Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF DR PAUL MICHAEL DENBOROUGH

I, Dr Paul Michael Denborough, Clinical Director of Alfred Child & Youth Mental Health Service (**CYMHS**) and headspace at Alfred Health of 55 Commercial Road, Melbourne, in the State of Victoria say as follows:

1. 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.

2. I have made a previous witness statement to the Royal Commission into Victoria's Mental Health System (**Royal Commission**), dated 9 July 2019 (**First Witness Statemen**l).

3. As my experience is predominately related to child, adolescent and youth mental illness, except where specified, all references to an individual relate to a child, adolescent or youth.

BACKGROUND

Please provide your full name and title and any postnominals for reference in your statement and use in the Royal Commission's publications and reports.

4. My full name is Dr Paul Michael Denborough. I am the Clinical Director of Alfred CYMHS and Headspace at Alfred Health.

Please outline your relevant background including qualifications, experience and provide a copy of your current curriculum vitae (in a form suitable for attachment to your witness statement and publication).

5. I refer to my previous witness statement dated 9 July 2019. My relevant background including qualifications, experience and curriculum vitae are set out at paragraphs 3 to 6 and attachment PMD-1 to my First Witness Statement.

Please describe your current role and your responsibilities, specifically your role as Clinical Director of the Alfred Child and Youth Mental Health Service and headspace.

6. My role and responsibilities as Clinical Director of CYMHS and Headspace are set out at paragraph 8 to 9 of my First Witness Statement.

Please confirm whether you are giving evidence to the Royal Commission in your personal capacity or on behalf of your employer or an organisation. If you are giving evidence on behalf of your employer an organisation, please confirm you are authorised to do so.

7. I make this statement in my own personal capacity and do not make this statement on behalf of Alfred Health.

COMMUNITY MODEL OF CARE

How can Victoria better identify and support adolescents and adults who need extra support for their mental health?

(a) What key changes would you recommend to Victoria's mental health system?

8. The key to a successful mental health system is for that system to be accessible and effective. In order to improve Victoria's mental health system, changes should focus on accessibility, effectiveness, and integration of services.

Accessibility

9. Accessibility is a particular issue in relation to Victoria's child and youth mental health system. Accessibility includes having enough staff working at services and minimising the stigma related to mental health. One way of reducing stigma is through co-design.

10. However, more can be done to improve accessibility, for example involving more volunteers to further assist young people in approaching headspace and seeking assistance.

11. A key aspect to accessibility is also program co-design. This requires the direct involvement of young people and their family in suggesting and developing programs and having involvement in the way they are run.

12. Another aspect which would improve accessibility to Victoria's mental health system is a change to focusing on how to assist people from the beginning of their involvement with the system.

13. At the moment, when someone makes an initial telephone call to a mental health service, generally that discussion is focused on assessing the individual for eligibility to the service rather than welcoming them into the service. While there is more awareness and less stigma around requesting help for mental health issues, I believe that people are still wary of contacting mental health services, and if they are turned away or referred on during that initial contact it can be particularly discouraging. Accessibility could also be improved by having walk-in programs available in the

communities that young people live (this is common in parts of Canada particularly the province of Ontario).

14. Services need to ensure that individuals and families who are reaching out are to be welcomed in so they feel accepted, supported and are not made to feel like they are not constantly justifying why they need help Language that invites, that is open and equalizing rather than pathologizing and stigmatizing this includes the language we use to describe what we do, who we help and who we involve. Another consideration is that the longer that an individual is left without support the more distressed they can become and their mental health issues can be exacerbated.

Effectiveness

15. In order to be effective, the mental health system must involve the patient's family and social network, and not just approach people as individuals. The traditional approach in psychiatry is to focus is on finding out what is 'wrong' with a person. However, to improve effectiveness the focus needs to be listening more carefully to the perspectives and issues being experienced by the individual and their family. This allows assistance and help to be provided more efficiently and allows the person and their family to have greater involvement in treatment options which will lead to more positive outcomes.

