-reaching life course consequences of ACE.

Figure 1: An example of the impact of ACE on the life course



Source: Centres for Disease Control and Prevention (2019). Preventing Adverse Childhood Experiences. Leveraging the Best Available Evidence.

Extensive research has identified a strong association between adverse childhood experiences and delinquency. Youth with greater exposure to ACEs are more likely to be involved in the juvenile justice system and, once involved in the system, also tend to experience poorer outcomes over the life course than those without such exposure.

While I caution the Commission against drawing a causal link between sexual abuse victimhood and sexual offending, I note that there are multiple studies to suggest that many sexual offenders were abused as children. Certain studies, identified by Cashmore and Shackel, which draw on retrospective self-reporting, indicate that the percentage could possibly be as high as 75%.

For further information on the link between child sexual abuse and negative long term psychosocial outcomes I again refer the Commission to Cashmore and Shackel's extensive review.

Question 3: Identify and describe the therapeutic responses that are most effective for addressing or minimising the impacts of child sexual abuse on victims that are discussed in your answer to question 2.

Effective therapeutic responses for individuals who are victims of child sexual abuse is dependent on both the context of the abuse, the severity and whether the individual developed a mental health disorder secondary to their abuse experience.

A single episode of non-penetrative abuse perpetrated by a non-family member with the victim in a stable and loving parent/caregiver - child relationship is often the cause of distress within the child and family but may not reach the threshold of a diagnosable mental illness. Interventions might include supportive counselling of the child, discussions relating to protective behaviours and assistance for the parents not to fundamentally alter their parenting into more hypervigilant overprotective parenting which can lead to developmental implications that outweigh the impact of the actual traumatic event (Cobham, McDermott 2014).

For sexual abuse that is more severe, often associated with multiple incidences of trauma over a more protracted period of time, as mentioned above, the likelihood of developing a mental illness is much higher.

The intervention process includes (a) treatment of the mental health presentation, (b) specifically addressing the trauma in any treatment and (c) working with the family.

Treatment of the underlying disorder simply involves attending to best practice, usually identified clearly in relevant clinical practice guidelines. For example, the treatment of depression is cognitive behaviour therapy (CBT) with or without adjunctive anti-depressant medication. Similarly, the treatment of anxiety is also CBT, often with an emphasis on avoidance behaviour and behavioural techniques such as hierarchical desensitisation. Again, medication maybe adjunctive. There is robust research that if the underlying condition is related to a traumatic event, then general CBT will not be efficacious unless the trauma is specifically addressed.

In the case of PTSD, the relevant intervention is trauma focused CBT. Again, for this therapy to be successful the traumatic event must be addressed, see the Australian Clinical Practice Guidelines in PTSD (Phelps et al., 2022). The importance of addressing the traumatic event is relevant for both single-event trauma and complex PTSD. When the PTSD is many years in the individual's past, complex PTSD may manifest as an emerging personality disorder, most typically borderline personality disorder. The evidence base for successfully intervening with borderline personality disorder is dialectic behaviour therapy (Phelps et al., 2022).

The third issue is assisting the family. As briefly mentioned above, consumers will often say they experienced impairments secondary to developing symptoms after being a victim of sexual abuse. Consumers often also say that they experienced impairment because of altered family functioning, for instance, a teenager not being able to engage in age-appropriate behaviour such as going to a movie with their friends or having a sleepover. The driver for this is parental over protection and hypervigilance secondary to altered parenting in these family systems. Often the parents or caregivers of victims of child sexual abuse need a body of work to encourage them to promote normal child and adolescent development.

Question 4:

(a) Identify and explain the origins of harmful sexual behaviours in children.

The 2020 Practice Guide: Responding to young people living in out of home care who engage in harmful sexual behaviour, published by the Australia Childhood Foundation, provides an excellent explanation of the multiple reasons why harmful sexual behaviour develops. CETC-Practice-Guide-Harmful-Sexual-Behaviour.pdf.

As outlined in the Practice Guide, the reasons can be summarised as follows:

- Experienced childhood trauma and victimisation.
- Exposure to poor role modelling of healthy relationships.
- Poor sexual knowledge.
- Exposed to pornography that is not understood at their stage of development.
- Engagement in exploitative dynamics for survival

Many children and young people who engage in harmful sexual behaviour have themselves experienced maltreatment including physical abuse, sexual abuse and being forced to live with family violence. This affects the way they see relationships, and are able to trust and be trustworthy, and often leaves them with unmet needs for love and affection (Creeden, 2017; McPherson et al, 2019).

Young people who have been sexually abused may engage in harmful sexual behaviour as a way of acting out and trying to make sense of what they themselves have experienced. If as part of their own sexual abuse they experienced acts of coercion and control, they may repeat this in their interactions with more vulnerable and younger children in an effort to regain their own sense of control.

As further identified in the Practice Guide children and young people may also engage in harmful sexual behaviour because they have been exposed to poor role modelling of healthy sexual relationships. For example, they may have witnessed sexual coercion in the household or been forced to watch pornography, which they lack the developmental maturity to process. These are the sort of messages that distort their understanding of relationships and normalise the use of power and control.

Harmful sexual behaviour in children and young people may also be the result of poor sexual knowledge, leading to confusion about what is appropriate, when, with whom and with what consequences. As noted in the Practice Guide, attempts at what the child / young person may deem to be normal explorative sexual activity may end up being harmful due to a lack of awareness of its impact on others.

Young people may engage in harmful sexual behaviour because they have been forced into exploitative dynamics in order to survive challenging environments. This may be particularly relevant in institutional settings and is discussed in under Question 6 below.

(b) Describe the extent to which those origins are understood in Institutional Contexts in Tasmania

Knowledge of the importance of gene-environment interactions appeared in the child and adolescent mental health literature from approximately 2005 with the celebrated paper by Caspi and colleagues (2005); a follow-up study of children from Dunedin, NZ over several decades. Scientific reports of changes in gene transmission speed based on environmental factors (epigenetics) is a more recent literature. Mental health professionals from less

biological traditions, (e.g., social work), or those trained in more psychodynamic principles (e.g., some psychiatry training schemes) will be less familiar with these new constructs. Given this, it is my contention, based on personal opinion rather than some empirical test, that practitioners in Tasmania have a limited understanding of this incredibly complex area. Some of the older concepts such as traumatic re-enactment maybe known but more nuanced understanding of new genetic, epigenetic findings and how these interact with underlying psychological theories is not well considered. It is unfortunate that for some even a basic understanding of the increased incidence of perpetrating inappropriate sexual activity is more likely in those who themselves have been victims of inappropriate sexual activity is not known.

(c) Identify and explain key features of a best practice clinical approach to the assessment of harmful sexual behaviours in children and the development and implementation of treatment plans

The best practice clinical approach for the assessment of harmful sexual behaviours in children is one that is developmentally and systemically informed. Developmentally informed means being aware and responsive to a young person's thoughts, feelings and behaviours being different (both in content and how they are portrayed) across developmental stages such as the preschool years, childhood and adolescence. Systemically informed means an understanding of the child within the family context. Therefore, inclusive of the influence of parents and parenting practices, siblings and other friends and family of influence. Further, given the high prevalence of mental health conditions in the population of children who engage in harmful sexual behaviours, and as mentioned last paragraph, these include both the disruptive behaviour disorders and trauma presentations, the individual conducting the assessment needs to be aware of these diagnoses and their respective diagnostic criteria.

