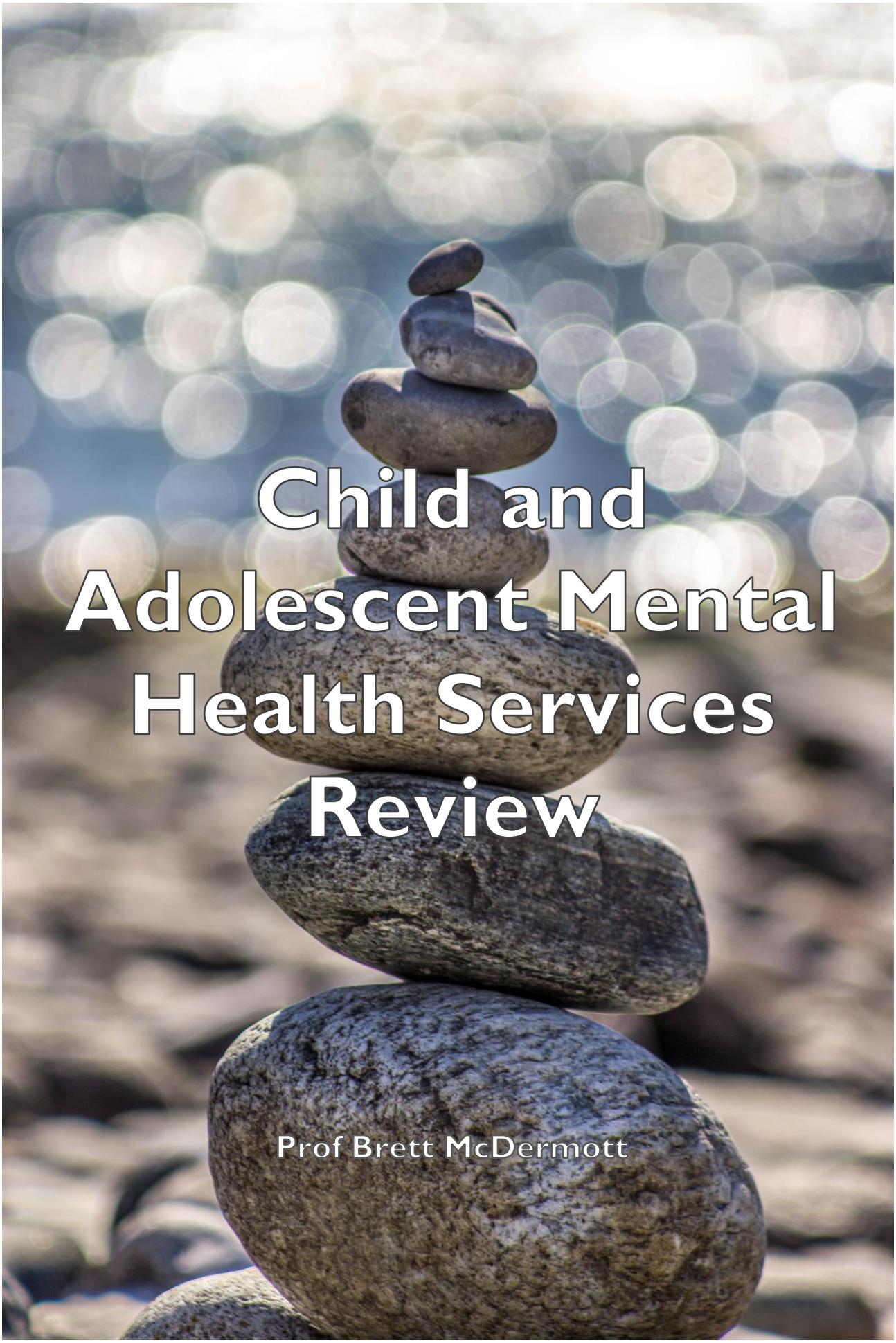

Child and Adolescent Mental Health Services Review

Prof Brett McDermott

Acknowledgements

The author acknowledges and pays his respects to the Palawa people of Lutruwita, the custodians of the lands covered by the services mentioned in this report.

Further, he acknowledges that health and other service providers must continue to focus on closing the gap between the psychosocial, educational and justice outcomes of indigenous and non-indigenous people.

This review included over 100 interviews of more than 40 individuals. It is with much thanks that they all donated their time to participate in the review. Special thanks to the team leaders and consultants of the three child and adolescent mental health teams who provided crucial information on numerous occasions.

I would also like to thank individuals from a range of government agencies, non-government organisations (NGOs), medical and allied health practitioners who all participated in the interests of providing the best possible services for children and adolescents and their families.

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Professor McDermott was a Director of Beyond Blue the Australian National Depression Initiative (2006-2016) and Chair, NHMRC-Beyond Blue Youth Depression Clinical Practice Guidelines Working Group.

His International appointments include; visiting Professorships in Malaysia and China (Shanxi University, Shanxi Medical University and Taiyuan Hospital) and a By-Fellow at Churchill College, Cambridge University, UK.

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Foreword

I am very pleased to provide the final version of the Child and Adolescent Mental Health Services (CAMHS) Review on behalf of the Department of Health. The completion of this review marks an important milestone in mental health reform in Tasmania and demonstrates a clear commitment to proceed with implementing a new state-wide CAMHS service that is more contemporary, and most importantly, more responsive to the needs of vulnerable young Tasmanians and their care givers.

The first version of this report was used to support consultation sessions with key stakeholders on the 28th of August. The four sessions held, covered the key recommendations of the report and proposed actions that could form part of a government response. In the following three weeks, stakeholders were given an opportunity to provide feedback, both on the report and the actions to be considered by government.

Nearly forty responses were received from individuals and organisations including the Commissioner for Children and Young People, CAMHS staff, paediatricians, child safety, Department of education, professional bodies, community sector organisations and medical and allied health practitioners. The feedback found that there was collective support of the main review findings and recommendations, with overwhelmingly positive feedback received. This final version now addresses the feedback received as well as providing it in a summary form at Appendix 1.

This final report contains the same seven key recommendations, they are unchanged. When implemented, will shape the process of integrating CAMHS services across inpatient and community settings. At the forefront of these recommendations is the establishment of a suite of new services designed to deliver a more responsive CAMHS, better tailored to the needs of children and young people, their families and carers.

The recommendations also aim to address historical issues and barriers to care faced by children and young persons such as difficulties experienced at key transition points (e.g. child to adult services or between forensic services and mental health).The recommendations include significant structural, practice and cultural changes underpinned by a range of workforce development and governance initiatives.

I would like to take this opportunity to thank the range of stakeholders that have provided input into this document. I would also like to personally acknowledge the dedication and commitment of the CAMHS teams in the difference they make to young Tasmanians accessing their services, despite the challenges they face working in an environment where current resourcing does not match the demand for services.

It is important to reiterate that this report is not reflective on individual CAMHS staff, but a reflection of an extremely complex system that needs significant change to better align with the broader mental health reform directions already underway in Tasmania, and new and emerging best practice. Finally, I would like to thank Prof McDermott for this important report.

Dr Aaron Groves
Chief Psychiatrist

06 November 2020

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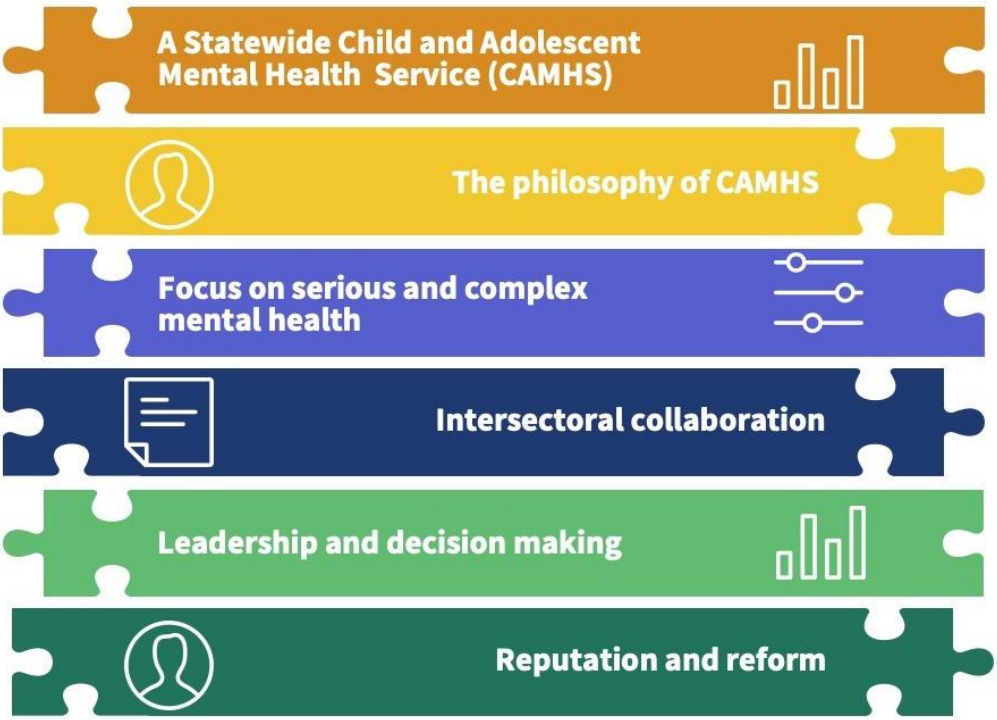
Executive Summary



There can be little doubt that child and adolescent mental health (CAMH) is one of the most complex areas of any health care undertaking. CAMH has a very large interface with paediatrics and general practice, and a burden of service provision for the CAMH population is placed on accident and emergency services. CAMH intersects with service providers in education and child protection, as well as areas with complex determinants, such as juvenile justice. Finally, CAMH interfaces with non-government organisations, such as those funded by the National Disability Insurance Scheme (NDIS), headspace, other youth organisations, and the residential care sector, among others. Children and adolescents who have mental health presentations may be involved in one or many of these organisations.

Infant and pre-school children are often seen in Child and Adolescent Mental Health Services (CAMHS). The intellectual and economic argument to provide state government funding for children in the first 1000 days of life is now very well-established. Such investment optimises brain development (and therefore intellectual functioning), ensures secure attachment behaviour, prevents much later adversity and concomitant service use.

CAMHS in almost all jurisdictions has struggled to meet the burden of CAMH presentations with the funding available. The reasons are clear and include strong policy and societal pressure to fund treatment of adults with severe psychosis, major depression and bipolar disorders. Extremely competent advocacy in Australia has done much to rectify funding and service gaps in the youth mental health area. However, this has not been followed up by similar investment in the earlier years.

Tasmanian CAMHS is in the enviable position of having well trained and dedicated staff. Further, whilst the current CAMHS leadership clearly acknowledge service gaps, there is a strong desire to meet the needs of a broader group of children and adolescents.

This review provides an opportunity to reflect on the current range of services, the current model of care and potential areas where CAMHS and the broader mental health leadership can make further reform. The benefits of reform are clear and include providing CAMHS expertise to a broader range of service providers, thereby improving consumers[1] outcomes. For clinicians, reform can be very challenging. Reform can also be an exciting time; to reflect on strengths and what works well, and the pleasure of innovating to solve problems. A clear additional benefit of the latter is an opportunity to collaborate with colleagues from other service settings who may hold different perspectives, but who are also attempting to improve the lives of the same consumers as those seen by CAMHS.

This review was undertaken within the framework of the relevant Tasmanian and National mental health strategies, which provide high level direction for mental health services as well as specific guidance on aspects of service delivery (e.g. service philosophy such as recovery orientation and service structure such as stepped-care approaches). The review uses the existing strategies to outline the current CAMHS model of care, as well as extensive consultation with the leaders of the three Tasmanian CAMHS teams. The review considers the views of relevant stakeholders as they pertain to the overall services as well as areas of interest such as high-risk consumer groups. The review concludes with recommended service enhancements to meet the gaps identified by review participants and the review author. What follows in this Chapter are some major themes identified during the review.

State-wide CAMHS service

The analysis of policies, procedures and business rules found that in many areas, (even something as fundamental clinical assessments), each CAMHS team has their own way of doing business. CAMHS-wide initiatives, resource sharing and collective problem-solving would greatly improve the child and adolescent experience. From a data perspective there are large differences in the numbers of people seen and the relative focus on clinical groups or diagnoses. There is the option to do nothing and to continue with this status quo. However, the arguments for a state-wide CAMHS service are compelling, and would:

- lead to one voice within mental health to advocate for CAMHS,
- lead to one specific set of policies and procedures, which in turn would be more understandable to consumers, potential referrers, relevant organisations and new staff, facilitate service enhancements,
- facilitate movement of clinicians between teams,
- allow for more understandable, usable, and comparable service-related data,

[1]Consumers: This document uses the term consumers to refer to children and adolescents accessing mental health services. It is recognised that in keeping with the language of recovery, consumers are now often referred to as people with lived experience or expertise and as appropriate the term is also meant in this context.

- create a state-wide approach to recruitment and staffing,
- assist other organisations who wish to interact with CAMHS (e.g. education and child protection services) to talk to one organisation rather than three smaller teams,
- create a critical mass of clinicians which would allow a richer training and education program as well as enable greater innovation, research and development.

The philosophical approach of CAMHS in Tasmania

Research commissioned by an extensive range of organisations providing services to specific groups of children and adolescents consistently find high rates of mental health challenges within their group of interest. For example, research on 'looked after children' or children in out-of-home care consistently report high rates of attachment difficulties, challenging behaviour and complex post-traumatic stress disorder (PTSD). In education settings, the mental health difficulties of those experiencing bullying is high; the bullies also o generally have poor mental health. Rates of self-harm in the CAMHS population have increased as have numerous other mental health challenges. Paediatricians struggle with mental health comorbidities in children with physical illness, and NDIS providers frequently seek child and adolescent psychiatric consultation due to the mental health challenges in consumers with disability.

Persistent calls for CAMHS expertise and involvement, in a range of situations, coupled with a sense of limited funding to respond, would naturally lead to clinicians feeling defensive about what they can provide from their service. Some may feel frustrated, devalued, even attacked by a relentless questioning of the current approach. Stakeholders external to CAMHS share these feelings of frustration. External stakeholders often cite the belief that CAMHS are more willing to state which cases they will not see rather than those they will, that is they operate by using exclusion rather than inclusion criteria.

There is an organisational danger to CAMHS that this exclusion focused philosophical position has the potential to lead to reputational damage for the service. This could further lead to the position that CAMHS is not considered part of the solution to contemporary psychosocial problems experienced by children and adolescents, when the reality is that they should be central.

Therefore, it is recommended there is a change in the vision of Tasmanian CAMHS to a service that not only holds the greatest expertise in child and youth mental health but is keen to export this expertise to areas of need. Further, it is a recommendation that CAMHS should collaborate widely, especially in opportunities that involve funding of new initiatives. These recommendations strongly complement the creation of a state-wide CAMHS.

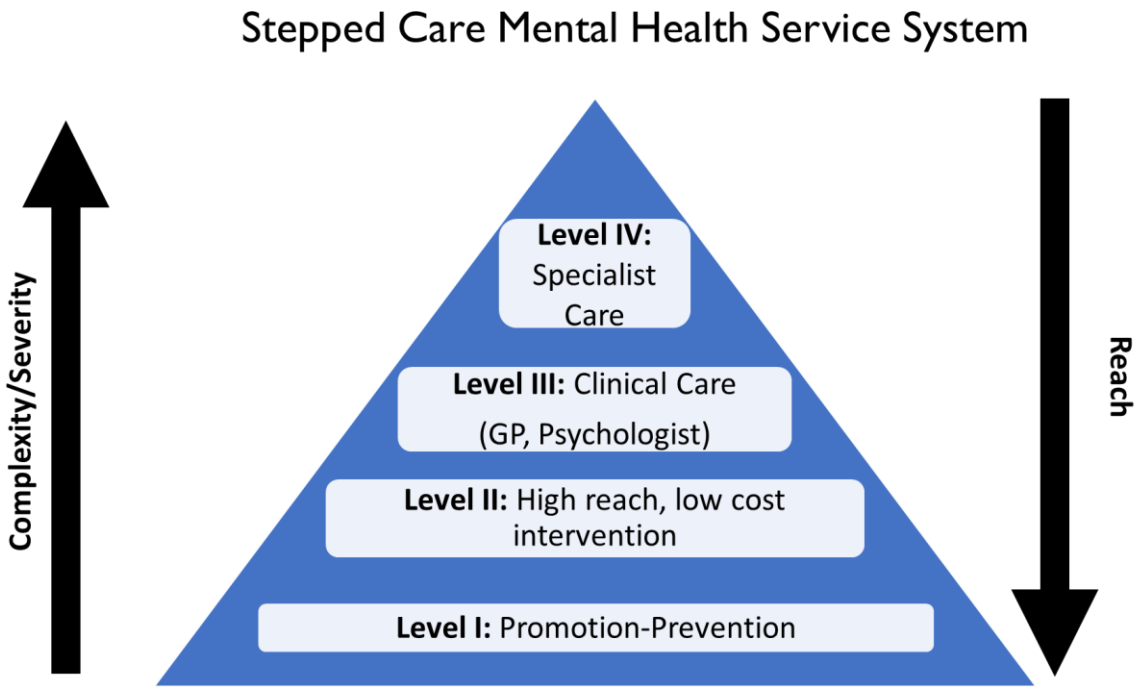
A stepped care service system

It has been increasingly recognised in Australia, that taking a "stepped care approach" to service provision, that defines the various levels of need, based on the best available epidemiological evidence, along with the services required at each level, is a priority national reform. The stepped care approach is depicted in figure 1.3.i.

This approach emphasises vertical integration within mental health services, with levels defined by consumer challenges and need, service reach and cost.

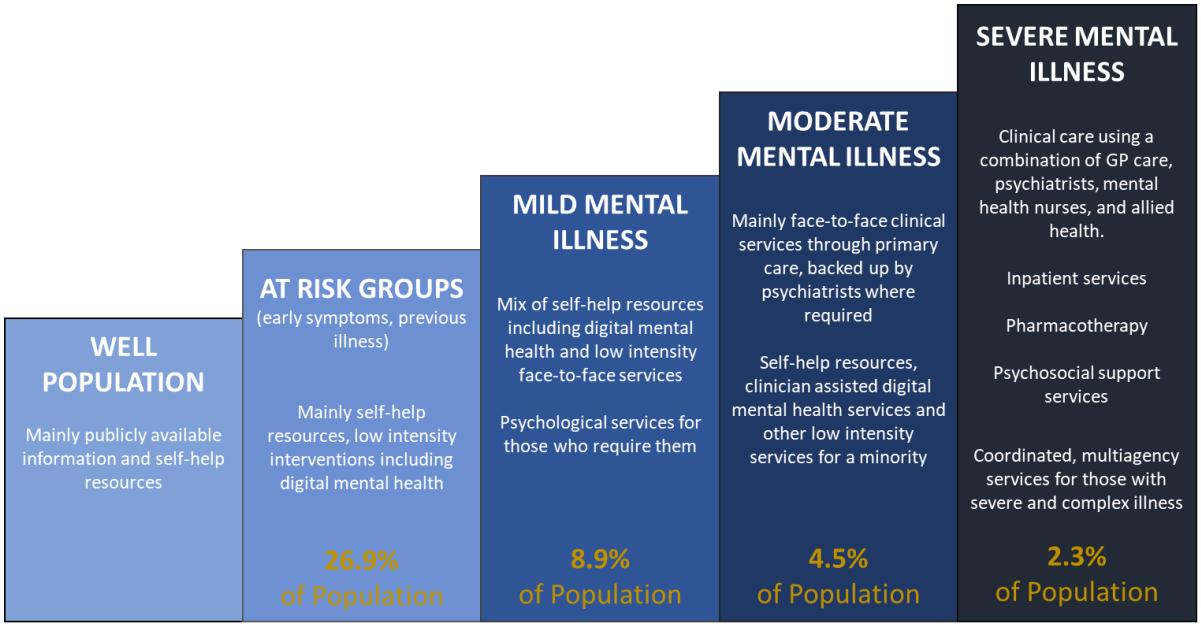
Throughout Australia, this is usually represented by 4 levels of increasing severity and complexity, with the highest-level being level 4. Public mental health services are, by definition, expected to provide Specialist Care referred to as level 4. Consistent with the model, they are expensive by virtue of employing the most highly trained staff, as well as, often providing the service in high cost restrictive settings such as inpatient units. These services are also low reach, seeing fewer patients than general practitioners and community based allied health practitioners. Level 4 services should not generally provide interventions or see patient groups which could be effectively treated in other settings or with other interventions. The stepped care model also incorporates an evidence-based approach. Interventions with an evidence-base should be adopted at all levels of the model, but especially at higher levels where consumers have more complex mental health challenges and use very expensive resources.

Figure 1.3.i: *A stepped care mental health service system*



These levels can also be represented as the proportion of the population at risk. Figure 1.3.ii provides population estimates specific to Tasmania as to the proportion of the child and adolescent population at risk for mental illness as well as the percentage likely to experience mild, moderate, or severe mental illness. It also outlines the care requirements associated with each level. It should be noted that individuals transition between these states and that the population requiring these stepped care interventions is constantly changing.

Figure 1.3.ii: *Stepped care mental health interventions from a population perspective*



Notes: Population percentages were extracted from the National Mental Health Service Planning Framework and modelled specifically to represent the Tasmanian child and adolescent population (0-17 years of age) for the 2019-2020 financial year.

Two questions this review sets out to answer are: 1) whether the current CAMHS model of care is a Level 4 service, and 2) does CAMHS in Tasmania see the most complex and severe presentations?

The challenge of severe and complex mental illness

It was noted above that there has been a major expansion in the acknowledgement by a range of external service providers that the young people using their services have mental health challenges and that the service has a duty of care to meet the needs of their consumers. The form of these mental health challenges is invariably complex and long standing. Rather than individual services seeing a single consistent diagnostic entity, challenges are usually across several diagnoses (e.g. comorbid Attention Deficit Hyperactivity Disorder (ADHD), autism spectrum disorder (ASD), and anxiety). These individuals may also exhibit multiple comorbid factors which further influence health, such as parental mental illness, experience of abuse and/or neglect, educational and/or learning difficulties.

This review was presented with an overwhelmingly consistent opinion by stakeholders that CAMHS did not see their service model effectively impacting these types of presentations. Indeed, many stakeholders stated they had ceased referring their most difficult consumers to CAMHS as a result of CAMHS being unable to assist these young people.

CAMHS is faced with a significant challenge. Research on the disproportionate burden of child and adolescent mental health illness on those in very complex consumer groups is compelling. Non-CAMHS providers and advocacy groups are increasingly aware of service initiatives elsewhere providing a CAMH service directly to these consumer groups (e.g. the Queensland Evolve service, is providing a CAMH service to children under the care of the Department of Child Safety). Further, national systems of care reform such as stepped care approaches clearly place state funded services at the apex (Level 4/Specialist Care), with the intent that they be orientated towards consumers with severe and complex presentations.

This review has found that this current period of mental health reform in Tasmania is an opportunity to adopt the changing conceptualisation of what comprises the core business of a state funded Level 4/Specialist Care CAMH service. The new service vision should embrace a re-orientation towards severe and complex mental illness and should explore funding and partnering opportunities to create new child and adolescent mental health services for highly disadvantaged and challenged consumer groups. This finding also echoes current state and national recommendations surrounding service priorities.

Finally, Action area five of the Government Response to the Mental Health Integration Taskforce Report (2018) specifically outlined the requirement to establish a dedicated state-wide response to people with complex needs, especially those with borderline personality disorder (BPD) (and complex PTSD) as well as those with both intellectual disability and mental illness. This action should also address the needs of children and young people who these types of complex needs. It is important that CAMHS embrace the needs of these people within their service philosophy so that it aligns with adult mental health services models. In addition, the current 5th National Mental Health and Suicide Prevention Plan (2017-2022), has as one of its priorities "Coordinating Treatment and supports for people with severe and complex mental illness". It is fundamental that CAMHS fully identifies its role in implementing this important national reform, within its renewed service vision.

Intersectoral collaboration and the need to be involved in innovative solutions

At the level of service provision and development, stakeholders agreed that a challenge of CAMHS was engaging in strong, determined intersectoral cooperation, generating collective solutions and subsequently developing innovative approaches to practice. Structural barriers to collaboration also exist. For example, as there is no state-wide CAMHS service, external organisations need to interact with three teams rather than one. Because CAMHS funding does not approach the amount required to meet the burden of need, CAMHS do not have an outward looking approach which welcomes collaboration and, in many respects, this is characteristic of many services that are seriously under-resourced. This lack of focus on children and adolescents with complex needs fails to align with the type of challenges other services need help with.

The problems of non-engagement are clear;

- CAMHS will be in danger of ongoing reputational damage,
- some clinicians will be frustrated and leave to other organisations that are seen to be more responsive to clinical need and,
- when funding opportunities do arise, they will not be given to CAMHS.

A natural consequence of this non-engagement is that some NGOs are now responsible for seeing CAMHS clients in a non-clinic setting and for more intense treatment as CAMHS do not have the capacity or resources to provide such care. This creates an administrative barrier between two organisations looking after the one client and prevents the benefits of an expanded CAMHS. As such, many reform recommendations deal with moving towards meaningful collaboration.

There are many advantages of a widely held perception that a service is dynamic, out-looking, flexible, innovative and at the forefront of service delivery, including:

- consumer confidence in the comprehensiveness, capacity and competence of the service to meet their needs,
- consumer confidence their needs will be met in Tasmania, rather than seeking services, or being transferred to services on the mainland,
- stakeholder confidence that CAMHS is the service that will effectively intervene with children and adolescents with the most severe and complex presentations,
- prospective employees will seek employment with Tasmania CAMHS rather than other child and youth options including work with NGOs or in private practice either within Tasmania or on the mainland,
- trainees will decide to undertake a career in the child and youth mental health versus adult mental health or other opportunities,
- policy makers and planners who wish to invest in child and youth mental health will consider the public health service/CAMHS as the obvious funding recipients to get the job done and
- advancing the advocacy role of CAMHS within health and the wider child, youth and family sector.

Clearly the opposite holds if services are not seen to be dynamic, flexible, collaborative and solution focused. Failure to embrace a strong reform philosophy, especially given the extent of reforms underway in the rest of the mental health system in Tasmania will inevitably lead to continued and more concerted criticism, further calls for reviews and erosion of confidence and capacity within the workforce and greater difficulties with recruitment than already exist.

The following chapter enumerates the review recommendations. For ease of reference recommendations are sequentially numbered.

1. Recommendations

1.1 Recommendation 1: One state-wide CAMHS service needs to be created

The leadership of Tasmanian CAMHS

Any reform agenda, including those with service enhancement, requires leadership of and from within CAMHS. The continuation of three small CAMHS teams is not consistent with meaningful reform. In adopting this recommendation, it also proposed that State-wide Mental Health Service (SMHS) and CAMHS leadership should consider:

- A coordinated state-wide CAMHS service be created, with the three current CAMHS teams reporting to a CAMHS Manager and Director. This would require the creation of a CAMHS Manager position and the funding of a state-wide CAMHS Director position, that in turn report to the Executive Director of SMHS.
- A new leadership structure is created, with:
    - **The Leadership Team** (Manager, Director, Leadership groups) create a new vision for CAMHS consistent with a new philosophical approach and aspiration to be a national leader in service provision. This should include championing increased data literacy by staff, aided by sophisticated use of service data.
    - **A Team Leader group** responsible for advice on service provision including state-wide service approaches
    - **A Professional Seniors group** (e.g. leads in social work, psychology, mental health nursing, OT, etc) responsible for advice on state-wide workplace relations and training.

1.2 Recommendation 2: CAMHS model of service better reflects the Australian National Mental Health Strategy

The philosophical approach of CAMHS in Tasmania

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.

CAMHS would benefit from repositioning itself as an outward looking, collaboration-seeking and solution-focused service that involve consumers and other stakeholders in their vision.

This approach is supported by numerous documents of national significance which together outline the current national reform agenda that has been endorsed by the Tasmanian Government.

In accordance with recommendation 2, SMHS and CAMHS leadership should consider alignment of services and processes to the National Mental Health Strategy, specifically:

- CAMHS better align its model of care with the CAMHS-relevant aspects of the National Mental Health Plans, for example:
    - Link with other sectors (1st Plan),
    - Importance of connection with teachers and school counsellors (2nd Plan),
    - Consumer access to services (3rd Plan),
    - Accountability, including measuring and reporting progress of consumers who have experienced physical, sexual and emotional abuse (4th Plan),
    - Develop tailored mental health care responses for children,
    - Focus on severe and complex mental illness (5th Plan).
- CAMHS better aligns its model of care with the National Framework for Recovery-Oriented Mental Health Services, in particular:
    - Domain 4 capability 4C – recovery-promoting service partnerships and
    - Domain 5 capability 5C – Partnerships with communities.

In line with this recommendation; SMHS Leadership and CAMHS leadership should consider a review of core business, with specific consideration of:

- mental health presentations in young people with other challenges such as those who also experience intellectual disability and/or autism spectrum disorder and/or developmental disorders.
- mental health presentations in young people with other challenges such as those who experienced sexual, physical and emotional abuse, and/or emotional neglect in children and adolescent with severe and complex mental health needs. Further, note 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.

Consistent with recommendation 2, SMHS Leadership and adult mental health practitioners should consider:

- The need to upskill their knowledge of areas contained in this review, including comorbid child and adolescent mental health presentations and trauma-related presentations.
- The current CAMHS capacity, and therefore funding, cannot meet the needs of individuals with severe and complex presentations; enhancement of CAMHS is required, in particular for people with severe and complex needs who are likely to access adult services in future years. Approaches to dedicating resources to assist with the transition should be adopted.

1.3 Recommendation 3: CAMHS embrace a range of model of service reforms to make service delivery more efficient, contemporary and cost-effective

The CAMHS model of care

To varying degrees across the three CAMHS teams, some routine practices and procedures are either not efficient, not cost-effective or do not reflect contemporary CAMHS practice. In line with this recommendation, SMHS and CAMHS leadership should consider the following service reforms to develop more efficient, contemporary and cost-effective care for the Tasmanian CAMH population.

The reforms are listed in an order consistent with when they might arise on a typical patient journey.

The Mental Health Help Line (MHHL)

- The current MHHL has undergone a separate survey, undertaken by the Department of Health, coinciding with this Review; survey results have informed this part of the review.
- The MHHL functions, reviewed as part of Tasmanian Mental Health Reforms (TMHR), need to lead to a more positive experience for consumers when referring a young person to CAMHS.
- A reformed MHHL function will need to incorporate staff with CAMHS skills to ensure the needs of the CAMH population are properly serviced.
- The reformed MHHL should have the capacity to directly respond to Health Professionals making referrals or needing urgent specialist advice in addition to providing advice, information, triage and phone assessment to young people and their families.
- The reformed MHHL needs to have the capability to respond to referrals that meet a triage classification that merits a quick response. This will need to be a feature of the new Acute Care Stream that is currently under development as part of the TMHR process. These reforms are especially important when calls are received for children under 12 years of age.

