Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF MS LYNNE ALLISON

I, Ms Lynne Margaret Allison MCAPP BSW (Hons) BA, of Level 1, 131 Thames Street, Box Hill in the State of Victoria, say as follows:

1 I am authorised by Eastern Health, to make this statement on its behalf.

2 I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

BACKGROUND

Qualifications and experience

3 I am a social worker and child psychotherapist with over 30 years' experience working within child and adolescent mental health services (**CAMHS**) and child and youth mental health services (**CYMHS**). I have worked at Eastern Health for 18 years and previously worked at the Royal Children's Hospital. My experience has largely been within specialist mental health services and included direct clinical work; individual, family and group based interventions; clinical and line management supervision of multidisciplinary clinicians, teams and services; and the provision of secondary and tertiary consultations, including professional development and education to a range of health, welfare and educational professionals.

4 I hold the following professional qualifications:

(a) Master of Child and Adolescent Psychoanalytic Psychotherapy from Monash University;

(b) Certificate of Child and Adolescent Psychoanalytic Psychotherapy from the Austin Hospital, Victorian Child Psychiatric Training Programme;

(c) Bachelor of Social Work (Honours) from Monash University; and

(d) Bachelor of Arts from Monash University.

5 Attached to this statement and marked '**LA-1**' is a copy of my curriculum vitae.

Current role and responsibilities

6 I am currently employed as the Associate Program Director of Eastern Health, Child, Youth Mental Health Service (from 2014), the Psychiatric Consultation and Liaison Service (**CL**) in 2017 and the Perinatal Emotional Health Service (**PEHS**), 2018.

7 In my current role, I am responsible for the strategic, operational and financial management of CYMHS, PEHS and CL services which form part of the Eastern Health's Mental Health Program. My role enables me to undertake quality improvement activities, refine and develop models of care, and collaboratively engage with key services within the Eastern region to promote more integrated and coordinated care pathways, with the overall aim of improving the health and wellbeing of children and young people within the Eastern region (where I refer to the 'Region' in this statement, I am referring to the Eastern region).

8 I strive to ensure that infants, children and young people experiencing severe and complex mental health difficulties have equitable access to high quality, effective mental health care which is respectful, collaborative and evidence-based. It should also promote recovery – that is, to engender hope, to have the opportunity to grow and develop toward expected developmental milestones, to feel safe, secure and cared for within their family and the community, to engage productively in education or work, and to develop meaningful peer relationships and feel part of, and be a contributing member of, the broader community.

Mental Health services provided by Eastern Health

9 PEHS was established at Eastern Health in 2018, following Department of Health and Human Services (**DHHS**) funding, to deliver antenatal and postnatal mental health care in the Eastern region to women and their infants up to 12 months post-partum. PEHS is a small multidisciplinary service comprising a consultant psychiatrist, coordinator, mental health clinicians and clinical nurse specialists (midwives), and aims to:

(a) promote the early identification of women with mental health difficulties in the antenatal and postpartum period; and

(b) deliver direct assessment, case management and therapeutic interventions to women, their partners and families, including infants.

10 **CL** comprises psychiatric consultants, registrars and senior mental health nurses. It seeks to provide high quality psychiatric consultation and through liaison services, provide assessment, advice, support and guidance in the management of medically

admitted patients with mental health problems across Eastern Health's three hospital sites — Box Hill, Maroondah, and Angliss Hospitals.

11 Eastern Health's CYMHS is a specialist mental health service providing clinical services to infants, children and young people, and their families, from 0-25 years of age within the Eastern region who present with severe and complex mental health difficulties. The CYMHS service comprises approximately 150 multidisciplinary clinical staff across acute psychiatric inpatient services as well as a range of community and specialist teams and services including:

(a) 12 bed acute adolescent psychiatric inpatient ward for young people aged 13 to 18 (located at Box Hill Hospital);

(b) an access team providing specialist CYMHS triage and intake function during business hours (after hours this is provided by Psychiatric Triage, a 24 hour, 7 day a week, all-of-age service) including telephone referral, urgent assessment, a short term assessment and treatment clinic (**STAT**), an Eating Disorders assessment clinic, and single secondary consultations (located in Box Hill);

(c) two early psychosis teams (located in Box Hill and Ringwood);

(d) an Intensive Mobile Youth Outreach Service (located in Ringwood);

(e) four community teams (located at Chandler House in Upper Ferntree Gully, Wundeela Centre in Ringwood, Carrington Road in Box Hill and at Yarra Ranges Health in Lilydale);

(f) a Specialist Child Team for children aged 0–12 years and their families (located in Box Hill);

(g) a Neurodevelopmental (autism) Assessment Team (located in Box Hill);

(h) an Adolescent Day program (located in Ringwood);

(i) an Eating Disorders Paediatric Team (located at Box Hill Hospital) and managed in partnership with the Women and Children's Program, providing paediatric Eating Disorders beds and an outpatient paediatric clinic;

(j) an Enhanced Eating Disorders Team, a multidisciplinary team with a strong family therapy focus, established in 2020 to provide intensive therapeutic support and intervention for young people with more complex and unremitting eating disorders, including having multiple admissions for medical rescue (located in Ringwood);

(k) a Child, Youth and Family Carer Participation Program, comprising youth peer advisors and family carer consultants;

(l) the Deakin Focus (Brief Intervention) Clinic providing Clinical Psychology student training and supervision (jointly funded by Deakin University, School of Psychology and Eastern Health CYMHS) (located in Box Hill);

(m) specific DHHS funded service capacity building roles – Youth Justice Senior Clinical position;

(n) the Youth Engagement and Treatment Team Initiative (**YETTI**), established in 2017 with funding by Eastern Melbourne Primary Health Network (**EMPHN**) to provide early intervention clinical services to young people, 12 to 25 years, with emerging severe mental health difficulties in primary health. The service comprises two multidisciplinary teams (Central and Outer East), with a third team operated under subcontract with Austin Hospital. The teams provide services through co-location across multiple sites including headspace Knox, Hawthorn and Greensborough and other health and welfare services to the local government areas of Knox, Yarra Ranges, Maroondah, Whitehorse, Monash, Manningham, Nillumbik and Banyule; and

(o) a Secondary Consultation and Community Education Program, providing a range of secondary, tertiary and community education programs to health, welfare and educational services across the region.

The long-term role of a community-based mental health system

12 A child and youth community-based mental health system should provide well integrated services to infants, children, adolescents and young people across the continuum from 0–25 years of age, be inclusive of families, and address the range of mental health concerns across emerging, mild to moderate and complex and severe presentations. The centrality of community based care across the continuum should be recognised.

13 Within the service system, the specialist child and youth community-based mental health system has two central roles:

(a) to provide direct clinical assessment, case management and treatment services for children and young people with severe mental illness or severe emotional and behavioural disturbance. This involves the provision of a full range of multi-modal evidence based interventions - individual, family, and group based - within a multidisciplinary, systemic and family-based framework. This necessarily also includes participation in, and engagement with the broader service system and networks to enable collaborative and well-coordinated care planning;

(b) to support the capability of key health, education and welfare agencies and services to identify, screen, refer and provide safe, effective care of children and

young people with emerging, or mild to moderate, mental health concerns through primary, secondary and tertiary consultations, education and training, liaison and service information.

14 As discussed below, in paragraph 46 of this statement, continuity of care for infants, children and young people with significant mental health issues requires prioritisation within the service system. As such, as far as is possible, service models should seek to minimise disruptions or transfers of care, and aim to provide children and young people with the right service at the right time and right place.

15 For the purposes of brevity I will use words, 'children and young people' to be inclusive of infants, children, adolescents and young people 0–25 years of age throughout this statement.

16 Finally, there are opportunities to enhance collaboration across CAMHS/CYMHS within Victoria. Currently there are limited formal opportunities for collaboration and information sharing. A future community mental health system should include formalised structures to support collaboration and the sharing of innovative practices between CAMHS/CYMHS and between CAMHS/CYMHS and broader health, welfare and education services.

Children, adolescents and young people at risk of developing mental illness

17 As per paragraph 13(b), CYMHS services have a role in supporting the early intervention of children, adolescents and young people at risk of developing mental illness. This can be effectively undertaken through the provision of capacity building, consultation and education to health, welfare and education services as outlined in further detail within paragraphs 93, 95 and 99 of this statement.

Children, adolescents and young people experiencing mild and moderate mental illness

18 Direct clinical services are generally provided through Commonwealth funded services such as headspace centres, stepped care services, community health services and privately funded psychiatrists, psychologists, mental health social workers and counsellors.

19 CAMHS and CYMHS do not have a direct role in providing services to children and young people experiencing mild to moderate illness, however as detailed in paragraphs 93 to 99 the service has a capacity building and support role with partner agencies.

20 In particular, Eastern Health CYMHS provides primary consultation services to the two headspace centres within our catchment. CYMHS Psychiatric Registrars provide three

sessions per week to headspace Knox and two sessions per week to headspace Hawthorn. YETTI, as described in paragraph 11(n), accepts referrals of young people with more complex mental health difficulties but who do not require specialist mental health services. YETTI additionally provides primary and secondary consultation to headspace centres and community health centres, with YETTI clinical staff co-located within these agencies alongside the direct clinical service role. Since commencement in November 2017, YETTI has engaged 271 young people in treatment and a further 351 primary and secondary consultations, with headspace, community health and primary healthcare clinicians, have been undertaken.

21 As per paragraphs 130 to 136 consideration of CYMHS services undertaking management of headspace centres should be deliberated – currently both Alfred CYMHS and Orygen successfully operate headspace centres. At present there are two headspace centres within the Eastern Region, and soon to be three, each run by different lead agencies. While unintended, and not due to any specific deficit within the lead agencies, this contributes to the further fragmentation within the service system and the associated development of consistent care pathways.

Children, adolescents and young people living with severe mental illness

22 The provision of services to children, adolescents and young people living with severe mental illness is clearly in the remit of CYMHS. CYMHS should provide access to timely assessment and a full range of evidence-based treatment services that support recovery within a skilled multidisciplinary team and guided by a collaboratively developed recovery plan (involving both the young person and family). Care is multimodal and may include:

(a) individual therapies;

(b) family therapy;

(c) parent work;

(d) group therapies; and

(e) youth peer and family carer peer support,

within a framework that addresses both the child/young person's individual, holistic needs and concerns, and the family's and service system around the young person. For example, through engagement an intervention with both the child and young person and their family; and through care team meetings and/or the development of collaborative safety management plans to guide helpful system response and intervention.