Given this complex matrix (developmental and systemic), the assessment should be by a skilled practitioner, ideally with a child and adolescent mental health background. For an adolescent it is a general principle to see the adolescent first and conduct a suitable review that focuses on relevant general topics first. This includes their developmental history from a social and emotional perspective, relevant issues from medical history, educational history, drug and alcohol use and forensic history. Whilst gathering this information, of special interest is any evidence of disruptive behaviour disorders in the past. Similarly, any evidence that the individual had been subject to sexual, physical or verbal abuse and or neglect. Towards the end of this interview any episode of sexual inappropriate behaviour should be explored from the perspective of what the young person was thinking and feeling at the time, and what if any motivation they had to engage in such behaviour. A full mental state examination should occur to conclude the interview. Following the time with the adolescent, the parents would be interviewed to corroborate information received and to add any important omissions to the story thus far.

The process is similar for a younger person with the important difference that for them to feel at ease in an interview situation, often the interview begins with the young person and parents in the room. Once they are comfortable it is ideal to see the primary age child by themself. Thereafter a similar process is conducted, importantly, with language that is developmentally appropriate for a younger person. Again, at the end the parents are seen. For a preschool child, a face-to-face individual assessment is not appropriate and overwhelmingly the interview is conducted with the parents providing what information they can.

(d) Describe the extent to which such features are implemented in Institutional Contexts in Tasmania.

In Tasmanian CAMHS teams (South, North and North West) the principles and processes inherent to best practice assessment of harmful sexual behaviours in children and the development and implementation of treatment plans exist. However, historically Tasmanian CAMHS have been criticised for their poor engagement with consumers with complex needs. Tasmania CAMHS, and indeed many CAMHS teams across Australia do not typically see young people with harmful sexualised behaviour as core business. Some jurisdictions (e.g., Brisbane) have dedicated services that offer assessment and treatment of this cohort. In Tasmania, the new CAMHS service (in development) specifically for children in out of home care will include assessment and treatment of consumers with these presentations. It is hoped that this expertise can then be generalised to other CAMHS service areas.

I cannot comment on implementation of these principles in non-CAMHS settings other than speculate that given the Ashley Youth Detention Centre psychologist position is currently unfilled, it is highly unlikely that setting has capacity for these assessments.

Question 5: Are you familiar with the framework developed by the AIM Project in relation to harmful sexual behaviours? If yes, please provide any views you have on the strengths and weaknesses of that framework as a tool for assessing and responding to harmful sexual behaviours.

I am not sufficiently familiar with the framework developed by the AIM Project, including not being employed by any service that has run this approach, to provide the Commission with an informed view.

Question 6: In your experience, are children and young people in institutional setting such as out of home care and youth justice at increased risk of child sexual abuse and/or harmful sexual behaviour? If yes, please explain your understanding of why this is so, both by reference to pre-existing vulnerabilities and vulnerabilities related to institutional settings.

Both from my understanding of the literature and clinical experience is that there is increased risk of abuse, including sexual abuse, in any institutional setting where there is a strong power imbalance between adults and the children in their care with limited oversight. The greater the vulnerability of the child, the greater the risk that they will be the target of abuse in these settings.

I am familiar with and support the findings of Royal Commission into Institutional Responses to Child Sexual Abuse and note that the risks of child sexual abuse in institutional settings, including OOHC and youth detention, are outlined comprehensively in the Royal Commission's Final Report. (Understanding child abuse in institutionalised settings; Volume 2).

I do not attempt to replicate information from that Report except to concur that the risk of abuse is affected by multiple, complex, factors including both pre-existing vulnerabilities of the institutionalised cohort (refer to the discussion of adverse childhood experiences in 2 a)-b) above, and vulnerabilities related to the institutional setting.

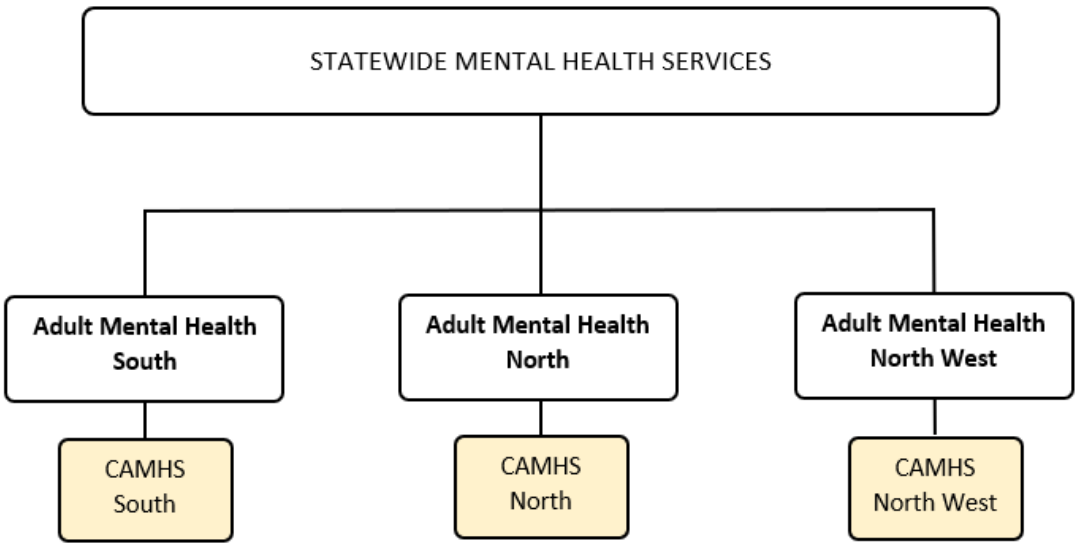
In relation to specifically children in out of home care, I again draw the Commission's attention to the Practice Guide; Responding to young people living in out of home care. CETC-Practice-Guide-Harmful-Sexual-Behaviour.pdf

As pointed out in that Guide, children and young people in out of home care, and in particular residential care, are susceptible to being drawn into exploitative relationships or groups to gain access to things they deem essential to their survival, such as money, drugs, alcohol, mobile phones and electronics. In these relationships, young people may then find themselves being forced into sex or being manipulated to force others to have sex with them (Hallett, Deerfield and Hudson, 2019). Young people in these circumstances are victims of exploitation but are also coerced into engaging in harmful sexual behaviours with other young people.

Question 7 CAMHS Structure

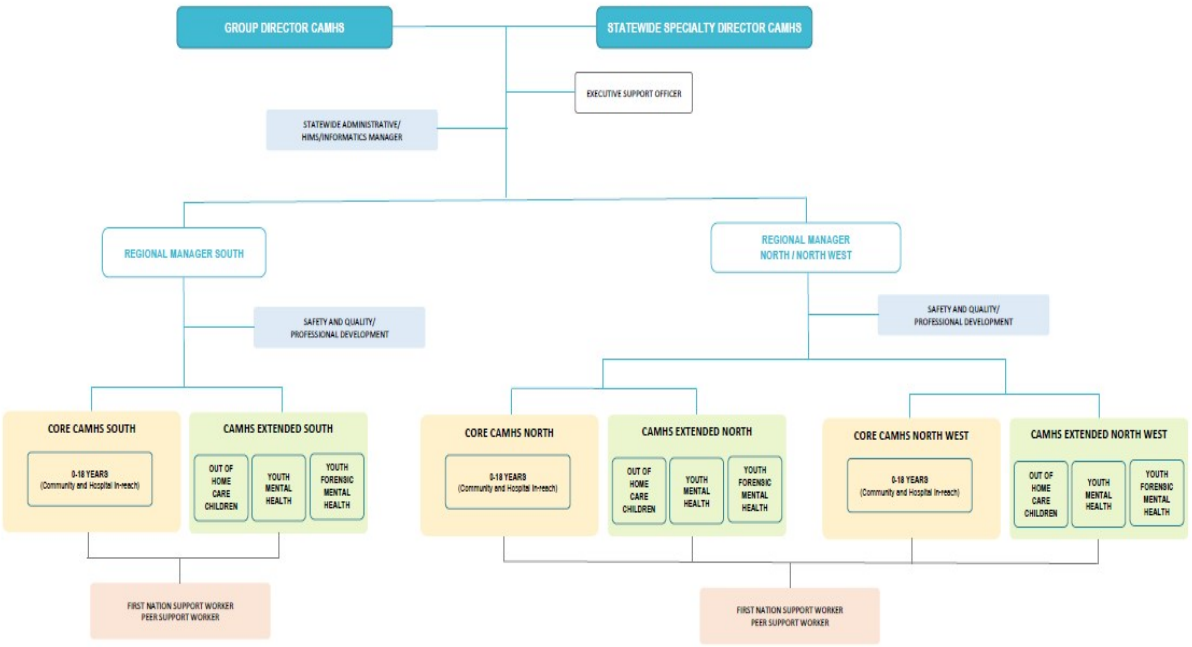
(a) Please provide the current structure of CAMHS