16. The approach of using co-design more regularly would also enhance the effectiveness of Victoria's mental health system. There are a number of therapeutic models which lend themselves to such co-design and collaboration. Close attention needs to be paid to monitoring progress against identified goals and collaboration should be sought from those in the person's life about the goals, approach and methods being used to address the concerns of and for the young person. Service delivery needs to be adapted to each person and their context and when close attention is being paid to progress or lack of, service providers need to be able to adapt how they are working. This way of working demands the establishment and prioritization of good working alliance and partnership between service users and providers.

(b) What key changes would you recommend to other service systems that support or engage with vulnerable children and adolescents; for example, schools and family welfare services or the justice system?

17. There are many improvements which could be made in these areas, however I do not consider that the structure necessarily needs to be redesigned. I consider there is a need to increase funding to allow the mental health system better inreach and co-location of services with Victoria's youth justice system, Victoria's education system and Victoria's child protection system.

18. These three systems, and in particular teachers within Victoria's education system, are particularly good at identifying youth who are vulnerable or may need mental health support services. However, those young people then need treatment and support and easy access to treatment

19. The issue which arises is that often workers in these systems are unable to refer young people into appropriate mental health services due to a lack of understanding as to how the system works and the operation of catchments. The difficulty is that where a system is under pressure, and the mental health system is, there is no incentive to market the service. The Alfred's website and social media presence is way out of date. If you google, you don't get the information you need. Our website doesn't help explain what we do and someone accessing our website wouldn't be able to work out what is on offer. There is a fear that if we are easily accessible, we'll be overrun. We have actual experience of this where we put some information on our website about our eating disorders program which was very basic but more than we have ever had before. This has contributed to an exponential increase in referrals. In addition people are coming to us with an understanding of what we do. This is excellent in terms of consumer choice and accountability but causes issues for us in being able to manage the demand.

20. In both youth justice and child protection, there are many vulnerable young people. Building relationships between mental health and these systems breaks down the barriers that prevent people from seeking help.

21. As outlined below at paragraphs 125 – 129, the Child and Youth Forensic Outreach Service which works within Brisbane's youth justice system is in my opinion, a great success and a model which could be replicated within Victoria's mental health and justice systems. The integration of a mental health team into the youth justice system allows for not only assessments to take place, but also for those individuals to receive initial treatment and further referrals into the mental health system as required.

What types of care for adolescents cannot adequately be provided for in community settings? E.g. What types of care must occur in a hospital?

22. Hospitalising adolescents is a last resort. Even where hospitalisation occurs, the aim is to keep hospital stays to a minimum. A community service setting that is well resourced, can focus on supporting families intensively, to help most young people at home rather than need hospitalisation.

23. Whether hospitalisation is required is not diagnosis specific. Generally, there are two scenarios which will lead to hospitalisation of an adolescent. First, where an adolescent

has a lack of capacity to make appropriate decisions. Second, where the adolescent is in a state of serious crisis.

24. Where an adolescent is hospitalised the aim is to ensure that all parties, including the individual and their family, are on board and engaged with the plan and that the period of hospitalisation is as brief as possible. A brief hospitalisation may be helpful to bring the family and others involved in the patient's life together.

25. In my experience, hospitalisation of an adolescent is determined by the social fabric around that individual, rather than their diagnosis. Generally if adolescents are living with their family, the aim is to try to support treatment in the home environment rather than hospitalise the young person. If a family is well supported, young people can often be kept out of hospital. This may require daily or twice daily visits to the family. However, there is a real question as to whether this can currently happen and whether it can happen safely, because the availability of in home care is seriously constrained.

26. Hospitalisation could be reduced by increased use of hospital in the home. There is a real need to increase the capacity for hospital in the home, with 24 hour teams who can support teenagers at home as an alternative to an inpatient setting.