23 Unfortunately, the current CYMHS service is limited by the available resources and as such, is unable to provide assessment and treatment to all referred children and young people meeting CYMHS intake criteria. Lack of resources also impacts on the ability to provide greater flexibility in available service models offered. In particular, most CYMHS and CAMHS services are office based and operate Monday to Friday, 9am to 5pm only. Office based services do not always sit well with the needs of vulnerable children or young people, and their families. Parents can also struggle to juggle work commitments with attendance at appointments. CYMHS need greater capacity to be able to offer appointments outside of office hours, alongside greater outreach or in-reach services in those circumstances where office based work is not suitable. This would, however require a significant additional investment in resources.

24 In any future system, retaining a family centred approach is essential to address the broad psychosocial needs of the child or young person. CYMHS also needs mental health clinicians who are dual diagnosis capable (alcohol and other drugs (**AOD**)) with accessible back up/consultation and support from youth AOD services where required.

25 Care needs to incorporate educational and vocational support services. One successful model is Eastern Health's partnership with Avenues Education, a specialist Department of Education and Training (**DET**) school which co-locates teachers within CYMHS community and specialist teams and within our Adolescent Inpatient Psychiatric Unit (**AIPU**), Groupworx day program, and Paediatric Unit (Eating Disorder patients). Avenues teachers, working in partnership with CYMHS clinicians, work to strengthen/re-engage young people at school, undertake educational assessments and support mainstream and specialist schools through the development of behavioural management plans or return to school plans.

Children and young people who are experiencing a suicidal crisis or following a suicide attempt

26 Children or young people often present to an Emergency Department when in a suicidal crisis, or subsequent to a suicide attempt, or following significant deliberate self-harm. Emergency departments, however, are not ideal places for young people to receive care as such children/young people are exposed to a noisy, loud and high stimulus environment. This can be frightening and overstimulating. Code grey events, including violence and aggression are not uncommon and not conducive to providing a safe space in which to engage, assess and safety plan with the child/young person and family. As per paragraph 54(a), a quiet, calm space, adjacent to the Emergency Department, large enough to accommodate accompanying family members, and enable "private" mental health assessment and safety planning is required. Where immediate acute psychiatric, or paediatric inpatient admission is not required, or referral for specialist mental health assessment and intervention within a CYMHS

community team indicated; routine follow up should be provided, through a brief mental health intervention model (similar to the STAT clinic, as referenced in paragraph 36 of this statement). Currently, due to the demand for specialist CYMHS services, follow up care and intervention is unable to be offered to all children/young people presenting to our Emergency Departments following a suicide attempt, or suicidal crisis or significant self-harm.

Families and carers of children and young people experiencing challenges to their mental health

27 Parents and carers with mental ill health represent a risk factor for child mental illness. Accordingly, clear collaboration between Adult Mental Health Services (**AMHS**) and CYMHS should be strengthened to ensure children are well supported and have access to early intervention for emerging mental health concerns.

Best practice examples of community-based mental health care for infants, children, adolescents and young people

28 Common factors of best practice examples of community based mental health care for infants, children, adolescents and young people include:

(a) clear evidence-base and clinical guidelines, recognising that these are not always available given the complexity and severity of presentations across diagnostic groups and multiple co-morbidities;

(b) sufficient resources and expertise (trained, competent multidisciplinary workforce) to deliver the range of indicated evidence-based treatments within flexible modes of engagement and service delivery — whether outreach, in-reach, office based, short term or longer term depending on need — to enable innovative, person centred and evidence-based care;

(c) multimodal therapeutic interventions which incorporate family, systemic focus and the holistic needs of the young person; and

(d) strong clinical governance which supports risk management and safe, effective and evidence based care.

29 Examples of best practice within Eastern Health CYMHS are discussed below.

Initial Consultation & Treatment in Recovery (ITCiR)

30 This caseload management system was implemented across CYMHS community teams in 2015 following a historically long wait list (two years) for assessment and intervention with one of the four community teams. The system had the aim of:

(a) streamlining pathways of care for severe and complex presentations;

(b) eliminating systems that require waiting periods;

(c) strengthening the service's recovery focus;

(d) ensuring a balance between effectiveness and accessibility;

(e) ensuring the continued provision of safe, quality and effective care;

(f) prioritising continuity of care; and

(g) creating a model that is sustainable, efficient and that can be scaled according to available resources.

31 The model enables monthly calculation of the four community teams' capacity to provide new appointments, based on available clinical EFT and into which initial consultations (**IC's**) are booked directly by our Access team with an allocated community team clinician who will then be responsible for the child/young person's ongoing care. IC's are collaborative initial appointments with the allocated clinician and child/young person and family from which an agreed recovery plan going forward is developed. This may be further detailed assessment and treatment depending on the wishes and needs of the family, or alternatively brief intervention. It should be noted, that crisis appointments continue to be provided within 24 hours and referrals to specialist teams are directly provided through our Access team and for which there is no waiting list, with the exception of the Neurodevelopmental (autism) Assessment clinic which is generally around six weeks.

32 While demand continues to outstrip supply, overall, ICTiR has been successful in improving the service's responsiveness and accessibility, whilst maintaining clinical outcomes and equity of clinical caseloads across the four community teams.

First episode psychosis

33 The two Early Psychosis Teams (**EPTs**) at Eastern Health are an example of best practice care. The teams were established over 2006 (Maroondah EPT) and 2007 (Box Hill EPT) to provide assessment and intervention for young people experiencing first episode psychosis. The teams' work is underpinned by a clear, staged Model of Care as per the Australian Clinical Guidelines for Early Psychosis. These multi-disciplinary teams provide a two year model of care which is recovery and systematically oriented and family inclusive and addresses the broad psychosocial needs of the young person and their family, including educational/vocational (Avenues Education), drug and alcohol and social needs. Young people can be seen at home or in community based clinics.

34 Initial funding for the EPTs was based on the known epidemiology of psychosis and population data. This approach has ensured that the service is sustainable. Referrals are accepted in a timely manner and there is no wait list for care.

35 One noteworthy limitation, however, is that whilst CYMHS provides care for young people up to the age of 25 years, for EPT clients — following a two year episode of care, and if 18 years or over — care is transferred to the adult AMHS. This exception to working up to 25 years of age followed the limited funding provision when Eastern Health CAMHS became a CYMHS in 2010 (see paragraph 48). Likewise, acute inpatient care for young people over 18 years of age remains with the AMHS (see paragraphs 78 to 79).

Short Term Assessment Clinic (STAT)

36 The STAT clinic is a recent development within Eastern Health CYMHS. The creation of the clinic followed our identification of the need for support for young people, who were referred to Eastern Health and did not require the full assistance of a specialist mental health service, but who would have benefitted from a more targeted approach that could not be provided within existing community supports or by private practitioners. STAT is situated within the CYMHS Access team, and is an adjunct to the usual provision of care, utilising an up to six session model of intervention with the young person and their family. It has a clear framework and criteria for admission with eligibility criteria including:

(a) situational crises, such as a relationship breakdown leading to suicidality or a serious suicide attempt with no prior history;

(b) post-inpatient care, where admission occurred subsequent to a situational crisis and in the context of no previous mental health issues;

(c) where a person's needs can be met privately, but they need guided support to access and engage; and

(d) previous clients who did not engage with community care, in order to better facilitate engagement.

The Specialist Child Team and Infancy Access Project

37 Prior to the DHHS Specialist Child Initiative which provided funding in 2016/17, with a further allocation of funding in 2017/18, to enable greater access to care for children under 12 years of age and who were previously underrepresented, the Specialist Child Team (**SCT**) had been experiencing a long term decline in both total referrals of children and in the number taken on for treatment. The SCT was developed to address this issue but also to focus in particular on the most complex and vulnerable

children and families referred to CYMHS, including children entering, or in out of home care, and children who have experienced family violence, abuse or trauma. A secondary role of the team is capacity building with the four community teams within CYMHS who also provide care and treatment to children and young people.

38 Internal evaluation of the SCT was undertaken in 2019, and confirmed that the team had met the aim of providing assessment and treatment to this group of highly vulnerable children. For example, analysis of a range of demographic and complexity factors of children receiving care with the team, indicated that the majority of referrals taken on had experienced failed past treatment by Tier one to two services, and the complexity of children seen was evident, with a range of two to twenty-four identified factors (one case) of complexity noted within individual presentations, with the mode being ten. Complexity factors included child protection involvement (50%), family violence (50%), parental mental health concerns (61%), harm to others (40.7%) and developmental delay/cognitive difficulties (32%).

39 Importantly, access for assessment and treatment noted that children under 12 years now represented 28.5% of accepted referrals across CYMHS and while demand continues to exceed the ability to provide care, care for children under 12 years is equitable across the age range.

40 The Infancy Access Project was initiated by the Child Team in 2017. The project aims to support improved early intervention with 'at risk' families, and in recognition of the under-representation of children under 4 years of age within CYMHS. Developed in collaboration with Maroondah Maternal and Child Health Service (**MCHS**), the project provides mental health assessment and intervention with families referred by the MCHS, and is delivered alongside the MCHS nurse in the family home and/or MCHS centre. Early results indicate a 29% increase in engagement with CYMHS by this previously under-represented group, and resources permitting, the project will expand to all local government areas in the Eastern region. The project was also awarded a small grant to enable formal evaluation of the program, which Melbourne University has been engaged to undertake.

Borderline Personality Disorder

41 Eastern Health CYMHS, noting the high rates of recurrent self-harm, frequent Emergency Department presentations and need for acute inpatient admissions and heightened risk of suicide for young people with a Borderline Personality Disorder (**BPD**); coupled with evidence of the effectiveness of early intervention for the disorder, sought to embed effective, evidence based care across the service. This has included the development of practice guidelines, '*Borderline Personality Disorder — Early intervention and treatment for young people under 25 years in CYMHS*' to

support best practice for inpatient and community mental health care. These guidelines are underpinned by the clinical guidelines developed by the National Institute for Clinical Excellence and National Health and Medical Research Council.