Figure 2 – Current CAMHS Structure



The three community CAMHS teams have only been joined in a statewide structure for approximately 9 months following the appointment of the Statewide Speciality Director. The Statewide Group Director was appointed approximately 5 months ago. Prior to this the Teams reported to the three health regions.

Figure 3 Proposed CAMHS Organisational Structure



On 8 April 2022 the Tasmania CAMHS clinical services group endorsed a significantly more sophisticated service response to address child and adolescent mental health in Tasmania, shown in Figure 3 above. (An enlarged version is also provided as **Attachment 2**.) Of note each community service is augmented with dedicated Teams to address the needs of youth, and individuals at high risk of mental illness; children in out of home care and those in the justice system. It is anticipated that later CAMHS reforms will include a dedicated adolescent and youth inpatient facility and day hospital.

(b) the services and programs that CAMHS currently delivers in Tasmania.

CAMHS works with children, young people and their families and/or care givers to provide support and specialist treatment. This includes assessment, psychoeducation and treatment services for mental health difficulties such as:

- Anxiety disorders
- Attachment disorders
- Autism spectrum disorders (assessment and/or mental health-related symptoms)
- Eating disorders
- Major depression and mood disorders
- Mental health concerns in pregnancy and following birth
- Psychosis
- Severe emotional trauma and adjustment problems
- Suicide risk and self-harm

Most treatment occurs in the CAMHS community (outpatient) clinics. It may also involve liaison with schools, General Practitioners, Paediatricians, other Government bodies (e.g.,

child protection and headspace) and service providers (e.g., NGOs) and other significant people in the child's/young person's life.

Assessments and treatments offered by CAMHS under an individual service plan may include:

- Crisis intervention
- Assessment of the presenting mental illness
- Assessment of related aspects such as speech and language or intellect
- Medication/pharmacotherapy
- Family therapy
- Group therapy
- Parental therapy
- Individual psychotherapy
- Supportive therapy
- Cognitive behaviour therapy
- Psychoeducation

CAMHS is currently in the processes of aligning its assessment procedures and treatment offerings statewide as part of the CAMHS reform.

Question 8: Identify and describe any concerns you have about:

(a) The ability of children and young people in need to access CAMHS services

My concerns, and the concerns of stakeholders, about the ability of children and young people to access CAMHS services are set out in detail in the CAMHS Review Report.

In summary, both consumers - specifically parents and caregivers and a wide range of service providers but especially General Practitioners and Paediatricians have experienced great difficulty getting referred children and young people with severe and challenging mental health needs assessed by CAMHS services. Some practitioners stated that in response they had stopped referring to CAMHS. There is no doubt that prior to the recent new funding available to CAMHS the service was underfunded. However, other barriers to access included cultural and structural factors that affect CAMHS' service delivery model, as well as service provision decisions in response to limited resourcing.

There had been ambiguity within CAHMS as to whether complex and severe presentations are part of CAMHS core business. Examples include one CAMHS team with a strong therapeutic emphasis on family therapy holding a position that young consumers without a family to 'work' with were not suited to the therapy offered and so not accepted by CAMHS. Another team provided extensive 4 hour assessments which prevented efficient use of time. Another team considered their work to be community based and expressed some resistance to seeing consumers who attended the local hospital Emergency Department. External stakeholders also expressed confusion over whether CAMHS sees itself as a Level 4 + service.

Importantly, the current period of mental health reform in Tasmania provides a strong opportunity for CAMHS to reposition itself as an outward looking Level 4+ service accessible to young people with the most complex and severe mental health needs.

The Review explicitly recommends a new CAMHS Model of Care, aligned to the Australian National Mental Health Strategy National, with a focus on severe and complex mental illness. It also recommends funding for and the development of new dedicated specialist services for

Tasmania's most vulnerable groups who have traditionally had the most difficulty accessing CAMHS services.

Significant progress is underway against the Review Recommendations and Government funding has been committed to the first two stages of reform.

However, I note that the third phase of reform, which includes the development of a much-needed adolescent mental health inpatient unit and mother and baby unit, is not yet funded. As demand for these services continues to rise, it is crucial that additional funding for the third phase of reform is secured as soon possible to allow development of these facilities to progress.

(b) The ability of CAMHS to offer trauma-informed care

It is my observation that there is limited ability and expertise within CAMHS to provide trauma-informed care to consumers with severe trauma-related presentations.

Stakeholder feedback obtained through the CAMHS review process identified a reluctance within CAMHS to provide interventions for trauma-related mental health diagnoses such as reactive attachment disorder (RAD), Complex PTSD or related complex challenging dysregulation and behaviour experienced by these individuals. Borderline Personality Disorder, a common mental illness experienced by someone who has experienced past abuse and/or neglect was a condition that required the consumer to be 18 years of age before diagnosis. There is an international movement to diagnose this condition earlier in life - often termed 'emerging Borderline Personality Disorder', which allows early intervention. The treatment of Borderline Personality Disorder with the strongest evidence base is Dialectic Behavior Therapy (DBT: Linehan 2022). DBT is now offered by all CAMHS teams, typically in group format.

Historically CAMHS has conveyed the view that its service delivery model is not suitable for presentations of severe trauma-related mental health illness. The delivery of trauma informed care to highly dysregulated / traumatised children will be a significant challenge to CAMHS and it is likely that substantial upskilling of the workforce will be required.

Importantly, a new CAMHS service for children in Out of Home Care is being developed (and funded) as part of the broader CAMHS reform. This service will deliver trauma-informed assessment and interventions through a multi-disciplinary team. Recruitment is currently underway for senior clinicians to lead this service.

(c) The dominant model(s) of care within CAMHS and the extent to which it or they are adapted to the needs of CAMHS clients. Please identify and discuss the benefits of alternative models of care that are available

CAMHS has traditionally operated as three disparate regional services, without a dominant model of care. Each regional services had its own practices, procedures and treatment offerings. To varying degrees across the three CAMHS teams, routine practices and procedures have been inefficient (both in cost and the number or patients seen) and in the opinion of the author, stated in the CAMHS review (McDermott, 2020) have not reflected contemporary best practice.

As part of the reform process the three CAMHS teams are in the process of being integrated into a single statewide CAMHS with a statewide model of care. The model will be strongly aligned to relevant aspects of the National Mental Health Strategy, including a focus on severe and complex mental illness and accountability, including measuring and reporting progress of consumers who have experienced abuse.