CAMHS Referral

- The MHHL should be established in such a way that it can provide a state-wide service, staffed with clinicians with CAMHS experience, to ensure it can provide the following functions:
    - provide a helpline function,
    - give consumers choice about non-CAMHS service options and
    - be a referral portal for state-wide CAMHS.
- The new Team Leaders group should be tasked with developing a state-wide referral process. Consistent with this new philosophical approach, the process should not list exclusions to service provision.

CAMHS Triage

- The use of a consistent priority categorisation system is a force for uniformity of process across all three sites and should continue to be encouraged.
- Multidisciplinary team (MDT) review of intakes is currently inefficient, uses valuable therapy time; instead, this function should be undertaken by a small intake group, similar to processes occurring throughout much of the rest of Australia.
- CAMHS services which post letters to families informing of appointments is not consistent with contemporary and timely consumer interactions. Teams should communicate with consumers by telephone and/or encrypted text or emails. Wherever possible it should be in line with modern community practices of managing bookings.
- Mental health management at the local level is strongly urged to provide guidelines and procedures that encourage and codify the of use contemporary communication with consumers.

CAMHS Assessment

- As part of changing the focus toward consumers with severe and complex mental illness, CAMHS should review its initial assessment process to align with best practice processes elsewhere in Australia.
- The notion that a consumer and family's mental health challenges can be fundamentally altered by a single session family consultation (SSFC) is not consistent with seeing child and adolescents with severe and complex mental illness. This practice should cease for this group of consumers who should be the priority of CAMHS as a level 4 specialist service.
- A four-session assessment (consumer review, parent review, family review, MDT meeting, feedback) is not consistent with contemporary practice, inefficient and decreases time for therapy. This practice should also cease.
- CAMHS should implement either the Choice and Partnership Approach (CAPA), or a similar intake system, as a process to rapidly assess consumers, manage waitlists and involve senior clinicians in assessment decisions.
- Assessments, in all cases, should create a provisional International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) diagnosis inclusive of primary and, whenever relevant, comorbid diagnoses and descriptive Z codes (and other relevant codes).

- Intervention decisions should routinely be made and discussed with consumers at the end of the assessment session. Each initial assessment should comprise of a decision about what treatment or other intervention are discussed with consumers, parents and caregivers.
- On occasion (but not in the majority of cases), further assessment and/or information gathering may be required to make decisions regarding advice to consumers and decisions based on assessment should be framed in a stepped care model with CAMHS routinely accepting those with severe and complex needs (level 4).

CAMHS acceptance into care

- CAMHS should define its role in the care and treatment of consumers with severe and complex mental illness needs, especially when it is provided by other systems; this should be core business.
- CAMHS should involve paediatricians in determining a clear partnership approach to the provision of services for those consumers presenting with co-morbid mental health issues and neurodevelopmental disorders being seen by paediatric services.
- CAMHS as a priority will define its role in relation to consumers who are a 'looked after child' who may be displaying dysregulated and challenging behaviour. In these cases, secondary consultation and collaboration with other service providers is appropriate until joint CAMHS-Child safety therapy services are funded.
- Consumers are accepted into care even if a clinic-based service seems unlikely to be effective. In these cases, secondary consultation and collaboration with other service providers is appropriate until more assertive outreach models are funded.
- Consumers are accepted into care if currently receiving care through the NDIS. In these cases, secondary consultation and collaboration is appropriate to benefit the consumer especially when service elements (e.g. psychiatrist input) are not available. CAMHS should articulate their role in the provision of treatment planning for those consumers receiving services through the NDIS.
- CAMHS should work more closely with Primary care, especially GPs, to ensure they are better able to meet service provision that cannot be provided by other providers of mental health care.

CAMHS provision of care–risk assessment

- CAMHS leadership will ensure all staff are trained and supported in implementing the State-wide approach to suicide and self-harm mitigation, known as Connecting with People (CwP).
- The conceptualisation of the cause of repeated self-harm in adolescents and older children, whilst multifactorial, should emphasise a trauma-informed/failure to self-regulate model, rather than a major depression model.
- The Team Leaders group should incorporate Connecting with People as an approach to suicide and self-harm mitigation into an overall approach that focusses on safety planning that is consistent across CAMHS.
- The Team Leaders group should agree upon replacing the Threshold Assessment Grid (TAG) with a more suitable alternative (once training is completed) for managing clinical risk.

- A system should be created whereby other health professionals, especially paediatricians and GPs, receive business hours (weekdays) advice about child and adolescent mental health presentations that are perceived to be a current high risk. This should be considered together with the recommendation in relation to the MHHL.
- A state-wide (covering the south, north and north-west) after-hours child and adolescent psychiatrist on-call roster should be created, once sufficient resources are available. To facilitate a state-wide roster the North and North-west CAMHS consultant and any future adolescent psychiatrists should participate in such an after-hours roster rather than being in an adult roster.

CAMHS provision of care–interventions

- There should be a state-wide initiative to deliver affect regulation interventions to young people with severely challenging and dysregulated behaviour.
- There should be a state-wide CAMHS emphasis on individuals who present with emerging borderline personality disorder. Such individuals should be offered an evidence-based intervention when it is clear they are on this diagnostic trajectory.
- There should be a state-wide coordination of current initiatives to provide Dialectic Behaviour Therapy in each CAMHS locations as part of the Tasmanian Mental Health Reform's implementation of a State-wide Borderline Personality Disorder (BPD)/Chronic Post Traumatic Stress Disorder (CPTSD) service.
- The provision of care of children and adolescents with eating disorders should be integrated into the proposed state-wide, whole-of-life eating disorders service, that is currently being established as a project jointly underway between the Commonwealth and the State Governments.
- Wherever possible, CAMHS patients should be admitted under a joint paediatric-CAMHS consultant responsibility ('bed card') as an interim measure prior to the creation of a discrete adolescent mental health inpatient unit. If this is not possible, then a clear delineation of the role of mental health care within paediatrics should be determined, including the possibility of the CAMHS Consultant having admitting rights to the Paediatric beds for adolescents admitted with severe and complex mental health issues.
- Amendments to current operational guidelines surrounding the care of patients with mental health conditions in paediatric wards should be made. Specifically, in relation to the document 'Admission of Patients with Mental Health Conditions to the Paediatric Ward Guideline P15/000547', the document should include sections and information relating to clinical expectations, support, utilisation of CAMHS nurses and training and supervision of paediatric nursing staff who are providing care for CAMHS patients. At a minimum when a young person is admitted with a severe mental health problem there should be a mental health nurse with CAMHS credentials on both day shift and afternoon shift, 7 days a week.

CAMHS process issues

- The Team Leaders group should be tasked with drafting recommendations to unify all aspects of the CAMHS clinical care pathways across the three CAMHS sites.
- The Team Leaders group should be tasked with drafting recommendations on documentation across the three CAMHS sites, note that as a minimum this should be compliant with the Australian National Minimum Datasets for Mental Health and the National Outcomes and Casemix Collection (NOCC).
- The CAMHS leadership group should consider formal benchmarking of service-related metrics (e.g. consumer characteristics and diagnoses, duration of care), consumer outcomes and workforce with other similar sized services. The most appropriate services would include those provided by large regional cities, elsewhere in Australia, with a responsibility for urban, rural and remote settings.

CAMHS enhancement of service provision

- This review highlights the need for a range of new services that need to be considered for funding and development in order to deliver contemporary CAMH services in Tasmania. Any future service enhancements to CAMHS in line with this review will require a significant change to the way in which current CAMHS is provided; shifting the focus to those with severe and complex presentations cannot be achieved from gains in workplace reform and more efficient processes alone.
- All service change should be consistent with past, current and future National Mental Health Plans, consumer and stakeholder expectations, and consultation with the wider sector who provide services to the CAMH population.
- CAMHS will be required to increase community capacity to support young people with complex and challenging mental health challenges prior to being able to cost-effectively operate an adolescent mental health inpatient unit.
- All new service initiatives will enshrine new business rules that focus on collaboration with and linkage to other service providers and systems.

1.4 Recommendation 4: Services for children and adolescents should be funded to be able to provide best practice interventions for those with severe and complex needs, and in so doing, provide stakeholders with the CAMHS expertise they require.

The following services are not currently available in Tasmania but are considered an essential part of a modern Child and Adolescent Mental Health Service to meet Tasmania's needs.

CAMHS for Out-of-Home Care Children

- Given the highly specialised and complex nature of the mental health care needs of many children in OOHC, a group who struggle to engage with traditional services, it is proposed that a dedicated service for this group is established. This team should be created to provide mental health assessment and treatment services. The team should be developed as a specialist/tertiary/Level 4+ service within a stepped care model (see

Chapter 1) and therefore for consumers who have severe and complex mental health challenges.

- Consistent with similar national and international services, this service should be multidisciplinary, primarily trauma-focused, have low practitioner caseloads, be capable of suitable intensity of work and provide care for the time required (often measured in years). These children are among the most disadvantaged in Tasmania and can make the greatest gains from this comprehensive approach.
- Consumers of this service will have equal access to other CAMHS services, including any future inpatient unit and day program. The level of intervention (and the highly specialised nature of this service) necessitates two services, one in the South and another covering the North/North West to provide services at a consistently high standard.
- Key performance indicators should be mutually agreed upon and reflect the need to treat current complex and severe mental health presentations, reduce current symptoms and impairment, improve functioning in OOHC and education settings and prevent adult mental health presentations.
- These teams should consider benchmarking and develop a shared learning approach with similar existing mainland services, some of which have been operating for 15 years and have a wealth of experience.

Assertive mobile outreach

- In line with the approach for Children in OOHC, a similar therapeutic approach is needed for a sizable proportion of Tasmanian adolescents with complex and severe mental health issues who do not engage with traditional clinic-based services.
- This is best achieved through as assertive mobile outreach team and this is urgently needed to provide a specialist/tertiary/Level 4+ service in a stepped care model for these adolescents.
- The services of the assertive mobile outreach team are for a negotiated time limited period (e.g. 6 months) with the aim of the consumer then utilising a community CAMHS.
- Clients of the assertive outreach team will remain case managed by community CAMHS.
- The current role of iConnect should be reviewed in light of expanded CAMHS assertive mobile outreach capacity.

Youth mental health service

- Consistent with the reforms underway as part of the TMHRP program, it is proposed that a dedicated youth mental health service is created from a small increase in CAMHS staff and the reallocation of some resources from Adult Mental Health Services.
- The youth mental health service should be part of the Continuing Care Stream and operate in such a manner that it reduces the impact of the transition between the CAMHS and Adult Mental Health Services. This will necessitate staff having skills

appropriate to this developmental stage and participating in both the CAMHS and Adult programs.

- As part of the current TMHRP, consideration of how the current and enhanced CAMHS and adult mental health services within the proposed Continuing Care stream are redesigned to create a dedicated youth mental health service.
- Preference should be given to this service being incorporated into an expanded CAMHS structure to increase the critical mass of CAMHS clinicians and flow on benefits to service provision (e.g. diversity of models of care, expanded workforce, ability to staff after-hours rosters, future better use of adolescent and youth inpatient beds).
- The youth mental health service model should have a recovery framework and multidisciplinary model of care. The service model should:
    - include both a dedicated response to individuals with early onset psychosis as well as other complex and severe mental health challenges (e.g. severe mood and anxiety disorders, personality disorders, substance abuse disorders),
    - have the capacity to deliver both clinic-based and off-site care,
    - embrace partnerships with other health providers, employment, accommodation, education, recreation and other service providers.

Inpatient Unit

- In line with the Tasmanian Government's support of the Clinical Planning Taskforce's report on the future of the Royal Hobart Hospital (RHH), this report proposes a discrete mental health inpatient unit for children and adolescents in Stage 3 of the RHH redevelopment.
- Furthermore, this unit should have bed numbers consistent with the National Mental Health Service Planning Framework. Planning should take into account the critical number of beds and staff needed to safely operate such a discrete unit, as the needs of the Tasmanian population is likely to only support the provision of one specialist unit. This will require consideration of how children, adolescents and families can access this unit from the North and North West of the state.
- This unit should be developed as a specialist/tertiary/Level 4+ service within a stepped care model and, therefore, for consumers who have severe and complex mental health challenges, who often present with an acute risk to themselves or others.
- Consistent with developing an inpatient unit, phase out admission of child and adolescent mental health patients to adult mental health inpatient units.
- Consistent with developing an inpatient unit, phase out admission of child and adolescent mental health patients to paediatric inpatient units, as a long-term goal, unless the individual requires acute medical management for an eating disorder or a concurrent physical illness.
- Prior to the establishment of a dedicated child and adolescent mental health inpatient unit, admissions to the paediatric/adolescent inpatient unit of CAMHS patients (non-eating disorders) should be under the direct clinical care ('the 'bed card') of a child and adolescent psychiatrist as early as recruitment of appropriate staff can be achieved.

- Planning for the RHH unit should consider whether in the long-term demand modelling and economies of scale, justify a small discrete child mental health unit as well as a developmentally appropriate youth mental health unit.

Day Program

- A day program should be developed as an integral component to the future development of an adolescent inpatient unit.
- The program should be developed as a specialist/tertiary/Level 4+ service in a stepped care model and therefore for consumers who have severe and complex mental health challenges.
- Admission to a day program should be available as a less restrictive option to an inpatient admission. As a medium-term measure prior to completion of the RHH stage 3, the option of providing the day program at the St John's Park site in Hobart and close to the LGH in Launceston, should be explored.
- Admission to a day program should be available for CAMHS consumers from all CAMHS services who require a more intensive therapy than is possible in a community or assertive outreach setting.
- Consumers who attend the day program will be discharged back into the care of the referring CAMHS service.
- Any model of care developed for the day program should include:
    - group work for consumers with social skills challenges,
    - intensive return to school interventions for children and adolescents with school refusal, and
    - discussion of accommodation options for parents to support admissions to a day program for families who reside distant to the site of the unit.

Youth Forensic Mental Health

- A youth forensic mental health team should be established as a priority.
- The team should provide:
    - child and adolescent mental health assessment and interventions including after-care for consumers previously detained at Ashley Youth Detention Centre,
    - a forensic consultation service to CAMHS teams, and
    - input (e.g. education, training, consultation) to juvenile justice teams.

Perinatal and Early Childhood Service

- The capacity of the current Perinatal Infant Mental Health Service should be increased to provide comparable cover for consumers in the North and the North West of Tasmania. This should include:
    - resources to provide mental health interventions in the post-natal period and
    - consideration of the creation of a 'perinatal and early years' service that provides child-parent/carer interventions for the extremely important but perennially underserviced 0-5 age group.

Telemedicine

- Telepsychiatry policies and procedures should be created to support routine CAMHS telepsychiatry assessment and interventions. These should include:
    - procedures to see patients in collaboration with local providers (e.g. with GPs, from GP surgeries) and
    - procedures to obtain informed consent to use platforms typically owned by consumers as a means of improving access and not creating barriers by using difficult to access or expensive software.

1.5 Recommendation 5: Reform of CAMHS should be supported by dedicated CAMHS management structures and workforce initiatives.

Workforce structure and mix

Providing services to young people with severe and complex mental health presentations, as well as successfully engaging with and completing a comprehensive reform agenda requires a diverse and highly trained workforce, supported by a CAMHS specific management structure which is approachable, flexible, supportive and capable of innovation.

In keeping with this recommendation, SMHS and CAMHS leadership should consider the following workforce related initiatives:

- Create a Team Leader's group consisting of the Team Leaders of the current three CAMHS services, with additional members as new services are funded (e.g. Team Leader Inpatient Unit, out of home care (OOHC) Team, etc.).
- The Team Leader's group meet monthly (more often dependent on current tasks). The state-wide Director and Manager are invitees to this group.
- Create the Professional Senior's group comprising one professional senior for psychology, social work, occupational therapy, speech pathology, mental health nurses and medical practitioners.
- Professional seniors are appointed to the Professional Seniors group for a fixed period (for example 3 years) and must include practitioners from each of the three CAMHS sites.
- The Professional Seniors' group meet monthly (more often dependent on current tasks). The state-wide Director and Manager are invitees to this group.
- The Professional Seniors group are tasked to represent their own professional group and the workforce collectively on CAMHS workforce related issues.
- The Professional Seniors group are tasked with ensuring all practitioners receive supervision consistent with the recommendations of their professional bodies.
- The Professional Seniors group are tasked with creating and overseeing a state-wide professional development calendar inclusive of whole of CAMHS case presentations, journal club, and visiting speakers.
- The Professional Seniors group are tasked with encouraging CAMHS practitioners to engage in quality assurance and research activities.

- The state-wide CAMHS Director and Manager should work with the SMHS workforce unit to address recruitment and retention issues across CAMHS.
- The state-wide CAMHS Director and Manager should consider employing a paediatrician with a clear interest in behavioural and developmental paediatrics as an interim measure until further child psychiatrists are employed.
- The lack of allied health diversity in North-West CAMHS should be viewed as a state-wide issue and leadership should work to rectify this.
- The lack of occupational therapy capacity in North and North-West CAMHS should be viewed as a state-wide issue and leadership should work to address this.
- State-wide CAMHS should investigate a range of mechanisms to ensure the consumer voice is more prominent, in service design and delivery, as well as practitioner education and training.
- State-wide CAMHS should investigate a range of mechanisms to ensure the parent and carer voice is more prominent in, service design and delivery, as well as practitioner education and training.
- State-wide CAMHS should engage an indigenous mental health consultant.
- State-wide CAMHS should investigate and report on the frequently stated perception that current salaries do not reflect experience level and job descriptions between nursing and allied health staff.

1.6 Recommendation 6: Mental health leadership strongly advocate for CAMHS community clinics to be provided with suitable accommodation.

Infrastructure

Of the three sites that CAMHS community teams currently operate from, two are not suitable for providing contemporary CAMHS services. It is essential for the effective running and delivery of high-quality services to have facilities that meet consumer and service expectations.

Consistent with recommendation 6, SMHS and CAMHS leadership should consider the following infrastructure related initiatives:

- The Clare House site is neither suitable for consumers with disability nor as accommodation for a community CAMHS. This site should be replaced.
- A new site for the Clare House service should be sought which has the capacity for co-location with other organisations that provide services to children, adolescents and families, and has suitable space for new CAMHS service initiatives.
- The North CAMHS (Launceston) site is unsuitable accommodation for a community CAMHS (e.g. therapy rooms are not suitably sound proofed) and there is insufficient space for group work or potential service enhancements. This site should be replaced.
- The mental health assessment room in the Accident and Emergency Department (A&E) of the North West General Hospital currently has a look and feel more consistent with an acute mental health or high dependency unit. Whilst this capacity

may be required, consideration should be given to creating a more consumer-friendly space suitable to use with children, adolescents and families.
- The small exercise areas of the adolescent mental health beds on the new Royal Hobart Hospital adolescent ward are extremely stigmatising given they are caged areas that look directly onto a visitor's space. Unless a suitable work-around is found (e.g. the outlook becomes completely covered) these areas should not be used.

1.7 Recommendation 7: Reform of CAMHS should be supported by an increased CAMHS capacity in service development, evaluation and research.

Research and Development

Continuous service development is a significantly better model than occasional small- or large-scale service review. Ideally service staff are exposed to and engaged in continuous quality cycles focused on new initiatives to better the consumer experience or outcome. It is also highly desirable that the service has the capacity for conceiving, initiating, conducting and completing high quality research of a standard that can be published in refereed scientific journals.

Consistent with recommendation 7, SMHS and CAMHS leadership should consider the following research and development related initiatives:

- The portfolio of a state-wide CAMHS research and development coordinator should be created. This should be a part-time responsibility of an interested and suitably qualified clinician.
- A state-wide CAMHS evaluation process should be created to record new quality improvement and research undertakings, including make this a standing item at Team Leaders meetings. Knowledge of these initiatives should be widely available.
- A streamlined process should be instigated to allow appropriate clinicians (e.g. Service Director, Manager, Team Leaders, those conducting research) rapid access to service data.
- A state-wide CAMHS evaluation process should be created to support research, including encouragement for staff to enrol in a research degree (e.g. M.Phil, PhD) or related endeavour.
- Advertising dedicated research time should be included in efforts to recruit new child and adolescent psychiatrists.
- Negotiations should be undertaken with the University of Tasmania (UTAS) to create adjunct academic positions in Medicine for CAMHS Allied Health and Nursing practitioners thereby creating a multidisciplinary CAMHS academic group.
- Negotiations should be undertaken with the UTAS and Tasmania Department of Health to create a senior academic position(s) in child and adolescent psychiatry and/or child and adolescent mental health nursing and/or child and adolescent allied health. Of note the psychiatrist position may assist with recruiting another senior child and adolescent psychiatrist to Tasmania.

2. Background and Rationale

2.1 Context of the review

The Mental Health Integration Taskforce Report (Department of Health, 2019) was released in April 2019 as a government election commitment to provide advice on improving integration of Mental Health Services in Southern Tasmania. In July 2019, the Government released its response to the taskforce report accepting all 21 recommendations and committing to eight actions that would address the report's findings. The Tasmanian Mental Health Reform Program (TMHRP) was established to implement the Government's response.

The Tasmanian Government response noted the importance of a model of care that integrated inpatient and community settings and was reflective of the specific needs of adolescents. It also highlighted the Commonwealth Governments funding of an Eating Disorders Centre in Southern Tasmania and the need for models of care that overcome transition issues and other concerns raised by the children and younger persons sectors.

Consequently, the Government Response, specifically committed to review the model of care for the child and adolescent mental health service (CAMHS) with a focus on the integration of service responses for children and adolescents across community and inpatient settings (Action 4). In addition, some other actions have clear relevance to CAMHS, such as Action 3: Establish an integrated post and after-care suicide response as part of the health hospital avoidance program, and Action 5: Establish a dedicated state-wide response to people with complex needs.

2.2 Aims and objectives

The objective of the CAMHS review is to "enable an integrated pathway for children and adolescents and their families and carers to navigate the mental health system". Two deliverables resulting from the review were:

(1) A comprehensive report outlining the review of the CAMHS service system and,

(2) The development of recommendations regarding Tasmanian CAMHS.

Further, these recommendations should be written in such a way so as "to provide guidance on service development of a specialised clinical service supported by State-wide Mental

Health Services that will be implemented in 2020 through the Tasmanian Mental Health Reform Program".

As previously noted in this report, an outcomes from this Report includes provision of a "model of care that integrates across inpatient and community settings and is reflective of the needs of adolescents that overcomes transition issues and other concerns raised by the children and young persons sector".

2.3 Project governance

The governance of the CAMHS review is based upon the Tasmanian government project management guidelines version 6.0. Consistent with this guideline:

- The corporate client is the State-wide Mental Health Service.
- The project sponsor is Dr Aaron Groves, Chief Psychiatrist, Department of Health.
- The business owner is Adrienne Gibbons, Clinical Executive Director, State-wide Mental Health Services.
- The project manager is Kathryn Gregory, Director of Nursing, program lead Tasmanian Mental Health Reform Program.

2.4 Snapshot of children and adolescents in Tasmania

The review considered the degree to which CAMHS are provided where children in Tasmania can access them. In addition, it sought to understand the relative distribution of disadvantage which are known to impact on the mental health of children and younger people. Figure 3.4.i illustrates the location and constitution of the three current CAMHS catchments.

The Local Government areas (LGAs) marked in blue make up the Northern CAMHS catchment, including Launceston, Campbell Town, and Deloraine.

The North Western CAMHS catchment is marked in Orange and comprises the urban areas of Devonport, Burnie, Queenstown, along with much of the Western coast.

The Southern CAMHS catchment comprises the urban and greater urban areas surrounding Hobart as well as a significant proportion of the interior of the state, including Ouse. The boundary lines on the map indicate boundaries between local government areas (LGAs).

Figure 3.4.i: *Colour-coded map of the three CAMHS catchments*

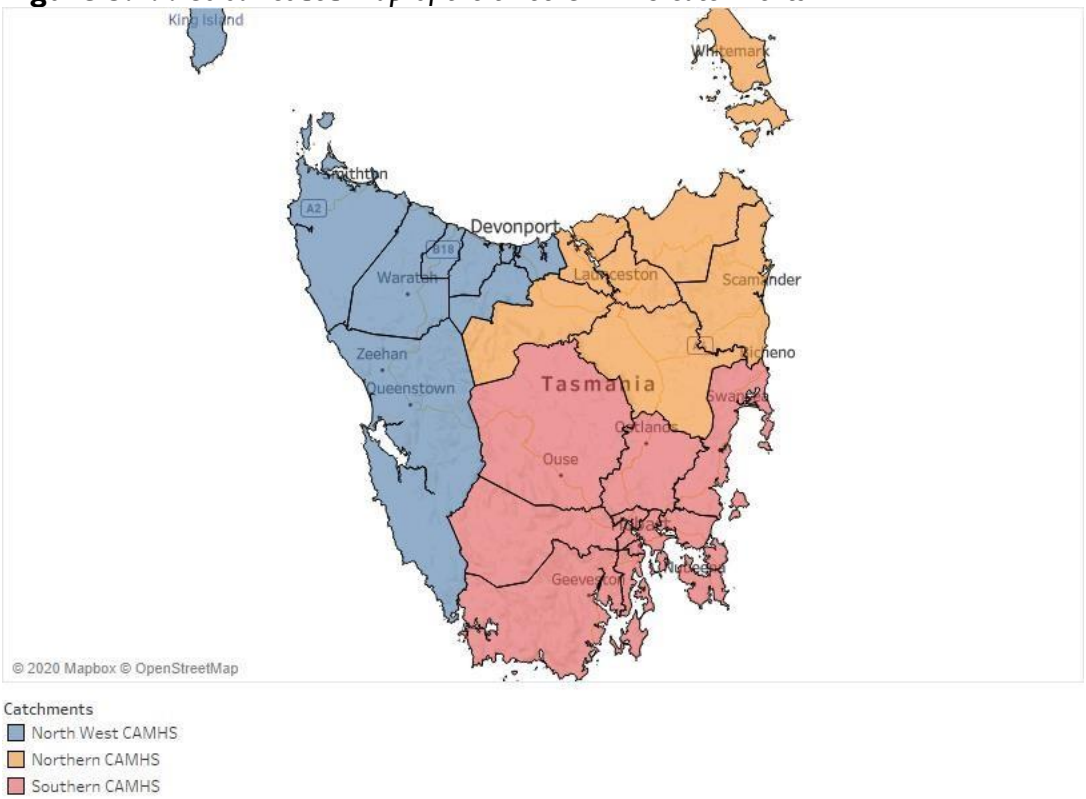


Table 3.4.i provides LGA level state scores for two commonly used Socioeconomic Indexes for Australia (SEIFA), namely the Index of Relative Socioeconomic Disadvantage (IRSD) and the Index of Economic Resources (IER). The first measure scores each area by summarising attributes of the population, such as low income, low educational attainment, high unemployment and jobs in relatively unskilled occupations.

This reflects the average level of disadvantage of the population of an area. The IER focuses on the financial aspects of relative socio-economic advantage and disadvantage by summarising variables related to income and wealth.

As expected, the IRSD and IER measures were generally in agreement with each other, with higher scores indicating lower relative socioeconomic disadvantage and increased economic resources, respectively.

Table 3.4.i: *Relative burden of disadvantage/economic resources by (LGA), Catchment*

Local Government Area (LGA[1])	Total Clinical Cases[3]	IRSD (2016) (Percentile Ranking)[4]	IER (Percentile Ranking)[4]	Relative burden of disadvantage (composite measure)	Relative burden of economic resources (composite measure)
Southern CAMHS					
Brighton	85	11	17	7,565	7,055
Central Highlands	3	14	34	258	198
Clarence	215	91	91	1,935	1,935
Derwent Valley	31	17	31	2,573	2,139
Glamorgan/Spring Bay	12	54	47	552	636
Glenorchy	210	27	11	15,330	18,690
Hobart	138	97	61	414	5,382
Huon Valley	65	67	71	2,145	1,885
Kingborough	130	94	97	780	390
Sorell	69	71	81	2,001	1,311
Southern Midlands	20	44	87	1,120	260
Tasman	2	34	51	132	98
Catchment Total/Average Burden Per Client	980			**34,805/35.5**	**39,979/40.8**
Northern CAMHS					
Break O'Day	23	21	27	1,817	1,679
Dorset	21	37	44	1,323	1,176
Flinders	6	74	37	156	378
George Town	14	4	7	1,344	1,302
Launceston	287	47	24	15,211	21,812
Meander Valley	63	81	84	1,197	1,008
Northern Midlands	60	64	64	2,160	2,160
West Tamar	51	87	94	663	306
Catchment Total/Average	525			**23,871/45.5**	**29,821/56.8**
North Western CAMHS					
Burnie	176	31	21	12,144	13,904
Central Coast	114	61	54	4,446	5,244
Circular Head	46	57	57	1,978	1,978
Devonport	190	24	14	14,440	16,340
Kentish	15	51	77	735	345
King Island	6	84	74	96	156
Latrobe	53	77	67	1,219	1,749
Waratah/Wynyard	71	41	41	4,189	4,189
West Coast	13	7	4	1,209	1,248
Catchment Total/Average	684			**40,456/59.1**	**45,153/66**
State Total	2,189	N/A	N/A	45.3	52.5

Notes/Sources:
1: LGA: Local Government Area
3: Active clinical cases are cases which were active at the time of data extraction. Total clinical cases refer to the number of unique individuals seen in the service over a 12-month period
4: Socio-economic indexes in Australia (SEIFA), 2016 2033.0.55.001 (Accessed 14/04/2020). IRSD: Index of Relative Socioeconomic Disadvantage, IER: Index of Economic Resources. Please note that for the purposes of this exercise, the inverse of these values (these values 100-the relevant value) was used.

Table 3.4.i displays the number of individuals in each LGA. The composite measures are an attempt to quantify the joint effect of patient numbers and measures of sociodemographic inequality on the psychiatric burden of disease across the state. The LGAs with the highest composite scores are highlighted in orange. These were Glenorchy, Launceston, Burnie and Devonport.

2.4.i Children in out-of-home care (OOHC)

OOHC children are a group of great interest to the CAMHS review given the very elevated burden of poor mental health in children and adolescents as well as early traumatic experiences conferring a significantly increased risk of a range of severe adult mental health disorders. These issues are discussed in more detail in section 5.2.

From a population perspective, the Australian Institute of Health and Welfare (AIHW, 2018) reported 1,305 children living in OOHC in Tasmania in December 2018, while as of 30 June 2018 there were 1,272 children in OOHC. A small proportion (2.1%) were under 4 years of age, 63.4% were between 5-14 years of age. The majority (94%) were in home-based care (Tasmania has the 3rd highest rate of foster care compared to other states and territories) and 17% in third-party guardianship, compared to 1.4% nationally. Approximately one quarter of OOHC children were identified as Aboriginal or Torres Strait Islander compared to 10.3% of children nationally who identifying as Aboriginal and Torres Strait Islander.