42 The guidelines support care provision within our community, specialist teams and acute inpatient care regarding the management and treatment of young people with BPD or sub-threshold personality disorder, and include the Principles of Good Clinical Care that apply to all Eastern Health young people with, or with emerging, BPD. While it may seem obvious, treatment can be compromised if these basic principles of good clinical care are neglected in the context of the interpersonal relationship disturbances and maladaptive help-seeking seen in BPD. The Principles of Good Clinical Care for BPD include:

(a) psychoeducation for the young person and family/carers regarding the impact of BPD and how to best support the young person;

(b) assertive, psychologically informed case management;

(c) explicitly collaborative approach to treatment;

(d) psychosocial recovery focus (education, vocation, recreation, social connection);

(e) identification and treatment of comorbid psychiatric and other health conditions;

(f) family/carer involvement;

(g) co-ordination of treatment planning with other professionals;

(h) crisis support and safety planning; and

(i) regular supervision for clinicians.

43 Current evidence-based psychosocial interventions for BPD in young people should also be provided where they are available, including Cognitive Analytic Therapy (**CAT**), Emotion Regulation Training (**ERT**), Mentalisation Based Treatment for Adolescents (**MBT-A**) and Dialectical Behaviour Therapy for Adolescents (**DBT-A**). To support delivery of evidence based care, Eastern Health CYMHS has, through a partnership with Orygen Youth Service, supported CAT training of selected CYMHS clinicians. Evidence based practice is further supported through a monthly clinical consultation, open to all CYMHS clinicians.

Eating Disorders

44 I have described the services provided by CYMHS to young people with Eating Disorders in paragraphs 11(i) and 11(j) of this statement.

45 Early intervention and evidence-based care is provided through close collaboration with Paediatrics and Mental Health, enabling clear pathways of care and high quality evidence based care. All CYMHS clinicians undertake Family Based Therapy Training for Anorexia Nervosa on commencement with CYMHS, with practice supported by monthly clinical consultation, accessible consultation to the Paediatric Eating Disorders team – and which includes a senior mental health clinician and clearly defined paediatric admission criteria for medical rescue. CYMHS has recently developed an Enhanced Eating Disorders Team to specifically work with young people with more complex and unremitting Eating Disorders, targeting those requiring repeated medical admissions and provides intensive therapeutic support and intervention.

Streaming of services for children, adolescents and youth by age

46 In 2010, Eastern Health CAMHS successfully transitioned to a CYMHS, providing specialist mental health care to children and young people, 0 – 25 years of age, in line with "Because Mental Health Matters: Victorian Mental Health Refor/m Strategy 2009-2019". The shift in model of care followed the recognition of the inherent risk and difficulties, particularly for vulnerable children and young people, where there are transitions of care and that young people required a youth friendly and developmentally focussed care provision. Further to this, young people's needs were not being met within the existing adult mental health system.

47 Internal evaluation of the model has been overwhelmingly positive – more young people have had access to specialist mental health than had previously been accepted within the adult mental health system due to their limited eligibility criteria, and clinical outcomes are also positive. Workforce development and training, anticipated to be of concern in embarking on the service change, did not eventuate as an issue, with the developmental, family and systemic framework usefully able to be extended to 25 years. The development of specialist teams and clinical programs has also supported evidence based practice across the service, and specialist care across the age range. For example, EPTs, Intensive Mobile (adolescent) Treatment Team, Specialist Child (children under 12 years) Team and the Eating Disorders service. In addition the service operates three clinical consultation groups – BPD, Eating Disorders and Children under 12 years – to further support best practice.

48 The limitations and issues identified were largely consequential to funding. Eastern Health received only 12% additional funding to service a 40% increased population, which resulted in the following:

(a) EPT clients remain being transferred to the adult service, as per paragraph 35 of this statement, following a two year episode of care and being over 18 years

of age. Ideally, and in line with current clinical guidelines, they would receive a five year episode of care with EPT, or until their 25th birthday. Acute inpatient care is also provided for 18-25 years within the adult mental health service, which is far from ideal. We also do not have a youth specific PARC (Prevention and Recovery Care) within the Region.

(b) Initial evaluation indicated an under-representation of infants and children under 12 years of age, as compared to what might be expected for a specialist mental health service based on epidemiology and population data. This followed demand for CYMHS increasing by upwards of 30% without sufficient increase in resourcing. This has since been addressed through targeted and 'reserved' appointments for children under 12 years, and through the establishment of the SCT and Infancy Access Project, following DHHS Specialist Child Initiative funding (paragraphs 37 to 40).

49 Given the positive experience of operating a 0–25 year old service, it is strongly recommended that this service model be more broadly established across Victoria, coupled with the appropriate resources to take on the additional age range. Issues of equitable access across the age range can be addressed through the development of clear guidelines and funding tied to the delivery of agreed key performance indicators (**KPIs**) regarding expected service provision. This could include active monitoring of service access across age ranges (e.g. 0–4, 5–12, 13–18 and 19–25 years old and as compared to epidemiology and regional population data) to be routinely undertaken.

50 Ultimately, the success of the model will be dependent on the available resources to support it, and the KPIs and guidelines established to ensure access and high quality, evidence based care provision across the 0–25 years age range.

Examples of high-quality systems and services that don't use age-based streaming

51 I am not aware of any services that do not use some form of age-based streaming. Some services may have some diagnostic based eligibility criteria in addition to age based criteria. Broad diagnostic streaming is useful in the case of diagnoses with clear evidence base, such as first episode psychosis, or Eating Disorders, for example. However, many young people do not present with a diagnostically clear profile, with the subsequent risk that they may miss out on service, if they do not fit the eligible diagnostic profiles.

Better identification and support for infants, children, adolescents and young people who need extra mental health support

52 There are two key areas requiring attention to better identify and provide support for infants, children adolescents and young people who need extra mental health support.

Service system

53 The first key area is the service system. Key changes that I consider need to be made are:

(a) Realignment of catchment areas to reflect local government areas.

(b) Greater Commonwealth and State mental health system coordination - required to minimise duplication and avoid the establishment of new services that are not integrated into the existing service system. For example, there are currently multiple suicide prevention strategies and initiatives at Commonwealth and State levels, creating inefficiencies, duplication and reduced effectiveness.

(c) The allocation of funding across mental health services should be transparent, equitable and based on epidemiology and population data.

(d) Consideration of CYMHS assuming the operation and management of local headspace centres to:

(i) support improved clinical governance and risk management;

(ii) support the development of clear, local coordinated pathways of care for young people

(iii) improved screening and identification of emerging mental illness; and

(iv) the development of local, regionalised and coordinated pathways of care to support the delivery of the right service at the right place and time.

But this would require protections to ensure that tertiary funds used for severe and complex mental illnesses were not re-directed to provide services at Tiers 1 and 2.

(e) The development by DHHS of CYMHS specific KPIs and Statements of Priority. There is currently limited oversight and governance across inpatient and community based mental health services – with KPIs focussed almost entirely on inpatient, despite community work being the core component of CYMHS. Hence, there is little guidance or accountability for individual health services in the delivery of expected CYMHS community services.

Models of Care

54 I have previously outlined the recommendation for a consistent CYMHS, 0 – 25 years. In addition, there are five further areas of need in relation to the Models of Care offered by CYMHS:

(a) Development of separate mental health spaces within/adjacent to Emergency Departments which are quiet and provide a safe area for skilled staff to assess

presenting children and young people, to develop a safety plan and provide follow up care (see paragraph 26).

(b) Development of age-appropriate psychiatric triage services.

(c) Additional resources, including community based clinical staff, to enable outreach/in-reach and flexible Models of Care. This would enable the community teams to deliver more flexible care in the young person's environment, including home and school.

(d) Development of further youth acute inpatient units for young people aged 18-25. Young people require youth-focussed places that attend to their developmental needs as opposed to being placed in adult wards, which experience high demand, acuity and often high rates of aggression – which can result in, despite best efforts of staff, trauma and a lack of hope.

(e) Increased flexibility in the boundaries between regions, especially with regard to vulnerable children and young people. For example, young people who are homeless, or in out of home care are currently required to transfer between services on moving to a new region. This presents a high risk of disengagement. Alternatively, it would be preferable for the service to continue community service provision for a period of time, such that the young person has engaged with the local service.

The professional mindsets, capabilities and skills that are needed for working specifically with young people in mental health

55 All mental health professionals need to be hopeful and believe in the capacity for change, non-judgemental, respectful, collaborative, kind and resilient. Those working in CYMHS should also be curious, creative and playful.

56 Children and young people typically live within families and the family/immediate support system is at the forefront of CYMHS Models of Care. As a specialist mental health service, CYMHS provides a family inclusive, multidisciplinary, multimodal and intensive psycho-therapeutic approach. Treatment is necessarily broad and needs to attend to the holistic needs of the child or young person. This includes education, community engagement, peer relationships, family dynamics and relationships. It is therefore important to highlight that the ability of the mental health workforce in CYMHS to engage and work with parents and families alongside the individual child or young person necessarily demands considerable expertise, training and supervision as it is highly complex work. In the majority of cases, children and families present with highly complex needs and vulnerabilities, often referred only after lengthy 'failed treatments' within other sectors and consequently they, and their parents/carers, may feel blamed for the difficulties and lack hope for change. In addition, for the vast

majority of children and young people seen, there is also complex involvement with service systems – educational, welfare – child protection, family support services, amongst others. As such, CYMHS clinicians need to have well-developed engagement skills in order to develop a productive and collaborative alliance with both the child or young person and their family and involved service system, so they can work together toward recovery.

57 In the CYMHS context, recovery is measured as the return to a more normal developmental trajectory with the hope or expectation that for many children and young people they will not need to be ongoing or episodic consumers of specialist mental health services as adults.

The capabilities and skills needed within the workforce to better engage with parents and carers of young people

58 As per paragraph 56 of this statement, working with parents, carers and families is a core capability of a CYMHS clinician. Generally, CYMHS clinicians are well equipped to engage with parents and carers of young people; however, increasingly, new clinicians struggle with the complexity of service systems and needs of parents and carers. Focussed training and supervision are necessary for CYMHS services to support CYMHS clinicians to develop a thorough understanding of relational dynamics and family and systems theory, whilst concurrently understanding the individual needs of the child or young person.

