SUBMISSION TO THE ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

Abstract

An individual submission based on a research study
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Background of the Author

Leanne Beagley has clinical qualifications in Occupational Therapy and Family Therapy and worked for 20 years in child and adolescent mental health settings before moving into policy leadership roles in government and then into executive leadership in primary care. She has a Master's in Business Leadership (RMIT) and a PhD (RMIT) in psychology awarded for the research described in this submission.

Background for the Submission

This Submission and recommendations herein is provided as an individual offering, utilising outcomes of a recent research study and the experience of the author in policy development, as a clinician and as a leader in mental health settings. It is a welcome opportunity to provide considered advice. The theme and focus is on the child and adolescent specialist public mental health services and how an improved performance framework could enable better outcomes for Victoria's children.

Executive Summary

As part of the public health system in Australia and internationally, the Child and Adolescent Mental Health Services (CAMHS) setting is a small, specialised, and unique environment – sharing the developmental context of paediatric health and the clinical mental health service delivery domains with adult and aged person's psychiatric services (Kelvin, 2005; Ford, 2007). CAMHS services are grappling with a set of expectations imposed by a stressed social welfare system to manage the sequelae of extreme trauma, challenging behaviour and the impact of family violence and trauma on children and adolescents in their care (Wolpert et al., 2014; Bor et al., 2014).

CAMHS settings are subject to a pervasive set of expectations emerging from elected government regimes linked with the voting community regarding accountability, efficiency, and effectiveness. The rise of the transparency and accountability agenda within the public sector has been documented extensively (Armstrong, 2005; Gaventa & McGee, 2013; Van Belle & Mayhew, 2016). In such a paradigm, accountability is neatly and simplistically measured by the articulation of the task of the organisation and the application of metrics to assess performance against that task.

The research which has prompted this submission aimed to explore and better understand differences in assumptions, perceptions, and experiences of the organisation of public Child and Adolescent Mental Health Services (CAMHS). Further, the implications these differences have for clinical care, management, and leadership within the organisation itself but also for government in its performance-monitoring role of CAMHS services more broadly are also examined and described.

The focus of study was in what personal experience might convey about broader shared issues and themes at an organisational level, and the key data collection tool used was semi-structured in-depth interviews. To elicit data on personal experience, participants who were stakeholders of CAMHS as clients, families, referrers, clinicians, managers, policy leaders, and collaborative partners were the focus of sampling. The data was initially segmented and filtered across broad themes and then coded and gathered into more detailed categories.

Themes emerged relating to

- the expectations and impressions of CAMHS,
- the clients themselves and their stories of complexity and trauma,
- the experience of CAMHS clinicians,
- barriers to accessing services,
- the experience of services provided once 'in' the system,
- issues related to the interface between CAMHS and other services and stakeholders, and
- impressions on what factors might make a 'good' CAMHS.

Overall, the findings underlined the view that CAMHS services should take an integrated multi-theoretical perspective, support wisdom in leadership, be accessible,

and have sophisticated collaborative capacity. Furthermore, a theme of shared power in decision making across a team including children, young people and their families, and other services emerged. Overall the findings are indicative of the fact that a performance framework that adequately addresses these complexities works against the risk that authenticity is lost when measures of organisational performance are reduced to one or two measures.

Recommendations for a performance framework for CAMHS are proposed. This includes a robust synthesis of the policy environment, a developmental lens across infant, child, adolescent and youth age groups, a clear definition of the primary task for CAMHS along with an understanding of the target client group, directly addressing the broadly conflicted interface between CAMHS and child protection services, attending to the organisational climate within CAMHS, and defining appropriate accountability measures.

Future research must focus on defining the target group for CAMHS, the best and most efficacious treatment models and clients experience of care. It is further recommended that future research explore models for understanding and leading or managing the unique organisational climate in CAMHS settings and particularly on the roles of clinical staff and leaders in the CAMHS settings. A particular area of focus should be in relation to the inherent stress of working in this setting, noting that this is not seen as weakness or poor performance, but rather as a natural consequence of engagement in the task.

In summary, the submission makes recommendations for a performance framework for CAMHS, and in doing so the author has sought to draw together the key elements emerging from the findings supported by the research community. If the comprehensive network of elements identified were all adequately addressed, it would have the potential to reliably bind public child and adolescent mental health services with a unique clarity of purpose in a community of care for children, adolescents, and their families.

Defining the mental health system

1. The mental health system could be described as any and all parts of the health system addressing mental ill health. It should be noted that with this definition, much of Victoria's mental health system sits outside the direct control of the State government and situates with the primary care and private health systems.