There has been marked growth in the number of OOHC children over the last five years, increasing by approximately 21% from 30 June 2014 to 30 June 2018. This reflects the notion that children arriving into care outnumber the children leaving care. Recently, children have been admitted to OOHC at a younger age and remain for longer. As of 30 June 2018, 84.7% of children had been in OOHC for one year or more; 26.7% between two and five years and 47.2% for more than five years. Tasmania had the second highest proportion of children in Australia, who had lived continuously in OOHC for longer than five years.

Rauter and colleagues (2018) reviewed 109 of Tasmanian's aged 4-6-year olds attending a paediatric screening clinic for OOHC in southern Tasmania. These authors noted, "Over their lifetime, cohort children were hospitalised for injury at more than twice the rate of Southern Tasmanian 4 to 6-year olds and specific admissions for suspected inflicted injury were 20 times higher". Inflicted injury is another term for physical abuse. Physical abuse in early childhood is a known risk factor for reactive attachment disorder (RAD). It is also related to coercive parenting, a major factor that leads to oppositional defiant disorder (ODD). In later life, abused children are at significantly higher likelihood of a range of mental health disorders including depression, PTSD, substance use disorders, BPD and psychosis (Cutajar et al., 2010). Adverse Childhood Experiences (ACE) are also linked to poor physical outcomes.

Rauter and colleagues also reported that on the Strengths and Difficulties Questionnaire (SDQ) , a nationally collected caregiver and/or parent report, OOHC children were rated as being significantly more likely to have emotional, conduct related, hyperactivity/attention and peer problems compared to Australian normative data. Indeed, half of carers reported OOHC children in their care were in the clinical range on the SDQ. These findings were reflected in the OOHC Monitoring report, released by the Tasmanian Commissioner for Children and Young People.

Whilst acknowledging the primary cause of health difficulties was related to adverse circumstances experienced prior to entering OOHC, the children in care had considerably more mental health challenges including self-harm, suicidal ideation and attempts, anxiety, depression, personality disorders, OCD, ADHD, separation anxiety, eating disorders, problematic sexual behaviour and sexually abusive behaviour. OOHC children also had social, emotional and behavioural concerns such as hoarding, soiling, hypervigilance, risk taking and antisocial behaviour, impulse control and emotional regulation issues and bullying/being bullied. The OOHC monitor report also noted higher numbers of children with developmental issues and intellectual disabilities (including autism spectrum disorder, failure to thrive, growth and developmental delays) and individuals with 'named' syndromes such as Foetal Alcohol Syndrome.

2.4.ii Adverse Childhood Experiences (ACE)

A useful methodology to summarise the extreme challenges to normal physical and emotional functioning following a child's experience of trauma is the adverse childhood experiences (ACE) literature. The ACE study, first conducted between 1995 and 1997, was one of the largest studies in the world to examine ten ACEs and their effect of later health and wellbeing. The original study and numerous subsequent studies outline 10 adverse experiences, five relating to the household (such as the experience of substance abuse, parent or carer separation and divorce, parental mental illness, domestic violence or criminal behaviour), three relating to psychological, physical and sexual abuse and the final two relating to emotional and physical neglect.

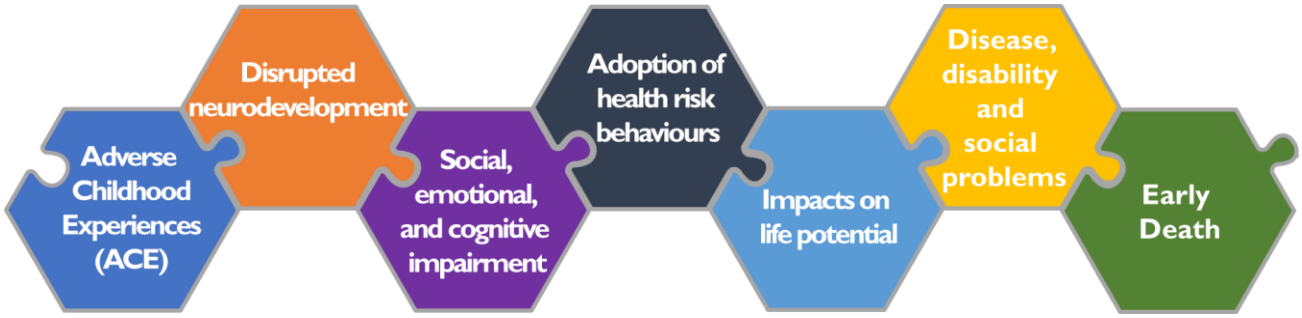
About two thirds of respondents report at least one ACE, with those who have reported one ACE highly likely to report at least one other. Because ACEs often appear in clusters, many studies have examined the cumulative effects of ACEs rather than examining individual experiences.

Chapman and colleagues noted that there was a linear relationship between the number of ACEs and depression, indicating that if a child had five or more events, their chance of depression in adulthood was five times higher, alcohol dependence approximately seven times, higher 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). The importance of ACEs is depicted in Figure 3.4.ii, which provides an understanding of the far-reaching life course consequences of ACE.

The evidence that intervening early for those children who have adverse experiences is compelling. Not only is there a reduction in suffering, morbidity and chronic

underachievement but also the opportunity to reduce adult service burden and create a more cost-efficient whole of life service response. The advantages for adult services, in minimising the trajectory is probably best highlighted, by the research of Middlebrooks and Audage (2008), who showed that for those people who had 6 or more ACEs the rate of suicide attempts was a staggering 3000% higher than those who had no ACEs; most of these occurred in adult life.

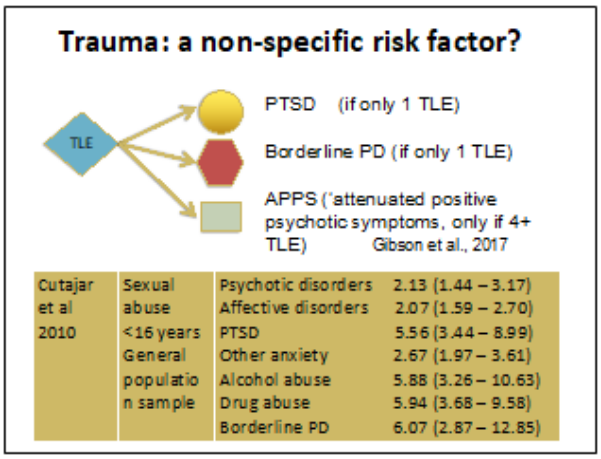
Figure 3.4.ii: *An example of the impact of ACE on the life course*



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

Thus, ACE and the related construct of traumatic life events (TLE) should be of great interest to both adult mental health practitioners, as well as CAMHS. TLEs, such as the experience of physical assault, transport accidents, sexual assault or rape, or a natural disaster, are common. An American study showed that 79% of university students aged 18 to 35 had experienced at least one TLE and 11% had experienced four or more (Gibson et al, 2017). These authors noted that there was a significant increase in adult PTSD and borderline personality disorder following the experience of only one TLE, during either childhood or early adult life. In the group who had four or more, individuals commonly experienced psychotic symptoms.

Figure 3.4.iii: *Examples of Traumatic Life Events (TLEs) and their impact in the likelihood of mental health disorders (represented as odds ratios)*



Of particular importance, is the publication by Cutajar and colleagues (2010) who reported the mental health outcomes of individuals who were sexually abused, before 16 years of age, and 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. This is important because the capacity to respond early, for these young people, can reduce the impact on them as well as the likelihood that they will need to access services later in life.

The prevalence of all ACEs in unknown in Tasmania. However, information that is publicly available on some ACE shows Tasmanian Children are likely to experience higher rates than in other parts of Australia. For example, Tasmania has the second highest rate of children in out of home care and substantiated rates of child abuse and neglect, and that 15% of all victims of family and domestic violence were children. Tasmania has one of the highest rates of children being unable to be assisted when requesting specialist accommodation and support. Better understanding the rate of ACEs in Tasmanian children will help plan services.

2.4.iii Early Development, the first 1000 days

Over the past 15-20 years, there has been a growing recognition of the fundamental importance of the period from conception until the age a child reaches 2 years in human development. This period is now referred to as the first 1000 days and has become a focus of significant effort by many Governments as well as receiving considerable attention from research, academic and service providers (PwC, 2019).

The first 1000 days, shapes the child's brain and neurological system, is the period of considerable neuroplasticity and a time when attachments and bonds are formed. Evidence has shown the role of a wide range of factors from nutrition and stress to trauma, toxins, and social and physical experiences and their profound effects on the developing brain. Consequently, effort to give children the best possible beginnings are important, not only for the first few years, but throughout their life (PwC, 2019).

For Tasmanian children to get the best possible start to their development, a range of agencies have important roles to play, from the time the child is conceived to reduce the impact of emotional stress on the parents, improving nutrition, exercise and avoiding substances and toxins through to the important early days of attachment and bonding. This includes an important role for perinatal and infant mental health services during this time.

In Tasmania, whilst rates of breast feeding are high, attendance at antenatal visits is high, pregnant mothers smoking rates are falling and the proportion of newborn infants remaining engaged with Child Health and Parenting Services (CHaPS), more is needed to ensure early development of those at most risk is enhanced.

3. Review Methodology

3.1 Overview

The review process rests upon three broad themes: 1) a review of relevant documents, 2) interviews with CAMHS providers (and whenever possible, augmenting these discussions with relevant clinical data), and 3) interviews with a broad range of stakeholders.

Chapter 4 is dedicated to the review of relevant local, state, and national documents. Tasmanian documents included are those that place the CAMHS review into context, including the vision for the health of current and future generations of Tasmanians. National documents include the five National Mental Health Plans. The choice to use all five documents as a backdrop for the review is out respect for over 25 years of endeavour by Australian mental health leadership and rank-and-file practitioners who created a series of documents that have been the envy of mental health services around the world.

The National Mental Health Plans were embraced by political leadership with a strong federal-state collaboration. The plans have led to major investments in mental health services which have been, per capita, at the higher end of investment by any country. Because of this, in this review, there will be a strong emphasis on relating the CAMHS model of care to the Australian National Mental Health Plans and related documents.

3.2 Review of Tasmanian documents

The current Tasmanian State Mental Health Plan is known as *Rethink Mental Health, Better Mental Health and Wellbeing-A Long Term Plan for Mental Health in Tasmania 2015-2015* (henceforth referred to as Rethink). It provides significant guidance for this review. Indeed, one of the key aspects of the new direction being taken by the state Government was outlined as follows (page 12):

- **Strengthening mental health services for infants, children and young people and their families and carers:** Experiences in early childhood and adolescence can determine mental health outcomes later in life. The Tasmanian Government is committed to strengthening mental health services for infants, children and young people and has increased investment in child and adolescent mental health.

Rethink outlines 10 "Reform Directions". Two of these are of importance for this review. Direction 4 is titled 'An integrated Tasmanian Mental Health system'. On pages 19-21 it outlines issues of relevance to the review including the acknowledgement of the mental health impact of early prejudicial life experiences, abuse and neglect. There is also a strong emphasis on collaborative models for intervention, including cross-sector partnerships (e.g. with Children and Youth Services) as well as "opportunities for co-location, establishment of multi-disciplinary teams and embedded mental health expertise in child protection service teams" (page 21). Chapter 8 of this review (Potential CAMHS Structure and Service Enhancements) proposes recommended reforms in this area.

Collaboration with the education sector was also discussed in this section of the plan (page 21). The school sector is of great relevance to CAMHS as a referring agency, as a system that can provide important collateral information or direct clinical observation. The school sector should also be a potential site for universal interventions to improve child and adolescent resilience and where early intervention services can be delivered.

Rethink also proposes 'Getting in Early and Timely Access to Support' (Reform Direction 6). Of specific importance to this review are, "intervention models focusing on the early years" (page 23) and suggested enhancements to the Perinatal Infant Mental Health service, especially service cover to the North and North West, and to provide post-natal services and services for the early years (e.g. to children up to 3 years of age). Another Rethink area is early intervention for adolescents. Chapter 8 of this review discusses a Young Persons Early Intervention Treatment (yPEIT) service that would address this need.

Several specific population groups identified in the Rethink document are discussed in this review, including people with complex needs given the origins of many consumers with personality challenges and disorders are their experience of abuse and neglect as children; Tasmanian Aboriginal children, and people in contact with the justice system. In this review service provision reforms about the latter are advocated. The review also talks at some length about children in out of home care.

Finally, Rethink considers workforce development, monitoring and evaluating progress. The CAMHS service enhancements outlined in this review require specific interventions that are not commonly undertaken by current CAMHS teams. It will be a significant challenge to employ practitioners with these skills or upskill current clinicians (e.g. employment in inpatient unit or day program, interventions for highly traumatised dysregulated children). Rethink comments on monitoring and evaluating progress in reference to the reforms undertaken ("our progress in achieving our vision", page 28). However, the CAMHS sector would benefit from a broader reform in this area, including more sophisticated use of service data and embedded evaluation of both existing services and new initiatives.

3.3 Review of National Documents

Bipartisan political support led to the adoption by Australian Health Ministers of a National Mental Health Strategy in 1992. The Strategy comprises a series of documents that include a

National Mental Health Policy (1992) and its revision in 2008, a Statement of Rights and Responsibilities and a series of five National Mental Health Plans, some of which were accompanied by funding agreements between the Commonwealth and the States and Territories.

A summary of the priorities and the achievements of the five national mental health plans are outlined in Figure 4.3.i. The first National Mental Health plan which covered the period (1993-1998) contained 12 priority areas. As well as a mental health category classification and costing study (MHCASC), a community awareness campaign was initiated as well as development of national mental health standards, see Whiteford and Buckingham (2005) and Rosen (2006). Achievements of the plan included a significant increase in co-location of psychiatric units with general hospital and an overall mental health funding increase of 24%.

Priority areas included:

1. Consumer rights
2. Relationship between mental health services and general health sector
3. Linking mental health services with other sectors
4. Service mix
5. Promotion and prevention
6. Primary care services
7. Carers and non-government organisations
8. Mental health workforce
9. Legislation
10. Research and evaluation
11. Standards
12. Monitoring and accountability

The Second Mental Health Plan 1998-2003 (Australian Health Ministers, 1998), prioritised a focus on the client and providing care for a broader range of individuals. Depression was also specifically targeted, given research finding the large contribution of depression to overall illness burden. New priorities included Promotion and Prevention, Partnerships in service reform and delivery, and Quality and effectiveness.

Promotion and Prevention initiatives focused on settings (families, schools and workplaces) to build resilience and enhance coping, especially at points of transition; i.e. healthy schools, antibullying and life stage programmes to improve parenting skills and healthy ageing. Teachers, school counsellors, GPs, community nurses, civil servants and emergency service staff were all seen as key groups. The destigmatising of mental health was a goal. Partnerships in service reform and delivery initiatives included creating strategic alliances with consumers, families, carers, the private mental health sector, emergency services, wider health sector, government and non-government agencies and community support groups. It was noted that partnerships for indigenous mental health should include general health and primary care, Indigenous networks and organisations, rural and remote health, justice systems and drug and alcohol services.

Quality and effectiveness initiatives were to include reviewing and updating the national standards, establishing benchmarks and models for best practice and a focus on education and training.

The Third National Plan 2003-2008 (National Mental Health Plans) continued with the themes stated in the two previous plans, with the aim of building on the reforms that had commenced. The renewed priorities included; Promote mental health of the Australian community; Prevent development of mental disorders; Reduce impact on individuals, families and community and to assure rights of people with mental disorder. The principles of the 3rd Plan included that all in need of care should have access to timely and effective services, irrespective of where they live; and that the rights of consumers and families must shape reform. Mental health care should be responsive to the continuing and differing needs of consumers and carers/families and communities, including the need to be culturally appropriate. Workforce and service-related principles included ensuring quality and safety (through National Mental Health Standards), essential investment in the workforce, encouragement of innovation and research and ensuring the sustainability of interventions. It was also recognised that mental health reforms must work within broader health sector and required a whole-of-government approach.

In 2006, in recognition of a need for a greater whole of government approach to tackling mental health, the Council of Australian Governments (COAG) released a National Action Plan, that was backed by over $5 Billion of new funding during the 5-year life of that plan. In addition, Australia conducted its second National Survey of Mental Health and Wellbeing in 2007 as well as commencing a National Youth Mental Health Initiative in 2005 and together these led to the revision of the National Mental Health Plan in 2008.

The Fourth National Mental Health Plan 2009-2014 (National Mental Health Plans) built on previous work with the main change being a further focus on social inclusion and recognition of social, cultural and geographic diversity/experience. The 4th Plan stated 5 priority areas;

1. Social inclusion and recovery,
2. Prevention and early intervention,
3. Service access, coordination and continuity of care,
4. Quality improvement and innovation and
5. Accountability – measuring and reporting progress.

The aim of social inclusion and recovery includes that individuals feel part of a community; exert choice over where and how they live and there is a holistic approach between community organisations, health care and housing. This priority was consistent with other initiatives, including the Social Inclusion Board, the Homelessness White Paper and the COAG National Partnership Agreement on Homelessness. The 4th Plan identified a national stigma reduction promotion strategy as a priority.

Prevention and early intervention initiatives included population-based primary prevention activities such as mental health promotion and reduction of known risk factors (i.e. abuse, assault and domestic violence). Secondary prevention included preventing progression through better recognition of emerging symptoms and early intervention. National suicide prevention activities and an agreed suicide prevention framework were also included in the 4th National plan.

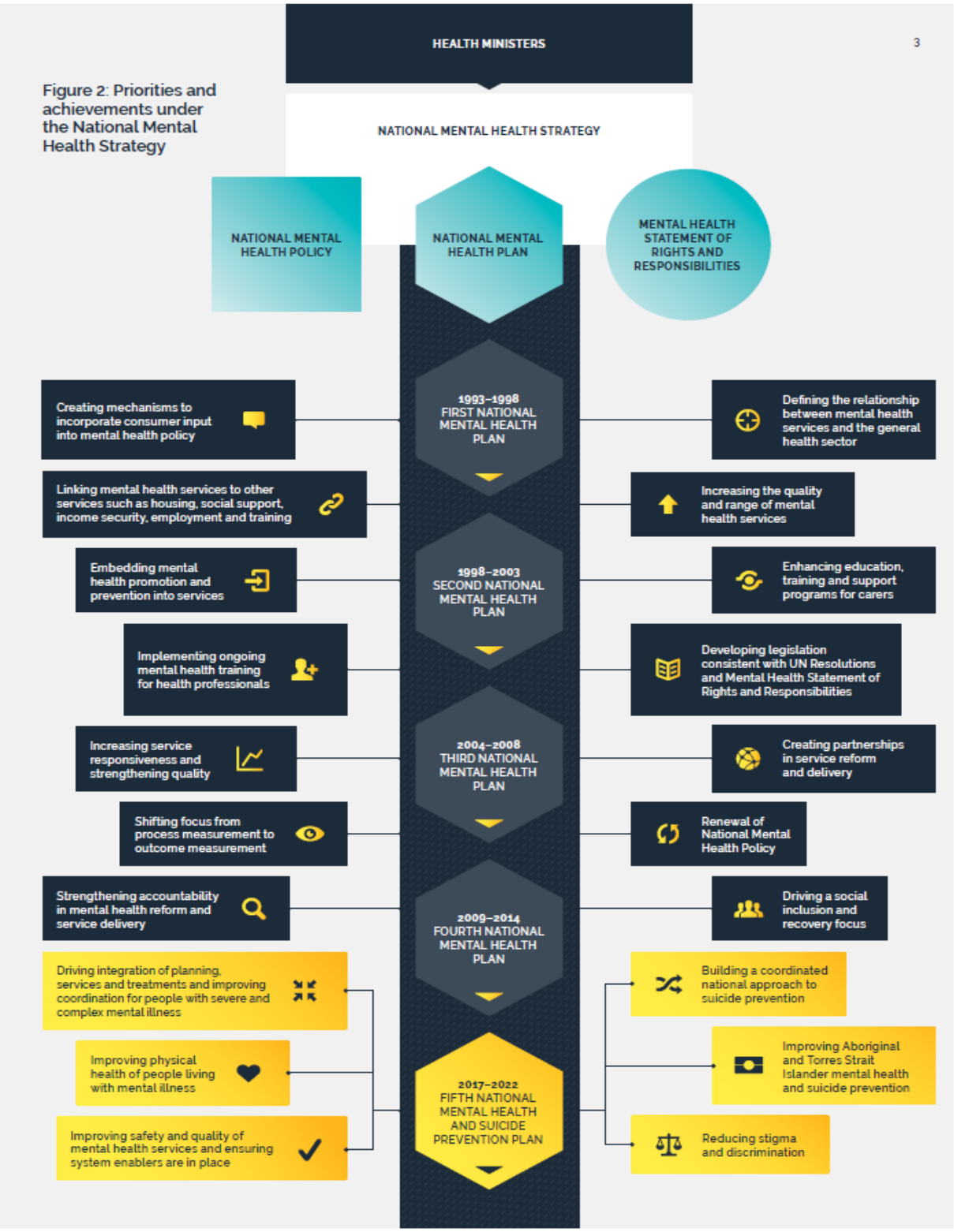
Priority three; service access, coordination and continuity of care included the development of a national mental health service planning framework which would include all possible care options (i.e. acute, long stay, supported accommodation services, ambulatory, community-based etc.) across public, private and third sector providers. This would also highlight variances for the needs of children, young people, adults and older people. The plan emphasised continuation of an initiative first stated in the 1st Plan, moving from a bed-based to a predominantly community based mental health system with improved coordination between services including mental health, alcohol and other drug and primary care.

The fourth priority; quality improvement and innovation included developing national mental health legislation, a National Mental Health Workforce Strategy, increased consumer and carer employment in community and clinical settings and expanding and better utilising the innovation in telephone and e-health services. Finally, the fifth priority, accountability focused on initiatives such as measuring and reporting progress and better using national mental health data collections.

The Fifth National Mental Health Plan 2017-2022 (National Mental Health Plans), has 8 priority areas for reform. They are:

- Achieving integrated regional planning and service delivery;
- Suicide prevention;
- Coordinating treatment and supports for people with severe and complex mental illness;
- Improving Aboriginal and Torres Strait Islander mental health and suicide prevention;
- Improving the physical health of people living with mental illness and reducing early mortality;
- Reducing stigma and discrimination;
- Making safety and quality central to mental health service delivery; and
- Ensuring that the enablers of effective system performance and system improvement are in place.

Figure 3.3.i: *Priorities and achievements under the National Mental Health Strategy*



Source: The Fifth National Mental Health and Suicide Prevention Plan

Work on the first priority area (achieving integrated regional planning and service delivery) included a commitment by all governments to apply the National Mental Health Service Planning Framework (NMHSPF, developed in the 4th plan) to joint regional level planning and providing supports on a stepped care approach to service planning. For the second priority area (suicide prevention), it was noted that there had been no significant reduction in rates of suicide in the proceeding decade. Implementing the National Suicide Prevention Implementation Strategy was a priority to ensure 11 elements, proposed by the World Health Organisation, are incorporated into existing strategies and plans. For the third priority, coordinating treatment and supports for people with severe and complex mental illness, it anticipated the benefits of the NDIS with tailored and coordinated access to services. Improving aboriginal and Torres Strait Islander mental health and suicide prevention, the fourth priority, included establishing a national committee to set future directions for investment and planning, improve access to and experience of mental health and wellbeing services and strengthening the evidence base of services to aboriginal and Torres Strait Islander consumers. The fifth priority focused on improving the physical health of people living with mental illness and reducing early mortality initiatives which committed to the principles of Equally Well – The National Consensus Statement for improving physical health and wellbeing of people living with mental illness. Priorities focused on building treatment of physical illness into the local treatment planning and clinical governance in regional areas and regular national reporting on the physical health of people with mental illness. The sixth priority, reducing stigma and discrimination requires taking into account the specific experience priority groups, including aboriginal and Torres Strait Islanders and the LGBTQIA+. Finally, initiatives to reduce stigma in the health workforce included implementing training to build awareness, respond proactively, provide leadership and empower consumers and carers to speak about the impacts of mental illness.

An aim of the plan was making safety and quality central to mental health service delivery by applying the National Standards for Mental Health Services (NSMHS) and the National Safety and Quality Health Service Standards (NSQHS). Other initiatives included monitoring consumer and carer experiences of care and ensuring service delivery systems monitored safety and quality of services. Enablers of effective system performance and system improvement were included in the plan, which involved collaborative work with the National Mental Health Commission and the National Health and Medical Research Council, to develop the Peer Workforce Development Guidelines, monitor the growth of the national workforce and develop the National Digital Mental Health Framework.

Throughout the 28 years of National Mental Health Reform it has been recognised that jurisdictions will implement reforms at a pace that is determined by the resources available and this has meant that progress has been unequal across the five National plans and between jurisdictions. Each new plan has been agreed by all Governments with a commitment to continuing reforms that commenced in earlier plans that may not have been completed, that is each plan represents an addition to previous reforms not a replacement of previous commitments.

Focus on CAMHS-related content from the National Mental Health Plans

In the 1st and 2nd National Mental Health Plans, child and adolescent mental health was considered part of the overall priorities and recommendations, however there was little that was easily identified as specific to the needs of children and young people.

In the 3rd Plan, child and adolescent mental health was separately identified as requiring agreed actions for the first time. In key directions 20 and 22, the plan specifically noted:

- (20.1) ensure the development of child and adolescent mental health services as a key component of the mental health services framework,
- (20.3) foster improved alignment of mental health policy with child, youth, family and older people policies at Commonwealth and State/Territory levels,
- (20.4) ensure that child and adolescent mental health services and mental health services for older people are better linked with the broader mental health and primary care sectors, and
- (22.1) enhance cooperation between mental health sector and other sectors (such as child and adolescent services) with better articulation of roles and responsibilities.

Furthermore, the 4th Plan committed to further actions addressing child and adolescent mental health, specifically in Priority 2 (prevention and early intervention); identifying that targeted prevention and early intervention programmes for children and their families through partnerships between mental health, maternal and child health services, schools and other related organisations must be implemented.

The plan also proposed that Governments would commit to expand the level and range of support for families and carers of people with mental illness and mental health problems, including children of parents with a mental illness and tailored mental health care responses for highly vulnerable children and young people who have experienced physical, sexual or emotional abuse or other trauma.

A stepped care service model

The Federal Government, together with State and Territory governments and the National Mental Health Commission have advocated for a "stepped care model" for mental health service delivery.

Across a system of tiers, this model enshrines integration; from helping healthy individuals become even more resilient, early intervention when mental health challenges begin through to integrated levels of clinical services and psychosocial support, as discussed in Chapter 1.3.

Some service providers and clinicians have long argued for a graduated service response that starts with less intensive interventions, which may be more effective in reducing symptoms and impairment and improving the quality of life of individuals with mental health problems (Marks, 2010; Bower and Gilbody, 2005). Key assumptions that underpin the stepped care approach include:

- The equivalence assumption, suggesting that for some clinical presentations the gains from low intensity interventions equal the gains from traditional psychotherapy,
- The efficiency assumption suggests that minimal intervention therapies are a more cost-effective use of resources and
- The accessibility assumption suggests that minimal intervention therapies are acceptable to both patients and professionals (Bower & Gilbody, 2005).

From a practical perspective, stepped care models start with a low intensity intervention, that is monitored to establish treatment benefits or lack of response and having the capability to step up to a higher intensity treatment. As minimal delay in progressing to the next level is important, the suggested duration of treatment per level is limited (six weeks to twelve weeks).

Published clinical practice guidelines which advocate a stepped care model (e.g. the UK's N.I.C.E guidelines) generally take the form of:

- Level 1 being 'watchful waiting';
- Level 2 is guided self-help plus or minus support to prevent patient drop out;
- Level 3 is face to face brief therapy; and
- Level 4 is longer term therapy, medication or a combination of both, specifically for consumers with complex and severe challenges.

One of the first applications of a stepped care model in Australia was the joint Tasmania Government – Beyond Blue funded child and adolescent response to the 2013 Dunalley Bushfire disaster (see McDermott & Cobham, 2014; Beyond Blue). This initiative provided services, locally delivered in the Tasman Peninsular, from level 1 (promotion and psychoeducation) to level 4 (trauma-focused cognitive behaviour therapy for individuals who met diagnostic criteria for PTSD). Figure 4.3.ii outlines some of the services provided in response to this disaster and their position in a stepped care model of delivery.

The stepped care model outlined in the current National Mental Health Plan conceptualises that Level 4 services are for individuals with complex and severe mental illness. The National Mental Health Service Planning Framework (NMHSPF) recommends State Government funded services for these individuals. CAMHS, as the State funded Level 4 service, should have a focus on individuals with severe and complex mental illness.

Figure 3.3.ii: *Example of a Stepped Care Response-Dunalley Bushfires 2013*

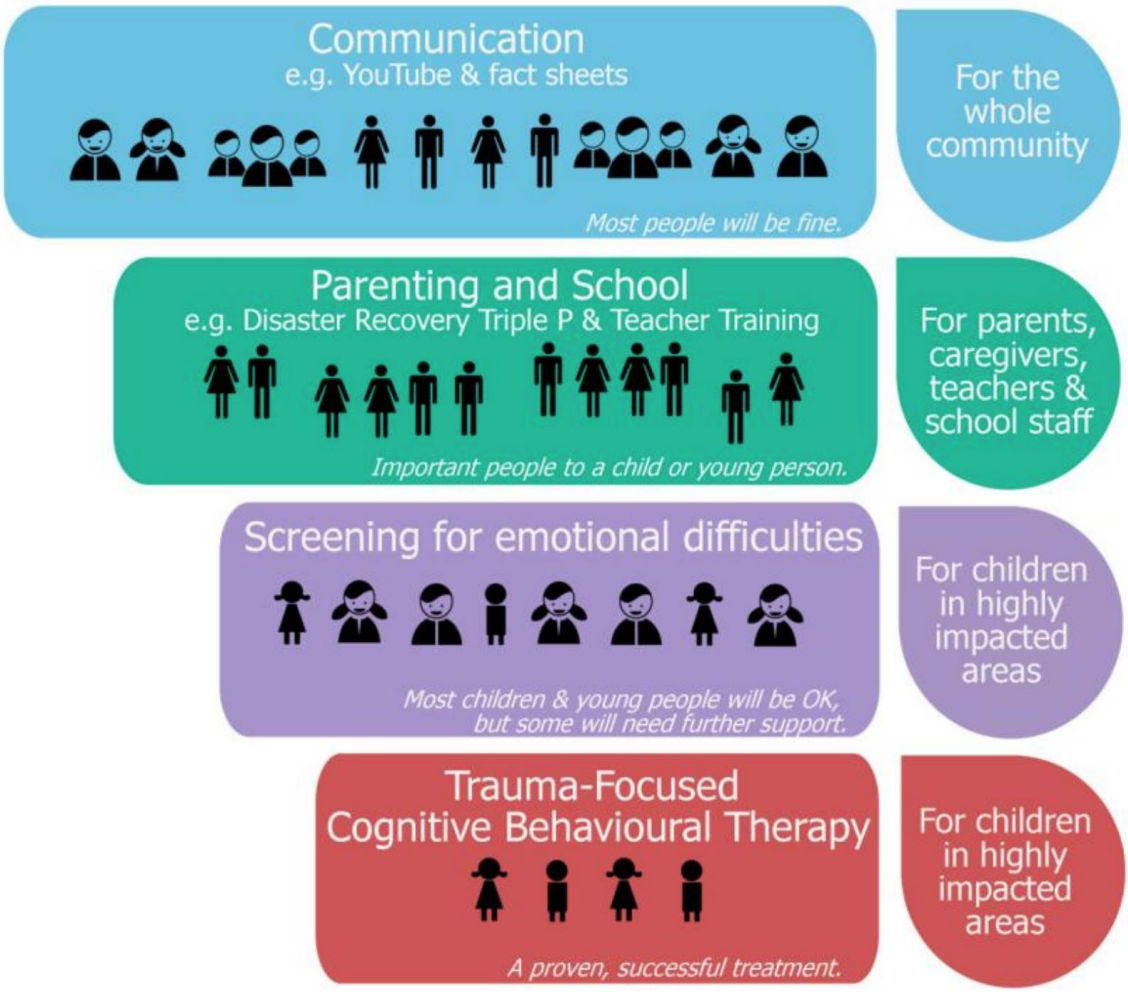


Figure Notes: Triple P: Positive Parenting Program

3.4 National Mental Health Service Planning Framework (NMHSPF)

The National Mental Health Service Planning Framework (NMHSPF) was developed as a commitment under the Fourth National Mental Health Plan to "develop a national service planning framework that establishes targets for … the full range of mental health services, backed by innovative funding models". The first version of the tool, a Microsoft Excel-based population mental health planning tool, was initially developed by the New South Wales Ministry of Health and Queensland Health between 2011 and 2013. The tool is currently in its third version (as of early 2020). Despite improvements, the NMHSPF estimation, outputs and general functionality remain much the same as the original version and have been able to inform CAMHS planning at a State level since late 2013.