The implications of the required professional mindsets, capabilities and skills identified above for the composition, training and deployment of:

Clinical workforces

59 There is need for a greater recognition of the additional skills and competencies required of the CYMHS clinical workforce. The training programs currently provided for the general mental health workforce are not sufficiently in-depth or targeted to meet the needs of the multidisciplinary CYMHS workforce. Staff would benefit from increased access to highly specialised postgraduate training and professional development, for example family therapy, child psychotherapy and a range of other individual, systemic and family based therapies to develop the necessary specialised skills. This type of specialised training is expensive for clinicians to undertake and CYMHS's do not have the budget to support this training. The lack of access to additional training creates a barrier to achieving the required level of expertise of the CYMHS workforce and the implementation of evidence-based care. One solution might be the establishment of a yearly scholarship program which is open to all

disciplines and which offers access to specialised training to clinicians from each CYMHS service.

60 Graduates can find the presenting clinical issues particularly challenging and core professional trainings are not sufficient to equip staff with the necessary clinical skills or resilience for the work. As such, on commencement, clinical staff need structured programs of professional development and support alongside clinical supervision. An Allied Health Graduate Program, specific to CYMHS for clinical psychology, social work and occupational therapy, is required. Ideally, positions would be 12 – 18 months, fixed term and include rotations across a range of inpatient, community and specialist teams. Completion of the Developmental Psychiatry Course, Mindful could be undertaken as part of a structured graduate program and would provide the theoretical frameworks and experience in assessment and diagnostic formulation and treatment planning.

61 The predominant community clinical workforce within CYMHS is Allied Health – Clinical Psychology, Occupational Therapy and Social Work, yet the support structures and leadership for Allied Health are under-developed relative to mental health nursing. Funded discipline specific leadership positions for the core discipline groups are required within mental health services and which can support student placements, graduate positions and the ongoing professional development needs of the disciplines. This also requires specific identified leadership positions within CYMHS, AMHS and Aged Persons Mental Health Service (**APMHS**), reflecting the differing specialised needs of the three age streams. It would be beneficial to establish regular collaborative forums for Allied Health staff, auspiced by the Director of Allied Heath within the Mental Health Branch of DHHS.

62 The current Enterprise Bargaining Agreements are not reflective of contemporary community based practice, or of the complexity and multidisciplinary nature of the work of CYMHS. There is an increasing disparity in salary and entitlements across the different disciplines for workers within CYMHS services performing similar roles. This is a consequence of the relative bargaining power of some disciplines over others, and has led to increasing anomaly in salaries and conditions across the multidisciplinary teams, impacting significantly on career progression, staff retention and morale. For example, depending on the base discipline of the clinician, there are different conditions and entitlements and significant pay discrepancies. Team leaders may be paid significantly more than their managers, and senior clinicians more than their team leaders.

Non-clinical workforces

63 Lived experience workforce is emerging within CYMHS but is currently largely unfunded, with the significant investment to date directed to adult mental health services. It will be important to critique the approaches and models regarding youth peer work, which has largely been built with regard to adult consumers. Our experience with the youth lived experience workforce indicates the need for the development of appropriate support and a governance structure which is specific to the CYMHS client population. Family/carer and youth peers have a critical role in service development and review and additionally are welcomed by youth consumers, who very much value their lived experience. Youth peers may however have a greater vulnerability to triggers and appropriate supervision and support systems must be embedded within the broader CYMHS management structure.

64 It would be helpful to have a state-wide CYMHS lived experience body (with family, carers and young people) to assist with the development of this workforce and to share knowledge, successes, challenges and expertise. We also need to keep in mind the need for, and consider how to obtain, feedback from children and younger adolescents.

Workforces in other service settings who may identify presenting mental health needs in young people

65 Capacity building is often undertaken with a range of health, welfare, educational and emergency services to promote the level of knowledge required to adequately support young people both at an individual level and in group settings. As per paragraphs 93 to 102, CYMHS has a role in capacity building such services and to support them with the skills and knowledge to enable provision of early identification of mental health concerns.

EASTERN HEALTH'S CYMHS

The core components of care at Eastern Health's inpatient unit for 13-18 year olds

66 Eastern Health operates a 12 bed acute psychiatric inpatient unit for 13-18 year olds. The unit operates a therapeutic milieu group program based on the "Safewards" model. Safewards is a clinical model aimed at enhancing the safety of all. The unit is one of four acute psychiatric units state-wide and often accommodates adolescents from outside the Eastern Health catchment, in addition to Albury-Wodonga, Goulburn Valley, North Eastern CAMHS region, Shepparton, Seymour and Wangaratta regions.

67 The average length of stay in the unit is around 4.9 days, the lowest of the four inpatient units in Victoria; this reflects a Model of Care that supports crisis

containment, assessment and a focus on community care and treatment. Longer admissions to the unit are available when required, for example, for major psychosis.

68 The unit also supports the broader service systems – welfare and education, providing care and support to very vulnerable adolescents and their families for example, through collaboratively developed service system safety management plans, which aim to support young people in residential care. The short-term and focused admissions offer respite and provide a "circuit breaker" for families or services for very complex high need adolescents. These young people will often be involved with child protection, residential care and non-government agencies.

Successes of the unit

69 The adolescent inpatient unit has a very successful relationship with Avenues Education. Avenues teaching staff are embedded within the unit and work alongside unit clinical staff to support and enrich group programs and support adolescents' engagement with their registered school (see paragraph 25).

70 The unit also has a strong relationship with the paediatric unit, supporting patients needing acute medical care. Through this relationship, we have collaboratively managed a number of complex patients.

71 Although the unit has many junior staff, it has a stable staffing profile. The unit has a strong focus on being inclusive, supportive and understanding of the individual adolescents seen within the unit.

72 The unit has a clear Model of Care for the management of deliberate self-harm, which reflects the high level of deliberate self-harm occurring in schools and the community. The model works well; it incorporates sensory modulation and a non-judgmental, thoughtful approach supported by clear safety planning, brief admissions and good co-ordination and linkage to community treatment discharge.

73 There is easy access into the unit and generally quick discharge. This approach is supported within evidence based treatment, particularly in relation to BPD (see paragraph 41 to 42). The ability to access easy readmission ensures that young people are not required to escalate in order to access readmission.

Challenges

74 The number of admissions is high and admissions are typically brief. The discharge planning, review, family meetings and the collaboration work with multiple agencies required for each admission leads to a very high workload for staff.

75 There are significant challenges related to resourcing on the unit. The unit does not have any senior allied health staff. There is no occupational therapist. The unit has one social worker and one psychologist, to coordinate care with the psychiatry registrars. Access to other non-mental health disciplines, such as physiotherapy and dieticians where required, can also be limited. The resourcing available to support the Group Program is also limited and very much reliant on the availability of teaching staff from Avenues Education. As a consequence, there are insufficient activities and programs over holiday periods or weekends.

76 For young people from rural areas, collaboration with their home 'CAMHS/CYMHS' team is vitally important. One positive benefit of COVID-19 has been the implementation of greater capacity for Telehealth and online platforms to support care coordination and discharge planning. Further exploration of systems for sustainable collaboration between rural and metropolitan CYMHSs would be worthy.

77 The limited availability of step-down facilities, in particular the absence of a YPARC within the Eastern Region, for young people who require a less acute setting also presents a significant challenge. As such, while the existing PARCs within Eastern Health accept people from 16 years of age, they are not youth-focused, or reflective of young people's often fluctuating clinical presentations and developmental needs, for example, through the inclusion of educational services, or support to re-engage with education. Additionally, there are no CYMHS intensive support services, or crisis support services outside of office hours within the Eastern region.

The importance of a new youth inpatient ward for young people aged 18 - 25

78 Young people of 18-25 years presenting with the need for acute inpatient care are currently admitted into one of the three Adult Acute Inpatient Units at Eastern Health. In the last 12 months, there were approximately 433 admissions of 268 unique young people admitted into one of these three units. Adult units are very busy, high acuity places with high occupancy rates. This can lead to vulnerable young people being exposed to people with chronic illness, alongside confronting behaviours including aggression - all in all, engendering a lack of safety, including sexual safety, and hope for recovery.

79 A dedicated youth inpatient unit, for young people aged 18 to 25 years, would provide greater access to age appropriate, specialised acute inpatient care, minimising delays in acute inpatient care and treatment currently caused by the enormous demand for acute beds within the adult mental health service. It would also provide age-appropriate environments, access to youth peer support, specialist clinical treatment, education and programs that support positive outcomes for younger people. As noted

in the 2019 VAGO report,[1] there are not any youth specific services such as youth inpatient units, youth PARCs or day programs in CYMHS within the Eastern Region.

The core components of care at Eastern Health's community-based service and the successes and challenges of providing this service

80 As previously discussed at paragraph 13, there are three main roles for CYMHS:

(a) Direct clinical assessment, case management and treatment services for children and young people aged 0-25 with severe mental illness or severe emotional and behavioural disturbance;

(b) Primary, secondary, and tertiary consultations; and

(c) Education and Training.

Successes

81 The Eastern Health CYMHS is a hard-working, outward looking, innovative service whose successes include:

(a) strong multidisciplinary teams with well embedded clinical review processes, clinical supervision and supported training opportunities;

(b) the access and workload management allocation system (referred to as the ICTiR) as outlined in paragraphs 29 to 32 of this statement has eliminated a historically long wait list;

(c) the Infancy Access Project and the development of the Specialist Child Team as outlined in paragraphs 37 to 40;

(d) the YETTI (funded by EMPHN) as outlined in paragraph 11(n);

(e) the current development of an integrated youth mental health, alcohol and other drugs and suicide prevention regional plan (funded by EMPHN);

(f) assessment and treatment of BPD, as outlined in paragraphs 41 to 43;

(g) Treatment of Eating Disorders and the establishment of the Enhanced Eating Disorders Team, as per paragraphs 44to 45; and

(h) a strong focus on research, with several projects being undertaken with minimal or no dedicated resources. Current research projects include:

(i) Peer Tree – a research project being undertaken by the Centre for Mental Health at Swinburne University, in collaboration with Eastern Health CYMHS and which seeks to address loneliness in young people. Peer Tree is a positive psychology smartphone application designed to help

[1] Victorian Auditor-General's Office - Report, Child and Youth Mental Health, June 2019.

reduce loneliness by strengthening social connections. This project was developed subsequent to another research project, Positive Connect, which successfully trialled a clinical group program for young people from our EPTs to good effect.[2]

(ii) The service has recently undertaken a Health of the Nation Outcome Scales for Infants (HoNOSI) Field Trial – as part of the National Health Information Strategy Sub Committee, with a view to potential national implementation. The HoNOSCI is a 0-4years outcome measurement tool to complement HoNOSCA (a measure of outcome for use in child and adolescent mental health services focussing on general health and social functions) and the HONOS (Health of the Nation Outcome Scales).