2. It should also be noted that a great deal of investment is made through education, courts, drug treatment, justice and corrections, police, disability, housing and the family support system that directly addresses and delivers programs targeted to those with mental illness. To better understand the current state of mental health care in Victoria at present, one needs to be aware of what constitutes 'the system', how problems should be identified, what the levers for change are, and how these should be approached in order to be managed either directly or indirectly.

3. In the community discourse defining what is mental illness is at the heart of the challenge. Some specific disorders or diagnoses seem to shift the community discourse towards more sympathy and respect, including: post-natal depression, eating disorders, and disaster-related and work-related trauma (e.g., bushfires, ambulance, police). Notably this more sympathetic stance can be limited when applied to other forms of trauma, such as that related to racial discrimination or refugee status (Morris et al., 2009; Silove et al., 2007; Morrice, 2013).

Child and Adolescent Mental Health Services in Victoria

4. Victoria's public mental health system designates child and adolescent services as those for 0-18 year olds (DHHS, 2016). However a number of issues arise with this delineation. Firstly, mother-baby or infant services are funded as adult services, despite their very real role in monitoring the mental well-being of the infant in the mother-baby dyad (Meltzer-Brody, 2014; Bisognano et al., 2014). Secondly, services for young adults starting at age 16 are funded through the adult mental health system (DHHS, 2016). Thirdly, the Commonwealth has defined youth services as commencing at age 12 and finishing at age 25, underlined by an extensive funding program for primary mental health care over the past decade through the "headspace" initiative (Headspace, 2016). These latter two issues create overlaps and confusion related to age which can be challenging for the community to understand and access services (DHS, 2008)

5. Alongside these structural challenges within the service system itself, children's difficulties emerge in the context of their families and social sphere. Lives are impacted within families but also more broadly at school and in the community. Thus, the service system that sits around a child and their family can become both part of the problem and part of a solution (DHS, 2006). As a result, CAMHS clinicians working with a child will most likely need to integrate and coordinate care with families, school support providers, the family's primary care provider (e.g., General Practitioner) and possibly private providers. This case coordination or shared care function is often critical in providing a consistent approach to a child and family who are distressed and dealing with challenging emotions and

behaviour. It should be noted that public CAMHS services are targeted for the most severe problems for children of all ages including those less than four years. This provides a general illustration of the breadth of engagement and depth of skill required by clinicians working in the CAMHS setting.

6. Many psychiatric disorders emerge early in life and have broad impact on families and communities (Gathright, 2016; Costello et al., 2005). Families who face the challenge of mental ill-health in the children and adolescents they are caring for are likely to seek help from specialist child and adolescent mental health services. Service delivery at this early age is likely to ease the longer-term negative impact of mental ill health on the child's life trajectory (Benjamin et al., 2013; Patel et al., 2007; Belfer, 2008).

7. Notably, there are differences between the delivery of mental health treatment in adult and CAMHS settings. For example as has been previously discussed the focus in CAMHS is primarily on consultation to other community, family, and school support providers to the family as well as to the client. Further, inpatient treatment is rare and only undertaken in extreme circumstances. Whilst in adult services, prioritizing community care to prevent admissions is an accepted notion, in practice acute and bed-based care draws the funding for staffing to manage demand for admissions away from community-based care.

8. Contrasts between adult and CAMHS services are therefore driven by the developmental context of the presenting client and the types of problems presented. For children and adolescents, these are largely relational and inter-personal. These issues then drive the service configuration, including more consultation to other services, more outpatient clinical care, and less bed based treatment, and the training levels of staff who in CAMHS are highly likely to have post graduate training in "talking therapies" such as psychodynamic child psychotherapy, cognitive behavioral therapy, narrative models and family therapy (Thompson et al., 2013; Henderson, 2015; Nixon, 2015; Lucey & Pol 2013).

9. Child and adolescent psychiatry as a defined field of health care has relatively recently evolved, in line with the emergence of sociological understanding of childhood as a unique developmental phase in life (Levine, 2015). According to Rey et al., (2015) across the world CAMHS services have evolved in some public health systems as separate branches of care or as subsets of paediatric health or, as in the case of Australia, within the broader psychiatric service system. Wolpert et al., (2014) add a helpful third dimension indicating that although CAMHS "descended from the child guidance movement of the 1920s" (p. 5) it also has strong psychiatry history. It is important to recognise that in recent times the focus on managing risk in community service domains has become an important component of the service delivery environment.