The NMHSPF is designed to allow mental health service planners, service directors and managers, and other users to estimate need and expected demand for mental health care and the level and mix of mental health services required to address this need, for a given population.

This is inclusive of mental health services across the lifetime and the full range of a potential workforce including allied, nursing, medical and other practitioners. The model draws on evidence, including published Australian mental health epidemiological data and expert opinion to:

- Estimate the prevalence of mental illness across all disorders within the Australian population, by severity;
- Assign expected service demand rates to each severity level;
- Break down the population with demand for services into 155 need groups based on age group, severity of disorder and complexity;
- For each need group, outline the average types and quantities of services required over a 12-month period to provide adequate mental health care across bed-based, community clinical and psychosocial support services;
- Describe the staffing, salary and operational parameters associated with different service types; and
- Combine the above to produce benchmarks for the resources (e.g. beds, staff, dollars) and activity (e.g. service contacts, hours) required to deliver adequate care to the defined population.

At least four of the 21 recommendations from the Mental Health Integration Taskforce (recommendations 2, 5, 9, and 10) specifically advocate for the use of the NMHSPF to guide aspects of service development and design improvements identified as important and its use was agreed in the government response to the taskforce recommendations. Over and above the uses for the tool identified in the government response, it is envisaged that addressing several other recommendations may require use of the tool and consideration of the resultant outputs. It is anticipated that the NMHSPF will be used in order to inform the development of services resulting from recommendations set out in this report.

3.5 National Framework for Recovery-Oriented Mental Health Services

The National Framework for Recovery-Oriented Mental Health Services (the Recovery Framework) was developed under the 4th National Mental Health Plan and released in 2013. As a component of the National Mental Health Strategy it has one of the highest degrees of recognition by people with lived experience of mental illness and mental health problems. The framework applies to all age groups, including older adolescents with mental health challenges, children with similar issues during the transition to adolescence, and the parents of these children and adolescents.

The Framework describes Recovery as the process that helps people to be able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues. Recovery is more than the alleviation of symptoms or distress; it includes an increased sense of wellbeing regardless of continuing symptoms. Personal and clinical recovery are complementary and supportive of one another.

The framework is designed for and by people living with mental health issues to describe their own experiences and journeys. Importantly, it is possible to provide recovery-oriented treatment in situations where choice is limited (i.e. even when subject to restrictions under Mental Health legislation), as well as joint or supported decision-making about risk management, promoting safety and jointly constructed service plans to increase autonomy. The clinical practice implications include collaborative working alliances with consumers are required and the need to foster personal responsibility and promote shared decision making. Consumers' self-determination is vital, and a balance needs to be struck taking into consideration medico-legal requirements and duty of care.

The recovery framework includes 5 domains and a set of 17 capabilities that support people to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations. Figure 4.5.i provides an overview of how the domains and capabilities relate to each other.

Figure 4.5.i: *Recovery framework domains and capabilities*

Domains				
	Domain 1: Promoting a culture and language of hope and optimism (overarching domain) The culture and language of a recovery-oriented mental health service communicates positive expectations, promotes hope and optimism and results in a person feeling valued, important, welcome and safe.			
	Domain 2: Person 1st and holistic	**Domain 3: Supporting personal recovery**	**Domain 4: Organisational commitment and workforce development**	**Domain 5: Action on social inclusion and the social determinants of health, mental health and wellbeing**
Capabilities	Holistic and person-centred service	Promoting autonomy and self-determination	Recovery vision, commitment and culture	Supporting social inclusion and advocacy on social determinants
	Responsive to Aboriginal and Torres Strait Islander people	Focusing on strengths and personal responsibility	Acknowledging, valuing and learning from lived experience	Challenging stigmatising attitudes and discrimination
	Responsive to people from immigrant and refugee backgrounds	Collaborative relationships and reflective practice	Recovery-promoting service partnerships	Partnerships with communities
	Responsive to gender, age, culture, spirituality and other diversity		Workforce development and planning	
	Responsive to lesbian, gay, bisexual, transgender and intersex people			
	Responsive to families, carers and support people			

Source: A national framework for recovery-oriented mental health services: Guide for practitioners and providers (2013)

Language is especially important, and person first indicators are used wherever possible (i.e. 'person with lived experience', 'experts by experience' rather than 'clients/service users/patients'). Mental health issues, challenges and emotional distress are used instead of mental illness.

Recovery approaches began in the1970s as part of a civil rights movement aimed at restoring human rights and community participation and although some have viewed them as an alternative to the medical model, it was originally viewed as a complementary approach.

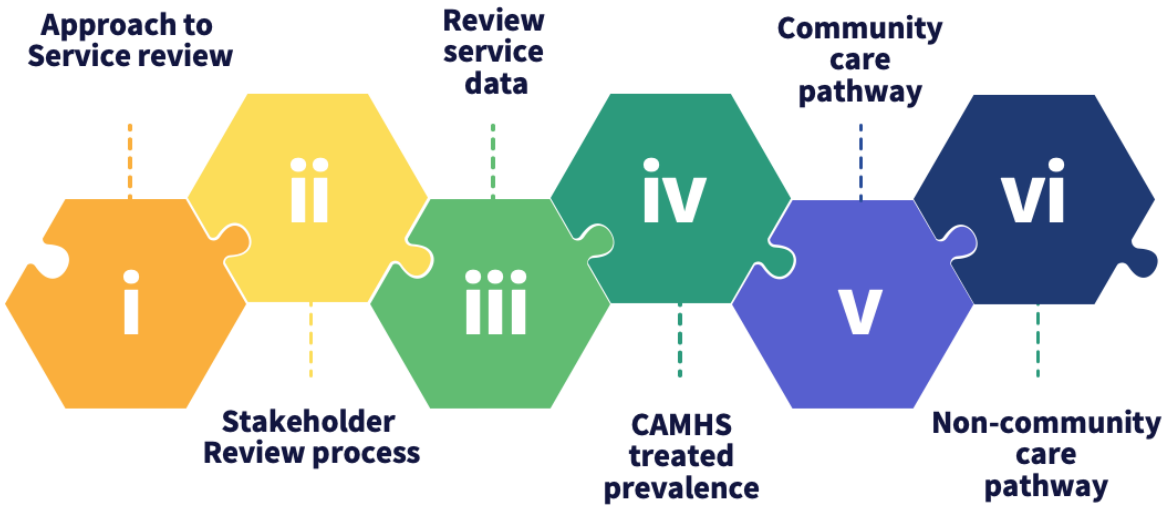
The approach outlines that recovery is individual to the person with mental illness, with the central paradigms: hope, self-determination, self-management, empowerment and advocacy. Commonly cited characteristics of recovery include a unique and personal journey, a normal human process (Mental Health Coordinating Council: this "demystifies the process of recovery"), an ongoing experience and not the same as an end point/cure and a journey rarely taken alone.

The experience of recovery is influenced by cultural identify, explanatory models of illness, distress and wellness.

In the context of child and adolescent mental health, individuals can be frequently identified whose lived experience of prejudicial early care, including sexual, physical and emotional abuse, has profoundly undermined their sense of identity, personal control and hope for both the immediate and long term. These challenges are invariably long standing.

For CAMHS to provide recovery-orientated interventions and services, it needs to engage these consumers and carers for long enough and with sufficient intensity to positively alter their trajectory. Brief interventions will not help consumers with severe and complex needs in a recovery journey.

4. CAMHS Provision of Care



4.1 Approach to service review

The team leaders from the three CAMHS teams across Tasmania were interviewed. Wherever possible this included the input of the team consultant or another staff member responsible for intake or duties related to the area relevant to the review topic discussed. Multiple interviews were undertaken and followed the typical clinical care pathway approach (e.g. referral, triage, assessment etc). Consultations with larger groups of clinic staff were also undertaken toward the end of the Review. However, as a consequence of a range of restrictions put in place as a result of the COVID-19 global pandemic, the ability to hold additional consultations with CAMHS services was curtailed.

4.2 Stakeholder review process

The service leaders/heads of organisations, health services, Government departments, statutory officers and NGOs that referred consumers to CAMHS, or in any way had a duty of care for children and adolescents with mental health challenges, were approached to see if they wished to participate in the review. All individuals approached confirmed they would like to be involved, and this was conducted through a mix of telephone or face to face interviews. A small group of consumers and parents/carers were asked about their experiences, although this was also somewhat limited as a result of COVID-19 restrictions. In addition, where an interviewed individual suggested other stakeholders who, in their opinion, would be interested in contributing, this was followed through by the Reviewer. Given both time constraints and the unusual contextual issues related to the COVID-19 pandemic, it was not possible to consult with all relevant stakeholders. However, given the consistency of the information that was provided during the review it is unclear whether a more exhaustive consultation would have yielded markedly different information.

4.3 Service data review process

The Reviewer experienced considerable difficulty obtaining service-related data. Data that has been reported in this review was existing data available to CAMHS Team leaders. In other parts of Australia, services would have access to a much greater amount of information about their service. A contemporary CAMHS service requires rapid access to appropriate data, the skills and literacy to use and interpret it, or access to a support system that can facilitate this, if they are to use information to improve their service. This report includes recommendations relating to data access and the use of information.

4.4 Treated prevalence by CAMHS and by socioeconomic status

Table 4.4.i outlines the population, reported caseload, and associated sociodemographic characteristics of the three catchment areas and the LGAs that comprise them. In general this aligned with the overall population distribution, with just over half (51%) of the state's child and adolescent population in the Southern CAMHS catchment (49,119 children and adolescents between the ages of 4-19), followed by 27.2% in Northern CAMHS (26,011 individuals) and 21.5% in North Western CAMHS (20,596 individuals).

The total and active annual clinical cases for the 2019 calendar year are also displayed in Table 4.4.i. The ratio of total annual cases to active clinical cases was similar across all three catchments, a potential indicator that the approximate treatment period for patients was similar. The ratio was approximately two, which indicates that the average duration of care was approximately six months (or that on average two patients were treated for every single available treatment place, assuming 100% service utilisation and no change in service capacity over the 12-month period).

The prevalence rate was calculated by dividing the total clinical cases by the population for each LGA/Catchment/Tasmanian population and is displayed in Table 4.4.i. The results indicate significant differences in morbidity levels across the state, although some caution in the interpretation of the rates is warranted given the relatively small number of cases and corresponding populations of some LGAs. The LGA with the highest level of diagnosed morbidity for children or adolescents was Burnie at 47 per 1000 population, or about 4.7% of the total population (marked in orange). The rate was similar for Flinders with a very small population (47 per 1000 population, 4.7%) and only slightly lower for Devonport (39 per 1000 population, 3.9%). The three LGAs with the lowest presentation rates (marked in green) were all in the Southern Catchment. The Southern Midlands (6.6 per 1000 population) had the lowest prevalence with Brighton and Tasman tied for the second lowest rate (8.5 per 1000 population). The overall rate for CAMHS activations across the state was 22.9 per 1000 population, or about 2.3% of the general population.

The prevalence of CAMHS presentations across the LGAs are presented in Figure 4.4.i based on the data reported in Table 4.4.i. Figure 4.4.i provides an indication of the deviation of LGAs from the state average CAMHS treatment prevalence (22.9 per 1000), with LGAs

markedly above the state average in red and those below in blue. The map clearly shows that the rate of CAMHS admission is elevated in the LGAs in the North East of the state, with the more rural LGAs indicating a lower than average prevalence. The greater Hobart area has the largest population density and as such dictates the average CAMHS treatment prevalence rate.

Table 4.4.i: *Approximate CAMHS population (5-19 years), number of clinical cases, presentation prevalence and state percentiles of socioeconomic disadvantage*

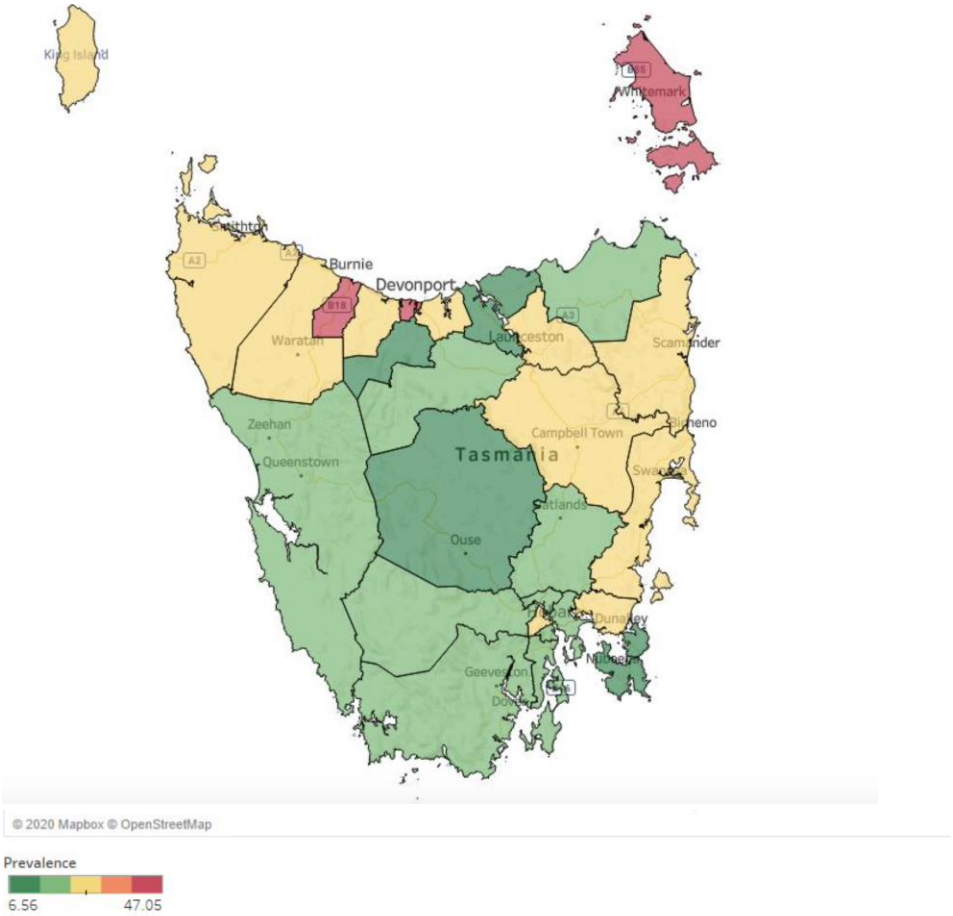
LGA[1]	LGA Population Estimate (5-19)[2]	Active Clinical Cases[3]	Total Clinical Cases[3]	Prevalence Rate (Total Clinical Cases per 1000)	IRSD (2016) (Percentile Ranking)[4]	IER (2016) (Percentile Ranking)[4]
Southern CAMHS						
Brighton	3,826	42	85	8.5	11	17
Central Highlands	351	1	3	21.0	14	34
Clarence	10,240	107	215	15.4	91	91
Derwent Valley	2,019	17	31	23.2	17	31
Glamorgan/Spring Bay	517	6	12	24.0	54	47
Glenorchy	8,760	107	210	16.3	27	11
Hobart	8,461	65	138	20.8	97	61
Huon Valley	3,125	33	65	17.2	67	71
Kingborough	7,557	65	130	24.9	94	97
Sorell	2,770	33	69	16.8	71	81
Southern Midlands	1,188	7	20	6.6	44	87
Tasman	305	1	2	8.5	34	51
Catchment Total	**49,119**	**484**	**980**	**20.0**		
Northern CAMHS						
Break O'Day	868	12	23	26.5	21	27
Dorset	1,149	12	21	18.3	37	44
Flinders	128	3	6	46.9	74	37
George Town	1,264	9	14	11.1	4	7
Launceston	12,318	142	287	23.3	47	24
Meander Valley	3,575	33	63	17.6	81	84
Northern Midlands	2,259	35	60	26.6	64	64
West Tamar	4,450	27	51	11.5	87	94
Catchment Total	**26,011**	**273**	**525**	**20.2**		
North Western CAMHS						
Burnie	3,741	87	176	47.0	31	21
Central Coast	3,960	53	114	28.8	61	54
Circular Head	1,626	24	46	28.3	57	57
Devonport	4,829	88	190	39.3	24	14
Kentish	1,088	7	15	13.8	51	77
King Island	244	3	6	24.6	84	74
Latrobe	1,929	29	53	27.5	77	67
Waratah/Wynyard	2,454	37	71	28.9	41	41
West Coast	725	6	13	17.9	7	4
Catchment Total	**20,596**	**334**	**684**	**33.2**		
State Total	95,726	1,091	2,189	22.9	N/A	N/A

Notes/Sources:
1: LGA: Local Government Area
2:Regional Population by Age and Sex, Australia, available: https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3235.02018 (Accessed 14/04/2020)
3: Active clinical cases are cases which were active at the time of data extraction. Total clinical cases refer to the number of unique individuals seen in the service over a 12-month period
4: Socio-economic indexes in Australia (SEIFA), 2016 2033.0.55.001 (Accessed 14/04/2020). IRSD: Index of Relative Socioeconomic Disadvantage, IER: Index of Economic Resources.

Figure 4.4.i illustrates the difference in the prevalence rates of treated CAMHS clients across catchments: Although Southern CAMHS had the highest number and the greatest proportion of clients, the number of active CAMHS patients relative to the population (termed prevalence) was the lowest in the state (20.0 per 1000).

The rate for Northern CAMHS was similar (20.2 per 1000). The prevalence in North Western CAMHS was 50% higher than other catchments (33.2 per 1000). Assuming the causes of psychiatric morbidity in Tasmania are similar to the rest of Australia, this discrepancy indicates a markedly poorer socioeconomic profile in the North Western corridor relative to the rest of the state. Lower sociodemographic rankings may also indicate a more clinically complex cohort with increased support requirements.

Figure 4.4.i: *Prevalence of CAMHS presentations across Local Government Areas (LGAs)*



Note: Green indicates a lower prevalence while red indicates a higher prevalence.

The last two columns of Table 4.4.i. provide LGA level state scores for two commonly used Socioeconomic Indexes for Australia (SEIFA): Index of Relative Socioeconomic Disadvantage (IRSD) and the Index of Economic Resources (IER). The first measure scores each area by summarising attributes of the population, such as low income, low educational attainment, high unemployment and jobs in relatively unskilled occupations. It reflects the average level of disadvantage of the population of that area. The IER focuses on the financial aspects of relative socio-economic advantage and disadvantage, by summarising variables related to income and wealth.

The IRSD and IER indices for Tasmanian LGAs are consistent with the higher treated prevalence in the north-west. For example, the IRSD and IER rates for the two major north west population centres are 31 and 21 (Burnie) and 24 and 14 (Devonport).

These rates are lower than for Launceston (47 and 24 respectively) and very much lower than Hobart (97 and 61 respectively).

4.5 Community care pathways

4.5.i Referral to CAMHS

Referrals from the Mental Health Helpline

All CAMHS services agreed that the usual referral process was via the mental health helpline (MHHL). All three services emphasised that the name of the MHHL was misleading; it was really a referral portal and triage rather than a helpline. CAMHS services noted that occasionally assistance was offered through the MHHL. However, this was dependent on the expertise of the practitioner and was less likely to be of high quality if the presenting individual was under 12 years of age. The MHHL was also used when professionals, including GPs and paediatricians, wished to refer to CAMHS.

Issues with the MHHL included all CAMHS services noting that GPs and paediatricians were chronically unhappy joining the telephone queue to refer patients. When directly consulted, GPs and paediatrician stakeholders were also firmly of this opinion. These perceived difficulties with the MHHL are thought to be an incentive for practitioners to send patients directly to Accident and Emergency (A&E) Departments, circumventing the MHHL process. All CAMHS services stated that child and adolescent mental health expertise demonstrated by MHHL staff was variable. This assertion was agreed to by both clinicians and consumers, with numerous examples.

In addition, the Tasmanian Department of Health undertook a survey of the MHHL in late 2019 that overlapped with CAMHS Review. It found a range of similar issues including the need for greater collaboration with all stakeholders in the assessment and discharge planning phase, improved communication and liaison with referral services, improving the transfer of care process and increasing specialised professional development opportunities for staff.

Referrals from Accident & Emergency Departments

All CAMHS services stated that between 10% to 20% of referrals came directly from their local A&E Department. All services have different processes for interactions with A&E and utilisation of local acute response teams. In the North West, the crisis assessment and treatment (CAT) team prefer all patients under the age of 18 to be assessed by CAMHS, with a local key performance indicator of a CAMHS clinician arriving at A&E within two hours to undertake this assessment being monitored on a regular basis. In the South, approximately 1 to 2 new referrals per week come from the Royal Hobart Hospital to the CAMHS team, who cover A&E from approximately 8:30 to 5:00 pm on weekdays. This often includes referrals from paediatrics, and occasionally from adult psychiatry or from A&E clinicians.

In the North, A&E presentations of known clients are seen by a CAMHS worker who will go to the A&E Department to review them. If not a known patient or if after hours, the assessments are undertaken by the CAT team.

An issue with these processes is that it was generally thought, most CAT clinicians did not have specific CAMHS training and as a result the specific expertise of CAT clinicians was much lower when reviewing children under the age of 12 years, or if the consumer presented with autism spectrum disorder, a major behavioural problem, a degree of intellectual disability or if the parents did not want to take the child home, compared to their assessments of adults.

Referrals from other sources

There is some inconsistency across the three services in dealing with referrals from paediatricians. In the North, a referral from the paediatric inpatient ward (if urgent) will be seen by a CAMHS clinician attending that service. If not urgent, it will go through to MHHL. This is similar in the North West, with the caveat that the referral process has recently been improved by a regular CAMHS-paediatrics meeting. In the South these referrals are seen by the RHH-CAMHS inpatient team.

Issues treating groups seen as difficult to provide services for

There are local business rules that prevent or actively discourage the referral of individuals with certain types of clinical presentation. For example, teams stated that paediatricians generally see individuals with ADHD in Tasmania. The Southern service also noted that paediatricians tended to manage individuals with oppositional defiant disorder (ODD) although, if there was increased complexity with other comorbid mental health problems, these individuals could be seen by CAMHS. Across the state, referrals of children less than five years of age are rarely seen, no matter the diagnosis. This pattern of service delivery differs from the larger mainland states of Australia.

Children with autism spectrum disorder or developmental disorders 'alone' are generally not accepted. Individuals with intellectual disability, especially if their IQ is very low, were generally not accepted into CAMHS. This was based on a perceived skills deficit to work with this population, as well as the perception of limited CAMHS resources. It was noted by several services and stakeholders that providing services for children with intellectual disability, and children and adolescents with challenging behaviours both with and without a mental health diagnosis, was a current gap in CAMHS service provision in Tasmania and is not provided for by any other service provider at a satisfactory level. There was a general perception this had become worse with the closure of pre-NDIS services. There was a widespread perception that the NDIS had 'not stepped up' to service this population.

Children who experienced sexual assault and abuse were generally not accepted by CAMHS. Numerous stakeholders were 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.

Youth with drug and alcohol issues were said to have been seen by the youth component of the local adult drug and alcohol service.

4.5.ii Triage procedures

All sites were consistent in their use of the triage category system. For example, a category 2 referral was deemed as urgent and was to be seen within two hours; a category 5 referral was not urgent and had to be seen within two weeks. It was noted from both the North and Southern services that 'category 5s' often have a second triage phase which included CAMHS contacting the family and/or the referrer. This was often required because there was either very little referral information or to clarify elements of the referral, including patient risk. Occasionally this process led to re-categorisation to a category 3 or 4. The Southern service process for a category 5 was to send an opt in (to attend an assessment or single session consultation) letter. It was noted that Southern CAMHS clinicians would prefer more contemporary forms of communication including texts and emails, however, the leadership group felt that this was not supported at a senior management level within the SMHS.

In the North West, all intakes were taken to a 9am MDT meeting attended by all clinicians. There was also the availability of an ad hoc meeting which usually involved the team leader, clinical lead, senior social worker and a consultant. The North service also has intakes presented and prioritised at a morning MDT meeting which is often attended by 10 to 15 clinicians. The Southern service has two intake MDT meetings a week, where all referrals are discussed.

4.5.iii Assessment

Variability of CAMHS assessment procedures were an example of the lack of a state-wide CAMHS coordination; all centres assessed patients in different ways. Clinicians from the Northern service estimated that 70% to 75% of assessments were a "one to four assessment" process. This comprised of one-hour sessions with; only the parent(s), the young person, a family session, presentation of the case to the MDT, and then a feedback session with the family. Occasionally this was extended to include a school observation. Generally, sessions were one per week equating to a four-week assessment period. The Southern service was seen to be in a state of flux, with a relative decrease in offering single session family consultations (SSFC) and an increase in 'one-off' assessments. It would appear the latter is now the preference and the service undertake between 6 to 10 per week. One-off assessments are usually conducted by a doctor but could be undertaken by any clinician. Sometimes two clinicians are present depending on expertise. The Southern team is currently working towards more standardisation of this procedure. The North-West team does not use the '1 to 4' process and generally completes assessments over one to two clinic visits. Assessments are generally undertaken by one staff member although this depends on experience. The TAG proforma was regularly used as part of the assessment; however, this tended not to be used in recent times given the TAG was seen to be more of an administrative task rather than a useful clinical tool.

The Reviewer became aware that the TAG is generally considered to be of little clinical utility and is likely to be replaced as part of a SMHS wide process to adopt a modern approach to risk mitigation.

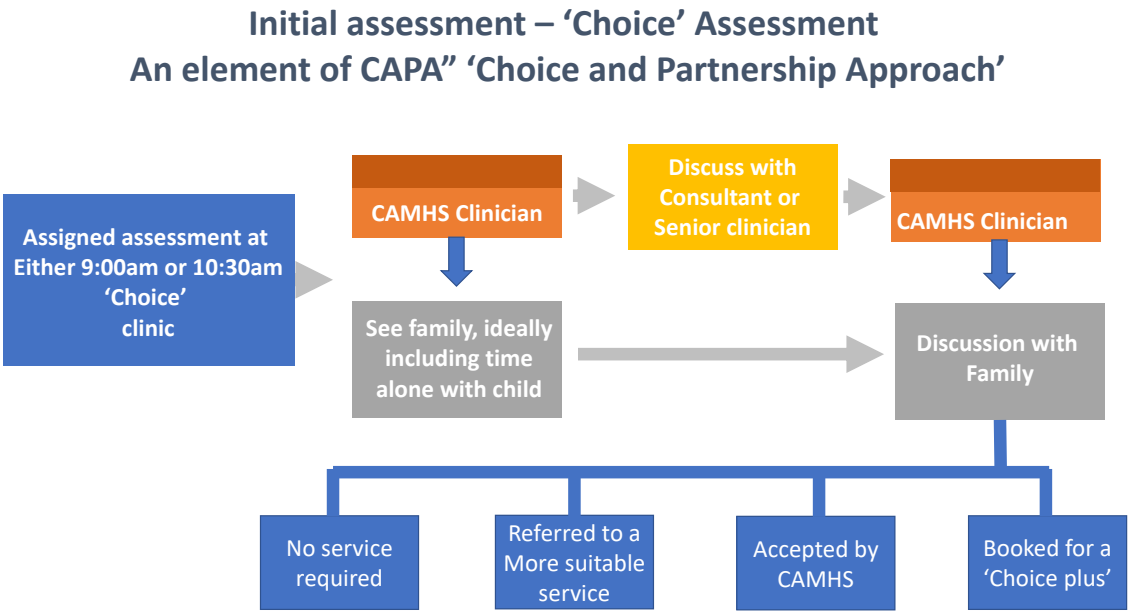
The various CAMHS assessment practices provide challenges to consumers and service efficiency. The '1 to 4' assessment procedure is a major commitment and burden to consumers with up to 4 hours of assessment prior to any therapeutic input. The procedure appears to be the default for the Northern team and does not relate to levels of presentation acuity. The procedure confers a risk of serious reputational damage to CAMHS given community adult mental health, paediatric services, general practices, and private practitioners all complete an assessment in approximately one hour. It is hard to justify how 4 hours can be required; indeed, the Medicare provider number for psychiatric assessment (item 296 initial consultation for new patients in the rooms) has 45min as the entry time to qualify for this item.

The Southern service offers SSFC, neither the North nor North West service do so. There are numerous concerns that can be raised about the SSFC process, indeed many stakeholders outside CAMHS, hold strong negative opinions about this practice. At its most fundamental, the last 15 years of National Mental Health Reform has been underpinned by the commitment of State Governments Specialist CAMHS to be tailored to focussing on those children and younger people with severe mental illness or complex mental health problems. Features of these presentations include high levels of risk and aetiological complexity.

If a presentation is effectively treated by a one session intervention it is highly likely the presentation was not severe or complex. Complexity often includes the experience of emotional trauma of some form (physical or sexual abuse, emotional neglect)–seeing a family group without time alone with the child or adolescent does not facilitate conversations about trauma, including some young people stating they are being abused. Similarly, assessing an individuals' suicidal distress cannot be either adequately or appropriately undertaken in a group setting (Lawrence et al 2015).