Challenges

82 There is an underinvestment in community multidisciplinary clinical staff within CYMHS.

83 More generally, greater Consultant Child and Adolescent Psychiatry and community based Allied Health and nursing staff would enable the service to support a greater number of children and young people.

84 Resources to support an extension of office hours (for example, 9am to 7pm) would better enable accessibility, family support and engagement, as per paragraph 107.

85 Additionally, a second multidisciplinary specialist child team would enable greater flexibility and capacity to provide outreach within the child's home, school, maternal and child health service. Currently the team is unable to provide outreach as required to meet the needs of the most vulnerable children and families, given the large geographic region of the service. It would be preferable to have clinicians allocated to Central East, with additional clinicians providing service to the Outer East. This would support evidence based care that indicates that vulnerable families may best engage with services that are delivered within their home, or trusted services such as schools, and maternal and child health centres.

86 Significant refurbishment, or the development of purpose built child and family mental health community facilities is required. Currently, the community CYMHS facilities are inadequate, not fit for purpose and not child, youth and family friendly. Lack of appropriate clinical space impacts on accessibility of services to children and families, is demoralising for clinical staff and presents significant issues of workplace safety.

[2] Pilot digital intervention targeting loneliness in young people with psychosis, Lim, M etc al, Social Psychiatric and Psychiatric Epidemiology, 25 Feb 2019; Is loneliness a feasible treatment target in psychosis? Lim. M et al - Social Psychiatric and Psychiatric Epidemiology, May 2019.

87 CYMHS and other community mental health teams need to be situated in facilities which are located in accessible areas (including accessible by public transport), as well as being child and youth friendly and fit for purpose. I would recommend an audit of community facilities to ensure that they meet these criteria. headspace National has developed Facility Guidelines that must be adhered to for all headspace centres, however there is not an equivalent infrastructure requirement for CYMHS. Adoption of similar guidelines would be a positive step.

88 There is a significant lack of suitable infrastructure within CYMHS. There is no WI-FI at any of the community sites, and an extreme lack of office and clinical rooms that can accommodate clients and their families. This is a major limiting factor to service expansion.

89 There is a risk that services that manage within their available budgeted resources and do not carry waiting lists may be perceived as meeting community demand and creating the potential for failing to fairly and equitably distribute funding. This creates a perverse disincentive for mental health services to develop sustainable demand management systems.

90 The absence of an acute inpatient unit for 18-25 years impacts on consistency and coordination of care (see paragraphs 78 to 79).

91 Finally, despite much innovation within Eastern Health CYMHS, there are limited resources to undertake and support evaluation of clinical programs and initiatives, or due to the high clinical demand, prepare conference presentations and journal submissions amongst other things.

The provision of secondary consultation and community educational services to integrate Eastern Health's CYMHS with other service providers and settings

92 Eastern Health CYMHS recognises that as a specialist mental health service, primary and secondary consultations with external agencies are a core component of the services we provide and has a well-established community education and secondary consultation program. Eastern Health CYMHS provides secondary consultation and community education for partner agencies in the form of:

(a) primary and secondary consultation and liaison with other health professionals and agencies; and

(b) community education seminars for community agencies and services within the Region.

93 Resources are a challenge: we coordinate our secondary consultation with one full time role only and limited administrative support. The CYMHS Coordinator of

Secondary Consultation and Community Education coordinates all requests for regular consultation. The provision of a regular secondary consultation to an agency is based on the assessed need of the agency, alignment with CYMHS strategic directions and the capacity of CYMHS to provide the consultation.

94 Secondary consultation and community education programs aim to build the skills, knowledge, confidence and capacity for external agencies to identify and work with children and young people experiencing emerging or mild to moderate mental health difficulties. As there is high demand for mental health services, but limited resources, it is important to maximise the support given to external agencies. It assists the understanding of referral pathways for children and young people and facilitates referrals and engagement at the right time and right place. Done well, it can make a huge difference to young people; it minimises delays in care and supports early intervention. Capacity building also enables services to increase their capability to engage, work with and support children and young people with existing or mild mental health difficulties.

95 Additionally, consultations support the establishment of relationships and networks with other key stakeholders, which in turn facilitates improved coordination and communication within the system. For example, secondary consultation services include education and wellbeing staff, student support services staff, family and welfare workers and child protection services.

96 Efficient co-ordination, formal agreements, and the regular evaluation of consultations is essential to ensure this work meets the agreed goals of the consultation, that effective and consistent support to engaged agencies is provided and that received feedback is actively reflected and acted upon.

97 The provision of community education brings a range of professionals across the Region from different health, welfare and education services. This can facilitate the integration of the evidence base with clinical practice. It also encourages and supports systemic thinking by encouraging staff to understand the sector and its needs more broadly. This assists with discharge planning, coordination of care by existing staff and, as a by-product, supports the professional development of staff.

98 The CYMHS Community Education component consists of seminars delivered by CYMHS clinicians with monthly seminars delivered to staff working in the education, health and welfare sectors in order to increase literacy in relation to mental health and to improve the identification of those at risk of developing a mental illness, refer appropriately and respond to, and support children and young people experiencing mental health difficulties living in the Region. Eastern Health CYMHS additionally

provides Youth Mental Health First Aid Courses to workers from health, education, welfare and emergency services to develop:

(a) skills in how to recognise the signs and symptoms of mental health problems in children, adolescents and young adults;

(b) knowledge of the possible risk factors for these mental health problems;

(c) awareness of the evidenced based medical, psychological and alternative treatments available;

(d) skills in how to give appropriate initial help and support someone experiencing a mental health problem; and

(e) skills in how to take appropriate action if a crisis situation arises involving suicidal behaviour, panic attack, stress reaction to trauma, overdose or threatening psychotic behaviour.

99 A small charge is made for Community Education seminars. The funds from these Community Education seminars support the provision of training and professional development for staff in evidence-based practice. For example, training in Family Based Treatment for Anorexia Nervosa.

100 For CYMHS clinical staff, engagement in the provision of secondary consultation and community education can also mitigate the intensity of a full-time clinical caseload and support sustainability of the workforce. This has been especially evident for our Access Team which previously had poor retention. It has now embraced provision of secondary consultation and education and has a high retention rate.

101 Most significantly, secondary consultation and community education programs for health, welfare and educational services, supports the running of a capable mental health system which reduces the number of mental health crises and the need for specialist mental health services.

The Postvention service following a suicide and its challenges and successes

102 The Youth Suicide Postvention and Prevention Project Community Response and Recovery Plan (**Postvention Plan**) has been in place since 2017. The Postvention Plan assists in integration of services across the Region and provides a protocol for suicide postvention. The protocol has both highlighted, and assisted us to address confusion and misunderstanding among various sectors of their roles and responsibilities in the event of the suspected suicide of a young person.

103 Eastern Health CYMHS coordinates the Postvention Plan from within existing resources and with the active support of partner agencies including Ambulance

Victoria, Victoria Police, Local Government Areas, headspace centres, Eastern Metropolitan Primary Health Network, Be You headspace and the DET. The success of the plan is reflective of the collaborative working relationships across the region, with all agencies having demonstrated great agility, flexibility and responsiveness in their response to an incident. For example, the provision of coordinated and timely responses for individual young people who are identified as at high risk may require direct, timely follow up and support by any one or more of the DET, headspace, LifeConnect, or CYMHS, depending on the young person's needs, risk and assessment. All services have responded with great commitment and enabled young people impacted by suspected suicide of a young person to be appropriately supported.

104 The Postvention Plan has also provided a platform for key services to work together to improve supports for young people and reduce suicide in the community. As the Postvention Plan is regionally based, there is good, current knowledge among services in relation to the Region and its service system. This enables the provision of more accurate and timely data around incidents within the Eastern Metropolitan Region, which allows services and supports to be mobilised quickly. Services are also positioned to quickly identify if there is any increase in suicide rates across the Region and ensure a targeted response. The Postvention Plan has led to the beginnings of a further regional project, the establishment of a Regional Youth Suicide Strategy - Targeting Zero.

105 There has not been any additional resourcing provided for the work of Eastern Health CYMHS in relation to the Postvention Plan. The work is undertaken by Eastern Health CYMHS staff in addition to their core role, which can be challenging, particularly as the plan requires immediate response and ongoing organisational requirements for its development and maintenance and coordinating response takes many hours of work.

106 In addition, we have noted the difficulty in providing support for young people who are no longer at school as there are less defined service links for those young people. It can also be more difficult to identify potential contagion effects among their peers. The Eastern Metropolitan Region Suicide Response and Recovery Steering Committee is discussing the use of social media, Facebook and Instagram to support greater reach with this population. Finally, continued high staff turnover across the broad health, welfare and education sectors can present a challenge, and necessitates regular regional updates and training for new staff regarding the plan.

FUTURE DESIGN FOR CAMHS/CYMHS

107 CYMHS should continue to provide direct clinical assessment and treatment for infants, children, adolescents and young people, aged 0 – 25 years, presenting with

complex and severe mental health concerns. For the majority of clients, care would be provided by community based clinical staff within multidisciplinary teams. Specialist and generalist services would include a full range of treatment modalities including individual, parent and family based work. Resources would enable provision of crisis assessment and support, through to longer term episodes of care based on the individual assessment and needs of the client and family and in light of the evidence base. Community care would be resourced to enable flexible models of care, including extended office hours, outreach and in-reach service models. Community care would be supported by a dedicated child and youth triage service, providing a gateway to clinical service delivery and would additionally provide both crisis and short term follow up and support, and an adolescent acute psychiatric unit for young people aged 13-18 and a youth inpatient unit for young people aged 18-25.