Some of the reform themes include:

- Better consumer access – by running 'displaced outpatient' clinics in locations such as Bridgewater-Gagebrook, Sorrel, the Huon and Channel regions (potentially Kingston), Georgetown.
- Increased range of conditions accepted – including those with ADHD or Autism Spectrum Disorder with comorbid anxiety or depression.
- Increased capacity to support Paediatrics by providing timely second opinions.
- More timely assessment using contemporary models such as CAPA (Choice and Partnership Approach) which has published evidence of being able to see more consumers with decreased waiting times and overall higher productivity (Clark et al., 2018).
- Increased capacity to provide after-hours CAMHS assessments with funding an extended hours CAMHS service at the Royal Hobart Hospital (recruitment currently occurring).
- Creating of a statewide CAMHS intake service.

(d) The availability of alternative services where CAMHS services are not available or are deemed unsuitable. To the extent necessary, please distinguish between the various CAMHS services currently operating across Tasmania.

CAMHS is funded to be a Level 4 specialist mental health service for children and young people in Tasmania. There is no alternative specialist mental health service for children and young people in the state.

There are other services available for consumers with mild to moderate (Level 2 / 3) mental health needs including GPs, paediatricians, private psychologists and organisations such as Headspace.

Stakeholders interviewed as part of the review process express confusion over when CAMHS services were available. Many expressed concern that CAMHS was not operating as a Level 4 service.

Paediatricians in particular expressed concern over being required to provide care for suicidal or highly distressed (Level 4+) young people where service from CAMHS was unavailable.

Question 9: In your experience, what type of approaches are effective in dealing with children and young people with exceptionally complex needs? To the extent that such approaches are in place in Tasmania, are you able to comment on their success?

When we talk about young people with exceptionally complex mental health challenges, we generally mean presentations with several comorbid diagnoses, parent/caregiver issues such as difficulties experienced by parents (e.g., their own mental health or substance abuse challenges), and the individual has a history of extreme trauma, which may arise from sexual and other abuse as well as other adverse childhood experiences. These presentations may occur concurrently with

dysregulated emotions and behaviours, issues with substance use, variable school engagement and possibly involvement with the youth justice system. It is well recognised that exceptional mental health needs are particularly prevalent in children who are in out of home care.

Young people with these types of exceptional needs require a trauma-informed approach, meaning that both the delivery of specific mental health interventions and broader service practices are informed by an understanding of the far-reaching impacts of trauma on an individual's functioning.

The key principles of a trauma informed approach are comprehensively described by Quadara and Hunter (2016) in their discussion paper for the Royal Commission into Institutional Responses to Child Sexual Abuse, which advocates a systemic change approach reflected at all levels of the service system:

To provide trauma-informed services, all staff of an organisation, from the receptionist to the direct care worker to the board of directors, must understand how violence impacts on the lives of the people being served so that every interaction is consistent with the recovery process and reduces the possibility of re-traumatisation. (Elliot et al., 2005, p 462).

There is currently limited expertise or capacity within CAMHS to deliver this type of approach. CAMHS is developing a specialist mental health service for children in out of home care, as part of the broader CAMHS reform, to address the gap. The Model of Care for this service is yet to be developed, however it is expected to be closely based on Queensland's Evolve Therapeutic Services (ETS) model, with which I am familiar and consider effective for the intended cohort.

Under the ETS model a multidisciplinary team of clinicians work intensively with clients over a relatively long period (often measured in years). Practitioners have low caseloads to facilitate this intensity of work and provide care for the time required. Clinicians also engage in providing psychoeducation and skills development to a range of partners and stakeholders.

CAMHS will be engaging a highly experienced child psychiatrist to the OOHC mental health service, which is expected to increase the capacity of CAMHS Community to deliver trauma informed care more broadly. The recruitment of such specialist staff will provide opportunities for clinicians to work across multiple teams and pursue training and research opportunities as well as help build the capacity of other service providers.

Question 10: Does CAMHS currently have a formal role in providing support to victim-survivors of child sexual abuse (including harmful sexual behaviours), or in the treatment of children who display harmful sexual behaviours? If yes, please explain the nature of that role.

CAMHS does not accept patients based on a consumer's experience of a mental health risk or causal factor. Rather, CAMHS should accept all patients with serious or complex mental health presentations regardless of the factors that are influential in creating that presentation. The consequence of this approach is CAMHS does not have a formal role to provide support to victims-survivors of child sexual abuse. It is not a sexual assault service. It does have a clear role to assess and treat these individuals if referred for this mental health service.

As I have noted in my Review Report (p 52) children who have experienced sexual assault and abuse have not generally been accepted by CAMHS. Numerous stakeholders have been concerned with this position, especially given the absence of an alternative mental health clinical service in Tasmania that meets the needs of this at-risk group.

Similarly, CAMHS has not provided treatment to young persons engaged in sexual offending.

CAMHS is not considered the most appropriate service to provide immediate support to victim-survivors of child sexual abuse.

However, as stated in the CAMHS Review, CAMHS should provide Level 4+ mental health care to children and young people with severe and complex mental health care presentations without exclusion. This includes children and young people from the above categories.

Question 11: Please identify and explain any current barriers to victim-survivors of child sexual abuse (including harmful sexual behaviours), or in the treatment of children who display harmful sexual behaviours, presenting to and/or accessing CAMHS services.

As noted above, CAMHS is not a sexual assault service. It is not appropriate for victims-survivors to access CAMHS for direct immediate support for sexual abuse.

However, it is CAMHS role to provide Level 4+ mental health assessment and treatment for complex and severe presentations, including those arising from sexual abuse. There has historically been a reluctance within CAMHS to recognise the treatment of complex and severe mental health presentations, and specifically those arising from sexual abuse, as part of its core business. This position is probably related to several issues.

Sexual abuse is unfortunately very prevalent, and many clinicians would hold the belief that presentations of young consumers who experienced abuse would overwhelm the capacity of CAMHS. Some CAMHS services have a preference for family therapy as the dominant model of care. This is a barrier given abuse often occurs in families with very complex family structures (e.g., numerous parent separations and re-partnering). Many such families struggle to commit to an ongoing process of change in parenting practices and family dynamics. Some CAMHS clinicians do not possess the skills to undertake the intense trauma-focused practices required.

Some CAMHS clinicians are likely to be sceptical about the potential of these young consumers to effectively use therapy and achieve good outcomes given their beliefs about the amount and severity of emotional damage these young people have suffered.

Question 12: Please explain the intended role and purpose of CAMHS's Children in Out of Home Care Intensive Support team.

CAMHS will develop an intensive, specialist Out Of Home Care (OOHC) Mental Health service as part of the broader CAMHS Reform project. The OOHC Mental Health Service will be a Level V mental health service within a stepped care model.

The service will be dedicated to children in statutory OOHC or who have become involved with the Child Safety System via a substantiated assessment of abuse or neglect. The service is designed to assess and treat children and adolescents with the most extreme mental health presentations in Tasmania.

The service will provide comprehensive psychiatric assessment, crisis management, and age-appropriate therapeutic interventions using assertive engagement strategies provided by a multidisciplinary specialist team with outreach capability.

Interventions will aim to reduce mental health difficulties experienced by the child or young person, improve their social and emotional wellbeing and increase their participation at school and in the community.

The service will also work with families and carers to resolve clinical and practical concerns so that children can be safe, prevent abuse and neglect, reduce mental health difficulties experienced by adults and children, and increase natural social supports. The service will utilise flexible delivery models that are not clinic based to remove barriers to access.