From the perspective of a stepped care model it is unlikely that this procedure would be a valid offering for a level 3 or 4 service. It is important to note, that this procedure could be a useful offering of a level 2 service and could be provided by an NGO or government entity in this context. Consistent with these comments, the evidence base for SSFC supports its use for the types of presentations that should not be the main business of Specialist CAMHS. The current direction of the Southern team to conduct more one-off assessments (as opposed to single session interventions) is strongly supported.

Figure 4.5.i: *An outline of The Choice and Partnership Approach (CAPA)*



The Choice and Partnership Approach (CAPA), see in Figure 4.5.i, has its origins in the UK as well as being the assessment model of choice in many New Zealand and Australian jurisdictions. At a typical 'Choice Clinic' (for example Townsville CAMHS, Queensland) 3-4 families attend the 9am assessment times, 3 mornings per week. After a 50-minute assessment the clinician briefly presents the case to a child and adolescent psychiatrist (if unavailable then to the team leader or clinical senior). The presentation includes a working diagnosis. A discussion follows about whether a mental health intervention is warranted and if so whether CAMHS would be the most appropriate intervening service compared to other options (e.g. headspace). In approximately 1 in every 10 presentations, the consumer is invited to return for a second assessment session (a 'choice plus') prior to reaching a working diagnosis. Complexity is usually not a reason for a choice plus, the more complex the presenting issues the more likely the consumer should be accepted by CAMHS. In the Townsville service between 18- 24 new patients are seen per week. The is no waiting list. Every patient is given a provisional diagnosis. Approximately 55% of consumers are offered a CAMHS intervention.

4.5.iv Acceptance onto care

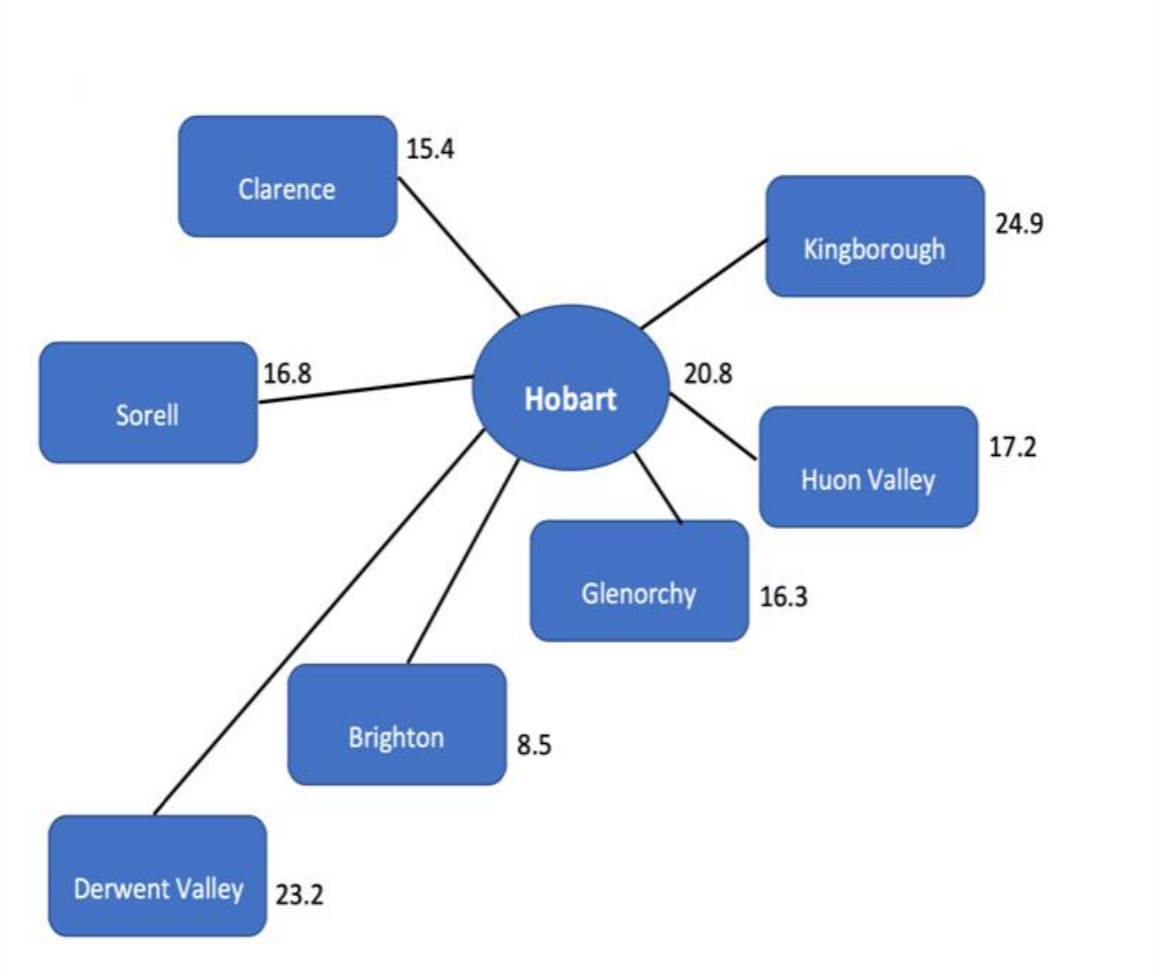
Figures 4.5.ii-4.5.iv represent each regional CAMHS 'total clinical cases' per 1000 child and adolescents (age range 4-19 years) for the 2019 calendar year.

Southern CAMHS

When considering total cases, it is very clear that the Southern CAMHS Service is not a Hobart-only service. Indeed, despite the clinic location, the total cases from the Hobart LGA area are not the highest of all LGAs with populations greater than 10,000 individuals. Among these LGAs, the rate of total cases per thousand population varies from Brighton (8.5 per 10000) to the Kingborough rate which is approximately three times that rate (24.9

per 10000). Figure 4.5.ii displays these locations and their relative direction and proximity from Hobart.

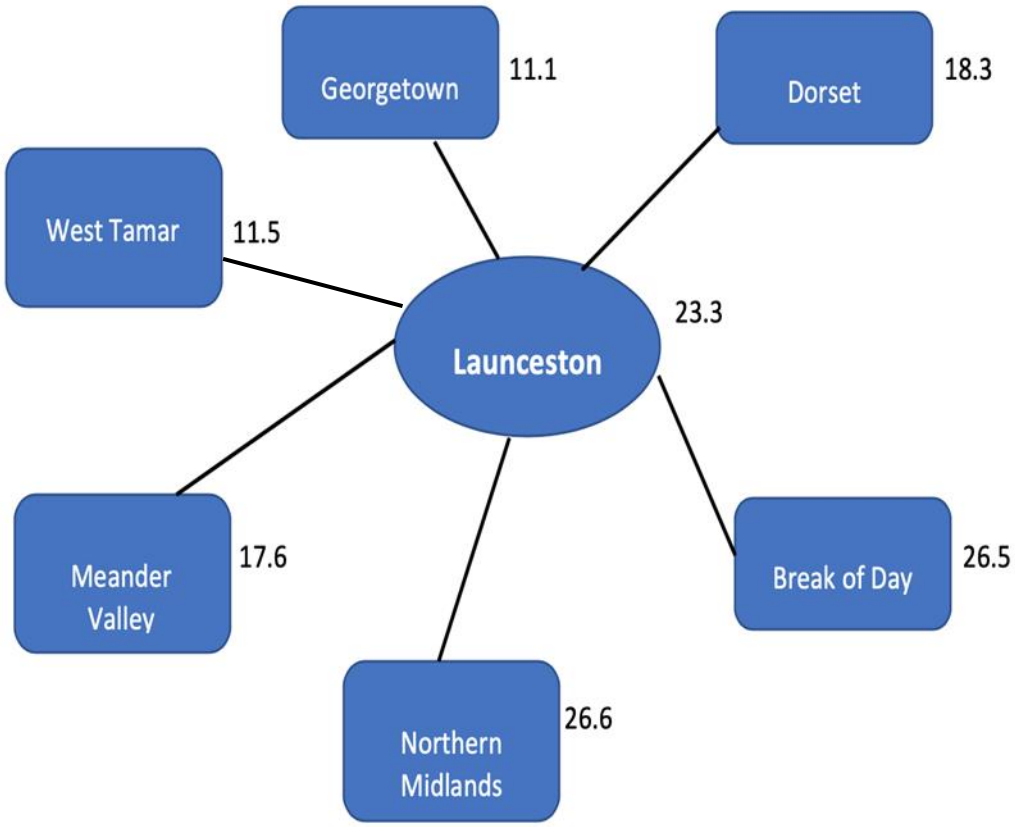
Figure 4.5.ii: *Southern CAMHS: Total clinical cases 2019 (per 1000 population age 5-19 years) by Local Government Area (LGA) with population >10,000*



Northern CAMHS

When considering total cases, 54.6% resided in the Launceston LGA. The next largest contributions to total cases were Meander Valley (12.0%), Northern Midlands (11.4%) and West Tamar (9.7%). The highest rates were from Break of Day and Northern Midlands LGAs (Figure 4.5.iii), however, there were low numbers of cases from these areas (23 and 60 respectively). The Launceston LGA has both a relative high rate and number of cases, approximately 4.5 times more than Meander valley, the next highest LGA. Georgetown stands out as being both lower across a range of socioeconomic indexes (see Table 4.4.i) and geographically closer to the Launceston clinic than in Break of Day or Dorset and yet the rate is only 11.1/1000.

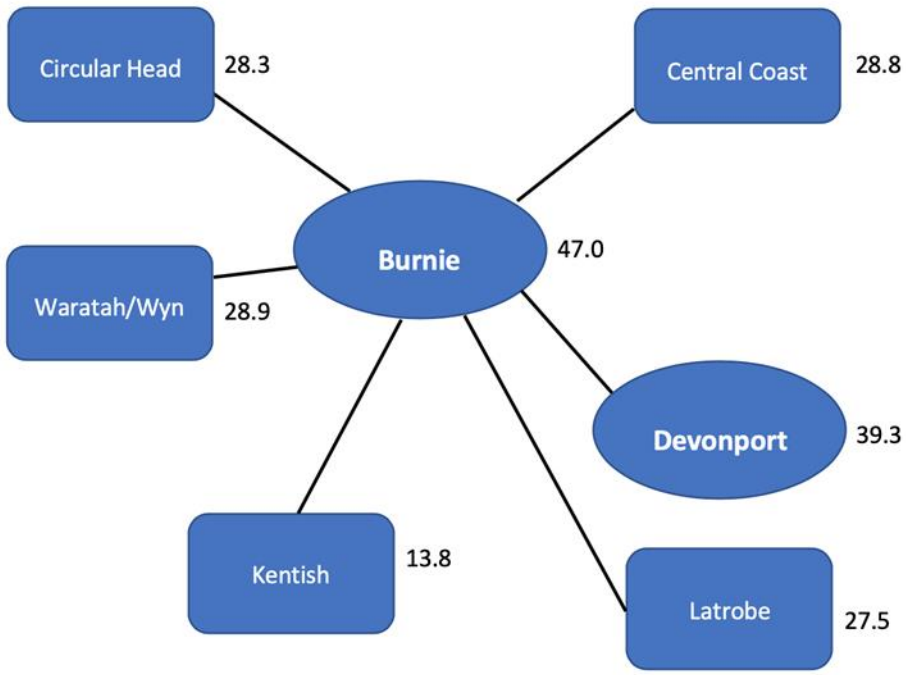
Figure 4.5.iii: *Northern CAMHS: Total clinical cases 2019 (per 1000 population age 5-19 years) by Local Government Area (LGA) with population >5,000*



North West CAMHS

When considering total cases, a similar proportion of total cases was seen in Devonport (27.8%) and Burnie (25.7%). Consumers from the Central Coast were also a large minority (16.7%), whereas individuals from other sites were relatively few (e.g. Waratah/Wynyard 10.4%, Latrobe 7.7%, Circular Head 6.7%), or very few (e.g. Kentish 2.2%, West Coast 1.9%). The rates of people being seen (clinical cases per 1000 children) were generally higher in the North West than rates in the South or North (Figure 4.5.iv). The two highest rates in Tasmania (excluding Flinders which only had 6 cases in 2019) were both in the North West: Burnie (47.0) and Devonport (39.3). Relative to other LGAs, high rates were also seen in Latrobe, Waratah/Wynyard, Central Coast and Circular Head.

Figure 4.5.iv: *North West CAMHS: Total clinical cases 2019 (per 1000 population age 5-19 years) by Local Government Area (LGA) with population >5,000*



4.5.v Clinical Interventions

Unless a majority of clinicians were interviewed or clinical notes analysed, it is very difficult to determine what interventions are actually being delivered to consumers and at what volume. This is not specifically a Tasmanian CAMHS issue, rather an international phenomenon. Unless the treatments are a part of funded (usually University protocol driven) research with built in measures of treatment fidelity, non-pharmacological CAMHS interventions are difficult to quantify.

In the case of Tasmanian CAMHS, the other difficulty relates to differences across the three sites. All teams have little access to child and adolescent psychiatry time. This clearly has an impact on psychopharmacology; both the instigation and monitoring of such therapy. All teams also have only limited access to speech and occupational therapy. The North West team currently has no clinical psychologist. The latter must impact on the delivery of evidence-based cognitive behavioural and related therapies. On a more positive note, all CAMHS teams clearly state their commitment to evidence informed care. In Chapter 8, when discussing service enhancements, a challenge of CAMHS in providing more assertive mobile outreach services to dysregulated often traumatised children will be the expertise currently held within CAMHS to effectively intervene with these consumers. It is likely that substantial upskilling of the workforce will be required.

4.5.vi Discharge from the service

All CAMHS sites were similar in their discharge procedures and stated that their discharge practices where consistent with polices and procedures throughout the SMHS (for example SMHS Exit/Discharge/End Episode of Care Procedure [P2012/0721]). This procedure requires that all exiting consumers receive a final MDT clinical review, have satisfactory ongoing follow-up, are referred to other service providers if appropriate, are aware of relevant re-entry procedures and have completed documentation.

The majority of the procedure is in dot points under the heading 'process' and includes detail about when exit planning should start, the possibility of maintaining an internal referral for cases of chronic illness, the need to finalise episodes of care, the need to have the MDT endorsement, a formal written exit plan and information on re-entry. There is also an exit completion checklist.

Of note, there is no CAMHS specific section for this SMHS procedure. This seems appropriate given the suitability of the current text to CAMHS. Although a CAMHS specific section could note that referral to other service providers could be both for the individual (e.g. headspace) or for the parents and/or caregivers (such as parenting programs from Relationships Australia). Other CAMHS specific exit details would be obtaining permission to include school authorities, e.g. Guidance Officers, in exit planning and documentation. Many CAMHS clinicians were of the opinion that Tasmania had relatively few NGO and other child and youth friendly stepdown options able to continue some level of care at a non-clinical level. Example of stepdown options may be stepdown assistance with social skills development, return to school, work readiness and pre-employment support, and assistance with accommodation.

4.5.vii Outreach by iConnect

A Federal funding initiative in 2014 led to the creation of the iConnect service. The contract was awarded to Life Without Barriers (LWB), the parent organisation of iConnect. LWB has extensive national capacity and visibility in out-of-home care service provision, as well as youth family support, intensive family engagement, and disability services. LWB's current contract finishes in June 2021. The iConnect service extends the capability of CAMHS by providing community-based rehabilitation and clinical interventions. This is operationalised by iConnect workers receiving referrals from CAMHS and following up these consumers in the community. iConnect also provide community-based family support interventions.

iConnect workers are from justice, youth mental health and family engagement service backgrounds. They receive extensive training to work in community settings and have at least one-hour supervision per week on reflective practice, case review and review of complex care plans. All iConnect cases are referred from CAMHS. Reasons for exclusion include if the patient's circumstances are highly unstable, they are an inpatient or often hospitalised, or are clearly becoming more unwell. Having complex challenges and needs is within scope, including those who deliberately self-harm or who have suicidal ideation.

Similarly, individuals who have child protection histories or are currently involved with child safety are not excluded. Diagnosis is not a reason for exclusion, although consumers with eating disorders are less often seen by iConnect.

Typical care lasts for 6 to 12 months, although it is feasible that someone could have a longer period of care. Generally, clients are seen weekly, occasionally more so, depending on their current mental health. On occasion an iConnect worker will work alongside the youth mentoring support worker; the latter helping with activity-based interventions and group program uptake. Educational support can also be accessed through LWB with funding from the Education Department. Caseload is typically 7 cases for a 0.8 FTE worker with a 'rule of thumb' of half a day input per client per week. Reviews occur every three months. Service exit is a coordinated case closure process generally over a three-month period. The capacity of iConnect includes two workers in the North-West and two in the North of the state. There are 1.5 FTE workers in the South augmented by 0.6 FTE youth mentoring and all the management capacity is in the South including 2 0.5 FTE and a 0.3 FTE admin.

There is little doubt that iConnect is very well respected by CAMHS and undertakes the crucial role of being mobile, out-reach and more able to provide assertive care then CAMHS. iConnect consumers are more likely to see individuals with complex and severe mental health challenges and somewhat, by definition, those that are less likely to attend a clinic. Discussions with the iConnect service managers showed a very clear understanding of referral pathways, training needs, supervision and processes around case review.

Chapter 7 discusses service enhancement of the mobile outreach capacity of CAMHS. Related recommendations are for further discussions with iConnect to define the role of this service in the reform process, especially after the current iConnect contract is completed. Options include the amalgamation of the iConnect capacity within CAMHS or going forward with an integrated public-NGO arrangement, see section 7.5.

4.5.viii Role of the Multidisciplinary Team (MDT)

A strength of CAMHS, both nationally and internationally, is the wealth of experience and perspectives that can be brought to any clinical scenario by a multidisciplinary team inclusive of allied health, nursing and medical practitioners. This is without dispute.

However, in Tasmanian CAMHS, to varying degrees across the three teams, routine clinical decision making is made by the MDT; this is both unusual and inefficient. For example, it is not uncommon for ten clinicians to be involved in intake discussions where two senior clinicians could efficiently undertake this task. It is not unusual for routine clinical reviews to be presented to the whole clinical team; again, a highly inefficient process which takes away a large amount of time which could be dedicated to direct clinical care.

The centrality of the MDT is notable in CAMHS documentation as well as in day to day practice. One CAMHS document cites the preference for clinicians to consider "conducting the (hospital) assessment with a colleague to facilitate accurate note-taking, more robust clinical decision-making". This preference may not be CAMHS-specific. The SMHS

Exit/Discharge/End Episode of Care Procedure P2012/0721 (which is not a CAMHS-specific document) states the, "MDT must endorse all consumer exit plans", again building inefficiency into this process.

CAMHS leadership should consider the resource implications of the MDT as the default for service provision decision making. It is clearly not an efficient use of therapy hours. With consumers who are well engaged in ongoing therapy and therefore well known to the therapist, a single therapist model is sufficient. The single therapist model clearly works well in private practice, in mainland CAMHS services and is widely employed by other counselling/therapy services. Further, CAMHS leadership should consider the 'message' a default co-therapist model and collective decision-making gives to clinicians; that is, are they not seen as competent, skilled or personally robust enough to see consumers by themselves?

4.6 Pathways to Inpatient Care

4.6.i Attendance at Accident and Emergency Departments

In the south of Tasmania, a service to the Royal Hobart Hospital (the 'hospital team') was created in 2009. The major impetus being one to two clinicians were frequently sent from the community setting to either the A&E Department or inpatient paediatric ward to assess patients and/or provide therapy. This was seen as disruptive for the workflow of the community team. Given the clinicians who attended hospital varied, it was difficult for paediatric services to establish collegial relationships with CAMHS clinicians and built on the systemic issues, further failing to promote consistency of practice. The hospital team initially comprised of a psychiatrist and senior allied health clinician. Later it expanded to include a second psychiatrist, psychiatric registrar, and allied health staff including a clinical psychologist and clinical nurse coordinator (CNC). Now there are approximately 5 to 6 FTE, often with two psychiatry registrars (if supervisors can be found). As with all in-reach hospital teams the work is variable in demand. Tasks includes both reviewing patients in A&E during working hours Monday to Friday and supporting the after-hours on-call service.

Both the North and North West services in-reach to A&E during working hours with existing clinical resources. North West CAMHS is particularly challenged by the need to service both the emergency department of the Mercy Community Hospital in Latrobe and the North West General Hospital. Tasmanian CAMHS data suggested an overall rise of A&E presentations year on year from 2013. This is consistent with the experience of other CAMHS services nationally. McDermott and colleagues reviewed adolescent mental health presentations to the only public hospital in Townsville (a city with population a similar size to Hobart) and found a 2-3-fold increase in presentations across the 5-year period 2012-2017 (McDermott et al., manuscript under review).

From the paediatric perspective there was a very strong request from numerous practitioners for access to child and adolescent mental health expertise and advice after-hours, on weeknights and at any time over the weekend.

It was clearly stated that this service gap required individuals who lacked the requisite skills to make decisions, especially in relation to patient safety. Erring on the side of risk aversion meant unnecessary hospitalisation and burden on services. Sending patients home without CAMHS consultation was seen by paediatricians as bearing a considerable risk, as management of clinical psychiatric risk is not their core expertise. It was also though to exact an emotional burden on staff, parents and carers. Lack of CAMHS resources was not considered a sufficient reason not to provide such a service. Indeed, examples were given of paediatric subspecialties, some of which had only 2 to 3 FTE total consultant workforce, providing a 24/7 on-call roster.

4.6.ii Paediatric Inpatient services

In the South of the state, the hospital team is discussed in section 4.6.i. Clearly the development of the team has assisted with consistency of care to CAMHS inpatients. This continuity has been undermined recently by the service being staffed by locums. Whilst the recruitment of CAMHS Consultant Psychiatrist is a significant issue, the reliance on locums makes it difficult to build a consistent comprehensive service.

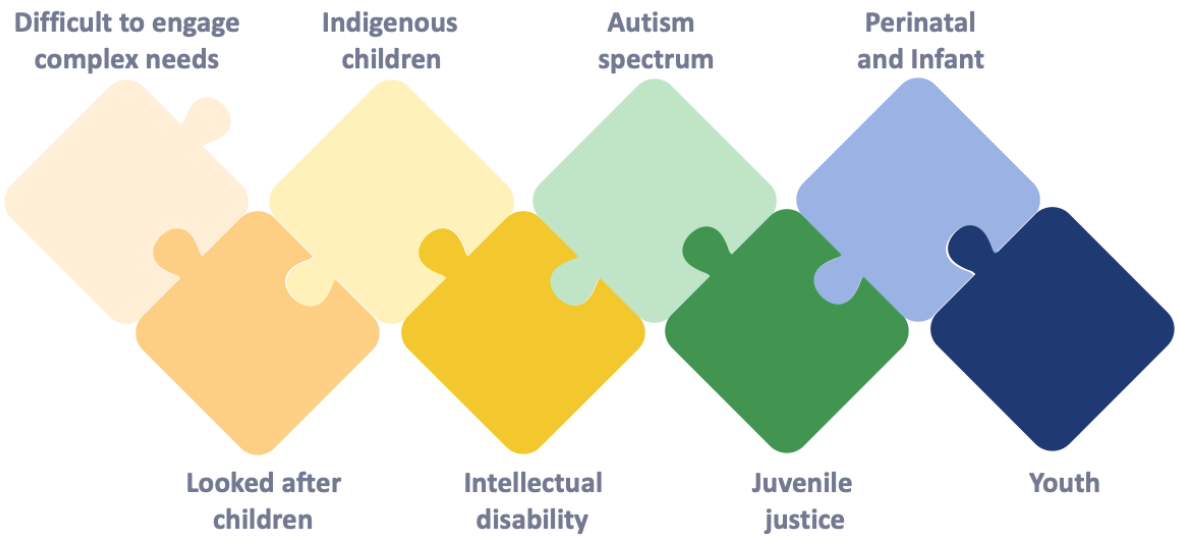
In May 2020, two adolescent mental health beds were opened in the new paediatric adolescent ward. The role of the hospital team is likely to expand with the opening of the adolescent beds. For example, training of paediatric staff in advanced interventions to regulate mood and behaviour is required, if adolescents with more severe and challenging presentations are being admitted to this unit. It was acknowledged that the model of care document would also need to be updated. Not having a permanent psychiatrist was seen as a significant impediment to this service, by all those who were consulted.

Concern was raised about the level of training required to provide adequate inpatient care for adolescents who are admitted with the most significant care needs. Throughout Australia, children and young people admitted to specialist mental health units have access to mental health nurses on all shifts to provide their care and treatment.

Most paediatricians stated that from 5pm Friday until 8am Monday, they were the only consultants responsible for the care of inpatients with primary mental health presentations, including consumers who may have early onset psychosis or severe suicidal behaviour/distress.

A strong desire was expressed by these paediatricians, identical to the request for expertise afterhours to A&E, for afterhours child and adolescent specialist mental health expertise being made available to the paediatric ward.

5. Specific Clinical Populations



5.1 Difficult to engage adolescents with complex needs

Discussions with CAMHS services in Tasmania highlight the perception of limited capacity to provide services to young people who habitually do not attend clinic settings and who reside with parents and carers who also struggle with attendance. Often the challenges faced by this population are multi-generational. Usually the young person has complex mental health needs such as the current consequences of past experience of trauma, concurrent dysregulated emotions and behaviours, issues with substance use, variable school engagement and possibly involvement with the youth justice system. Numerous CAMHS practitioners cited the need for the presence of a family that could make use of the service offered. Through the engagement of iConnect, there is some capacity for CAMHS patients to receive outreach services (see section 4.5.vii).

Stakeholders are consistent in seeking reform that increases the capacity of CAMHS to see individuals with either complex mental health presentations, or mental health presentations occurring in partnership with complex needs. An example of the latter is a young person who may be experiencing major depression who is case managed by juvenile justice in the community. Similarly, a patient who has depression and comorbid autism spectrum disorder who lives in a separated family and sees a paediatrician. Both examples were given by stakeholders as well-known presentations that are currently unlikely to be seen by CAMHS.

Numerous documents and reports suggest these clinical groups require a more comprehensive, if not a dedicated, response. Whole government responses are advocated to diminish 'horizontal fragmentation' between child and youth focused services. Local documents have also focussed on this issue. For example, the Community Service Mapping for Young People Referred for Mental Health and/or Behavioural Problems in North West Tasmania (Bridgman, Cross, & Cheek, 2014) noted the strong qualitative feedback of limited services for complex presentations.

Clearly more resources would improve the capacity of CAMHS to meet this service need. However, equally important would be changes to the CAMHS model of care, that identifies these clinical groups as important.

5.2 Looked after children

Section 2.4.i of this review discussed children in care/'looked after children' and will not be repeated other than to note that research conducted in Tasmania (see Rauter et al., 2018) is consistent with the robust national and international literature that reports much higher rates of child and adolescent mental health disorders in looked after children.

Further, longitudinal research finds that the continuation of mental health diagnoses into adulthood are related to an excess of psychosocial challenges, including decreased progress in the education system, under and unemployment, relatively high rates of poverty and homelessness, and poor physical health. An informative area of literature is the ACE research, also discussed in section 2.4. Again, this research is compelling and reports a far greater likelihood of depression, alcohol dependence, and suicide in individuals who experienced adverse childhood events. It is the Reviewers' opinion that CAMHS must be central to a whole of government approach to the well-being of these individuals and this is reflected in specific recommendations, as well as suggested service enhancements discussed in Chapter 7 of this report.

5.3 Indigenous children and families

Indigenous youth have a higher prevalence of both mental and physical health challenges (Milnes et al., 2011). The published rates, when compared to non-indigenous comparison groups, are disturbingly high. Milnes and colleagues reported 33% of indigenous 18-24-year-olds reported psychological distress compared to 14% in non-indigenous youth (2011). A survey of West Australian indigenous people reported 54% experienced a psychiatric illness (Parker, 2010). Substance abuse, including hospitalisation for these conditions, is also overrepresented in both indigenous males and females compared to non-indigenous groups (Parker, 2010). These results are consistent with the higher levels of reported mental health risk factors seen across the contemporary literature.

Furthermore, Soole and colleagues' analysis of the Queensland Suicide Register found significant levels of abuse and neglect, and drug and alcohol use in Australian indigenous youth who completed suicide. Findings which have been replicated by Ivancic and colleagues (Ivancic, 2014). The very high indigenous suicide rate (between 4-12 times greater than non-indigenous youth) is particularly sobering (Parker, 2010; Soole et al., 2014; Reifels, 2014). All these results are particularly troubling given that indigenous people are less likely to seek health care for either mental or physical illness (Westerman, 2004).

Given indigenous children and families experience more adverse childhood experiences than other groups and indigenous children have higher rate of out of home care in Tasmania, then it would be expected that they should be over-represented in attendees to CAMHS.

There was no anecdotal evidence that this was the case. Indigenous children and adolescents also often have complexities regarding parent separation, divorce and residing with kin. A CAMHS model of care that emphasises the need to work with families potentially discriminates against these indigenous children and their families. It is recommended that CAMHS leadership conduct an analysis of this data and instigate a process to monitor indigenous child and adolescent attendance. Further, no separate CAMHS initiative for indigenous youth was described.

Whilst the Review does not argue for a separate indigenous CAMHS, numerous reforms recommended in this report would be of significant benefit to indigenous consumers, including the capacity for an assertive mobile service and a focus on looked after children and those in the juvenile justice system and the broader conceptualisation of complex and serious mental health. However, at a minimum, CAMHS should employ a state-wide indigenous consultant to upskill practitioners in cultural awareness, and the mental health and psychosocial challenges from an indigenous perspective, promote service uptake with indigenous young people and their family members and be a strong voice in new service creation.

5.4 Intellectual disability

It is beyond the scope of this review to provide a detailed analysis of child and adolescent mental health presentations in young people with intellectual disability. It is fortunate that much of this work has been done in the form of systematic reviews and meta-analysis. In 2020, Buckley and colleagues published a systematic review on this topic. The group reviewed 19 studies, including 6151 children and adolescents with a learning disability. When measured on the Developmental Behaviour Checklist, the prevalence of a child and adolescent mental health disorder was 38%, while on the Child Behaviour Checklist, the prevalence was 49%. On both measures the reported prevalence was significantly higher than in the non-intellectually disabled child and adolescent mental health cohort. The most common presentations in the intellectual disability group were attention deficit hyperactivity disorder (ADHD) (30%), conduct disorder (CD) (3 to 21%) and anxiety disorder (7 to 34%) (Buckley et al., 2020).