108 CYMHS would also have a key role in providing support to agencies and local service providers through primary, secondary and tertiary Consultation and Liaison services. In this way, CYMHS would support the capabilities of the broader health, educational and welfare sectors to identify mental health problems at a mild to moderate level and to minimise the development and deterioration of those difficulties to moderate conditions, through appropriate treatment and support by the right service, at the right time.

The benefits and challenges of providing a service across the 0 to 25 age range

109 As discussed at paragraphs 46 to 50 above, our experience indicates that there are multiple benefits in providing a CYMHS service across an age range of 0 - 25 years:

(a) the service is person centred and family inclusive;

(b) it minimises points of transition across critical developmental points in a child or young person's life, such as kindergarten to school, primary school to high school and end of school or turning 18 years;

(c) it provides greater access to clinical care for young adults with high prevalence mental health disorders and who would not have been able to meet the more narrow eligibility criteria of the adult mental health services; and

(d) it provides youth-friendly family inclusive, relational and systemic focussed care.

110 There was considerable anxiety within CYMHS staff prior to the 2010 implementation of the 0-25 service, but this quickly abated and our experience indicates that it is an effective and sustainable model. Young people have been able to access mental health services which they did not previously receive, the young people and their

families have seamlessly engaged with the systemic, family inclusive Model of Care and continuity of care and specialist treatment remain accessible across the age span. Many young people live in families so the age grouping fits with the developmental tasks of separation/individuation which have extended into early adulthood. The age grouping is also consistent with headspace centres/services.

111 Accessibility across the age range was initially a focus of concern at Eastern Health. However, this was addressed through additional over prioritisation of children under 12 years, and assisted with resourcing provided within the DHHS Specialist Child Initiative, as per paragraphs 37 to 40. By mid-2019, children under 12 years of age represented 28.5% of all CYMHS clients.

112 Adolescents and young people tend to receive priority due to a higher frequency of acute risk presentations in Emergency Departments, as compared to children. The development of a triage scale that incorporates developmental risk would be helpful, the current triage scale utilised having been developed for adults.

Ensuring equitable access to services

113 It is important to consider access from the perspective of equity of access, noting that CYMHS services currently provide care for fewer patients of any age than the epidemiology suggests would need to be seen within a tertiary service. As such, the issue of access to services is reflective of the large resource deficit, resulting in difficulty in accessing the service across all age groups (0-4, 5-12, 13-18 and 18-25 years). This may particularly impact on infants and children that present with developmental risk and issues of cumulative harm as compared to the often more acute presentation of adolescents and young adults. This can be successfully addressed, as has been within Eastern Health CYMHS as outlined in paragraphs 37 to 40. Equitable access could also be protected through the development of DHHS guidelines, deliverables and KPIs.

114 The inclusion of age or diagnostic specific teams can also support evidence based care across the age spectrum, noting the importance of retaining flexibility in the cut-off ages. Examples include the SCT as has been outlined at paragraph 37; intensive day programs for adolescents and young adults who may have disengaged from school or work; intensive mobile treatment team targeting high risk adolescents; and neurodevelopmental services for children. The development of a school refusal program for primary school children would also be useful.

115 Models of care that can effectively engage with families with complex needs, particularly with younger children, require additional resourcing. This work is intensive

and requires considerable skill and expertise. Achieving this engagement is hard with high workloads and a limited ability to provide outreach.

116 All CYMHS services should have a five year negotiated plan, which includes equity of access for all age groups, 0-25 years, and with clearly articulated base line services that should be provided for each age group. Key deliverables should include detailed key risks for each age group, with associated action plans developed, and with KPIs developed to monitor and evaluate progress.

117 Sufficient resources should also be made available to CYMHS to both deliver these services and to enable development of innovative programs and expand proven Models of Care. For example the provision of in-reach to maternal and child health services, as described in paragraph 40 in addition to support to evaluate programs and outcomes. It is noteworthy, that the state-wide CAMHS And Schools Early Action (CASEA) program, for example, was initially developed within a small multidisciplinary community team with Eastern Health CYMHS (then CAMHS).

A consistent aged-based transition point from infant, child and youth mental health services to adult mental health services right across Victoria

118 The introduction of a single transition point from CYMHS to adult services at age 25 across Victoria would be of significant benefit. This would result in a simpler and less fragmented service system with greater consistency of access, treatment and care. As mentioned earlier in this statement at paragraph 46, multiple transition points risk fragmentation within the service system.

119 A single point of transition would enable greater input for young people who are currently missing out on accessing necessary mental health assessments and treatment, particularly those aged 18-25 years old who do not meet the restricted criteria for entry into AMHSs. The 0-25 age grouping is consistent with headspace centres and reflects the development of mental health difficulties. It also enables targeted intensive intervention which incorporates systemic and broad psychosocial focus and addresses the risk of young people “falling off a cliff” at 18 years.

120 There is a real question as to whether a single point of transition could be implemented given the complexity of the current service system across Victoria. A hybrid approach may be required – this in itself would go a long way to simplifying the service. It may also require the realignment of some catchment areas or regions.

Opportunities to strengthen integration between CYMHS and other child and family services

121 The development of clear pathways and collaboration with child and family services is an ongoing requirement across the sector. As a 0-25 service, we necessarily have extremely close partnerships with broader child and family services and continually strive to strengthen these partnerships. This requires clear roles and responsibilities of different services and the coordination of resources to prevent duplication and eliminate gaps in services.

122 In-reach into maternal and child health services has been effective and could be used as a successful model for further engagement. CYMHS services could also be located in hubs within the community and co-located with child and family services. However, CYMHS needs to ensure that its services remain focussed on providing specialist mental health intervention, in a safe, non-judgemental place friendly to children and young people and their families.

The provision of Hospital in the Home by CYMHS for Acute Care

123 Hospital in the Home has a number of potential benefits for CYMHS patients. It offers a less restrictive option, which is potentially less traumatising than an inpatient admission. It may also reduce the risk of potential deterioration resulting from admission, particularly where admission may be contra-indicated or where there may be a risk of contagion in an adolescent inpatient unit. Hospital in the Home can also enable intensive family work and support to be undertaken more easily than where an individual child is admitted. It would support recovery by maintaining the child/young person's connection to their community. Consumers may also see Hospital in the Home as a more acceptable option than an acute inpatient admission, especially in the mother /baby perinatal space.

124 Hospital in the Home may be suitable for:

(a) intensive family therapy, for example, first episode psychosis;

(b) Eating Disorders that are not progressing where it would enable greater support to parents to manage meals and avoid disempowering parents which is a significant risk with admission; and

(c) perinatal mental health as an alternative to a mother/baby unit.

125 The use of Hospital in the Home would require a detailed risk assessment to ensure the safety of clinical staff, the patient and their family and will not meet the needs of all children, young people, or parents and infants. Inpatient care will still be required in the cases of the Hospital in the Home care provided being insufficiently intensive,

where the risks are too great or the home situation not conducive; such as where families require respite, where there are other children who may be placed at risk, where the young person does not reside in a family home, or where there is family violence.

The advantages, successes and challenges of CYMHS integrating physical health, alcohol and other drugs support and vocational support into their core service offering

126 CYMHS should provide integrated assessment, treatment and support. Young people will often not engage with, nor is it necessarily preferable to engage with, multiple services. This means addressing the holistic needs of a young person is important. It does not mean direct service provision by CYMHS of all facets of need, where other services have greater expertise. An in-reach model should be considered as an option. For example, having vocational services provide in-reach to CYMHS would provide necessary expertise without diluting the specialist mental health function of CYMHS.

127 An example of good practice is the Eating Disorders Service where an integrated physical, mental health and dietetics assessment is undertaken, and from which a clear treatment plan is developed outlining roles and functions. For example, medical monitoring may be provided by a general physician or paediatrician, mental health support by CYMHS and a dietetic consultation available to CYMHS clinicians as needed – all with close liaison and collaboration.

128 As per paragraph 25, the partnership with Avenues Education is another example. Avenues has teachers within each of our community and specialist teams, on the Paediatric Ward and on the AIPU. This provides educational support to the children and young people in close partnership with our service.

129 Regarding AOD, CYMHS staff need to be dual diagnosis capable, with specialist youth AOD services available with which we can consult and to whom we can refer patients. AOD issues are a core part of providing support within our EPTs as many young people have a dual diagnosis and may not want to see another service. Any partnership with AOD services needs to be collaborative, with clear roles delineated for each service. In-reach and out-reach models would support greater flexibility and collaboration across the sector.

The benefits and risks of CYMHS operating headspace centres

130 The operation of headspace centres by CYMHS would have a number of advantages including:

(a) increased clinical governance and safety/risk management;

(b) increased professional development and capacity building of headspaces to provide safe and effective care; and

(c) enabling greater integration of care for adolescents and young people aged 12-25 years.

131 While the headspace model has very successfully created an identifiable brand for youth mental health, it is not well resourced. It relies on partner agencies to provide 'in-kind' contributions and can offer clinical care of varying expertise and experience, leading to discrepancies across centres. The benefits of CYMHS services operating headspace includes capacity building, training, building expertise, enabling supervision for clinicians and incorporating placements, alongside the opportunity to develop regional coordinated pathways of care.

132 As outlined in paragraphs 20 and 21, Eastern Health CYMHS currently provides clinical support to the headspace centres within our region. CYMHS necessarily needs to engage with its local headspace centres to ensure coordinated and clear pathways of care alongside the support of robust clinical risk management. Greater efficiencies and streamlining of referral and intake processes, would be possible where governance is provided through the regional CYMHS and would facilitate greater integration of care and consistency across the service system.

133 However, operation of headspace centres by CYMHS creates a risk that specialist mental health funding will be diverted to support Tier 1 and 2 care with a resultant reduction in the ability to provide assessment and treatment for the most vulnerable and complex children and young people. This could be managed through the clear differentiation of criteria and robust systems.