27. With anorexia nervosa tertiary mental health services in Melbourne have historically been positioned as the "last step" in care. With other conditions this is mostly appropriate. To prevent hospitalization for anorexia nervosa tertiary mental health needs to be assertively offering the "first step" in treatment with immediate multi-disciplinary family focused treatment. Evidence shows us that when a young person is able to avoid being hospitalized they have much better treatment outcomes

28. Providing alternatives to hospitalisation requires an increase in youth outreach services. These services do not exist in Melbourne for youth. The adult crisis teams were aimed at trying to help people in their homes. However, there has never been an equivalent where Crisis Assessment and Triage Teams can support intensive treatment in the home for children and young people.

In considering a community-based mental health system over the longer-term (i.e. over 10 years), what is the ideal role and what services should be provided for:

(a) Adolescents and young people at-risk of developing mental illness?

29. Providing expert mental health care to young children including infants I believe would be a cost effective and humane way to deal with this group. There are many young children who are exhibiting emotional and behavioural problems who currently either get no intervention or brief individualised responses which do not involve the whole family

(b) Adolescents and young people experiencing mild and moderate illness?

30. Headspace is a good example of efficient treatment for mild to moderate illness. As the program has been co-designed with young people and families it is a less stigmatised system. This co-design makes a significant difference. However, there is scope to increase the involvement of families in treatment.

31. Headspace could also be expanded provide services from 0-25, rather than 12-25, as there is limited service for that very young age range unless they have severe and complex problems. Headspace provides a holistic "one-stop shop" for people 12 and over but this sort of system is not available for children under 12 and their families. In saying that fee for service delivery has largely been designed around evidenced-based practice models for individuals and some work needs to be done to improve the capacity of these providers to work more systemically and with more flexibility.

(c) Adolescents and young people living with severe mental illness?

32. Young people who are living with severe mental illness require more intensive ongoing support and specialist assistance than those young people experiencing mild to moderate mental illness.

33. Services like headspace are often unable to work with severe mental illness, which requires block funding in order for services to fund staff to provide ongoing and specialist assistance. There is often mention of the "missing middle" where people are deemed too unwell for Headspace but not unwell enough for the state funded service. One solution to this is at the Alfred where we are responsible for the entire system of mental health care both mild moderate and severe which makes it less likely that young people fall " between the cracks" and we are forced to find solutions as we are the ones accountable

34. The treatment provided should be in collaboration with the young person's family and support network. Specialist responses also need to be available for some groups, such as those with anorexia nervosa or involved in youth justice.

35. To allow services to provide these more extensive and intensive programs I believe that they need to be provided with block funding to support those programs. Ideally this would result in the mental health service being provided with both block and activity funding and being able to provide a range of mental health services targeted for people aged 0-25 with mild to severe mental illness. This is currently what happens at Alfred Health. Headspace is essentially federally funded activity based funding via Medicare with some block funding for infrastructure. This fee for service model is efficient and effective for the mild or moderate problems. The State funded CYMHS is block funded and I believe this is necessary in order to provide services like outreach and multi-disciplinary input which is required for people with complex difficulties.

(d) Adolescents and young people who are experiencing a suicidal crisis or following a suicide attempt?

36. Providing accessible and effective family based mental health treatment to young people who are suffering from suicidal crisis will make a difference. Effective responses to suicidal crises are usually those that mediate risk factors like isolation, disconnection and loss of meaningful engagement. This is why working with a person's network and community is so vital. I note in the interim Royal commission report a young person's "Hope" team/s will be funded which in my opinion is an excellent idea.

(e) Families and carers of adolescents and young people experiencing challenges to their mental health?

37. At the Alfred, we see the client as being the whole family, or their social network. It is vital that families and carers are welcomed into community care services and provided with support as soon as possible. Family peer workers, parents with the lived experience of caring for a person with a mental illness, can help other families by walking alongside them as well as having a direct impact on how clinicians work with families

38. It is difficult to make an impact with people in isolation. You also need to be working with the people who love and care for them. While obviously some young people are estranged from their families, we still want to meet them with their social network at that initial meeting. We always want to start the engagement with a meeting with the whole family or network, rather than with the individual. Once you miss that first meeting it becomes difficult to engage with a family or support network. The family may perceive that they are not important to the process and the individual may feel that the best way to receive help is on their own

What are best-practice examples of community-based mental health assessment, treatment and care for adolescents and young people? Why do they work well?