Consultations with CAMHS and stakeholders identified that the intellectual disability group is not one frequently seen by CAMHS. It is likely that given their range of challenges, some individuals with intellectual disability meet criteria for the NDIS. However, it is a very widely held belief that the services provided by the NDIS in Tasmania are not adequately replicating or replacing the services that existed before this scheme. Clearly many individuals with intellectual disability are seen by paediatricians. Paediatricians have high-level skills around the treatment of attention deficit hyperactivity disorder (ADHD). The comprehensive treatment of disruptive behaviour and anxiety disorders in intellectually disabled groups requires the input of either a comprehensive NDIS service which provides both clinical psychology and child and adolescent psychiatry input or CAMHS.

As part of the Review, the establishment of a new State-wide Mental Health Service for people who have both mental illness and intellectual disability was identified. The Operational Service Model was in development. It is critical that this new service, whilst still in the early stages of development ensure it addresses what it will undertake to address the needs of young people who have both Mental Illness and Intellectual Disability and that this is integrated with other recommendations in this review.

5.5 Autism spectrum disorders

Similar to the introductory comments in the previous section concerning children and adolescents with intellectual disability, it is beyond the scope of this report to provide a detailed review of presentations in children and adolescents with autism spectrum disorder with and without other comorbid mental health presentations. It is however important to note that autism spectrum disorders are mental health diagnoses and if it were not for the NDIS, many jurisdictions see these conditions as in scope for service delivery by CAMHS. Further, autism spectrum disorder is very frequently co-occurrent with other child and adolescent mental health presentations including anxiety disorders and disruptive behaviour disorders (oppositional defiant disorder, attention deficit hyperactivity disorder (ADHD) and conduct disorder (CD)). There is also emerging research that individuals with autism spectrum disorder often experience stress related symptoms and PTSD.

As mentioned in the last section, it is a widely held belief that the NDIS in Tasmania has not adequately replaced the previous services provided to this group. This lack of intervention is made more acute by the shortage of private child and adolescent psychiatrists in Tasmania, meaning that parents and individuals with an NDIS package do not have the option of purchasing this expertise. This is likely to be an issue across much of Australia rather than being Tasmania specific. Some CAMHS in Australia do provide consultation and second opinion services to individuals that have an existing NDIS package, especially if referred by a paediatrician. The latter see this as highly supportive. Other CAMHS provide comprehensive assessment services to assist consumers and their families make the case for an NDIS package. This important assessment and advocacy role should be seen as very consistent with consumer orientated care. Given the relative lack of private child and adolescent psychiatrists in Tasmania this role is relatively more important.

Finally, and influencing many aspects of this review, is the understanding there has been a recent increase in research clarifying the child and adolescent mental health burden that exists for consumers with a range of physical and neuro-developmental conditions. It is appropriate that advocacy groups use this new knowledge to advocate for CAMHS engagement. For example, the prevalence of mental health disorders in children with cerebral palsy has been recently clarified and includes a prevalence of mental health disorders 3 to 4 times greater than controls without cerebral palsy (Rackauskaite et al., 2020). The issue of increased CAMHS involvement in these clinical groups will be ongoing and should be addresses as part of the consideration of current CAMHS, future CAMHS service expansion and the new State-wide Mental Health and Intellectual Disability Service (see Section 5.4).

5.6 Juvenile Justice

In Tasmania, the Youth Justice Service is inclusive of the Community Youth Justice Teams which are based in the South, North and North-West of the state. The teams work closely with the Magistrates Court presenting reports and supervision including compliance with orders. Community conferencing is a large part of the work. Practitioners in this space consider the service small with little capacity to provide other than a basic service.

Service providers believed there was some interface with CAMHS. Under section 105 of the *Youth Justice Act* a magistrate could order an assessment with forensic mental health or CAMHS. The latter is clearly dependent on the young person's age. Perennial difficulties included youth justice clients not wanting to engage with assessments. If they do not attend, it is reported to be a quite protracted process to reschedule with CAMHS.

Other than a formal pathway from a magistrate's order, workers thought there were numerous occasions when a mental health assessment would have been helpful. These were seen as very difficult to obtain. Other avenues were also difficult. Many young people in the youth justice system were already disengaged from school and therefore unlikely to see a school psychologist. It was thought after the age of 14, there were limited options through child safety. Pursuing an NDIS pathway was also difficult due to the frequent absence of a supportive parent. The latter was important not only to practically assist with getting to appointments but also limits opportunities to obtain a developmental history and any health-related documentation.

A specific issue was when a young persons' offence was of a sexual nature. It was thought that there was limited, if any expertise, in Tasmania to provide a therapeutic intervention. Effective interventions would benefit the individual, as well as society, given one desired outcome would be a decrease in subsequent sexual offending. Another 'local' issue was the perception that young Tasmanians in the youth justice system had one of the highest recidivism rates across Australia and improving their access to CAMHS could be one factor in remediating this.

From a workforce perspective, the Ashley Detention Centre has the resource of a psychologist, usually 0.6 FTE. This clinical resource was for a centre with an 11-bed capacity. The age of detainees' ranges from 10 to 17 years of age. Most individuals in custodial care were in the 16 to 18-year range. It is unusual for there to be female detainees. It was said that Aboriginal and Torres Strait Islander youth were over-represented. The resources of the Southern community team are approximately 4.8 community youth justice workers, community development officers and three youth workers for higher need individuals. The team budget is essentially salary based with a small amount for any other expenses. The team does not have the capacity to provide or outsource other treatment for young people. At any one time there are approximately 80 young people on supervised orders, 20 reports requiring attention and 30 community service orders. The caseload of workers is approximately 15. Input depends on the relative risk of individuals and can be up to multiple times per week.

From the perspective of workers in the juvenile justice system, thoughts about improved input from CAMHS include consultation with, and interventions for:

1. juvenile justice clients with typical mental health symptoms (including sleep issues), trauma related presentations (including dysregulated behaviour) and substance abuse;

2. input on what is the most therapeutically effective use of worker input with this high-risk group;

3. assistance in mental health issues that lead to accommodation breakdown and subsequent instability and

4. assistance in providing assessment, documentation and advocacy that will be of benefit to young people accessing the NDIS and other opportunities.

Whilst not the most robust literature, research on individuals in juvenile justice settings shows consistently that intellectual disability is frequently reported. In an Australian detention setting, 50% of participants had borderline or low IQ and 14% were in the extremely low range (Haysom et al, 2014). In a non-custodial juvenile justice setting, these findings have been replicated with proportionally more individuals with impairments of memory, executive functioning and IQ (Moffitt, 1990). These findings are not surprising given that neurocognitive deficits can lead to poor impulse control (Johnson et al., 2016) and self-regulation challenges, the latter often manifest as impulsivity and poor control of behaviour. Adolescents may manifest these impairments through symptoms of conduct disorder (CD), a major precursor for involvement in the criminal justice system. CD is more likely if the individuals' parent(s) experienced antisocial personality disorder, alcohol dependence, mood disorders and schizophrenia (INSERM Collective Expertise Centre, 2005).

Research has established that some individuals within the juvenile justice system are not 'neuro-typical'. Citations include the presence of genetic abnormalities such as Klinefelter syndrome and Fragile X as well as Fetal Alcohol Spectrum Disorder (FASD), which has been diagnosed in these populations. It seems plausible that many in the youth juvenile justice system may have FASD given the known associations of FASD with poor educational attainment, high rates of unemployment and over-representation in the foster care (Streissguth, et al., 2004).

In young people within a youth detention centre in Western Australia, 89% met criteria for at least one domain of severe neurodevelopmental impairment, and 36% were diagnosed with FASD (Bower, et al., 2017).

In a Queensland setting, 60% of adolescents in a custodial setting who had been referred to a developmental paediatrician met criteria for FASD. The review heard that whilst data was not readily available the issues faced by youth the ADC was similar to that reported elsewhere in Australia.

It is the opinion of the author that current CAMHS services to juvenile justice consumers and support of this system in general is particularly poor. There is no forensic youth mental health service, rather they rely on the fly-in fly-out services of a very experienced practitioner who does not have the capacity to provide ongoing care nor community follow-up. In the absence of any other specialist care in the detention centre or follow up on release, the care defaults to that provided by paediatricians who reported being unable to provide this without specialised CAMHS support. Chapter 7 details potential service enhancements required to meet this need.

5.7 Perinatal and Infant

Advocacy of the then director of Southern CAMHS led to the creation of the perinatal service in 2013. It was stated to the Reviewer that some recurrent funding from the Southern CAMHS budget created the service; however, this is contested. The original conceptualisation was a hub and spoke model from Hobart given it was always likely the more senior perinatal clinical expertise was in Hobart. The model included supervision of clinicians in the North and North West of Tasmania. Given the available resources, it was thought unlikely that perinatal services would ever be able to run a 24-7 after-hours consultation service.

Service information from the perinatal 'snapshot' document indicated that referrals came from women screened after delivery (approximately 2000/year) or who attend an antenatal clinic who score greater or equal to 13 on the Edinburgh Perinatal Depression Scale (EPDS), those with a known past history of a mental health disorder (usually anxiety or depression) or individuals on psychotropic medication.

Consumers are typically 27.5 years of age (standard deviation 6.2), have an unplanned pregnancy (61%), are 'partnered' (82%), are not using substances (86%), are not involved in child protection services this pregnancy (83%) or last pregnancy (86%) and are referred for depressive symptoms either self-declared or identified on the EPDS. These referrals are 4 to 6 times more common than referrals for substance use or psychosis; other presentations are even less common. After assessment, approximately one third of consumers are deemed not to have a diagnosis. The most usual diagnoses are depression (25%), anxiety (15%) and personality disorder (10%).

The service operates in normal working hours and holds five half-day clinics per week. Four hours per week are put aside for emergencies. Work is usually commenced during the antenatal period with limited capacity to provide services in the post-natal period. The latter is usually managed by GPs with consultation from the Perinatal Infant Mental Health (PIMH) service. Liaison with other services is a significant workload including attending child protection meetings and writing child protection reports.

Service expansion was advocated by many stakeholders. Interventions were clearly needed during the post-natal period. Many stated a need for psychiatrist, psychiatry registrar and mother-infant resources in North and North West.

Further, future Royal Hobart Hospital redevelopment, as part of Stage 3, is expected to include the development of up to four perinatal beds as a single state-wide service to provide the safest service to those women experiencing Puerperal Psychosis or the most severe forms of Post Natal Depression. Such a development could also include a day program, a partner program and become a centre of excellence in treatment of Perinatal and Infant Mental Health issues. Of note it is likely that if the admission criteria for the four beds included significant maternal sleep disturbance in the postnatal period, along with moderate to severe depression, then it was anticipated the 4 beds would be well used. This is supported by the National Mental Health Service Planning Framework.

From a reform perspective, any increased funding on the early years can be very clearly justified. This investment would decrease current symptoms and impairment in the consumer as well as benefits to their partner. Early investment promotes both infant brain development and secure attachment. It therefore improves resilience and potentially child, adolescent and adult mental health challenges.

To many, the 'ideal' perinatal mental health service would be a strong antenatal service led by adult mental health with a focus on new mental health presentations and the care of consumers with existing moderate or severe mental health challenges who become pregnant. This service would extend into the postnatal period with care of postnatal depression, puerperal psychosis, other puerperal presentations (especially if substance use disorders are involved) and supervision of consumers who require inpatient care. The 'ideal' service would then provide CAMHS-led postnatal services with a focus on parent-infant attachment.

This service could encompass pre-school children (0-3 or 0-5 years of age, depending on which definition is employed) given this group is currently significantly underserviced. Put in simple terms the most effective PIMHs will require the expertise found in both Specialist Adult Mental Health Services and CAMHS.

One reform challenge which faces the current Tasmania CAMH services is a perception of ownership and/or collaboration with the PIMH service. Prior to any PIMH service expansion, it must be better integrated and 'owned' by CAMHS, especially if expanded to include the early years. This is consistent with a whole of government approach to supporting and linking services for children, youth and families but it will require significant CAMHS leadership.

This is especially true given the breadth of other reforms and service enhancements suggested in these recommendations and potential service enhancements outlined in Chapter 8. Finally, the review was aware of the current arrangements with Mother and Baby services provided by St Helen's Private Hospital in Hobart and proposes that further development of the Specialist PIMH occur alongside and in partnership with the private providers.

5.8 Youth

Across the typically seen CAMHS age range (up to 18 years of age), approximately 14% to 40% of 10–19-year-olds meet criteria for one or more mental health disorder (Lawrence et al., 2015; Collinshaw et al., 2004; Kessler et al., 2012). When considering youth more broadly, 1 in 50 Australian youth experience a severe mental health disorder (Lawrence et al., 2015). In 2015, the report of the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing revealed that the most common youth mental health presentation was ADHD (7.4% meeting diagnostic criteria) followed by an anxiety disorder (6.9%), major depression (2.8%) and conduct disorder (CD) (2.1%) (Lawrence et al., 2015). Substance abuse disorders also typically emerge during adolescence. Adolescent mental health disorders frequently relapse (Pisani et al., 2012) and confer significant psychosocial impairment (van Geelen et al., 2016; Caruana et al., 2018). Suicidal ideation is common across youth mental health presentations and is the leading cause of death of Australian 15-19-year-olds (ABS, 2018; AIHW, 2018). Youth help-seeking for suicidal ideation is very low (Pisani, et al., 2012).

There is little evidence of any current direct CAMHS involvement in service provision for youth greater than 18 years of age. For those individuals under 18 years of age, referrals are made to and received from headspace. When the responses of other services (who for example run programs for individuals up to 25 years of age) were mentioned, a frequent response that was that CAMHS has no current capacity to undertake this work.

However, there is substantial research on the potential problems that arise from "transition points" between services particularly if age or developmental criteria are the basis for a change in service provider and model. Increasingly, services that can straddle age criteria to provide a more comprehensive approach are favoured by young people and their families and supports.

It is well recognised that the years between the ages of 12 and 24 are especially critical for the development and maturation of individuals, with significant challenges such as, physical changes, sexual development, growing independence, leaving school, developing intimacy, changed peer interactions and the onset of risk taking.

Individuals negotiate these challenges in different ways, however the presence of previous adverse experiences and of mental illness, can make this a very difficult period.

Furthermore, for some people the emergence of issues arising from gender diversity is often most profound during this time and is known to be associated wither rates of emotional and psychological distress. Whilst the majority of Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ) people lead happy, healthy and fulfilled lives being exposed to violence, abuse, stigma and discrimination can lead to the development of depression, anxiety, psychological distress and suicide.

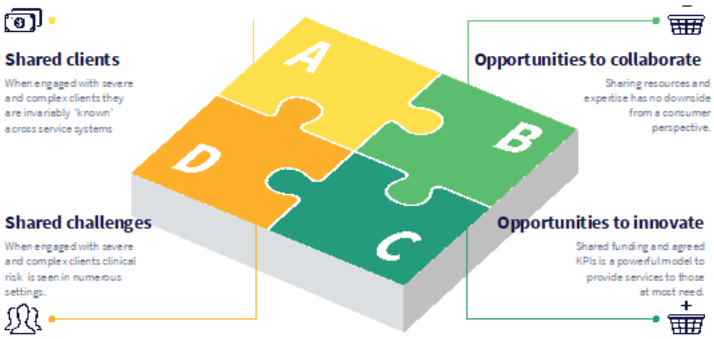
Therefore, consideration should be given to how CAMHS are provided in such a way to tackle the challenges of transition points, development and emerging adulthood that will for many go well beyond the age of 18.

Section 7.6 gives the example of a youth early intervention service (yPEIT) in Queensland that goes beyond service provision for early onset psychosis to include other severe mental disorders. It argues that a specialised service provides a more consumer focused and specialist service as well as the benefits from an increase in the number of CAMHS clinicians.

It should be considered that the yPEIT model includes young people with Substance Abuse disorders. Arguments from the Youth Framework for the Alcohol and Other Drug (AOD) sector in Tasmania for a youth SUD treatment capacity include:

- AOD problems are more prevalent and dangerous during adolescence;
- Adolescence is the key developmental period of emergence of substance use problems;
- Early intervention produces better outcomes;
- a youth service mitigates the potential for exploitation and antisocial modelling in an adult AOD system and
- Cost effectiveness, the immediate and long-term benefits of a specialist substance misuse treatment for young people is likely to significantly outweigh the costs.

6. Key Stakeholders



6.1 Children's Commissioner

The Commissioner for Children and Young People Tasmania, Leanne McLean and her staff are key stakeholders given there can be 'no health without mental health' (see Prince et al., 2007). Along with discussions of the current perceived needs of children and young people, this report has been informed by key commission publications including *Investing in the Wellbeing of Tasmania's Children and Young People* (Commissioner for Children and Young People, 2020).

6.2 Child Protection Services

The OOHC Monitoring report noted that funding special care packages for OOHC children was seen as crucial, whilst acknowledging these were the most expensive and intensive version of care. Children receiving these packages were noted to require "*extraordinary level of need for care, including therapeutic, medical, disability or similar supports*". The 2019-20 Tasmanian Budget committed an additional $16.9 million for special care packages. The monitoring document detailed a complex arrangement in which 15 organisations provided a range of service initiatives (e.g. emergency care, residential care, respite care).

There is a specific paediatric screening clinic for OOHC children in Southern Tasmania offered by the Royal Hobart Hospital staff. This includes monthly access to a child and adolescent psychiatrist, but only operates in the south of the state. Some of the service provision issues noted in the report include long wait times for children, with no priority access; outpatient mental health care demand exceeding supply across all sites in Tasmania, a shortage of specialist psychologists and psychiatrists, a shortage of inpatient care and no inpatient option for alcohol/drug addiction or mental health treatment for individuals with eating disorders.

A recommendation of the monitoring report was extending any examination of the model and cost of care for children and young people in OOHC with the most complex, specialised needs. This would include an investigation of mechanisms to promote Tasmanian Government agencies working more collaboratively and sharing accountability for achieving wellbeing outcomes for children and young people in OOHC.

This is clearly consistent with a 'joined up' approach with CAMHS and a strong recommendation follows to engage in joint service design and funding of a dedicated child and adolescent mental health service to support both OOHC children and more, generally, children under the care of Tasmanian child protection services. Such a service would, to a large extent address the mental health component of report's recommendation 5(b); "(The Tasmanian Government) Implements a policy of priority access to health services for children and young people in out-of-home care in Tasmania".

A key theme of this report is that children in care experience severe and complex mental health presentations, which should be the core business of CAMHS. The current need cannot be met with the current service model and funding structure. Section 7.4 outlines potential service enhancements to meet this need. Given the current expenditure on special funding care packages, the recommended new service initiative is likely to provide both significantly better mental health care and less expenditure than the current model in the long term.

6.3 Paediatricians

Paediatricians consulted during the review process were uniform in their strong desire to be supported by CAMHS, especially around the issues of clinical risk in young people who were suicidal and/or who have extremely challenging behaviour, and secondary consultation (with or without ongoing management) of individuals with mental health presentations that are comorbid with the typical clinical presentations to paediatricians.

On the issue of clinical risk, paediatricians were uniformly of the opinion that too many adolescents and young people with suicidal ideation and distress or who had attempted self-harm were being cared for by paediatricians rather than CAMHS. It was thought the current service system 'enshrines' this.

For example, if a young person with severe suicidal thinking was admitted to the paediatric ward of the Royal Hobart Hospital, from the end of week-day business hours on Friday until the start of normal business hours on Monday, there was no CAMHS clinical input to the management of the case. In this example, the consultant in charge of this case was a paediatrician; a similar scenario is experienced afterhours on weeknights.

Paediatricians were aware and grateful that in the past there was ad hoc, non-formalised, not rostered support provided on an individual basis. They were also clearly aware of the current shortage of child and adolescent psychiatrists in Tasmania. Nevertheless, there was a strong desire for child and adolescent mental health expertise to be provided after hours.

The review notes that in most of Australia it would be CAMHS who would have the primary clinical responsibility for the group of children currently being seen by paediatricians in Tasmania and if CAMHS were unable to have primary responsibility due to resources then they would at least provide a dedicated clinical support at a higher level than is available in Tasmania.

Challenges in obtaining secondary consultations was a similar problem. Paediatricians felt that obtaining access to the service was often very difficult, and they shared similar frustrations with the MHHL, which has already been outlined in this review and generally felt that, similar to issues around child and adolescent consumers with high risk, they were often seeing individuals with moderate to severe mental health presentations without the training to undertake this work.

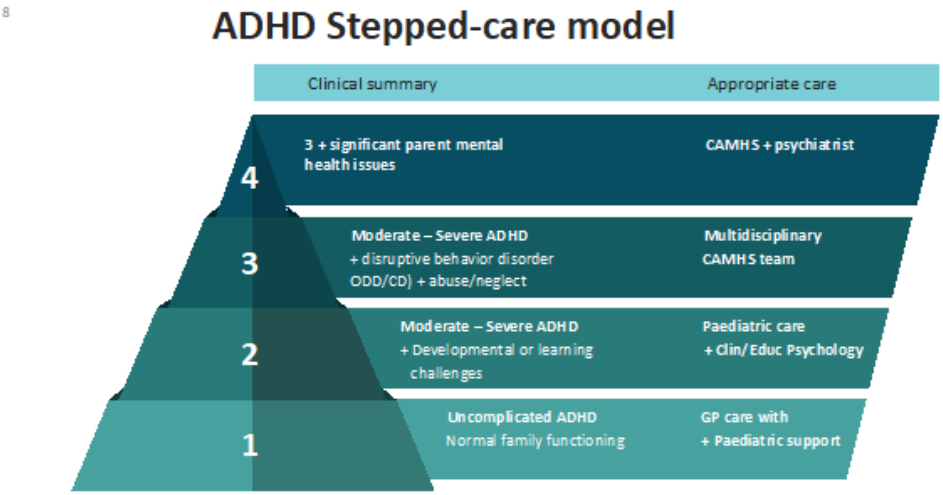
For example, referring to Figure 6.3.i (the ADHD stepped care model), paediatricians felt that both at level three (ADHD with significant mental health comorbidity) and level four (consumers with ADHD, mental health comorbidities and parents with a mental illness, substance abuse or other well-being challenges) the burden of mental health care was on paediatricians, when it should be CAMHS.

Obtaining a consultation for these extremely complex consumers was said to be very difficult to obtain. This was said by paediatricians to especially be the case if the family was not intact.

Similar to the desire for more input and expertise around developmental psychiatry, paediatricians felt they were filling a child and adolescent mental health service gap by seeing young people with very severe prejudicial early life experiences and subsequent trauma related presentations. This has been discussed in many areas of this review.

Many paediatricians questioned whether the core business of CAMHS was the treatment of consumers with severe and complex presentations; that is, they were not sure whether, from a stepped care perspective, CAMHS was currently operating as a level 4 service.

Figure 6.3.i: *An explanation of the stepped care model in a CAMHS context*



Along with a desire for more senior and specialist clinical input with consumers with disruptive behaviour disorders, paediatricians felt there was an urgent need for a child and adolescent psychiatrist with an interest in developmental and neuropsychiatry.

It was felt assistance for consumers with autism spectrum disorder and behavioural phenotypes with comorbid mental illness was a clear need. Especially those with comorbid depression and anxiety, potential psychosis, advice whether psychological or occupational therapy interventions would be of benefit and psychopharmacology advice.

It is the Reviewer's opinion that any reform of CAMHS needs to fully address the issues raised by paediatricians. From the consumer perspective, it is acknowledged that individuals with the most pressing mental health challenges should be provided care by professionals with the greatest training in this area. In the domain of child and adolescent mental health this is not usually paediatricians but child and adolescent mental health professionals. Within the current funding framework there are numerous possibilities for efficiencies which could liberate therapeutic time for collaborative interventions with paediatricians. Mental health leadership should also consider the recruitment strategy of specifically targeting these and similar gaps with a funding profile and job description that would be of interest for a person with the desired expertise; for example the inclusion of dedicated research time for a suitable candidate with an interest and track record in child neuropsychiatry.

6.4 Education Providers

Education stakeholders interviewed included professional support staff of the Department of Education, inclusive of managers, and social work and psychologist practitioners.

Most stakeholders commenced their feedback by stating they have clear examples of very helpful advice from CAMHS including one-off secondary consultations where a CAMHS clinician provides input around a particular student that the education system and its staff is struggling to contain in an educational setting. Indeed, some stakeholders said that in the south of the state this one-off consultation process had improved over the last 12 to 14 months with increased CAMHS accessibility. It was also noted that the multidisciplinary team meetings at the Royal Hobart Hospital around children with exceptional circumstances was attended by a senior CAMHS practitioner and the Department of Education staff found this extremely helpful.

Consistent amongst stakeholders were some issues about difficulty with referrals being accepted by CAMHS and issues which they conceptualised as 'clinical risk'. Department of Education staff felt that many referrals were not accepted by CAMHS even if there had been significant work pre-referral, either in the education, child protection or other service settings. Department of Education staff felt that the more dysfunction there was around the student, the less likely CAMHS were to accept the patient. One stakeholder thought that this was an issue of discrimination for those that had increased complexity; either with significant parent/carers and family challenges, trauma histories or history of recent substance abuse. Other stakeholders use the word equity; there was a lack of equity in that the more vulnerable children did not meet the current CAMHS intake criteria. As already outlined in the review, this is contrary to the factors which suggest the greatest need for a specialist CAMHS response.

The issue of clinical risk usually revolved around students who were in suicidal distress. Examples were given of students who attended hospital, were admitted and then discharged to return to school with no information given to school authorities that the child had, even the night before, been in an inpatient unit. Department of Education staff were sophisticated in their understanding that parents needed to be involved in giving consent for this information to go to the school. However, their impression was that parents were never asked if the information could be shared. Invariably school staff were made aware of a student's hospitalisation, again often the night before school attendance, when another student told them this information was freely available on social media. Many stakeholders reiterated this point, using the word they had "never" been informed of a young person's recent hospitalisation for suicidal ideation and/or suicidal behaviour. They stressed in these circumstances it was extremely difficult to act in the best interest of the student and also other students who may be influenced by that student's suicidal behaviour.

Department of Education staff commented that they have attempted to have meetings with CAMHS specifically on this issue with the purpose of creating formal policies and procedures about this matter of significant clinical risk, without success. It was also noted this was especially difficult because there was no state-wide CAMHS organisation to deal with.

Stakeholders specifically talked about the Southern CAMHS' single session family consultation process. Stakeholders wished to strongly convey that some consumers had given them feedback that this was, "the worst experience of their (the consumer's) life". Stakeholders felt that for many the process was not only seen as not useful but a negative experience that may cause harm. Some Department of Education stakeholders said they were unwilling to refer anybody to CAMHS given feedback about the single session process. Other stakeholders noted similar disquiet with the 4-session assessment process undertaken by Northern CAMHS. Especially when, after 4 hours of assessment, the consumer was not accepted by CAMHS to receive an intervention.

A summary of stakeholder feedback from Department of Education staff is very consistent with stakeholders from other groups; difficulty getting students accepted by CAMHS despite often significant work prior to referral and quite marked concerns about the issue then defaulting to education staff holding clinical risk for students when they were not appropriate (not a level for clinical intervention service) to carry that risk.

The review found that there was a significant discordance between what Department of Education staff thought about CAMHS and what CAMHS knew of this set of concerns.

6.5 Primary Health Network, General Practitioners and headspace

This area of the stakeholder consultation included discussions with individual GPs, senior managers of Primary Health Tasmania (PHT), and both clinicians and managers with headspace services.

Headspace is included in this area of the report given headspace services are commissioned in Tasmania by the Primary Health Tasmania. Services include The Link Youth Health Service which provides headspace Hobart services, as well as short-term psychological interventions (STPI) with PHT funding. Cornerstone Youth Services provide headspace in Launceston and a satellite service in Devonport. The Devonport service is soon to be expanded into a standalone headspace and there is the pending launch of a headspace in Burnie. Similar to Hobart, Cornerstone Youth Service also provides a STPI program and a Youth Enhanced Team. STPI has a focus on mild to moderate mental health presentations. There is some capacity to see perinatal, child and adolescent consumers but these are the smallest elements of the overall program. The Youth Enhanced Team (and #synergy in the south of the state) have an outreach component and this is seen to be a major point of difference with the service model of CAMHS.

All individuals consulted noted that they had the experience of some clients who had received a high-quality intervention from CAMHS. However, in their opinion this was on a therapist to therapist relationship basis. It was not supported by clear referral pathways, policies and procedures. Indeed, there were anecdotes of attempting to create memorandums of understanding with some CAMHS services. It was generally considered that these attempts had not been successful.

A clear theme of discussions was a strong feeling there was a lack of clarity in the sector about who was responsible for different types of presentation. headspace, through clear direction from headspace national guidelines, is not a level 4 service for severe and complex presentations. Those in the GP/Primary Health Tasmania/headspace space thought this was at odds with the type of individuals referred to them by CAMHS and the referrals by them that CAMHS did not accept. Numerous clinical vignettes were provided on the theme of headspace practitioners holding a clinical risk, for example a young person who was persistently suicidal, who would not be accepted by CAMHS. A frequently stated reason was non-acceptance was because the consumer was currently being seen by headspace.

The theme of feedback from GPs was very similar to all other service provider groups; in their (collective) opinion they experience great difficulty getting CAMHS to accept referrals. GPs feel they are poorly equipped to carry the degree of clinical risk for many young people with severe and complex mental health presentations. GPs also feel they are not receiving specialist child and adolescent mental health opinions that are required for safe practice. This is especially in the case of psychopharmacology. The other area frequently mentioned is young people with a physical or neurodevelopmental condition that has comorbid depression, anxiety or challenging behaviour. GPs feel these types of referrals are very frequently not accepted.

A surprising number of practitioners stated that to get a CAMHS opinion the consumer would need to state they were suicidal, present to an A&E Department after-hours, be admitted and then seen by either a CAMHS hospital team or in-reach CAMHS service the following day. This situation does not arise elsewhere in Australia when the CAMHS focusses on more severe presentations.

As in the previous section of this chapter, the review was surprised to find that many in CAMHS were unaware of the degree of concern being raised by GPs, headspace and other level 1 and 2 mental health providers of the difficulty accessing CAMHS and that CAMHS did not understand the level of support that could be provided by primary mental health providers.

6.6 Adult mental health

The relationship between CAMHS and adult mental health was discussed with a range of adult mental health practitioners.

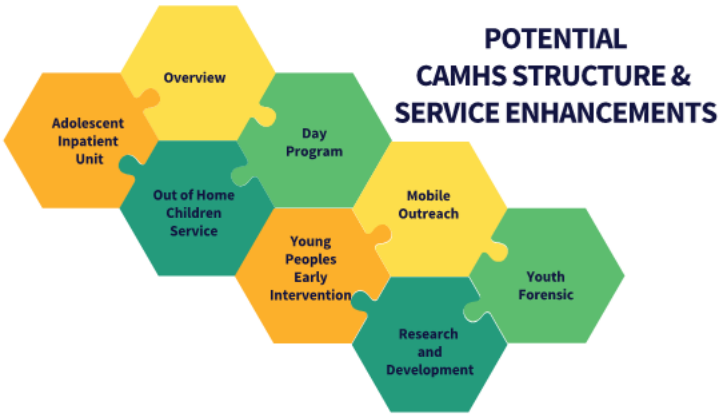
Several themes emerged. Firstly, there was thought to be very little interaction, either formally or informally, between CAMHS and adult mental health. It was noted that there was some interaction around young people in adult mental health inpatient units, however, this was less common than the admission of these consumers to paediatric inpatient beds.