134 Eastern Health CYMHS currently covers six large Local Government Areas which include two (soon to be three) headspace centres. While headspace centres typically adopt a "No wrong door" approach, in practice they see young people from the areas immediately surrounding the centre. Therefore, there is a risk of inequitable access to mental health services in regions that do not have a local headspace centre. A better model may be the operation of a central or 'regional' headspace centre with a range of satellite/outreach headspace teams across the region (which would replicate CYMHS, but at Tier 1 – 2). This would have efficiencies of scale as there would be one management team, for example, and have the advantage of providing localised access.

135 The current funding model for headspace centres is not sustainable. It relies on short term contracts which lead to staff instability.

136 There is a risk that the operation of headspace by CYMHS would result in diminished care of children, 0 -12 years. This could be managed via clear delineation of functions, as we have done with YETTI, which operates at the Tier 2 level and which is funded by the EMPHN – see paragraph 11(n).

The role played by CAMHS/CYMHS in providing Autism Assessments

137 The Neurodevelopmental Assessment Team at Eastern Health provides Autism Spectrum Disorder (**ASD**) assessments for both internally referred patients and those referred from the broader community. Primary assessment is undertaken by community health services, private paediatricians or psychiatrists. The team only accepts referrals for secondary assessment for complex cases or where there is diagnostic uncertainty. As such, referrals are made due to the complexity of the case or presentation.

138 There are essentially two main criteria for accepting referrals for an ASD assessment:

(a) first, where the child or young person has been reviewed by a consultant psychiatrist or paediatrician, specifically to explore whether a diagnosis is warranted or not, and that the diagnosis could neither be confirmed nor excluded by that person; and

(b) secondly, where the child or young person presents with a level of complexity and/or comorbidity that warrants a multi-disciplinary tertiary level assessment.

139 Both of these criteria exist to reserve the team's limited time and resources for more complex cases, and to try to encourage the child or young person to first be assessed by someone qualified to make the diagnosis. Interestingly, we have found that the Neurodevelopmental Assessment Team remove the diagnosis, as often as the diagnosis is made.

140 Eastern Health's Neurodevelopmental (Autism) Assessment Team consists only of 0.3 EFT consultant psychiatry, 0.3 EFT Clinical Psychology and 0.3 EFT Speech Pathology. With additional clinical resources, we would be able to accept more referrals and provide increased follow-up support and advice. At present, the team is only able to make the diagnosis and provide a report with recommendations. It has a very limited capacity only to support schools and other services with recommendations and the implications arising from a positive diagnosis.

141 The Neurodevelopmental Assessment Team assists community teams through secondary consultation by providing advice and support to clinicians suspecting a diagnosis of ASD in their patients, but who do not necessarily require a full team

assessment. It also provides consultation to our CYMHS community teams around the impact of ASD (or other neurodevelopmental disorders) on any particular patient's presentation and how this might inform their treatment planning going forward.

142 The advantage of having a Neurodevelopmental Assessment Team within CYMHS centres on the association of ASD and other mental health diagnoses – ASD being a risk factor for a number of mental illnesses. When ASD and other developmental assessments occur within the CYMHS context, it provides for a comprehensive assessment of the role of developmental difficulties in young people presenting with mental health problems and informs the interventions offered by the mental health service.

Potential reforms, including to reduce waiting periods for an assessment and improve care, treatment and support

143 Waiting lists have long been used to demonstrate demand, addressed by allocation of additional resources. Perversely, this can result in a disincentive to establish a sustainable Model of Care, where there is generally no waiting list.

144 Typically, Eastern Health's Neurodevelopmental Assessment Team has not had a waiting list – with the average length of time between referral and appointment six weeks. As described at paragraphs 137 to 138, autism assessments conducted by the Neurodevelopmental Assessment Team are focused on clear criteria, with primary autism assessments redirected to community health services or private paediatricians. A current limiting factor is the lack of provision of adequate paediatric services within community health services.

145 As such, to address waiting lists across Victoria I would suggest the development of clearly defined criteria where initial assessments can be accessed, possibly through community health or private paediatrics. CYMHS Autism assessments, which are typically multidisciplinary and intensive, could then focus on those presentations requiring a multidisciplinary assessment – in this way resources could be more efficiently targeted. This approach can also be supported by the CYMHS Autism teams providing targeted secondary consultations and professional development opportunities to community health and private paediatricians.

PERINATAL MENTAL HEALTH

Successes, challenges and opportunities for reform in the provision of perinatal mental health services

146 Perinatal mental health services should ideally provide services from the antenatal period to 2 years of age. They should provide an early intervention role for the mother-

to-be or 'recent mum/parent' and use evidence-based practice to support recovery. The approach of perinatal mental health services should necessarily include partners and the infant.

147 In order to improve perinatal mental health in Victoria there is a need for:

(a) improved and equitable access to perinatal emotional health services across Victoria including antenatal, postnatal community support and access to mother-infant beds;

(b) appropriate infrastructure to support services, for example sufficient clinical spaces that are accessible and parent and infant friendly;

(c) extended service hours to enable greater support for highly vulnerable women and their families;

(d) in-reach to maternal and child health centre which are perceived as acceptable, safe and non-stigmatising places to deliver care;

(e) the capacity to register the non-birth parent as a consumer of perinatal services;

(f) funding to support an extended duration of perinatal services (up to 24 months of age); and

(g) accessible training opportunities related to the specialty.

148 It is suggested that perinatal mental health services be better placed within CYMHS. CYMHS are family oriented and can provide continuity in relation to infant mental health services where this is required.

149 Each Victorian region should have timely access to a mother baby unit. There is currently no mother baby unit in the Eastern Metropolitan Region, this means mother and infants travel outside the region to receive inpatient care for which there is frequently long waiting lists.

150 An alternative to mother/baby unit worthy of exploration would be the establishment of a Hospital in the Home program for perinatal mental health services.

151 The PEHS at Eastern Health was established in 2018 following DHHS funding in 2017-18. While this has been a very welcome beginning, the level of funding does not enable the service to provide an adequate level of support. The service is a small clinical team (with approximately 3.5 EFT) against approximately 4,800 - 4,900 births delivered annually at Eastern Health sites, not inclusive of women within the region delivering privately, or in hospitals outside of the Eastern Region. Consequently, the service is currently limited to women birthing at Box Hill Hospital only, with no current

service provision to the Angliss Hospital and Yarra Ranges Health (operates an antenatal clinic). The service is also unable to provide a crisis response, outreach, group programs and with the exception of the partnership with Maroondah Maternal and Child Health Centre (described in paragraph 153) cannot accept post-natal referrals.

152 In addition, the perinatal mental health service lacks dedicated clinical space. Within Box Hill Hospital the team has extremely limited access to clinical rooms. Clinical spaces are multipurpose, and as such not conducive to high quality clinical care of women and their infants.

153 The Eastern Health PEHS provides in-reach one day per week to a Maternal and Child Health Centre in Maroondah City Council, accepting post-natal referrals from that centre. As Maternal Child Health Services are universal services, routinely providing support for mothers, their partners and infants, in-reach is an effective model for perinatal mental health services to deliver care. Families typically feel safe, and supported within these settings and the stigma of engaging with a mental health service reduced. It further supports close collaboration between the perinatal service and maternal and child health, supporting early identification and referral as needed alongside well-coordinated care.

154 There is a need to ensure all families have equitable access to perinatal emotional health services.

Workforce challenges experienced by CYMHS

155 There are significant workforce challenges within CYMHS. The complexity of the work requires a highly trained and specialised workforce. It has become increasingly difficult to provide the extensive supervision and training requirements new clinicians require. Teams need to include a balanced mix of the core mental health disciplines – psychiatry, occupational therapy, social work, clinical psychology and mental health nursing; alongside access to speech pathologists, neuropsychologists and dietetics. Teams need to have clinicians with a range of post graduate cross discipline training in family therapy and child and adolescent psychotherapy, alongside other in depth trainings, for example, cognitive analytic therapy. Clinicians need to have a thorough understanding of systemic issues and be able to work in a flexible and collaborative way with a multitude of services – family services, child protection, disability, drug and alcohol, youth justice, etc. The current training user-pay funding models work against clinicians obtaining the additional post graduate trainings required. Given existing HECS debts, clinicians are understandably reluctant to take on additional debt to complete additional training. Likewise, services are not funded to support clinician training and there is a deficit of designated allied health graduate positions.

156 There is no dedicated funding for the establishment of youth peer and family /carer consultants with lived experience within CYMHS, despite the increased recognition of the importance of lived experience in peer support and service development and review. Eastern Health CYMHS, using clinical EFT, has employed youth peer workers and family/carers consultants. These workers are supported by a senior mental health clinician with lived experience as a family/carer. In development of a CYMHS lived experience workforce, consideration needs to be given regarding the particular needs of this workforce around supports and governance. In particular, youth peers need to be well-supported with access to training and supervision to ensure they are not inadvertently harmed through their work. Their roles must be structured to provide an authentic and genuine youth voice and as such may need to be fixed term, and in this way would differ from adult mental health services that have ongoing consumer roles. Services should also consider ways to ensure how children and younger adolescents can be engaged to provide their lived experience, such that CYMHS does not inadvertently privilege the voices of older adolescents and young adults (including family and carers).

157 A dedicated state-wide child and youth peer lived experience support group would be useful – and would mirror the Carer Lived Experience Workforce (**CLEW**) that has recently been developed for CYMHS services.

Barriers to workforces providing optimal care, treatment and support to infants, children, adolescents and young people

158 There are significant difficulties attracting appropriately skilled and experience allied health and mental health nursing staff. These difficulties, coupled with continued very high demand and increasing complexity and severity in presentation, within a risk averse working environment, present a barrier to the provision of optimal care to children and young people. In addition, poor infrastructure - lack of access to appropriate rooms and spaces suitable to working with young people and their families - and a lack of access to technology all contribute to the delivery of suboptimal care.

159 The existing workforce is aging and newly employed staff often lack the required skill sets and competencies required and require considerable specialised training and support including:

(a) training in working with systems;

(b) family therapy;

(c) trauma;

(d) parent child dyadic work; and

(e) parent work.

160 As a result, new workers frequently struggle with the emotional demands of the work and vicarious trauma and burnout is a significant and ongoing concern.