The OOHC Service will be a statewide service, with a statewide leadership and multidisciplinary teams of clinicians operating from sites across the state.

a) The service gap that the work of the team is intended to fill

There is currently no dedicated specialist mental health service for children in OOHC in Tasmania. The development of the intensive OOHC is intended to fill this gap.

Children and young people in OOHC are amongst the most vulnerable group in Tasmania. They experience high rates of developmental and mental health problems, warranting special attention and access to mental health care that is competent in assessing and treating their complex mental health needs.

This group, as a consequence of their experiences prior to entering care, and within the care system, are more likely to have significant child and adolescent mental health needs that are often unrecognised, undiagnosed and consequently untreated. Further, this places them at significantly increased risk of a range of severe mental health disorders in adulthood.

A dedicated mental health service for children in OOHC is considered an essential part of a modern child and adolescent mental health service.

b) Client profile and referral pathways

Client profile

It is envisaged that the OOHC Mental Health Service will be available to children and young people under the age of 18 years with extreme and complex mental health needs, who fall into one of the following categories:

- subject to an interim or finalised *Care and Protection Order* and in OOHC or other care environment; or
- subject of a Substantiated Child Safety Assessment

There may also be scope for the service to accommodate, on a case-by-case basis, children or young people presenting with acute mental health issues that places them at risk of entry into the statutory system and OOHC.

Referral pathways

Given the highly specialised nature of the OOHC service, access will be referral based.

Precise referral pathways are yet to be defined. They will be developed in collaboration with service partners and stakeholders as part of the Model of Care for the service.

It is envisaged that referrals will be assessed by a Referral Panel, with strong input from the Consultant Psychiatrist and Team Leader responsible for the CAMHS OOHC portfolio.

While the exact composition of the panel will be determined as part of the Model of Care, it is expected to have representatives from the Community Paediatrics OOHC clinic, the Department of Education, Child Safety Services, Youth Justice and Tasmania Police.

It is anticipated that the majority of referrals will be from Community Paediatrics and Child Safety Services, although there may be occasions where other agencies and services, including the Department of Education and Tasmania Police, provide referrals.

There may be instances where the panel is able to refer the client to a discrete specialised service e.g. sexual assault service, prior to accepting a case.

The panel may also refer a client to other CAMHS services, i.e., Multisystemic Therapy, when appropriate.

c) Front-end role of the panel

The exact role and functions of the referral panel will be developed as part of the Model of Care.

It is however expected that referral panel will be based on the Evolve Therapeutic Services model operating in Queensland.

d) Key features and benefits of the Evolve Therapeutic Model of Service 2013

Evolve Therapeutic Services (ETS) is a specialist intensive mental health intervention service for children/young people on interim or finalised child protection orders in OOHC. The service is provided by Queensland Health, integrated with and managed by Child and Youth Mental Health Services (CYMHS). ETS provides interventions for individuals with severe and complex mental health support needs.

The ETS model of model of care specifically notes that there are therapy and service influences which create the need for lower clinician caseloads, compared to a community CAMHS team. Some considerations include the outreach and travel requirements, multiple partners and collaborators, support needed across education and often judicial systems, physical health issues of the consumer, and documentation requirements. It is also acknowledged that clients of ETS often require more intensive work than CAMHS consumers.

e) Expected annual caseloads and period of engagement with clients

Annual caseloads

The intensive treatment to be provided by the OOHC service necessitates lower clinician caseloads compared to other CAMHS services, see 12(d).

It is expected clinician caseloads will be capped at **8-10 cases** to balance the intensive nature of the model.

Working on the assumption that the OOHC service will engage 14.0 FTE clinicians across the state (in addition to dedicated psychiatric resources) it is estimated that the annual caseload for the statewide service will be approximately 100-140 cases per year.

Period of engagement with clients

The service will provide consumers with highly intensive therapeutic support, delivered on average at least twice a week over a medium to long term period of up to two years.

There will be scope for clients to transition to CAMHS Community or other services allowing when and where appropriate.

f) Measures of success, including in relation to clients who have experienced sexual abuse (including harmful sexualised behaviours) or display harmful sexual behaviours

High level outcomes and outcome measures of the OOHC Mental Health Service are highlighted below. These do not include specific symptom or illness-related measures for clients who have experienced sexual abuse or display harmful sexual behaviours. More detailed KPIs / measures of success will be developed as part of the Model of Care.

Outcomes

- Improved access to mental health care for target consumers (children and young people in or at risk of OOHC with complex and challenging mental health needs)
- Improved quality of mental health care assessment and treatment for target consumers
- Increased integration of mental and physical health care for child and young people at risk of OOHC
- Improved collaboration between the OOHC Service and Child Safety Services
- Improved stability of OOHC placements
- Decreased inter-generational transmission of abuse

Outcome measures

- Engagement of a statewide multidisciplinary mental health workforce dedicated to children and young people
- Target consumers in all parts of the state have access to appropriate psychological and psychiatric treatment and interventions
- Increased referrals received from Child Safety
- Reduced number of disrupted OOHC placements due to consumer mental health issues
- Reduced number of children involved with Child Safety entering into OOHC.

g) Current status and expected timeframes for implementation

Leadership positions to establish the OOHC service have been created, with the recruitment process expected to commence in April 2022.

A first stage of preliminary consultations to inform service delivery has been undertaken with key stakeholders and service partners.

A discussion paper (draft Models of Care) for the new service stream is currently being drafted for consultation with service partners and key stakeholders via working groups/consultation forums.

The process will be undertaken during April to September 2022 with the view to test the Models of Care in the second half of 2022.

It is anticipated that the Models of Care will be finalised and a pilot service in operation by Oct-Dec 2022.

h) anticipated barriers and challenges to implementation and suggestions as to how these might be overcome

Recruitment

The key anticipated challenge to implementation is recruitment of suitably qualified mental health clinicians in the current labour where demand for mental health workers outweighs supply.

To address this challenge CAMHS has embarked on an aggressive recruitment campaign, casting the net locally, nationally and internationally.

A key pillar of CAMHS' broader recruitment strategy is the establishment of a Centre for Excellence in partnership with the University of Tasmania. The Centre will provide increased pathways for mental health training and specialisation, including clinical placement rotations for Allied Health and Nursing students who wish to undertake a career in CAMHS. This is likely to be the most comprehensive CAMHS training in Australia.

The Centre would also be advanced as a way of attracting new staff to Tasmania given the vision of being a leading centre of excellence in the field of mental health service delivery.

Limited intake capacity

Given the high level of specialisation of this service, intake will necessarily be limited to allow for intensive long-term treatment. There is a risk that demand for the service will outweigh intake capacity.

However, the referral system for this service will help ensure only consumers with the most complex and challenging needs are accepted for this intensive model of treatment.

Urgent case management / intake will be considered by the treating team immediately on a case-by-case basis.

Regular intake meetings will be held to coordinate timely and appropriate service responses to increase both consumer and other stakeholder engagement with the service.

Co-location of the OOHC Mental Health Service, where possible, with other health services, e.g., community paediatrics, will also help to ensure consumers receive timely support.

In addition to the creation of the specialist intensive OOHC service, initiatives will be undertaken as part of the broader CAMHS reform to build the capacity of CAMHS community to treat children and young people in out of home care who may not require Level V specialisation in a stepped are system.

Question 13: Describe the intended role and purpose of CAMHS's Youth Forensic Unit,

A dedicated specialist Youth Forensic Mental Health Service will be created as part of the CAMHS reform for children and young people under the age of 18 years who are involved with or at risk of involvement with the youth justice system.