10. Tension has emerged between the symbolism of education and promoting wellbeing, health and illness paradigms, and social services models where risk management dominates (Wolpert et al., 2014). As part of the public health system

in Australia and internationally, the CAMHS setting is traditionally a small, specialised, and unique environment – sharing the developmental context of paediatric health and the clinical mental health service delivery domains with adult and aged person's psychiatric services (Kelvin, 2005; Ford, 2007).

11. CAMHS are grappling with a set of expectations imposed by a stressed social welfare systems seeking to manage the sequelae of extreme trauma, challenging behaviour and impact of family violence and trauma on children and adolescents in their care (Wolpert et al., 2014; Bor et al., 2014).

12. CAMHS clinicians seek to provide more than symptom relief, crisis management, and bed-based care to children, adolescents, and their families who are clients of the service (Kazdin, 1996; Wolpert, 2009). Indeed, they undertake specialist assessments, provide an analysis and formulation of the problems presented, devise a treatment plan, and provide direct therapeutic interventions and treatment which may include individual, group, and family therapy over a number of months or even years (Kazdin & Nock, 2003; Belfer, 2008). In addition, indirect interventions such as collaborative service planning and provision, consultation with and to other providers, and referral to other specialists also form part of their mental health service plan (Ko et al., 2008; Worrall-Davies & Cottrell, 2009; Thompson et al., 2013).

13. The demands of the clinical endeavour for CAMHS clinicians are complex (Lambie & Stewart, 2010). They are required to manage a range of tasks across multiple domains both within the care provided to each individual child and family (typically many of whom present with very complex and personally confronting difficulties) while also expected to collaborate and partner with others to ensure integrated and comprehensive care packages. (Littlewood et al., 2003).

14. Such clinical demands occur at a time when the health system in Australia, like other such countries, has developed to a point where the political imperative for governments is to deliver high quality and highly accountable efficient and effective service outcomes. This has been translated in practice to a set of identifiable measures that purport to assess a number of elements ranging from the adequacy and safety of care to clinical outcomes to the financial sustainability of the health service (Eager et al., 2003).

15. In child and adolescent mental health settings the primary task is about understanding fractured development jeopardised by trauma, behavioural and social difficulties, and the intensity and at times abusive relationships between adults, children, and youth (Freidman & Hernandez, 2002). It could be argued that, in general, in Victoria CAMHS clinical models are not as symptom-focussed as approaches are in adult psychiatric settings, they purport to take a more therapeutic healing stance with children and families, and are fundamentally psychosocially and psychoanalytically orientated (Briggs et al., 2015; McDougall, 2014).

Mental health service performance: structures and processes

16. The challenges facing governments and the funded health service delivery system has driven the development of increasingly rigorous accountability systems for expenditure against activity (Glynn & Murphy 1996; Hawke, 2012). Changing public sector accountabilities have been studied and described by key analysts over the past 20 years, as governments across the world reform their functions seeking efficiency and effectiveness in delivery of public services through, for example, directing functions previously provided by government to private industry and not-for-profit government providers (Monfardini, 2010; Goh, 2012).

17. Fryer, Antony and Ogden (2009) examined the effects of the changes implemented by the UK government in the 1990s and 2000s, and concluded that the intended improvements across a range of domains such as transparency and value for money "had not yet materialized" (p. 480). They argued that the problems inherent in developing and implementing performance management systems successfully as falling into three areas: technical (problems with setting indicators and gathering data); systems (problems with integrating a performance management framework into an organisations existing systems and strategic agenda); and "involvement" which gathered issues such as leadership, staff engagement and stakeholder inclusion (p. 489).

18. The Victorian government has sought to generate improved performance of health services through articulating a sound policy framework, overseeing solid service and quality design and implementation planning, setting and communicating clear and negotiated targets, resourcing services appropriately, contracting for outcomes, and providing transparency of data (Department of Health, 2011). Services (including mental health services) use data to understand their service delivery, benchmark against each other, and improve their services. Government uses data, standards accreditation, and financial sustainability measures to understand how services do their business and work with them to deliver service integrity, sustainability, and excellence (DHHS, 2016).

19. Building a picture of health service performance, then, in Victoria includes compliance with all relevant legislation, compliance with quality and clinical standards, and compliance with funding and service agreements or *Statements of Priority*. The latter includes targets and indicators for client care and other quality indicators (e.g., health and safety, financial sustainability, staff retention, sick leave etc.).