Adult mental health practitioners were aware of issues with the lack of child and adolescent psychiatry input after hours across the state and this issue was thought to be more acute in the South. Many noted the current lack of child and adolescent psychiatrists in Tasmania as well as commenting on their perception CAMHS was in general significantly underfunded and under-developed.

One theme often cited was that of the lack of a youth mental health service in Tasmania. The adult practitioners consulted were strongly supportive of a youth service and noted it presented an opportunity for more effective interactions between CAMHS and adult mental health services. It also provided the opportunity for much improved transition process from adolescent to adult mental health services.

Practitioners noted that at a minimum a youth service should be an early onset psychosis service, but ideally it should see other severe and complex presentations including consumers with emerging or established personality disorder, and severe mood and anxiety disorders and those with eating disorders.

7. Potential CAMHS Structure and Service Enhancements



7.1. Reformed CAMHS structure and potential service enhancement

A current service map of Tasmania CAMHS details three separate teams that have line management to regional mental health structures (management and clinical governance).

Whilst teams have internal divisions around specific initiatives (e.g. delivery of dialectic behaviour therapy, family therapy, interest in eating disorders) only the largest service (Southern CAMHS) has a separate structure in the form of a hospital team. Southern CAMHS also has some state-wide capacity around gender identity presentations.

Non-clinic based CAMHS initiatives are outsourced to iConnect, which provides mobile outreach. The requirement for inpatients services is outsourced to paediatrics or, in some cases, adult mental health. There are no programs to provide a more intensive therapeutic experience, such as a day program.

There are no programs for children at high risk for mental illness or other consumer groups with an established higher prevalence of child and adolescent mental health presentations and/or poor adult outcomes.

The latter includes children in care, children with neuro-developmental presentations, and children in the juvenile justice system. There is no dedicated service for youth with significant mental health problems.

Ideally, CAMHS service comparisons would be made with numerous other CAMHS services nationally. This review did not have the scope to undertake this. However, service profiles are provided for two other services, both well known to the author of this review.

The Reviewer was the Executive Director of the Mater Child and Youth Mental Health Service in Brisbane. This service had the same approximate catchment area as the population of Tasmania and is therefore directly comparable.

Referring to Figure 7.1.i, the left-hand side of the service map is similar to Tasmania, albeit with four community clinics not three. Unlike the Mater service, Tasmania CAMHS does not have an inpatient unit for children and adolescents, a day program nor a drug and alcohol service. The latter part of the Mater service was inclusive of a standalone building with a five-bed residential detox, a drug and alcohol specific day program with a strong occupational rehabilitation emphasis and a clinical space. The consultation liaison service was also more comprehensive than the current hospital-based offering at the Royal Hobart Hospital. Along with a 24/7 A&E service, it also included a separate eating disorders team, Velocardiofacial Syndrome and neuropsychiatry clinic and a mother-infant treatment service. The research unit itself had 4-5 FTE with a focus on applied CAMHS research as well as running the state-wide child and adolescent disaster response team. The service employed both indigenous and carer consultants. The management unit had the capacity to manage the service budget and was responsible for the service workforce management, training and education. Over time the service created a private practice clinic that was available to service medical and allied health staff who preferred a public-private employment mix.

Figure 7.1.i: *Service organisation of the Mater Child and Youth Mental Health Service in Brisbane*

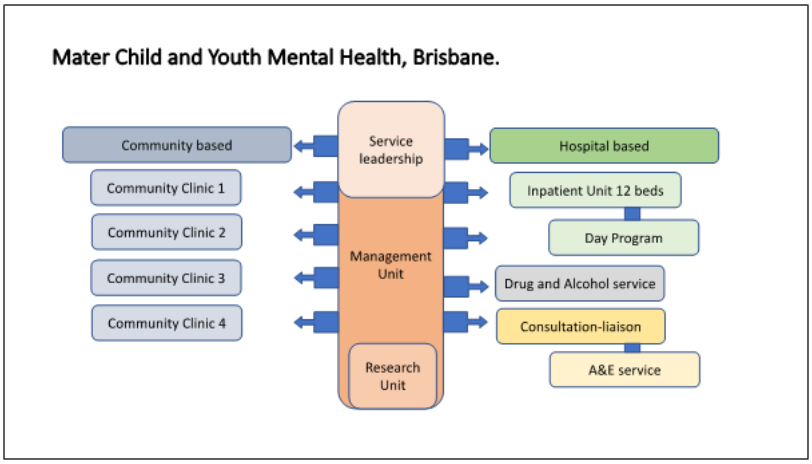


Figure 7.1.ii details the child and youth mental health service in Townsville, has a population of approximately 190,000 and a wider catchment population of approximately 220,000; the same order of magnitude as the population of Hobart and therefore directly comparable.

Like the southern CAMHS service, Townsville only has one community CAMHS clinic. Thereafter the differences in service provision to children and young people with mental health presentations is profoundly different.

Townsville community CAMHS have robust telepsychiatry services to three regional towns. Townsville has significant outpatient capacity for OOHC children through a separate team (the Evolve therapeutic service). It has a specific assertive outreach capacity (AMYOS) that is integrated to other service initiatives. It has the management of a youth team that has a purview beyond early onset psychosis and sees individuals from 16 to 25 years of age. It has a forensic outreach team.

All these community initiatives are supported by an integrated adolescent inpatient unit and day program. It is notable also by having considerable indigenous mental health capacity with approximately three FTE indigenous mental health consultants. The service at any one time employs between 7 to 8 child and adolescent psychiatrists and runs both an emergency consultation daytime roster as well as a comprehensive after-hours child and adolescent mental health roster.

Figure 7.1.ii: *Service organisation of the child and youth mental health service in Townsville*

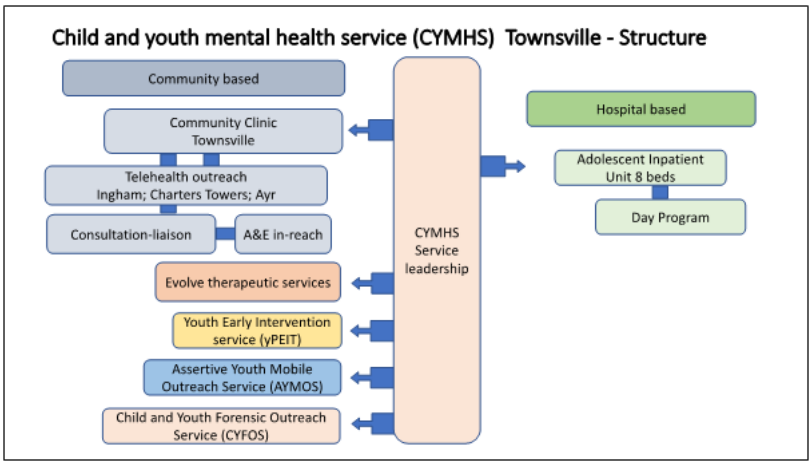
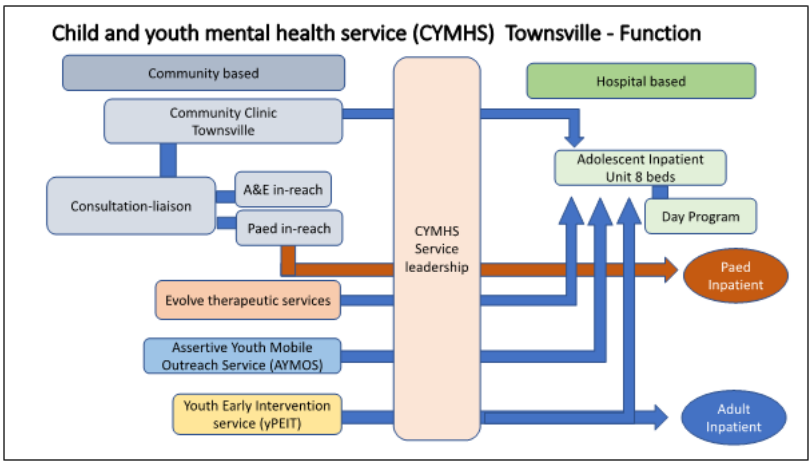


Figure 7.1.iii outlines the functional relationships within the Townsville service. The creation of specific teams for consumers with complex and severe mental health needs necessitates the support of an inpatient unit. Inpatient admissions tend to be brief, given the capacity of community services to manage the challenging, often risk-taking behaviour of these consumers. The age range of consumers seeing the youth team results in some consumers being admitted to the adult inpatient unit. As such, this team needs to work across adolescent and adult services. Paediatric inpatient beds are rarely used for mental health presentations; when used they are for individuals with eating disorders who require nutritional resuscitation and occasionally for consumers presenting with somatoform disorders.

Figure 7.1.iii: *Functional relationships within the Townsville service*



7.2. Adolescent Inpatient Unit

This review was informed that the Clinical Planning Taskforce has made recommendations in relation to Stage 3 of the Royal Hobart Hospital and that this has been supported by the State Government. This development is intended to include a dedicated Child and Adolescent Mental Health Inpatient Unit as well as a Perinatal and Infant Mental Health Inpatient (Mother and Baby) Unit. This review supports such a development and, the justification for an inpatient unit is briefly described below and such a unit is discussed as it relates to other potential service reforms.

It was discussed in section 5.7 that it is well established that adolescents have significant rates of mental health morbidity, with major jurisdictions reporting between 14% and 40% experiencing one or more mental health disorders (Lawrence et al., 2015; Collinshaw et al., 2004; Kessler et al., 2012; Das et al., 2016) Prevalence rates vary depending on the specific disorder and cohort studied. In Australia, the most typical presentations are ADHD, anxiety, major depressive disorder (MDD) and conduct disorder (CD) (Lawrence et al., 2015). Evidence suggests the rates of adolescent mental illness steadily increased up to the Global Financial Crisis (GFC) of 2008 (Collinshaw et al., 2004; Collinshaw et al., 2014; van Geelen et al., 2016).

It is unknown what the longer term effects of the COVID-19 pandemic will be, especially on children and younger people, however, contemporary modelling and the GFC-mental health relationship with unemployment strongly suggests an adverse effect on adolescent and youth mental health including the possibility of an increased rate of suicide. Before COVID-19, suicide was typically either the leading or second cause of death for 15-19-year-olds in Australia (Borschmann et al., 2018; ABS, 2016).

Deliberate Self Harm (DSH) is a significant risk factor to adolescent suicide and most commonly presents as either self-cutting or self-poisoning (Pisani et al., 2012; Scoliers et al., 2009; Runeson et al., 2016; Kolves et al., 2018). Regardless of the method, the issue is significant within the adolescent population, with between 8-10% of 12-17-year-olds reporting an occasion of DSH within the last twelve months, which increases to 11.6% when looking at only 16-17-years-olds (Zubrick et al., 2015). In a NZ adolescent inpatient group DSH and/or suicidal ideation were the most common cause of admissions (Park et al., 2011).

The economic impact of serious adolescent mental health problems is significant and, of itself, a strong argument for a dedicated mental health response. The total economic impact of youth suicide, including the direct costs and lost productivity was approximately $2.8 million (AUD) per suicide.

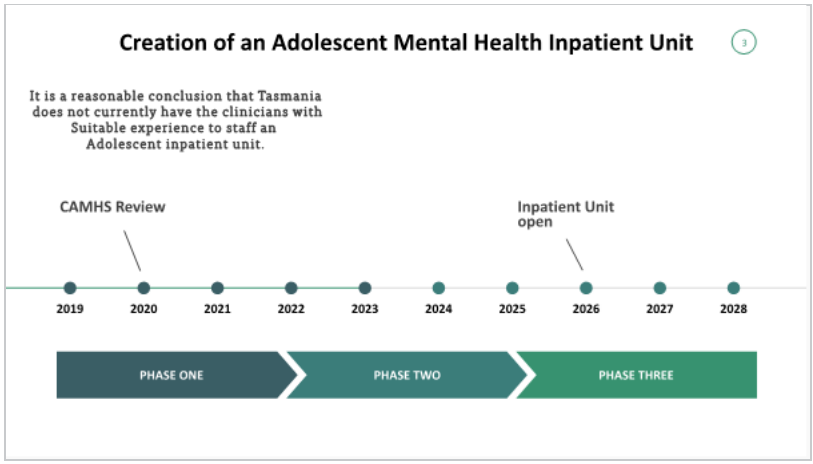
The costs of DSH treatment and admissions must be significant given the number of related hospitalisations. In a longitudinal study in Ireland approximately 30% of individuals presented with DSH on more than one occasion and a small number (~1%) presented on 10 or more occasions (Perry et al., 2012). This trend has been replicated in at least one Australian hospital (Kolves et al., 2018).

The literature reflects a range of issues with admitting adolescents to adult mental health units, including;

- a lack of understanding of the developmental needs of adolescents,
- safety issues conferred by admission with disturbed adult patients,
- staff being under skilled in dealing with adolescent behaviour,
- the interaction between dysregulated behaviour and other types of psychopathology (Scott et al., 2001; Barker, 2009, 11Million, 2007) and
- family work and education support can rarely be provided it in adult settings (Worrall et al, 2001).

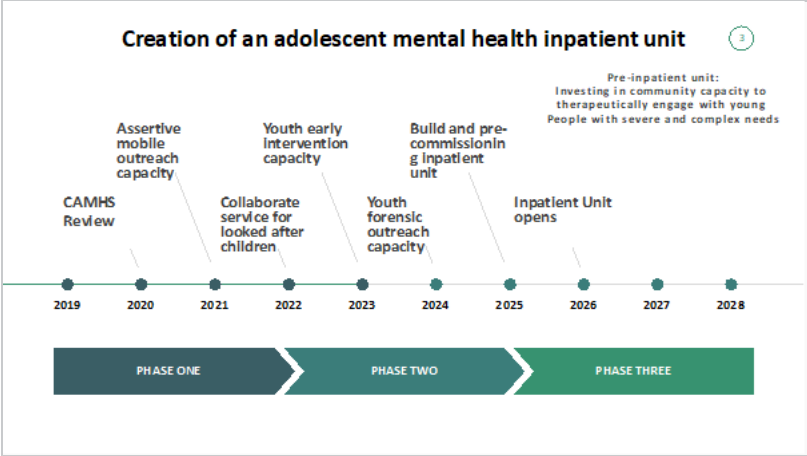
Admission to an adolescent inpatient unit is not universally helpful and the suitability of many admissions have been questioned, including adolescents with behavioural disturbance with or without conduct disorder (CD) (Weithorn et al, 1988) and the possibility of creating stigma, being exposed to restrictive practices and medicalisation of inherently social difficulties by the practice of medical admission (Kaltiala-Heino, Frojd, 2007).

Figure 7.2.i: *Timeline for creation of an Adolescent Mental Health Inpatient Unit, without increasing supporting service capacity*



An important consideration of in the creation of an adolescent inpatient unit is the capacity of local clinicians to manage the challenges and risk-taking behaviour of this patient group when discharged back to community care. The alternative to brief crisis admissions or highly goal orientated admissions is a prolonged length of stay. The problems with the latter include the potential of symptom contagion from other inpatients, behaviour escalation in the unit due to perception of the being in an authoritarian restrictive setting and increasingly institutionalised behaviour. Figure 7.2.i sets out a timeline where no additional community supports are put in place to improve community capacity prior to the opening of an adolescent mental health inpatient unit. The second timeline (Figure 7.2.ii) mitigates these inpatient unit challenges by first investing in a series of services that increase the capacity and critical number of clinicians able to support complex and severe presentations in the community.

Figure 7.2.ii: *Timeline for creation of an Adolescent Mental Health Inpatient Unit, increasing supporting service capacity*



7.3. Day program(s)

The key aim of any day program is to provide a more intense therapeutic experience for children and adolescents with severe and complex mental illness. Along with a primary mental health diagnosis, the typical client group also has developmental needs and significant impairment across multiple domains, usually in both the school and home settings. Consistent with the National Mental Health Strategy, day programs allow treatment in a less restrictive setting than an impatient unit.

Further, by living in the family home or other care environment when not attending the day program, young people have the daily opportunity to generalise change into their social ecology. This is preferable to moving from an inpatient setting, occasionally precipitously, back into a challenging environment.

Further research has established that individuals in day programs have equal levels of severe psychopathology to those in inpatient settings, with both groups having more symptoms and impairment (lower competency) than community CAMHS patients (McDermott et al., 2002), as described Figures 7.3.i. and 7.3.ii. Specifically, for Figure 7.3.i, the average symptom score as measured by the Child Behaviour Checklist was similar for those receiving day treatment (73.20) versus those receiving inpatient care (72.55).

Figure 7.3.ii indicates that the scores were similar across the two groups with regard to each of the subdomains of the Child Behaviour Checklist (Social, Activities, and School) as well as the Youth Self-Report (YSR) measure.

Figure 7.3.i: Parent report of child psychopathology across service setting

Table 1

Mean scores on the Child Behavior Checklist of children assigned to one of three treatment settings or seen for psychiatric consultation only

	Inpatient care (N=126)		Day treatment (N=68)		Outpatient care (N=250)		Consultation only (N=130)		
Symptom area	Mean	SD	Mean	SD	Mean	SD	Mean	SD	F[a]
Total psychopathology	72.55	8.33	73.20	8.52	64.58	10.54	66.64	11.40	17.58
Internalizing symptoms	72.11	9.90	68.84	11.37	63.44	10.63	63.88	12.42	12.53
Externalizing symptoms	67.30	11.15	70.75	10.72	60.89	12.24	62.15	14.20	12.28

[a] For all comparisons, df=3, 427, p<.001

Source: McDermott BM, McKelvey R, Roberts L, Davies L. Severity of children's psychopathology and impairment and its relationship to treatment setting. *Psychiatr Serv.* 2002;53(1):57-62.

Figure 7.3.ii: Parent report of child competency across service provision setting

Table 2

Mean competency scores on the Child Behavior Checklist (CBCL) or the Youth Self-Report (YSR) of children assigned to one of three treatment settings or seen for consultation only

	Inpatient care (N=126)		Day treatment (N=68)		Outpatient care (N=250)		Consultation only (N=130)				
Measure and competency area	Mean	SD	Mean	SD	Mean	SD	Mean	SD	F	df	p<
CBCL											
Total	35.70	8.39	33.56	7.76	39.27	8.99	39.41	9.45	9.85	3, 450	.001
Social	35.61	9.36	34.38	8.96	39.15	9.02	39.58	10.17	8.31	3, 518	.001
Activities	41.48	8.35	39.98	8.41	43.37	8.58	43.90	8.09	4.76	3, 524	.01
School	39.82	9.00	36.43	8.18	41.02	9.60	41.02	9.60	4.46	3, 472	.01
YSR total[a]	39.15	10.46	39.39	10.81	42.84	10.29	47.54	10.88	4.13	3, 180	.01

[a] No significant between-group differences were found on the YSR activities, social, or school competency scales.

Source: McDermott BM, McKelvey R, Roberts L, Davies L. Severity of children's psychopathology and impairment and its relationship to treatment setting. *Psychiatr Serv.* 2002;53(1):57-62.

The intervention philosophy of a day program should be;

- recovery orientated,
- strength based,
- evidence informed,
- built on multidisciplinary input,
- creative, especially creative therapies that engage young people and encourage therapeutic interaction,
- inclusive of families including family work,
- systemic, especially with specific strategies for school engagement or engagement and
- include opportunities for social inclusion such as the normal developmental opportunities of adolescence.

Some of the attributes of a successful day program would be a considerable challenge for Tasmania CAMHS given earlier comments about experience seeing consumers with severe, complex and trauma-related presentations, and stakeholders' views about collaborative engagement and care.

Day programs should:

- be embedded in the stepped care model
- accept referrals from community CAMHS after an adequate trial of therapy in that setting,
- be integrated with an impatient unit for individuals who need brief crisis intervention or therapy in a more restrictive setting, and
- facilitate discharge back to a community case management setting.

Along with the necessity to provide care for those with severe and complex needs, it should be noted that day programs are inherently group-based interventions. Essential to joining a group or creating a new group is the assessment of the relative risk of individuals.

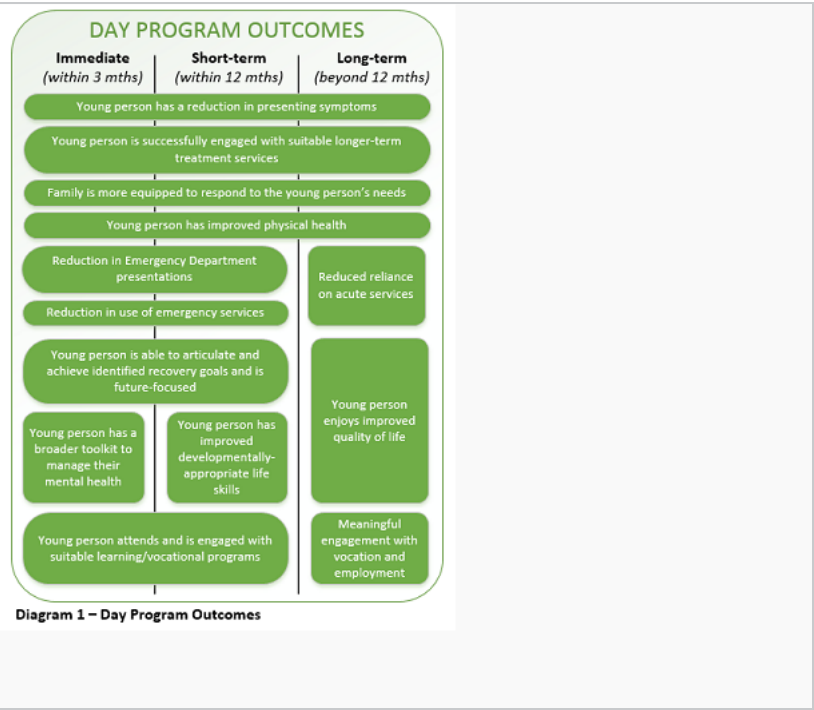
Challenging behaviour such as a past history of aggression and violence, and/or past history of highly sexualised behaviour need to be carefully considered both as risks potentially posed by an individual, as well as the quantum of individuals with these type of risk factors in a given group.

These individual and multiple risks need to be weighed against the primary desire to offer access to this more intensive therapeutic experience.

Figure 7.1.iii Townsville CYMHS highlights a day program aligned with an inpatient unit (collectively denoted AIUDS: Adolescent Inpatient Unit and Day Service). Referral pathways to the Day program are outlined in Figure 7.3.iii. Of note, individuals who meet the referral criteria can be referred from a range of other CYMHS services, not only the community CAMHS team.

The desired outcomes of a day program are outlined in Figure 7.3.iii. Across the immediate (~3 months) and the longer term (>12 months) goals are symptom reduction and include decreased reliance on emergency services, better engagement in longer-term therapies and improved quality of life.

Figure 7.3.iii: *Townsville Children and Youth Mental Health Service day program outcomes*



Source: Day Program Model of Service Queensland Public Mental Health Service (Queensland Health, February 2020)

Table 7.3.i details the workforce profile of the Townsville day program. Whilst there is no 'ideal' workforce profile, important attributes include experienced child and adolescent mental health clinicians, knowledge of group dynamics, and staff expertise which covers a broad range of interventions.

Creative therapies (e.g. music or art therapies) assist young people expressing and understanding emotions; cognitive behavioural approaches have a strong evidence base for anxiety and depression as well as social skills enhancements; occupational therapy assists with affect regulation.

Day programs are never 'stand-alone' initiatives. Day program case managers need to collaborate closely with community case managers who referred the consumer and who will provide after-care following discharge from the day program. Collaboration is also required with the inpatient service.

Day programs challenge consumers to function at a higher level, for example a young person with persistent school refusal returning to school. Occasionally this leads to decompensation and necessitates a brief crisis admission.

Table 7.3.i: *Day program workforce (Townsville, QLD)*

Position title/ Description	Professional Discipline
Clinical Lead	**Senior Occupational Therapist**
Senior Allied Health Clinician	**Psychologist**
Allied Health Clinician	**Multidisciplinary Allied Health**
Allied Health Clinician	**Occupational Therapist**
Advanced Health Worker	**Multidisciplinary Allied Health**
Psychiatrist	**Medical**

Source: Townsville Day Program

7.4. Dedicated service for OOHC children

There are numerous examples of a dedicated child and adolescent mental health service responding to the needs of OOHC children. By way of example, a summary of the Queensland Evolve program (Evolve Therapeutic Services Model of Service, 2013) is provided; primarily because it is well known to the Reviewer as an author of the original business case for the service. The review implies no superiority of this initiative over others that are of equal merit that are specific for this clinical group. This report strongly advocates a dedicated CAMHS service for OOHC children and if agreed upon, a process should be undertaken to determine the best elements of all contemporary Australian services.

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. Of note, this clinical categorisation is inclusive of a broad range of diagnostic presentations: attachment disorders, anxiety, mixed mood and conduct disturbances, post-trauma symptoms and syndromes, deliberate self-harm, suicidal ideation, substance misuse, educational difficulties, and language or communication disorders.

ETS is funded by the Queensland Department of Communities, Child Safety and Disability Services (DCCSDS). Along with the funding organisation, ETS has an interagency partnership with the Department of Education, Training and Employment (DETE). Consistent with an active partnership model, ETS engages in psychoeducation and skills development across the range of partners and stakeholders, as well as with foster and kinship carers.

Referral to ETS is only available through child protection services. Referrals are considered at a local Evolve Panel. To be eligible children and adolescents must be experiencing (ETS, 2013; page 3):

- The presence of multiple, intense and persistent emotional and/or behavioural problems;

- A high level of risk (i.e., to themselves and others);
- Severe functional impairment across a variety of domains; and
- The presence of additional risk factors.

The appropriate therapeutic intervention requires (ETS, 2013; page 3):

- A collaborative interagency service response;
- A specialist assessment and understanding of the psychological and behavioural impact of child abuse and neglect; and
- An intensive mental health therapeutic intervention.

Key ETS service components include:

- working with other service providers,
- referral, access and triage,
- assessment,
- clinical review,
- recovery focused planning,
- clinical interventions,
- a team approach,
- coordinated care,
- continuity of care,
- discharge/external transition,
- collection of data, record keeping and information, and
- mental health peer support services.

The ETS 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. The typical multidisciplinary service mix is (ETS, 2013; page 38):

- Team Leader
- Consultant Child and Adolescent Psychiatrist
- Clinician (Allied Health and Nursing)
- Administration Officer
- Service Evaluation and Research Coordinator
- Professional Development Coordinator
- Indigenous Program Coordinator
- Multicultural Liaison Officer (Cultural Consultant).

ETS services are weekday services during business hours. Consistent with the challenges of ETS consumers, clinical care pathways for after-hours crisis management are essential. On occasion this includes consumer-specific after-hours management plans that are available in A&E departments. In the Townsville service, brief crisis admissions to the child and adolescent mental health inpatient unit are often warranted. Of note; the assertive, outreach, inter-sectoral, low therapist caseload model can greatly assist to limit the requirement for inpatient admissions.

Table 7.4.i: *Child and Adolescent Mental Health Service for Out of Home Care Children*

Position title/ Description	Professional Discipline
Team Leader	**Psychology**
Professional Development Coordinator	**Multidisciplinary**
Senior Mental Health Clinician	**Multidisciplinary**
Senior Mental Health Clinician	**Psychology**
Senior Allied Health Clinician	**Psychology**
Multidisciplinary MH Clinician	**Occupational Therapy**
Multidisciplinary MH Clinician	**Occupational Therapy**
Multidisciplinary MH Clinician	**Psychology**
Multidisciplinary MH Clinician	**Psychology**
Mental Health Clinician	**Nursing**
Psychiatrist	**Medical**

Source: Townsville ETS Program

Table 7.4.i outlines the workforce of the Townsville team. The skill mix includes several senior mental health clinicians and dedicated child and adolescent psychiatrist time. The team also includes a dedicated professional development coordinator given the extensive range of professional skills required to care for this consumer group.

Interaction with residential services

The typical ETS consumer has been in the child protection system for many years and, unfortunately, have often experienced multiple breakdowns of first kinship and then foster care placements. Instability of placement conveys multiple challenges and disadvantage such as changes of school and peer groups, breakdown of relationships with siblings, exposure to different parenting approaches and family customs. These challenges are a cause of emotional distress or of developing new mental health disorders; they also exacerbate underlying attachment difficulties and pre-existing problems such as Disruptive behaviour disorders.

Any ETS-like service needs to interact very closely with the residential aspects of the child protection residential care system. In Townsville, there is the full range of care with parents, kinship carers, foster parents or young people in 'therapeutic residential care'; group homes with 4-6 residents with 24/7 care arrangements and run by NGOs.

Recent developments in the sector and what is currently available in Tasmania is out of scope of this CAMHS review, however, is clearly crucial to the well-being of this consumer group.

Any reform that instigates a much needed ETS-like service should review this aspect of care including contemporary 'professional foster-care' options. For example, suitably renumerated, supported and supervised foster care options from very high needs clients inclusive of specific training in trauma-informed care, and carer self-care and regulation of their own emotional state. ETS teams can be central in providing much needed training for these initiatives.

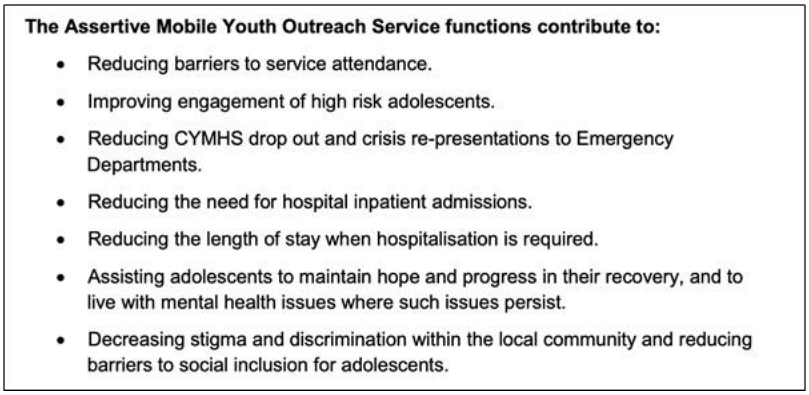
7.5 Mobile outreach service

The benefit of an outreach service to augment the clinical interventions of community CAMHS requires little justification, given an outreach service, iConnect, is already funded (see section 4.5.vii). A theme of Chapter 8, 'Reformed CAMHS structure and service enhancement' is to provide examples from other jurisdictions (primarily those the Reviewer has worked in) of services that extend the range of interventions offered to consumers. The Queensland Assertive Mobile Youth Outreach Service (AMYOS) is briefly considered below. This should be read along with the discussion of the Tasmania iConnect service.