This new service will offer specialist mental health assessment, treatment and support at multiple stages of a young person's journey via a number of avenues.

The service will have three key elements:

i. Multisystemic Therapy Program - a specialised program operated under registered license conditions.
ii. Youth forensic consultation and liaison service and statutory functions (e.g., S105 of the Youth Justice Act 1997).
iii. In reach assessment and treatment for youth in or exiting youth detention.

Collectively these elements will be delivered by a multi-disciplinary team to provide a highly specialised service. If a child or young person involved in the youth justice system does not require this specialist service, they will have equal and appropriate access to other CAMHS services as and when they require.

a) The service gap that the work of the unit is intended to fill

There is currently no dedicated youth forensic mental health service in Tasmania. Although there is some limited interface between youth justice and CAMHS, there have traditionally been many barriers to accessing mental health service for young people involved in the youth justice system.

There is also a lack of programs aimed at preventing entry into the youth justice system for children and young people who are already displaying severe antisocial behaviour.

Youth justice-involved young people who have significant and complex mental health needs and are involved in the justice system are a highly vulnerable group. Among this cohort, mental health challenges commonly co-occur with other complex health and social problems necessitating a coordinated, multi-disciplinary response.

b) Client profile and referral pathways

The Youth Forensic Mental Health Service will target two client groups:

- Young persons with antisocial/offending behaviours referred into the MST® Program
- Young persons in youth detention.

Client profile for the MST® Program:

Generally, this cohort is at the lower end of the offending spectrum and participation in the MST program is to prevent their entry into the Youth Justice System. The program may also be suitable for young people exiting detention, or who are serving a non-custodial sentence.

The target population comprised young people between 12 – 16 years of age (and potentially some 10-11- or 17-year-olds considered on a case-by-case basis) who have been engaged in serious anti-social and/or delinquent behaviour for a period of at least 12 months, which places them at risk of the following consequences:

- disengagement from education
- involvement with the court
- juvenile detention
- placement in OOHC (to a lesser extent)

Anti-social/delinquent behaviours will include:

- Theft and other criminal behaviours
- Aggressive/violent/assaultive behaviour (but excluding sexual offending as the main offending type)
- Substance abuse
- Selling prohibited substances
- Chronic school absences or problem behaviours at school

The target cohort people might present with diagnoses including, but not limited to:

- Conduct Disorder
- Oppositional Defiant Disorder
- Substance Use Disorders,
- ADHD.

Young people might also present with co-occurring needs in conjunction with anti-social behaviours e.g., trauma-related symptoms, depression, anxiety, mild or moderate intellectual disability and/or autism spectrum disorder level 1 /childhood autism based on mild difficulties. Formal diagnosis will not be a precondition to entry into the program.

The MST Program is not intended for juveniles engaged in sexual offending (where sex offending occurs in the absence of other delinquent or antisocial behaviour).

Referral pathways

All intake into the Youth Forensic Mental Health Service will be referral based. The referral process will be developed as part of the Models of Care for this service, in consultation with the Youth Forensic Mental Health Service Working Group.

Referral to the MST® Program

Access to the MST program will be through a referral system that meets the registered MST license conditions. An MST referral form is available, and the Project Team will work with the MST Network Provider to refine this for a specifically Tasmanian context.

It is envisaged that referrals will be accepted from stakeholders including:

- Youth Justice Services
- Department of Education
- Tasmania Police
- CAMHS Community Team

It is proposed that referrals will be assessed by an MST Panel. While the composition of the panel is yet to be determined it is likely to include representatives from Tasmania Police, Youth Justice, Child Safety, CAMHS and the Forensic Youth Mental Health Service Psychiatrist and Team Leader (Program Manager).

c) Key features and benefit of Multisystemic Theory as well as any challenges and/or limitations

MST is an intensive community and family-based service, premised on voluntary participation, that addresses the multiple influences that contribute to serious antisocial or illegal behaviour

in youth between the ages of 12 – 16 years old who are experiencing severe and complex (externalizing) mental health problems.

MST addresses the multiple factors known to be related to juvenile delinquency across the key systems within which youth are embedded i.e., family, school, community, peer group etc., to promote behavioural change in the youth's natural environment.

The ultimate goal of MST is to:

- empower parents to develop the skills and resources they need to address challenges that arise in raising children and adolescents; and,
- empower young people to cope with family peer school and neighbourhood problems.

In MST the therapist (MST Practitioner) is responsible for removing barriers to service accessibility and for achieving outcomes with every case. Clinicians deliver services in the family's home at a time convenient to the family (often evenings) and the family has access to the service 24 hours a day, 7 days a week.

The long-term effectiveness of the program has been proven through robust scientific research.

Limitations

As a voluntary program, MST is limited to client families who consent to take part in the program. Under the MST model clinicians do not work with children and young people without family / carer participation. However, once a family has consent to the program there is a very strong onus on MST clinicians to foster maximum family / carer engagement.

Importantly, other CAMHS services, including the OOHC service and the Youth Mental health Service (both of which are to be developed as part of the CAMHS Reform) will be accessible to clients with complex mental health needs who do not have a primary carer or where there is a lack of family engagement.

Referrals to MST are not appropriate for young people whose main problem behaviour is sexual offending or harmful / inappropriate sexual behaviour. Referrals may however be appropriate where low level inappropriate sexual is one of multiple other problem behaviours such as substance abuse, truancy and non-sexual offending.

Young people who have experienced sexual abuse and / or display harmful sexual behaviour will be able to access other more suitable CAMHS services, including the OOHC service described in Section 12 above.

d) Expected annual caseloads and period of engagement with clients

MST

Under the MST model clinicians work intensively with families for 3-5 months.

Each clinician has a caseload of 4 – 6 families.

It is expected that, on average, each clinician will work with approximately 12 families a year.

It is intended that as part of the MST program 12 x MST clinicians will be engaged across the state, as well as 3 x MST supervisors who would have a small caseload of 1 – 2 families.

This would mean that the average annual caseload for the MST program statewide 150 – 160 families annually.

In reach service

The expected annual caseload and period of engagement for clinicians working in the forensic service but not in the MST program will be determined as part of the Model of Care.

However, it is expected that all young people in youth detention and exiting detention will have access intensive wrap-around therapeutic support.

e) Measures of success including in relation to clients who have experienced child sexual abuse, (including harmful sexual behaviours) or display harmful sexual behaviours).

Specific KPI/measures of success for the Youth Forensic Service will be developed in consultation with stakeholders as part of the Model of Service.

It is not known at this stage if there will be specific KPI / measures of success in relation to clients who have experienced child sexual abuse, (including harmful sexual behaviours) or display harmful sexual behaviours).

MST

The MST program is not intended to apply to young people who have experienced complex trauma arising from abuse. This cohort would be more appropriately treated by the OOHC service described above.

The MST program is also not intended to apply to young people whose sole problem behaviour is harmful sexual behaviour.

Overarching MST program outcomes, as required under MST license conditions, are:

- Elimination or significant reduction in the frequency and severity of the youth's referral behaviour(s);
- Parents empowered with the skills and resources needed to independently address the inevitable difficulties that arise in raising children and adolescents, and to empower youth to cope with family, peer, school, and neighbourhood problems.

Case specific goals or measures of success are determined by each family participating in the program.