161 The development of a clear state-wide CYMHS workforce strategy should be undertaken which incorporates a clear understanding of the remit of specialist child and youth mental health services, including the central role of community-based care. The strategy would need to include:

(a) recognition of the core disciplines within the multidisciplinary teams, that is, social work, occupational therapy, psychology, alongside mental health nursing and child and adolescent psychiatry;

(b) understanding of the different frameworks and skill sets which differing disciplines bring and recognition of the individual discipline training and professional development needs required to support them – to ensure the right people with the right skills to provide care, treatment and support at the right times;

(c) Allied health leadership within the Mental Health Branch of DHHS for allied health to complement the Chief Nurse role;

(d) the development of a CYMHS allied health graduate program, including psychology, social work and occupational therapy with designated two year positions which would include rotational placement within CYMHS inpatient, community and specialist teams;

(e) greater accessibility to a range of state-wide training opportunities including the Developmental Psychiatry Course, Working with Infants, Working with Families and Family Based Treatment for Anorexia Nervosa;

(f) additional supported in depth training and scholarship opportunities for CYMHS clinical staff with several years of experience, for example, a Masters of Family Therapy;

(g) the introduction of family and systemic training within undergraduate health professionals courses; and

(h) review of all CYMHS infrastructure with a focus on providing community areas and child, youth and family friendly spaces that are accessible.

Assisting workforces to continually learn about and translate emergent research and evidence in their field

162 A state-wide centre for child and youth mental health research and clinical practice would be ideal to assist the clinical CYMHS workforce to learn about emergent research and evidence, and translate it into practice. Such a centre would ideally have

a role in both disseminating research findings and in supporting training of clinical staff in research and locally based clinical research projects and opportunities.

163 Clinicians are keen to explore valid research ideas, develop and trial innovative quality improvements, however there is no capacity within the service to undertake rigorous evaluation or to disseminate findings, for example prepare journal articles, etc.

164 Finally, the workforce would be assisted by clarity from the DHHS as to its expectations, including defining baseline capabilities and service provision.

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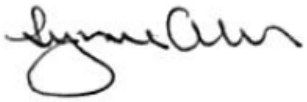

print name LYNNE ALLISON

Date 25 August 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT LA-1

This is the attachment marked 'LA-1' referred to in the witness statement of Ms Lynne Allison dated 25 August 2020.

Curriculum Vitae

Lynne Allison

Professional Qualifications

1997 Master of Child and Adolescent Psychoanalytic Psychotherapy (MCAPP), Monash University

1990 Certificate of Child and Adolescent Psychoanalytic Psychotherapy, Austin Hospital, Victorian Child Psychiatric Training Programme

1985 Bachelor of Social Work (Honours), Monash University

1982 Bachelor of Arts, Monash University

Professional Experience

2014 to Present **Associate Program Director, Child & Youth Mental Health Service (CYMHS), Perinatal Emotional Health Service (PEHS) & Psychiatric Consultation & Liaison, Mental Health Program, Eastern Health**

Responsible for the strategic, operational and financial management of Child & CYMHS, PEHS and C & L:

CYMHS, as a specialist mental health service, provides a full range of clinical services to infants, children, young people up to the age of 25 years and their families, presenting with severe mental health issues within the Eastern region.

The service comprises approximately 150 multidisciplinary clinical staff across four community teams, a range of specialist teams and services including an Access team, first Episode Psychosis Teams, Intensive Mobile Youth Outreach Support Team (IMYOS), a Specialist Child Team, Neurodevelopmental (autism) Assessment Team, an adolescent day group program, an Enhanced Eating Disorders Team, an Adolescent Inpatient Psychiatric Unit, a lived experience team, Deakin (Brief Intervention) Team, The Youth Engagement and Treatment Team Initiative (YETTI - funded by the EMPHN), and a community development and community education program.

PEHS is a small multidisciplinary service, established in 2018 to deliver antenatal and postnatal mental health care to women and their infants up to 12 months of age in the Eastern Region. The PEHS aims

to promote the early identification of women in the antenatal and post-partum period with mental health difficulties, improve referral pathways between hospital and primary care health services and clinical mental health services; and to deliver direct assessment, case management and therapeutic interventions with women, their partners and families.

The Psychiatric Consultation & Liaison Service, comprising Psychiatric Consultants, Registrars and Senior Mental Health nurses, seeks to provide quality psychiatric consultation and liaison services across the three hospital sites of Eastern Health – Box Hill Hospital, Maroondah Hospital and Angliss Hospital.

Highlights over this role have included:

- The implementation in 2014 of "Initial Consultation and Treatment in Recovery", a model enabling the sustainable management of access to CYMHS community teams, eliminating an historical waiting list, and its associated inefficiencies, whilst maintaining the centrality of quality, evidence based clinical treatment and care and improving collaborative partnering with children, young people and their families.
- The successful development and delivery of the Youth Engagement Treatment Team Initiative (YETTI) in 2017. This service, funded by the Eastern Melbourne Primary Health Network, provides early intervention clinical service to young people, aged 12 to 25 years with emerging severe mental health issues across the Eastern Region, and through partnership with Austin Health in the areas of Nillumbik and Banyule.
- Development of the Perinatal Emotional Health Service in 2018 to provide perinatal mental health services to women birthing within Box Hill Hospital. The service also provides in-reach to the Maroondah Maternal and Child Health Service one day per week.
- Development of the Specialist Child Team in 2017 - this multidisciplinary team was established to provide direct clinical service through an intensive and flexible model of clinical case management, assessment and treatment for children under 12 years and their families presenting with complex mental health difficulties. This service was developed to complement, improve and support the capability and effectiveness of the four CYMHS community teams working with children under 12 years of age, and to provide secondary consultation and community education to key stakeholders within the Eastern Region, with the aim of improving the health and well-being outcomes for children and their families.
- Development of the Infancy Access Project in 2017; this project was established as a pilot with Maroondah City Council and in recognition of the poor access to mental health care and treatment of infants and children under 5 years of age who present as 'at significant risk' of mental health difficulties. The project provides consultation, assessment and treatment to

infants and pre-schoolers and their parents, through an in-reach model to maternal and child health centres. The model has since been expanded to the City of Yarra Ranges and the City of Whitehorse and is currently being formally evaluated by Melbourne University.

- Development of the Enhanced Eating Disorders Team in 2020 to provide intensive and innovative clinical interventions for young people presenting with severe eating disorders necessitating multiple medical admissions for medical rescue, and with a past history of unsuccessful treatment.

2014 to 2017 **A/Associate Director of Allied Health**
Mental Health Program & State-wide Services,
Eastern Health

This role was responsible for providing effective leadership and management of the allied health workforce, comprising Occupational Therapy, Social Work, Psychology and Speech Pathology, within the Mental Health Program (Aged Persons Mental Health Service, Adult Mental Health Service, and Child & Youth Mental Health Service) and State-wide Services (Turning Point and Spectrum). This included ensuring professional specific standards of practice were met and the provision of appropriately skilled and available workforce through credentialing and scope of practice, professional development and performance standards, as well as professional entry level and postgraduate education programs, professional research programs and relationships with universities.

2010 to 2014 **Manager CYMHS (Early Psychosis and Community Teams)**
Mental Health Program, Eastern Health

Responsibilities included the provision of operational and financial leadership for the two Early Psychosis Teams and two community teams within CYMHS, including ensuring effective provision of patient centred care and recovery oriented treatment for all clients and their families accessing the service, and to undertake quality improvement activities to continue to develop and enhance service provision

2007 to 2010 **Team Leader, Box Hill Community Team - CYMHS**
Mental Health Program, Eastern Health

Responsible for the day to day operational leadership of a multidisciplinary team with the aim of ensuring a high level of treatment and recovery oriented care to CYMHS clients and families and including: line management and clinical supervision to team members; monitoring of key performance indicators; undertaking quality service improvements; management of referrals and allocation; providing secondary consultation and enhancing service

delivery with external agencies; the development and implementation of a collaborative project with Eastern Primary Health Network and headspace to facilitate after hours mental health response for young people presenting with mental health issues.

2004 to 2010 **Coordinator – Developmental Psychiatry Course (Mindful)**
Eastern Health Child & Adolescent Mental Health Service (CAMHS)

Eastern Health, CAMHS representative on the Master of Child Psychoanalytic Psychotherapy and Graduate Diploma in Child Psychotherapy Studies Course Management Sub-Committee.

2004 to 2010 **Stream Senior - Social Work**
Eastern Health Child & Adolescent Mental Health Service (CAMHS)

Responsibilities included ensuring that professional standards of practice were maintained and developed for all Social Workers employed across CAMHS; social work staff recruitment; development of supervision and professional development plans for Social Workers; provision of supervision for Social Workers; coordination of student placements; participation in Clinical Care Committees and relevant working parties - e.g. Discharge Planning Working Party, Supervision Working Party, Group Therapy Review; the provision of consultation, education and support to community agencies/services; and undertaking the CAMHS representative role on the DHHS Child Protection Reference Group.

2002 to 2007 **Senior Social Worker**
Eastern Health Child & Adolescent Mental Health Service (CAMHS)

Chandler House Community Team	2002 to 2006
Box Hill Community Team	2006 to 2007

Provision of a full range of clinical services including psychiatric assessment of children, adolescents and their families; a range of therapeutic treatments - individual psychotherapy, parent therapy, family therapy and group therapy; case management of complex cases; management of primary and secondary consultation referrals; primary consultation, secondary consultation and liaison with a variety of community agencies including schools, Department of Human Services, Family Support Services, Maternal and Child Health Services; undertaking community education seminars on issues relevant to the mental health of children, adolescents and families; provision of supervision to staff and students.

2002 – 2003	**Social Worker, Eastern Health CAMHS**
2002 – 2004	**Senior Child Psychotherapist, Royal Children's Hospital Melbourne**
1991 – 2002	**Child Psychotherapist, Royal Children's Hospital Melbourne**
1986 – 1991	**Social Worker, Boronia Community Mental Health Services**
1985 – 1986	**Social Worker, Community Services Victoria**

Membership of Professional Associations

Member of Victorian Association of Child Psychotherapists (VCPA) Executive 2007 to 2010

Chair of the Industrial Relations Sub-committee, VCPA 1996 to 1998

Member of Education Sub-committee, VCPA 1996 to 2004