20. The current funding model has limitations, which are the subject of further planning work being undertaken within Victorian and Australian governments (DHHS, 2016). Understanding the cost of care and appropriately funding for efficiency and effectiveness remains a work in progress. Insofar as this matter relates to the demand for services, the level of funding per inpatient bed affects the capacity of services to manage extreme acuity effectively, and this may have an impact on

therapeutic programs being able to be offered and possibly on the capacity to deliver focussed clinical outcomes.

21. Importantly, mental health services, whilst acknowledged to be a sub-component of the healthcare domain, have not traditionally received prioritisation for comprehensive development and resource allocations, and are perceived to be somewhat "behind" in the commissioning of relevant and appropriate performance and accountability measures (Kilbourne et al., 2010; Fisher et al., 2013). Mental health services lag many years behind in the delivery of funding models that create a discernible link between cost of service delivery, the price paid for the services, and the outcomes delivered to patients (Rosen et al., 2012; Rosenberg & Hickie, 2013; Eagar et al., 2003).

22. Multiple stakeholders exist for public mental health services, including the clients themselves and their families and social networks, potential service users, related community support services, the service providers (clinical staff), service leaders, auspicing hospital networks, policy leaders and government funding providers (Fiorillo et al., 2013; Shapiro et al., 2015; Hawkins et al., 2014). It should be noted that with the emergence of a broader socio-political discourse in relation to mental health and mental ill health, the broader community is increasingly becoming more informed and more demanding as stakeholders in public mental health service delivery (Jakubec & Rankin, 2016; Lewis, 2014; Thoits, 2013). Furthermore, each stakeholder group is likely to have a different perspective on what constitutes a 'high performing' mental health service (Patel, 2014; Rogers & Pilgrim, 2014)

23. Ciavardone (2006) argues that mental health service leaders and staff may be the last to understand that the performance standards applied by government are real and are relevant directly to them and the services for whom they work. Whiteford (2005) argues that mental health services will never be taken seriously if they can't find a way to develop a model of funding based on outputs rather than inputs of performance measures" (p. 2).

Performance in public Child and Adolescent Mental Health Services

24. At a service level, current models for measuring performance of a Child and Adolescent Mental Health Service have been shaped by production management theory, health management academics, and adult mental health service managers (Birleson, 2008; Burgess et al., 2004). Whilst there is an expressed desire to do so, they are not yet systematically informed by research, by clinicians themselves, by service users, or by other community stakeholders. As access barriers and demand pressures increase, so too does pressure on governments to improve productivity, funding and policy frameworks who are all seeking to deliver more efficient services (outputs and productivity) and more effective services (quality) (Hilty et al., 2013; Priebe et al., 2013; Collins et al., 2013; Santucci et al., 2015)

25. Studies of service quality are extensive in the mental health field, including child and adolescent mental health and are largely linked to particular clinical interventions for particular client cohorts. Linking clinical inputs to clinical outcomes

is more challenging in mental health research than in regular health care. Furthermore, measuring the actual experience of clients is an emerging field of research. In a study of 6224 clients, Miller et al., (2006) provided therapists with ongoing real time feedback regarding the client's experiences of the therapeutic alliance and progress towards the client's goals. This practise-based evidence not only resulted in higher retention rates of clients in therapy, but also doubled the overall effect size of services offered. It was noted in this study that for sound implementation of this model, services have to believe that privileging the client is a good idea and have to want to be accountable (to the client) for service quality.

26. In considering the unique treatment context of child and youth mental health, it is important to return to Kolvin and Trowel (2002) who underlined the critical nature of diagnosis in this age group being developmentally and longitudinally informed. So the treatments need to be also. For example, the developmental context of a pre-school child dictates close work with primary carer and family, particularly where the child may have limited language or may be deeply anxious and require reassurance. Developmental psychology is a broad area of theoretical and research endeavour of critical import to the understanding of the psychological needs of children and adolescents (Shaffer & Kipp, 2013; Shaie, 2013; Hergenhahn & Henley, 2013).

27. The developmental context will also inevitably involve school – a critical and important protective factor in improving a child's mental health and wellbeing (Flakierska-Praquin et al., 1997). Salmon and Farris (2006) argue the importance of the multi-agency collaboration that is undertaken by a CAMHS service to support the environmental and contextual factors in delivering comprehensive care that addresses all aspects of the presenting problem. Therefore, services provided for children and families need to include facilitation of interagency or multi-sector care planning for their communities - care pathways within and between services ensuring that responses are aligned with need and risk across the age range (Myors, et al., 2013; Bunger et al., 2014).