These might include for example, a reduction in the number of days the young person is absent from school, or an increase in the number of days that the young person refrains from substance (measured objectively e.g., by urinalysis tests, breath scans, etc.).

f) Role in relation to clients who enter the Youth Justice System

The Youth Forensic Service provides in reach assessment and treatment for youth who enter the youth justice system and who have complex and challenging mental health needs.

Assessment services will include whether the young person has a mental health condition, the appropriate mental health treatment required, and input into risk management and treatment planning and offence specific interventions. The service will also provide and broker support for youth in and exiting youth detention.

It is envisaged that there will also be strong integration between the Youth Forensic Mental Health Service and the Out of Home Care Mental Health Service and the Youth Mental Health Service.

g) Current Status and expected timeframe for implementation

Leadership positions to establish the Youth Forensic Mental Health Service have been created, with the recruitment process set to start in April 2022.

A first stage of preliminary consultations to inform service delivery has been undertaken with key stakeholders and service partners.

Extensive preparatory work, including a feasibility assessment, has been undertaken to ensure the pre-conditions are in place to implement an MST Program in Tasmania.

Contract negotiations are underway to engage the Australasian Network Provider for MST Services (Life Without Barriers) to deliver program training and support, as required under MST licence conditions. The program itself would be delivered by CAMHS not LWB.

A discussion paper (draft Model of Care) for the Youth Forensic Mental Health Service is currently being drafted for consultation with service partners and key stakeholders via working groups/consultation forums.

The process will be undertaken during April to September 2022 with the view to test the Model of Care in the second half of 2022.

It is anticipated that the Model of Care will be finalised and a pilot service in operation by Oct-Dec 2022.

h) Anticipated barriers and challenges to implementation and suggestions as to how these might be overcome

Recruitment of suitably qualified staff is expected to be a key challenge. This is discussed in more detail under Section 12 h) above.

Question 14: CAMHS Review

a) Structure of CAMHS

The CAMHS Review recommended (Rec. 1) the integration of the three separate CAMHS teams (South, North and North West) into a single coordinated statewide CAMHS Service, with a statewide leadership and management structure. The review also calls for a reformed structure that supports service enhancement.

A Statewide CAMHS Group Director, Ms Dominica Kelly, was appointed in December 2021 to lead the integration process progress and develop consistent statewide service streams aimed at supporting more efficient, contemporary, evidenced based mental health care for children and young people.

b) Provision of service to children and adolescents with severe and complex needs

The Review explicitly considered whether CAMHS in Tasmania accepted the most complex and severe mental health presentations.

It was presented with consistent feedback from stakeholders that CAMHS did not see its service model as effectively impacting consumers with these presentations.

Many stakeholders stated that they had in fact ceased referring their most difficult consumers to CAMHS as a result of either CAMHS not accepting these referrals or considering their service was unable to assist these young people.

The Review found that the current period of mental health reform in Tasmania is an opportunity for CAMHS to adopt the changing conceptualisation of what comprises the core business of a state funded Level 4/Specialist Care CAMH service. It further found that in order to positively impact the lives of young Tasmanians with the most complex and challenging mental health presentations, CAMHS should acknowledge that those with severe and complex challenges are its core business.

The Review explicitly recommends (Rec. 2) that CAMHS realign its Model of Service to better reflect the Australian National Mental Health Strategy, including, specifically, a focus on severe and complex mental illness.

It further calls for the funding and development of a range of new services with a focus on severe and complex presentations. These include a mental health service for children in OOHC and Youth Forensic Mental Health Service – discussed respectively in Sections 12 and 13 above.

c) Implication for service provisions for victim-survivors of child sexual abuse (including harmful sexual behaviours) or for children displaying harmful sexual behaviours

In line with Recommendation 2, the CAMHS Review calls for a re-consideration of CAMHS' core business including specifically in relation to complex and severe mental health presentations in young people who have experienced sexual, physical and emotional abuse, and/or emotional neglect.

It further notes the need to provide interventions for trauma-related mental health diagnoses such as reactive attachment disorder (RAD), Complex PTSD, emerging personality disorder or related complex challenging dysregulation and behaviour experienced by these individuals.

CAMHS is not considered the most appropriate immediate service for victim-survivors of child sexual abuse. This role more appropriately falls to Child Safety Services and dedicated sexual assault support services. However, it is the role of CAMHS is to provide mental health care to victims-survivors who develop complex and severe mental health issues.

The Statewide CAMHS Group Director and Specialist Director are currently working with the CAMHS Clinical Leadership Group (Psychiatrists, Team Leaders, and Clinical Leaders) to develop consistent statewide service reforms. This includes the development of a CAMHS vision and mission statement that acknowledges CAMHS' role as a specialist Level 4+ service, and the development of consistent intake, referral, and assessment processes to ensure young people with complex and severe mental health needs, including victims-survivors of sexual assault or who display harmful sexual behaviours, can access timely and appropriate treatment.

References

Question 2:

Garcia A, Gupta M, Greeson J et al. (2017) Adverse childhood experiences among youth reported to child welfare: Results from the national survey of child & adolescent wellbeing. Child Abuse and Neglect Vol 70 August 2017, 292-302.

Phelps J, Lethbridge R, Brennan S et al. The Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder and Complex PTSD. Updates in 3rd Edition (2022). First published in Australian and New Zealand Journal of Psychiatry August 27, 2011.

Cashmore J, Shackel R. (2013) The Long-term Effects of Child Sexual Abuse. Child Family Community Australia Paper No. 11 2013.

Kendler, K, Bulik, C, Silberg J, et al. (2001) Childhood sexual abuse and adult psychiatric and substance use disorders in women: An epidemiological and cotwin control analysis. Archives of General Psychiatry 57(10), 953–959.

Dinwiddie S, Heath A, Dunne, M. et al. (2000) Early sexual abuse and lifetime psychopathology: A co-twin-control study. Psychological Medicine 30(1), 41–52.

Canton-Cortes D, Canton J, (2010) Coping with child sexual abuse among college students and post-traumatic stress disorder: the role of continuity of abuse and relationship with the perpetrator. Child Abuse and Neglect 2010 Jul. 34(7) 496-506.

O'Leary P, Gould N.(2009) Men Who Were Sexually Abused in Childhood and Subsequent Suicidal Ideation: Community Comparison, Explanations and Practice Implications. The British Journal of Social Work, Volume 39, Issue 5 950–968.

Ullman S, Townsend S, Filipas H. (2007) Structural models of the relations of assault severity, social support, avoidance coping, self-blame, and PTSD among sexual assault survivors. Psychology of Women Quarterly 31(1), 23–37.

Bendall S, Alvarez-Jiminez M, Hulbert C. (2012) Childhood trauma increases the risk of post-traumatic stress disorder in response to first-episode psychosis. Australian and New Zealand Journal of Psychiatry Jan 1, 2012.

Lataster T, van Os J, Drukker M et al. (2006) Childhood victimisation and developmental expression of non-clinical delusional ideation and hallucinatory experiences: Victimisation and non-clinical Psychotic experiences. Social Psychiatry and Psychiatric Epidemiology 41(6), 423–428

Wurr C, Partridge I, M. (1996) The prevalence of a history of childhood sexual abuse in an acute adult inpatient population. Child Abuse & Neglect 20(9), 867–872.

Cutajar M, Mullen P, Ogloff J et al (2010a) Psychopathology in a large cohort of sexually abused children followed up to 43 years. Child Abuse & Neglect, 34(11), 813–822.

Dube S, Anda R, Whitefield C, et al. (2005) Long-term consequences of childhood sexual abuse by gender of victim. American Journal of Preventive Medicine, 28(5), 430–438.