AMYOS: an outreach model of care integrated with CAMHS

The hallmark of typical interventions is assertive engagement and follow-up. Case management and intersectoral collaboration is core business. Interventions are flexible, strength-based and guided by an individual recovery plan. Interventions are underpinned by a developmental approach and trauma theory. These are always evidence-based, for example mentalised-based therapy, dialectic behaviour therapy, solution-focused therapy and structured problem-solving. Pharmacological intervention is used in accordance with appropriate clinical practice guidelines. Families are involved wherever possible including increasing family member capacity to understand the young person's presentations and to respond appropriately. Families are also supported through advocacy and linking to other supports. Comprehensiveness of case management includes facilitating the young persons' access to a general practitioner to improve their physical health.

Figure 7.5.i: *AMYOS Service Functions*

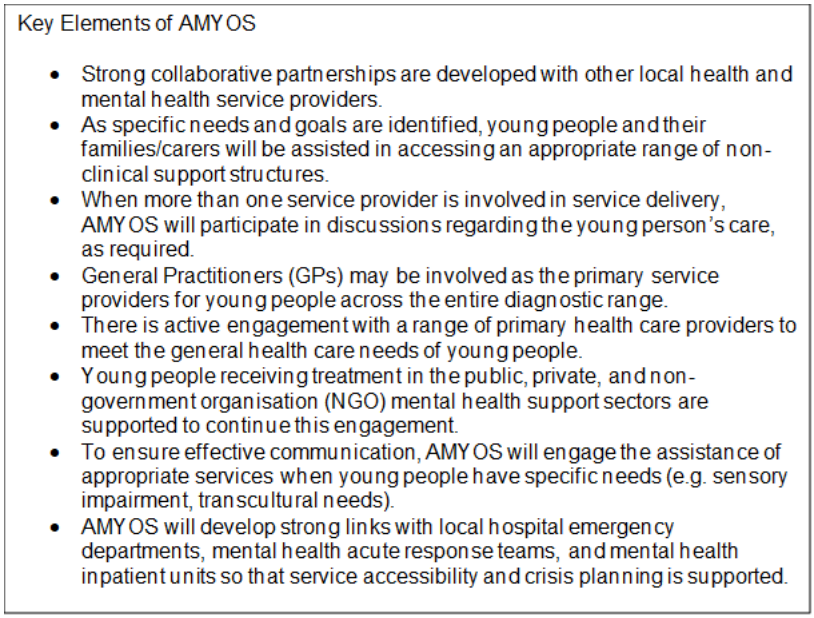


Source: Assertive Mobile Youth Outreach Service Model of Service (Queensland Health, 2016)

Figures 7.5.i and 7.5.ii outline the functions of AMYOS and the key service elements, respectively. Some of the functions are immediately useful to Tasmania CAMHS, such as improving engagement and service attendance. As mentioned in section 7.1, some AMYOS compliment a system that includes inpatient and day program services. For example, facilitating early discharge or intensive work that promotes attendance to a day program. From a work perspective, AMYOS operates weekdays during normal working hours. The typical caseload is 8 consumers per full time clinician. AMYOS clients are typical of the complex and severe challenges faced by consumers who attend community CAMHS. However, AMYOS clients are also those that have not been able to utilise a clinic-based service.

AMYOS teams tend to be small, for example a minimum team would 0.2 FTE Child and Adolescent Psychiatrist, and 2.0 FTE mental health clinician. Workforce size depends upon the other mix of service available including day program, inpatient service and services for OOHC children.

Figure 7.5.ii: *AMYOS Key Service Elements*



Source: Assertive Mobile Youth Outreach Service Model of Service (Queensland Health)

7.6 Youth Early Intervention Service

Numerous stakeholders across a range of services and disciplines wished to include "youth" (variously defined) in the CAMHS review. Reasons included a lack of current public mental health youth services in Tasmania at the serious and complex (stepped care level 4) level, no service to augment the offering by Headspace, no service that could transition patients from CAMHS to adult mental health and no youth service that could advocate for a more youth appropriate inpatient experience. Given the Reviewer's belief that the only way CAMHS can meet consumer and community expectations is to expand the size and range of services offered, a youth service integrated with CAMHS is a potential way forward. The service detailed below is an example of a youth service integrated with CAMHS.

Similar to the section on the ETS/children in OOHC, this example is provided primarily because the Reviewer has worked with the service. The Reviewer implies no superiority of this initiative to other youth models, other than as highlighted in the discussion below a benefit of the model is being more inclusive than a focus on individuals with early onset psychosis.

yPEIT: a potential service model

Over the last 20 years Australia has engaged in significant investment in youth mental health. This service expansion has been in response to research noting most adult mental health conditions have their onset during the adolescent developmental period; although more recent research suggests many presentations have their aetiological roots in pregnancy, infancy and childhood.

Further, the youth period is a time of stressful developmental challenges such as developing stable moral, political and psychosexual orientations and stressful transitions such as the end of secondary school education and transition to the workforce or tertiary education.

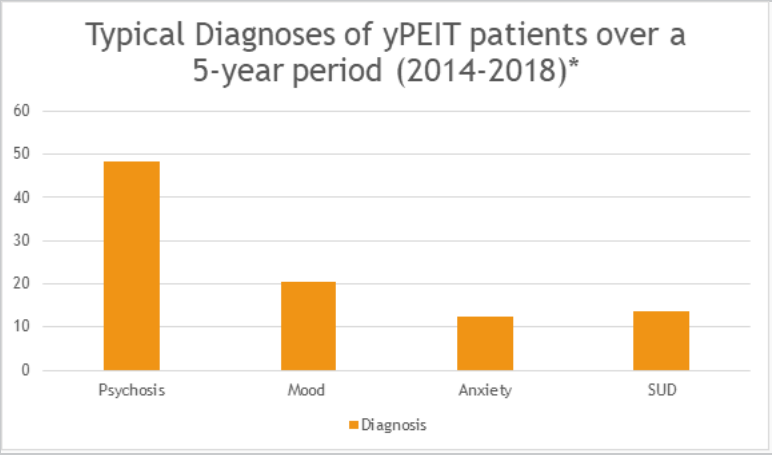
Much of the service expansion into youth mental health has focused on early onset psychosis. Clearly this is appropriate given the severity of this condition and the first two to five years of psychosis being a critical intervention period to minimise psychosocial disability. Even before diagnosis, 20% of those later diagnosed with early onset psychosis present with self-harm.

Recent development in the youth mental health area has emphasised that a focus on psychosis potentially discriminates against youth with other serious mental health presentations. For example, mood disorders during the youth developmental period are more prevalent than psychoses and rates of youth suicide are unacceptable high; Anorexia nervosa is frequently experienced by youth, potentially causing serious physical disability and long periods of hospitalisation; Personality disorders are typically youth-onset, chronic, distressing to the individual and a significant burden to A&E Departments and mental health services.

The Young Peoples Early Intervention Team (yPEIT) was created in 2013 as a specialised mental health service for young people aged 15-24, who reside in the catchment area of a regional city in North Queensland, Australia. yPEIT focuses on the early recognition and treatment for young people experiencing early psychosis (EP) and other emerging severe and complex non-psychotic disorders.

The service was developed following positive feedback about the pre-existing EP Intervention (EPI) program, along with the desire to provide a similar intensity of early intervention services to young people who present with severe and complex mood and anxiety disorders (with or without substance use), obsessive compulsive disorder, social phobia and emerging personality disorders. Figure 7.6.i highlights the range of primary diagnoses of yPEIT consumers over the last 5 years.

Figure 7.6.i: *Range of Typical Diagnoses in a yPEIT program over a five-year period (2014-2018)*



Notes: *Individuals with personality disorder were seen in another setting.
Source: Operational Service Data, yPEIT Service (Queensland Health)

yPEIT is a component of the Child, Adolescent and Young Adult Service (CAYAS), which in turn, is an element of the area health service Mental Health Service Group. yPEIT works in partnership with primary care, headspace, vocational employment and non-government organizations (Richmond Fellowship, Carers Australia), youth accommodation, educational and recreational networks. Key service elements of yPEIT include flexible access for assessment and treatment, assertive outreach, flexible treatment options delivered from a clinic, via home visits, community or at a headspace youth hub. Interventions include family work, group work, a functional recovery program, sensory modulation approaches, cognitive remediation, social inclusion programs (e.g. street soccer), psychoeducation and psychopharmacology. yPEIT provides a service to the consumer for up to two years. The yPEIT model of service is delivered by a multidisciplinary team including Consultant Psychiatrists, Registrars, Mental Health Clinicians; Occupational Therapists, Mental Health Nurses, Social Workers, and Employment Consultants (see Table 7.6.i for team composition). The yPEIT workforce includes 1.0 FTE psychiatrist given the team continues to care for yPEIT consumers when admitted to either the adult or adolescent inpatient to mental health unit.

Table 7.6.i: *Proposed yPEIT workforce*

Position title/ Description	Professional Discipline
Team Leader yPEIT	**Multidisciplinary**
Coordinator-Early Psychosis	**Occupational Therapy**
Nursing Coordinator-Early Psychosis	**Nursing**
CNC MH Clinician	**Nursing**
Senior MH Clinician	**Occupational Therapy**
MH Clinician yPEIT	**Multidisciplinary**
Psychiatrist	**Medical**

Source: yPEIT Model of Service (Queensland Health)

7.7. Adolescent forensic mental health service

Section 5.6 highlighted that there is currently no adolescent forensic mental health service. There is some capacity to provide forensic assessments and opinions, however, this does not include any capacity for after-care. This lack of service provision is within the context of known high rates of child and adolescent mental illness, including neuropsychiatric presentations, in this consumer group.

Child and Youth Forensic Outreach Service (CYFOS)

The CYFOS service (greater Townsville district, north Queensland) has been chosen as a comparison given it serves a population of approximately 224,000, not dissimilar to the size of Hobart. The higher indigenous population of Townsville creates a greater need for youth justice services given current (and highly regrettable) crime and incarceration trends (see AIHW Bulletin 145, Dec 2018). Mitigated against this, the CYFOS resources could be seen as applicable to Tasmania as a whole.

The major areas of CYFOS are consultation, assessment and treatment. Consultation includes helping youth justice services understand the young persons' mental health diagnosis and related challenges and impairments. Alternatively, in the case of clinical services, advising case managers on levels of aggression or sexually abusive behaviour. Assessment services include whether the young person has a mental health condition or providing a specific forensic mental health assessment. Along with a multidisciplinary mental health approach, CYFOS includes the ability to undertake a developmental assessment by an adolescent paediatrician.

The latter, in many cases, is highly relevant. In a manuscript currently under review, 60% of young people referred to the CYFOS paediatrician met diagnostic criteria for Fetal Alcohol Spectrum Disorder (FASD) (Chakrabarty & McDermott, submitted manuscript).

Table 7.7.i: Workforce of Child and Youth Forensic Outreach Service (CYFOS)

Position title/ Description	Professional Discipline
Team Leader	**Social Work**
CNC/Senior MH Clinician	**Occupational Therapy**
CNC/Senior Clinician	**Multidisciplinary**
MH Clinician	**Social Work**
MH Clinician	**Occupational Therapy**
MH Clinician	**Social Work**
Senior Health Worker	**Social Work**
Psychiatrist	**Medical**
Admin Officer	

Source: CYFOS Model of Service (Queensland Health)

The workforce of CYFOS is multidisciplinary including child and adolescent psychiatry time (outlined in Table 7.7.i). Some of the psychiatrist salary is currently used to employ a paediatrician with an interest in adolescent medicine. The governance structure of CYFOS is provided in Figure 7.7.i.

Interventions provided by CYFOS

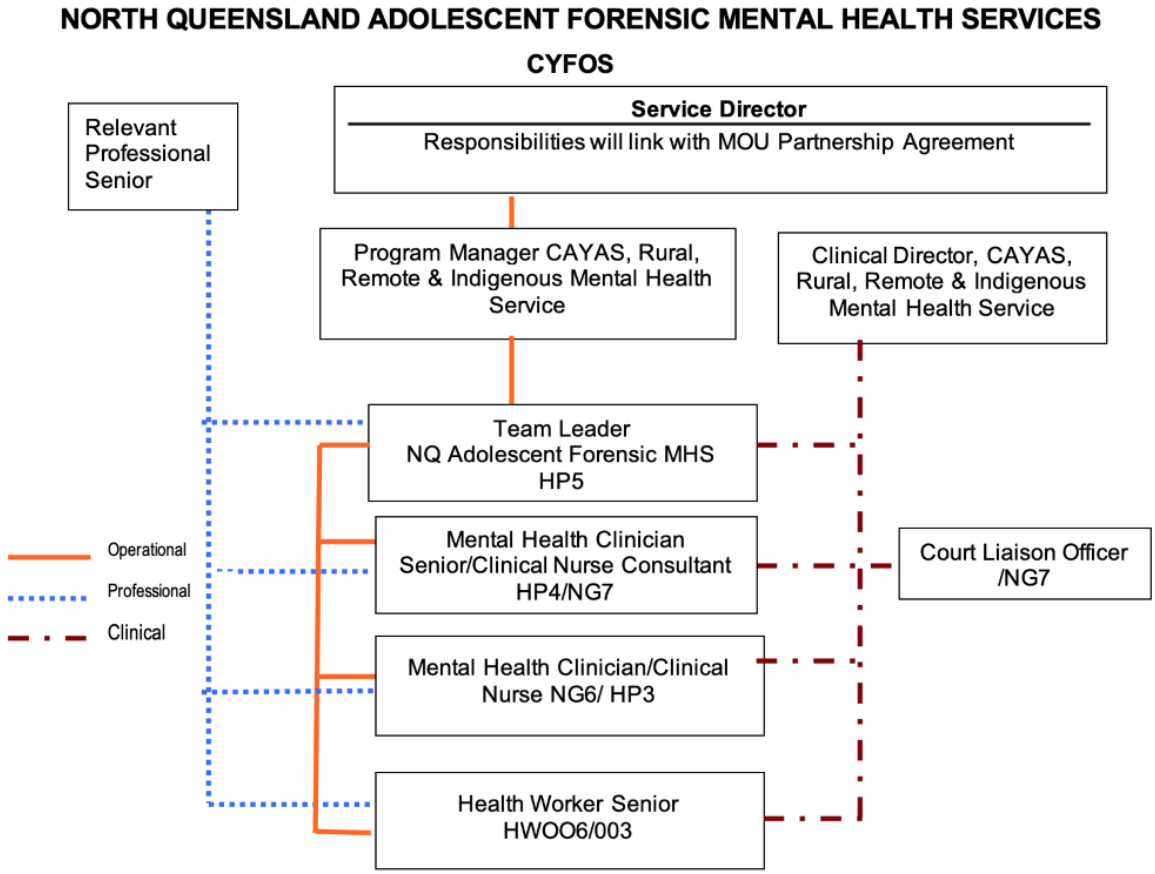
In the court setting:

- mental health screening and referral service to facilitate early intervention, promotion and prevention of mental illness.
- No assessment is made relating to the offences or further risk of offending
- The Court Liaison Service provides Fitness For Trial and Unsoundness of Mind assessments for simple offences.

CYFOS provides:

- specialised forensic assessments (sexual, violence, arson and animal cruelty),
- input into risk management and treatment planning and offence specific interventions.
- mental health assessments, mental health treatment and risk assessments when a person with a mental health concern presents to Youth Justice.

Figure 7.7.i: *CYFOS Governance/Lines of responsibility*



Source: CYFOS service (Queensland Health)

Referrals:

- Child and Youth Mental Health Services and Evolve Therapeutic Services, YPEIT/AMYOS, AIUDS (Queensland Health)
- Youth Justice Services (Department of Justice and Attorney General)
- At the Children's Courts – anyone can refer to the CYFOS Court Liaison Service

Finally, CYFOS has treatment goals beyond mental health symptom reduction. These include improved consumer quality of life and improved engagement with education providers and employers. Improvement in intra- and interpersonal functioning is likely to lead to decreased recidivism.

CYFOS also has marked systemic benefits to CAMHS by providing high quality dedicated care to this complex consumer group.

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9. Stakeholders

The review provided the opportunity for staff and stakeholders to talk to the strengths of their organisation, the challenges they face and any issues of concern. To enable the latter, no individual is named in this review either in the text or list of stakeholders as a way of supporting the need for people to feel able to express their views and experiences openly. The views of the Children's Commissioner are those available in publications from that office. With these individuals' the document was the basis of material (e.g. quotes or statements) used in this review. Some individuals (e.g. CAMHS Team Leaders) were interviewed on multiple occasions.

Participants in this review included:

Members of Department of Health Mental Health staff:

- All CAMHS Team Leaders (and acting Team Leaders)
- All CAMHS currently employed Child and Adolescent Psychiatrists (locums were not included unless participated in Team consultations)
- CAMHS clinicians interviewed with Team Leaders around specific discussions points e.g. 'intake officers'
- CAMHS clinical and administration staff in large 'Team discussions'
- Senior management staff that CAMHS practitioners report to
- Senior psychiatrists that CAMHS psychiatrists report to
- Senior perinatal psychiatrist
- Child and Adolescent psychiatrist providing forensic and intellectual disability specialist input
- Adult State-wide Mental Health Services staff
- The Mental Health Reform Program team
- Epidemiologist employed by State-wide Mental Health Services

Stakeholders:

- Commissioner for Children and Young People and staff
- Chief Psychiatrist
- Paediatricians in public practice
- Paediatricians in private practice
- General practitioners
- Child protection senior managers and staff
- Department of Education, professional support staff
- Juvenile justice youth services practitioners
- Primary Health Tasmania staff
- Headspace staff
- Managers of iConnect service
- NGO stakeholders e.g. Anglicare

APPENDIX 1.

CAMHS Review Feedback Results

Background

The objective of the CAMHS review is to 'enable an integrated pathway for children and adolescents and their families and carers to navigate the mental health system.' The CAMHS review process was led by an external consultant, Professor Brett McDermott.

In line with contractual arrangements, Professor McDermott also provided expert clinical knowledge of child and adolescent mental health as well as expertise in clinical leadership of child and mental health services and other service options (across inpatient, outpatient, emergency and child protection) as part of the review.

The review process commenced in December 2019. In August and September 2020, an advanced draft of the CAMHS report was circulated to approximately 13 stakeholders, representing current CAMHS management, community sector organisational management and senior staff in other government agencies, representatives from paediatric services and Mental Health Services executive staff and unions.

To obtain further feedback in relation to the main findings of the CAMHS review and the proposed action areas for the government response, four targeted stakeholder consultations were held on Friday 28 August 2020 chaired by Dr Aaron Groves, Chief Psychiatrist, and Professor Brett McDermott.

Consultation attendees were divided into broad professional groups which included current CAMHS clinicians, community sector organisations and other government agencies, representatives from paediatric services and Mental Health Services executive staff and unions.

All individuals receiving an advanced copy and all consultation attendees were invited to provide written feedback about each of the seven key recommendations, the three key action areas for a proposed government response, and any aspect of the presentation. The feedback period commenced on 28 August and closed on 25 September.

Purpose

To accurately and comprehensively characterise the feedback provided as part of the consultation process surrounding the CAMHS review and the proposed government response.

Feedback process

A copy of the feedback form used is provided in Appendix 1. This form was made available via HTML link, barcode scan, and submitted to possible respondents as a Word document attached to a follow up e-mail soliciting feedback. Despite the provision of a standardised feedback form, participants were encouraged to provide feedback in whatever form they felt comfortable.

The feedback form followed the structure of the proposed government response outlined in the presentation, requesting respondents rate their general level of agreement with each proposed action (it should be noted that action one included five parts, which participants were asked to rate the overall action in addition to each constituent part). Participants were also able to provide written feedback about any aspect of the presentation, its findings, or the government response. The feedback form was available in paper following the consultation as well as to meeting invitees after the consultation. Feedback via the Tasmanian Mental Health Reform Project email list and other relevant channels was also monitored.

Feedback Results-Quantitative Data

Results from the feedback process are outlined below. Overall, 38 responses were provided, of which the quantitative section rating their agreement on the proposed government actions was completed for 35 of them. The quantitative results are outlined in Table 1 below.

Table 1: Agreement with the proposed government response to the CAMHS review

Reform Agenda Question: To what extent do you agree with…	Average endorsement (on a scale of 1-10, with 10 being completely agree)	Interquartile Range (IQR)
…action one: **Addressing known service gaps?**	9.49	9-10
…action one, part one: **Establishment of a Children and Youth in Out of Home Care Intensive Support Team?**	9.57	9-10
…action one, part two: **Establishment of a Youth Forensic Mental Health Service?**	9.34	8-10
… action one, part three: **Establishment of a Youth Early Intervention Service?**	9.49	9-10
…action one, part four: **Strengthening and expansion of existing services into a Perinatal and Early Years Mental Health Service?**	9.26	9-10
…action one, part five: **Introduction of eating disorders day treatment programs?**	8.94	8-10
…action two: **Changing the function of the existing CAMHS services?**	8.74	7-10
…action three: **New organisational structure to drive and maintain meaningful change?**	8.97	8-10

The vast majority who responded were in favour of the proposed government actions. The highest rates action was action one, part one: The Establishment of a Children and Youth in Out of Home Care Intensive Support Team, which received an average endorsement score of 9.57 out of 10. The action which received the lowest average endorsement was action two: Changing the function of the existing CAMHS services. Despite this, the average endorsement was still high, at 8.36 out of 10. All of the actions surrounding addressing known service gaps received an average score over nine, with the exception of the introduction of eating disorders day treatment programs, which scored slightly lower (average: 8.84). It should also be noted that fifteen of the 35 respondents (43%) indicated that they were in full agreement with all proposed actions, with many others showing high levels of agreement overall.

Feedback Results-Qualitative Data

Qualitative feedback surrounding the reform was provided via both the feedback forms as well as through various email; some was collated as transcribed and paraphrased verbal feedback from each of the information sessions. Quotes provided below are largely verbatim but do include paraphrased information where required. In summary, there was overwhelming support and agreement for the proposed government actions and the findings of the review.

"The proposals are excellent and in my view definitely capture some of the key gaps."
"Overall, a good understanding of the current challenges identified."
"The outcome recommendations were not unexpected, and very much needed!!!"
"On the surface agree CAMHS both outpatient and inpatient needs wholescale overhaul and appropriate funding."
"I look forward to engaging with the rollout of these much-needed and long-awaited reforms."

Some expressed trepidation surrounding the staffing requirements of the reforms and the need for experienced and highly trained clinicians to take up roles in some of the reform initiative as well as up-skilling of existing clinical staff.

"All area are predicated on significantly increased funding, and the development of a state-wide entry level CAMHS training and supervision including Assessment skills: assessment, formulation, diagnosis / provisional diagnosis, case-management skills: specialised therapies, therapeutic engagement, co-management and planning for resilience / recovery programs including Discharge planning and referral"
"The recommendations and proposed initiatives are very encouraging - the challenge will be to resource these and to find sufficiently skilled and qualified staff for any new/amended organisational structures and programs."
"I anticipate the biggest issue will be recruiting suitably trained and experienced staff to fill the positions for the different teams / services unless remuneration is commensurate with mainland pay rates."
"There appears to be a high turnover of clinical staff in child and adolescent psychiatry and other health service practitioners, such as psychologists. This does not allow the service to grow FTE when the government is continually trying to recruit new staff into existing positions. Any cultural issues that may be leading to these resignations need to be addressed alongside industrial reasons for clinicians not remaining in the service or coming into the service. Attraction and retention incentives need to be considered alongside competitive salaries and access to, promotion prospects and further training and research opportunities."

Many were keen to point out the need to ensure that the reforms are conducted at a state-wide level and that all individuals are provided with access to these newly implemented services, especially those in rural and remote locations.

"Development of services across the State should not be simply to increase the capacity in Hobart. It is imperative to have robust regional CAMHS."
"XXX welcomes a restructure of CAMHS to a state-wide service model. However, in implementation of a state-wide service, XXX suggests that careful consideration is placed on accessibility for young people. Tasmania has a geographically dispersed population with 35% of the population living outside of Launceston, Greater Hobart and Burnie hubs. Additionally, even those young people living within major centres can experience barriers to accessing transportation. XXX suggests that consideration will need to be made to ensure access for young people, not just via telehealth supports but also face to face supports."
"Is there capacity to consider conjoint positions in particular parts of the state (e.g. north-west Tasmania, more rural/remote areas)?"
"I was impressed by much of the presentation, though I have particular concern about consultation with psychiatry in our regional/rural area, and also the under-resourcing that will continue to be our biggest challenge … we are struggling outside of our metro centres to attract graduates or keep experienced practitioners, and the ones who work in our rural areas are overwhelmed with referrals."
"The biggest concern is that the North West region has been left behind with most recent developments in the healthcare sectors. We often hear of the establishment of statewide services with appointments then made in the south, and sometimes the north, while often do not have regular access to such new appointees."

There was marked discussions surrounding comments made in the report surrounding single-session family therapy, with respondents identifying the practice in both a positive and negative light.

"I cannot understand how so many can be assessed/problems solved in a single family session-surely this says the wrong children/families are being seen. Children with complex and severe problems cannot be assisted with this model of care. whilst many of the proposals require additional resources the model of care can/should be addressed now."
"Prof McDermott has not made any reference to the SSFC research undertaken at CAMHS and the extremely high satisfaction rate of 70-100% for all family members. These findings have been peer reviewed and will be published"
"I think it is important to highlight that the Single Session Family Consultation is of one of the most innovative and world-class programs we offer: is evidence based and well researched, by our both service and by national/international bodies. The evidence demonstrates that this is a strength-based model that is empowering to families (which can be diverse in their makeup) and effective as an intervention, not as an 'assessment' as was noted by the reviewer."

Summary/Impressions

Overall, a high level of agreement with the actions proposed was observed. Slightly fewer than half of all respondents who provided quantitative data (43%) agreed with all of the recommended actions

It should be noted that much of the qualitative feedback did discuss scepticism and some expressed reservations surrounding if the recommendations would even be implemented. As discussed in the attached briefing note, there is the risk of reputational damage if services and the recommended reform are not progressed.

Appendix 2 : CAMHS FEEDBACK DOCUMENT

CAMHS Stakeholder Consultation Feedback

Many thanks for attending the Stakeholder Consultation on the 28th of August 2020 presenting findings of the review of Child and Adolescent Mental Health Services (CAMHS). The purpose of this feedback form is to gather your thoughts in relation to the recommendations made and to give you an opportunity to provide us with written feedback. It is important that we receive your feedback as a stakeholder in a large and sometimes complex system. Your feedback will allow us to better draft the government response to the report and ensure that everyone's voice is heard and acknowledged.

1) **To what extent do you agree with action one: Addressing the known service gaps?**

Developing new programs to ensure everyone receives a specialist, age appropriate service.
Please rate the extent to which you agree with this recommendation on a scale of 1 (Disagree Completely) to 10 (Agree Completely)

O	**O**	**O**	**O**	**O**	**O**	**O**	**O**	**O**	**O**

Disagree Completely *Agree Completely*

2) **To what extent do you agree with action one, part one: Establishment of a Children and Youth in Out of Home Care Intensive Support Team?**

A highly specialised intensive mental health intervention and consultation service for those children/young people who have complex mental health care needs.
Please rate the extent to which you agree with this recommendation on a scale of 1 (Disagree Completely) to 10 (Agree Completely)

O	**O**	**O**	**O**	**O**	**O**	**O**	**O**	**O**	**O**

Disagree Completely *Agree Completely*

3) **To what extent do you agree with action one, part two: Establishment of a Youth Forensic Mental Health Service?**

Multidisciplinary team, including adolescent psychiatrists, that provides specialist assessment, offence-specific interventions, risk assessment, and management plans.
Please rate the extent to which you agree with this recommendation on a scale of 1 (Disagree Completely) to 10 (Agree Completely)

O	**O**	**O**	**O**	**O**	**O**	**O**	**O**	**O**	**O**

Disagree Completely *Agree Completely*

4) **To what extent do you agree with action one, part three: Establishment of a Youth Early Intervention Service?**

Focuses on early recognition and treatment for young people experiencing early psychosis and other emerging severe and complex non-psychotic disorders. Key elements include flexible access for assessment and treatment, assertive outreach, and a range of interventions tailored to individual need.
Please rate the extent to which you agree with this recommendation on a scale of 1 (Disagree Completely) to 10 (Agree Completely)

O	**O**	**O**	**O**	**O**	**O**	**O**	**O**	**O**	**O**

Disagree Completely *Agree Completely*

5) **To what extent do you agree with action one, part four: Strengthening and expansion of existing services into a Perinatal and Early Years Mental Health Service?**

An expansion of the current PIMHS, to get greater state-wide coverage and consistency. The expansion will also allow PIMHS to provide a greater range of treatment options.
Please rate the extent to which you agree with this recommendation on a scale of 1 (Disagree Completely) to 10 (Agree Completely)

O	**O**	**O**	**O**	**O**	**O**	**O**	**O**	**O**	**O**

Disagree Completely *Agree Completely*

6) **To what extent do you agree with action one, part five: Introduction of eating disorder day services?**

Development of day programs to provide time limited, evidence-based therapies for those in need of strategies to manage their eating more independently, moving towards a healthier relationship with food and eating.
Please rate the extent to which you agree with this recommendation on a scale of 1 (Disagree Completely) to 10 (Agree Completely)

O	**O**	**O**	**O**	**O**	**O**	**O**	**O**	**O**	**O**

Disagree Completely *Agree Completely*

7) **To what extent do you agree with action two: Changing the function of the existing CAMHS services?**

Better alignment of the current CAMHS model of care to relevant state and national strategy, specifically:

- A focus on promoting and developing improved partnerships with GPs, the education sector, and other child, youth and family programs.
- A re-calibration of services to include the care for those with severe, complex or persistent mental health issues including those who may lack parental or familial supports.

Please rate the extent to which you agree with this recommendation on a scale of 1 (Disagree Completely) to 10 (Agree Completely)

O	**O**	**O**	**O**	**O**	**O**	**O**	**O**	**O**	**O**

Disagree Completely *Agree Completely*

8) **To what extent do you agree with action three: New organisational structure to drive and maintain meaningful change?**

A State-wide Leadership and Management structure that includes medical and administrative functions. This would entail:

- Reorganising existing senior positions to establish state-wide manager and director positions.
- Develop new governance arrangements in the form of leadership and senior groups to better standardise approaches to service provision, training and staff development to reflect a new approach to CAMHS.
- Improve approaches to continuous service improvement including links to research and program evaluation.

Please rate the extent to which you agree with this recommendation on a scale of 1 (Disagree Completely) to 10 (Agree Completely)

O	**O**	**O**	**O**	**O**	**O**	**O**	**O**	**O**	**O**

Disagree Completely *Agree Completely*

9) **What other feedback or recommendations do you have in relation to what has been presented? Are there areas of the CAMHS service where you would like to see changes which were not discussed? Was there anything that you wanted to hear about which was not discussed?**