28. Key to collaboration is engagement with families. The all-knowing medical expert paradigm underpinning clinical models in CAMHS arguably works effectively within an acute health paradigm but has limited utility where individuals and families need involvement in decision-making. Such decision-making involves setting priorities in their own lives particularly as service models move past diagnosis to functional impact in someone's life of the troubles they are struggling with (Smith et al., 2015; Shields, 2015).

29. It is the view of the author that there is a challenge in the current system where services are directed to those who are most vulnerable, severe, complex and ill. It is particularly problematic because "diagnosis" has become disproportionally important in determining service access (compared with functional impairment). This mitigates against responding to vulnerability and risk in the individual and caring systems (families). Such a perspective also fails to articulate the contribution

of poverty, disadvantage, homelessness, abuse and neglect as both determinants underlying and consequences of mental illness.

30. Current measures or clinical indicators include activity (occupancy of beds, volume of throughput, community service hours delivered); access to services and responsiveness (percentage of new clients, triage response times, waiting times in emergency departments for a mental health beds, lengths of stay); quality of care (lengths of stay, 28 day readmission rates); client outcomes; continuity of care (pre- and post discharge contacts); and safety for patients (seclusion rates, mechanical, and physical restraint rates). These performance indicators relate to aspects of flow and throughput rather than quality, safety or effectiveness and actual targets (by which so-called "good" performance might be identified) are set in a handful of these measures (Furber & Segal, 2012).

31. Themes in the findings of the study related to performance in CAMHS was notably not related to the details of data and clinical indicators but more to accessing services, capacity to deliver appropriate and timely care, people's experience of the service at a subjective level, and client outcomes. There was a view expressed that data gathering and other administrative tasks were a burden and somewhat irrelevant – almost as stark as that they were obligations that came with the job but were essentially meaningless.

32. Access for those who most need the service at the time they need it was seen as critical. Building hope was a key element in good CAMHS service delivery in the findings and this was grounded in working with clients and families to make sense of the past, engage with the present and build a vision of the future. CAMHS was seen to be working well when there is an integrated multi-theoretical perspective, wisdom in leadership, accessibility, and collaborative capacity. This included shared power in decision making across a team, with young people and their families and with other services.

33. As indicated above, it is argued by Furber and Segal (2012) that the current performance indicators for Australian CAMHS (readmission rates, service access metrics) relate to aspects of flow and throughput rather than quality, safety or effectiveness. As a result they suggest that health economic capacity in CAMHS services should be developed to enhance understanding of the links between cost, price and treatment delivered as well as outcomes to underpin opportunities to advocate for funding and expansion of services. It is the view of the author that this would also assist CAMHS in defining and articulating role and primary task, and strengthen explanatory models of service delivery.

34. Furthermore, Cowling et al. (2009) and Brann, Coleman and Luk (2001) insist that performance frameworks cannot be robust without some form of client satisfaction measures which link to supporting client choice. In their work on performance indicators for mental health services in Australia Eager, Burgess and Buckingham (2003) pull the threads articulated above together and argue that what is needed is a comprehensive measurement framework that helps shift the focus from expenditure to value for money

Recommendation for a performance framework for CAMHS

What follows below constitutes recommendations for a CAMHS performance framework and includes implementation enablers noting that some factors are already being addressed and some structures are already in place.

1. Policy scaffolding and robust detailed implementation planning.

There is a substantial and legitimate role for government in planning, oversight, target setting and monitoring of services. Ham (2015) calls it a “proper role” and advises that government capability in Victoria will need to improve to do this role justice (p. 8).

Building on current strategic intent described by different levels of government and encapsulated in local service design is critical to ensure cohesion in a shared vision for service delivery. Often the policy frameworks create an important guide but risk being adult and individual focused (rather than children and families) and can be too broad to create clarity for authentic implementation at a service level.

A performance framework for health services including a CAMHS service should clarify expectations directly. It should be grounded in evidence based policy and strategy, solid service design, robust implementation planning, clear target development and communication, resourcing, contracting, consolidating, feedback systems, compliance with legislation, compliance with standards, funding and service agreements, targets and indicators for outputs.

2. A developmental lens – infants, children, adolescents, youth.

The very real differences and complexities of mental health service delivery for children and for adolescents and their families warrant a different, tailored and nuanced approach to consideration of performance frameworks especially including the developmental psychopathology context. Effective services for small children cannot be the same as those for youth.