Fergusson D, Boden J, Horwood, L. (2008) Exposure to childhood sexual and physical abuse and adjustment in early adulthood. Child Abuse & Neglect, 32, 607–619.

Molnar B, Buka S, Kessler R. (2001) Child sexual abuse and subsequent psychopathology: Results from the national comorbidity survey. American Journal of Public Health, 91(5), 753–760.

Adverse Childhood Experiences (ACE)

Chapman D, Dube S, Anda, A (2007) Adverse Childhood Events as Risk Factors ofr Negative Health Outcomes. Psychiatric Annals. 2007; 37 (5).

Biological Factors

Tozzi Q, Corcoran L, Cannon D. et al (2020) The Impact of Childhood Trauma on Developing Bipolar Disorder: Current Understanding and Ensuring Continued Progress. Neuropsychiatric Disease and Treatment Dec 14, 2020, 16: 3095-3115.

De Brito S, Diving, E, Sebastian C. et al. (2013) Reduced orbitofrontal and temporal grey matter in a community sample of maltreated children. The Journal of Child Psychology and Psychiatry 2013 Jan 54(1):105-12.

Reynolds S, Carrey N, Jaworska N, et al. (2014). Cortical thickness of youth with major depressive disorder. BMC Psychiatry 14, 83.

Bick, J, Zhu, T Stamoulis, C. Effect of Early Institutionalization and Foster Care on Long-term White Matter Development: A Randomized Clinical Trial. (2015) JAMA Paediatrics 1693; 211-219.

Tomoda A, Suzuki H, Rabi K et al. (2009) Reduced prefrontal cortical grey matter volume in young adults exposed to harsh corporal punishment. Neuroimage 2009 Aug 1 47 T66-71.

Sheffield J, Williams L, Woodward D et al. (2013) Reduced grey matter volume in psychotic disorder patients with a history of childhood sexual abuse. Schizophrenia Research. 2013 Jan 1; 143(1) 185-91.

Rinne-Albers Mirjam A., Boateng C, van der Werff S, et al. (2020) Preserved cortical thickness, surface area and volume in adolescents with PTSD after childhood sexual abuse. Scientific Reports 10.1 (2020): 1-9.

Puetz V, Parker D, Kohn N, et al. (2017) Altered brain network integrity after childhood maltreatment: A structural connectomic DTI-study. Human brain mapping. 2017 Feb 38(2): 855-68.

Caspi A, Hariri AR, Uher R, Mpffitt TE. Genetic sensitivity to the environment: The case of the serotonin transporter gene and its implications for studying complex diseases and traits. American Journal of Psychiatry, 2010, 167:509-527.

Hart H, Lim L, Mehta M, et al. (2017) Reduced functional connectivity of fronto-parietal sustained attention networks in severe childhood abuse. PLoS one. 2017 Nov 30;12(11) e0188744.

Fujisawa T, Nishitani S, Takiguchi S, et al. (2019) Oxytocin receptor DNA methylation and alterations of brain volumes in maltreated children. Neuropsychopharmacology. 2019 Nov 44(12) 2045-53.

Smearman E, Almli L, Conneely K, et al. (2016) Oxytocin receptor genetic and epigenetic variations: association with child abuse and adult psychiatric symptoms. Child development. 2016 Jan 87(1) 122-34.

Cicchetti D, Hetzel S, Rogosch et al. (2016) An investigation of child maltreatment and epigenetic mechanisms of mental and physical health risk. Development and psychopathology. 2016 Nov 28(4pt2)1305-17.

Currie J, Spatz Widom, C. (2010) Long-Term Consequences of Child Abuse and Neglect on Adult Economic Well-Being. Child Maltreatment. April 20, 2010.

Lansford A, Dodge K, Petit, G et al. (2002) 12-year prospective study of the long-term effects of early child physical maltreatment on psychological, behavioural, and academic problems in adolescence Archives of Paediatric and Adolescent Medicine 2002 Aug 15 6(8); 824-30.

Centres for Disease Control and Prevention (2019) Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence. Atlanta, GA: National Centre for Injury Prevention and Control, Centres for Disease Control and Prevention.

Question 3

Cobham, V McDermott B. (2014) Perceived Parenting Change and Child Posttraumatic Stress Following a Natural Disaster. Journal of Child and Adolescent Psychopharmacology 24(1)

Phelps A, Lethbridge R, Jones, K et al. (2022) Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder and Complex PTSD Melbourne: Phoenix Australia.

Question 4:

Mitchell J, Tucci J, Fernandes, C. (2020) Practice Guide: Responding to young people living in out of home care who engage in harmful sexual behaviour. Centre for Excellence in Therapeutic Care: Sydney.

Creeden K. (2017) How Neuroscience Can Inform Our Understanding of Sexually Harmful Behaviour by Youth. In B Schwatrz (Ed). Handbook on Youth Who Engage in Sexually Abusive Behaviour. New Jersey: Civic Research Institute.

McPherson L, Fernandes C, Gatwiri K et al. (2019) Working with young people with harmful sexual behaviour – Research Briefing. Sydney: Centre for Excellence in Therapeutic Care

Caspi A, Sugden K, Moffitt T et al. (2003) Influence of life stress on depression: moderation by a polymorphism in the 5-HTT gene. Science. 2003 Jul 18; 301(5631) 386-9.

Question 6:

Royal Commission into Institutional Responses to Child Sexual Abuse 2017 Final Report Understanding child abuse in institutionalised settings, Volume 2 (Nature and Causes)

Mitchell J, Tucci J, Fernandes, C. (2020) Practice Guide: Responding to young people living in out of home care who engage in harmful sexual behaviour. Centre for Excellence in Therapeutic Care: Sydney

Hallett S, Deerfield K, Hudson K (2019) The Same but Different? Exploring the Links between Gender, Trauma, Sexual Exploitation and Harmful Sexual Behaviours Child Abuse Review 28(6):442-454.

Question 7:

McDermott BM. Child and Adolescent Mental Health Services Review – Commissioned by the Department of Health, Tasmania, November 2020

CAMHS website at: Child and Adolescent Mental Health Service | Tasmanian Department of Health

Question 8:

McDermott BM. Child and Adolescent Mental Health Services Review – Commissioned by the Department of Health, Tasmania, November 2020.

Australian Health Ministers Advisory Council. A national framework for recovery-oriented mental health services; policy and theory. Canberra, Commonwealth of Australia 2013.

National Mental Health Plans. Access from Australian Government Department of Health website at: What we're doing about mental health | Australian Government Department of Health

Linehan, M. (2022) Dialectic Behaviour Therapy in a Nutshell. The California Psychologist, 2022: 1-3.

Clark S, Emberley D, Gardner W. Improving Access to Child and Adolescent Mental Health Care: The Choice and Partnership Approach. Canadian Academy of Child and Adolescent Psychiatry, 2018; 27(1) 5-14.

Question 9:

Quadara, A, Hunter C. (2016) Principles of Trauma-informed approaches to child sexual abuse: A discussion paper, Royal Commission into Institutional Responses to Child Sexual Abuse, Sydney.

Elliot D, Bjelajac P, Fallot R. et al. (2005). Trauma-informed or traumadenied: Principles and implementation of trauma-informed services for women. Journal of Community Psychology, 33(4), 461–77.

Evolve Therapeutic Services Model of Service. Queensland Public Mental Health Services, 2013.

Question 10:

McDermott BM. Child and Adolescent Mental Health Services Review – Commissioned by the Department of Health, Tasmania, November 2020

Question 12:

Evolve Therapeutic Services Model of Service. Queensland Public Mental Health Services, 2013