39. Getting off to a good start is critical. Being seen quickly and welcomed in the first meeting involving the whole family is best practice. The so-called "single session" model is one such approach. In this model, it is collaborative, strengths based and solution focused. There is a focus on what is right with the person and their family, not just what is "wrong" and the session revolves on working on what the family needs/wants and less on a problem saturated assessment. Open Dialogue is another best practice model which focuses on a social network and emphasises choice and empowerment. It requires psychiatrists to be "on tap not on top" and to provide opinions rather than "delivering edicts" from above.

40. Eating disorders provide a good example of why such an approach works well. The model involves seeing an individual as soon as possible and involving their family and support network at that initial session. The initial session should be focused on collaboratively finding a solution, rather than spending time focused on identifying a problem.

41. This kind of assessment and treatment is not common practice, as traditional methods of psychiatry have often viewed mental illness solely within an individual rather than also considering the individual's wider social context. There is also traditionally been a lack of emphasis on the vital role families and social network have in helping people recover from mental distress. There has also been a tradition of wanting to understand the problems in depth before trying to be helpful which can inadvertently lead to people feeling blamed and shamed.

What are the key barriers to the delivery of effective community-based care for adolescents and young people? For example, how can barriers preventing young people from help seeking and engaging be overcome?

42. The mental health system creates an initial barrier by not being accessible nor welcoming. The families of an individual experiencing mental health issues often have very painful and traumatic stories to tell. Often they are required to tell them to a number of people before receiving assistance. Victoria's mental health system needs to be sophisticated enough to allow people to be linked to the right person and service from the very beginning to ensure they can tell their story and receive help, rather than just be assessed for eligibility and not receive help or be passed on to another service. In order to create such a sophisticated system you need experienced people on the 'front line' taking those initial telephone calls. The system needs a default position of trying to help everyone who asks for it rather than trying to limit the help to people who the system determines is bad enough to need it.

43. There is a high emphasis on risk in the current mental health system and, in particular, trying to guess whether someone is going to harm themselves. Many clinicians are uncomfortable working with family members and support networks, due to concerns around privacy and risk. In addition, suicide investigations are focused on looking back in retrospect and finding out who made the mistake. This inhibits clinicians from being useful, leads to people practicing in a defensive way and prevents them from having the confidence to help people as a result of these investigations (or by another name Root Cause Analysis) If there are any recommendations they always lead to more restrictive practices which ironically makes the system less helpful and thus more risky. This is not to say that there shouldn't be reviews of tragic events like suicide. The review should focus on the care provided and examine its quality i.e. were the person's views and preferences taken into account, was care provided using recovery orientated practice

rather than looking for a "root cause" Clinicians in virtually every service are asked to fill in tick box risk assessment forms usually in secret from the client despite this being against recommendations made in NICE guidelines. The culture that this use of RCA and tick box risk forms creates is one of fear of blame in clinicians and is a massive barrier in services delivering recovery-orientated practice, which is both federal and state government policy.

44. It is important to understand that not many adolescents or young people request help themselves. Requests usually come from their families. Therefore, tailoring co-designed services, programs and spaces to both the individuals and families will result in a more effective service being provided with better outcomes.

Should services for children, adolescents and youth be streamed by age, and why?

45. The ideal age range for child, adolescent and youth services is 0 to 25 years old. Even though the mental health problems experienced over that age range will differ, the skill set required by clinicians is similar. I consider an age range of 0 to 12 years to be too narrow as it reduces the critical mass of patients and reduces the resulting efficiency and innovative work.

46. An age range of 0 to 25 years has been a massive success. The 'youth' age range was extended approximately 10 years ago to incorporate young people between ages 18 to 25 years as they were missing out on critical services as a result of 'ageing out' of youth services but still being too young to be properly treated within the adult system. Between those ages it is important that the individual's families and support network are involved in the patient's treatment as it is difficult to make an impact on an individual's mental health on their own and at this age they are usually still reliant on their families to some degree.