The findings of this study indicated that to provide clinical care with the level of complexity presenting to CAMHS requires understanding of the presenting issues, particularly the impact of trauma. This understanding must be nested in the developmental context of a child or adolescent, and treatment responses should account for the multiple system interfaces in that child’s life.

Working structurally to prepare a team adequately for such a response to its client community may lead to segmentation of clinical responses between infants, pre-school, primary school, adolescent and youth age groups making them consistent with education and primary care models to support collaboration.

3. Define the primary task of CAMHS

The performance framework should be based on an agreed description of the task and role of CAMHS as distinct from the role of other services. Whilst there is a current description of CAMHS it has been found to be inadequate in tailoring consistency of target group, service response and outcomes. This is perhaps as a

result of the tendency for large government organisations to seek broadly consistent descriptions of services and measures of outcomes.

Attending to this task will assist directly with managing external expectations and drive internal service development to align to the expressed primary task. It is expected to reduce the anxiety inherent in the system by affirming a description of the work of CAMHS, one that is likely to make sense within CAMHS and across stakeholders. Negotiating and consulting on this definition could provide the first steps in managing expectations. The proposed description informed by the present study is: “a public mental health service creating a safe place to develop a shared understanding of the most troubled children and their families, and to foster growth through caring, reflecting and lifting the burden of blame and shame”.

4. Comprehensively define the intended target group

Such a definition must include clear descriptions of the client target group. This will then impact on access requirements and define the services to be offered. The definition would need to be confirmed and reconfirmed through broad consultation (clients, families, external referrers, clinicians, government). This recommendation addresses the study findings that CAMHS may not be dealing with those who have the most comprehensive difficulties. There is a need to find an agreed way to define and describe this group.

The challenge in this work would be to discern appropriate measures of complexity that do not rely only on diagnosis, given the contested nature of that paradigm in CAMHS. They should also not rely only on measures of severity symptoms as is currently in practice, given again the contested nature of the tools utilized and the individual psychopathology paradigm that does not adequately reference the complexity at play within a family, peer and community system of relationships. Developing a measure of complexity could be based on a score derived across a range of assessment domains. This would provide an opportunity to ensure that those at the highest level of complexity were in fact the ones able to access the service. Holding services to account for targeting delivery of care to children and teenagers presenting with severity and complexity would require an agreed measure of complexity.

5. Directly addressing the child protection and CAMHS interface

A performance framework should identify and measure explicitly the impact of collaborative efforts between CAMHS and other providers especially in the service of child protection clients and their families. The findings of this study indicate that this collaborative interface is seriously compromised and requires direct targets and performance requirements if the care provided to clients is to be impacted directly.

Resolving this conflicted situation will require senior government leadership of a policy framework for both child protection and CAMHS that drives expectations for collaboration, models change, calls out and explores the defence mechanisms and engages service leaders in working through options for change.

6. The importance of organisational climate in CAMHS

The performance framework should reference, integrate and therefore legitimise the impact of the work itself on the staff group and actively attend to this as a domain of service function and resourcing. The findings pointed to the need for CAMHS clinicians to be provided with boundaried reflective space within which to examine the internal organisational climate and understand and act on defensive strategies, especially those that may be affecting client access (with structural barriers and interpersonal obstacles), treatment pathway (which decision-making and role conflicts in treating teams) and continuity of care (poorly integrated service interfaces).

This means ensuring that organisations that fund and manage CAMHS understand that quality service delivery legitimately includes making space, time and resources for clinical supervision, reflection and review for all staff members individually and as groups. It means additional cost and efforts to balance and demonstrate efficiency against safety, quality and treatment effectiveness.

7. Accountability

All the elements described to date need performance measures and a reporting regime to ensure services are meeting the espoused and agreed task and are publicly held to account. These should be uniquely focused on the services being provided for this age group across all settings and avoid hybrids of adult mental health or regular health models.

Systems for gathering and public reporting of clinical data and some data related to staff resources have been well-established in Victoria. However, they are known to have limited utility clinically and are the subject of ongoing deliberations at state and national levels. The challenge here is to report a set of measures that extend past clinical throughput to clinical outcome, experience of care, collaborative efforts, staff engagement and climate – all the elements that have emerged in this study. Integration of research on efficacy, the dynamic and personal impact of the work itself on front line clinicians and on clinical outcomes needs to more directly inform future endeavors.

The Full thesis can be found at

https://pdfs.semanticscholar.org/968f/4ae29dde6b6f2b1027dc0fce17ae17587dbd.pdf

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