(a) What are the challenges associated with age-based streaming?

47. While the major challenge associated with age-based streaming is transitioning patients between services. In my experience, a large number of young people age 25 do not need to transition as they have recovered by the time they reach an age at which they would be required to transition into adult services.

48. Some individuals with severe mental health illnesses, such as psychosis, will need to transition to adult services and may be reluctant to do so. However based on my experiences, it is preferable to transition patients to adult service at 25 rather than 18. I consider this to be a result of the children, adolescent and youth services involving families much more than the adult system. For young people between 18 to 25 years, their families are still often quite involved in their care, so having a system which supports that involvement is beneficial to the outcomes for that individual. The adult

system usually regards the individual as the client, whereas the child and youth system views the family unit as the client.

(b) Could the aims of aged based streaming be met through alternative means? For example, by streaming based on different criteria.

49. I consider that age-based streaming is the ideal method to ensure that children, adolescents and youth are receiving high quality and effective mental health services.

50. There was a report commissioned by the mental health branch into catchment area options several years ago. Option 1 was minimal change but had some sensible suggestions. Option 2 was more radical and suggested dividing Melbourne into all age catchments with a total population size of roughly 600,000 people. Option 3 was three large catchments for Melbourne. In my opinion option 2 is the best in terms of making one hospital accountable for a manageable sized population for the whole age range would minimise the transition problem across ages.

(c) Are there examples of high-quality systems and services that don't use age-based streaming

51. Not that I know of. The fee for service medicare model is not age based but it is not really a system.

What improvements could be made to ensure that the physical health needs of people with a mental illness are understood and treated, alongside their mental health needs? Please describe your observations of any best practice models in Victoria or elsewhere.

52. A major improvement which could be made is to ensure that the staff who are responsible for an individual's physical health, are integrated into the mental health team.

53. As one of my particular areas of speciality is anorexia nervosa, I have considerable experience in considering the physical health requirements of individuals who are also experiencing mental illness.

54. At CYMHS, the mental health team has a dedicated nurse who is directly responsible for the physical health of those individuals. Previously a patient's physical health was managed outside of the mental health team, usually by a general practitioner or paediatrician. I am not aware of any other service which combines mental and physical health resources into the same team, however at CYMHS we have seen a number of benefits from setting up the service in this way to provide seamless well-coordinated care.

55. The mental health staff have an appropriate contact to raise concerns regarding an individual's physical health and the physical health practitioner feels part of the team, as opposed to simply assessing a patient with no context as to their mental health.

56. While most young people are physically healthy there are a number of instances where physical health concerns arise such as with psychosis, particularly if prescribed neuroleptic drugs and anorexia nervosa.

From your experience and research nationally and internationally, what are some of the mechanisms and structures available to better integrate community based and acute mental health services to create pathways for people living with mental illness?

57. In order to integrate community based and acute mental health services it is essential that the funding received by mental health services needs to be integrated. At Alfred Health we run both state and federal funded programs and therefore receive both kinds of funding. As discussed previously this minimises the problem of the "missing middle"

58. While criticisms do arise as a result of Australia having two 'levels' of funding, I consider that if the two 'levels' were integrated better it could be the best model. If we compare it to other models such as the National Health Service in the United Kingdom, the mental health teams aligned with local government areas and are often too small to have the critical mass to provide a comprehensive treatment service. While the Australian system requires improvements around integration of its two levels of funding, I have heard of a proposal to set up a regional body that would receive both federal and state funding and then allocate. I am not sure if this will mean simply giving state money to the PHN or setting up another body in parallel to the PHN.I do not believe it will be feasible for PHN to run the state hospital system. The best solution would be if we did move to the all age catchment of 600,000 they would be able to pool both the state and federal money.

59. I also consider that in order to better integrate community based and acute mental health services, different methods of tenders should be explored. There is no perfect system but I do like the notion of non-competitive tendering.

Families and carers

Have you seen or developed service models for the care of young people and adolescents that can help to develop family and carer engagement over time?

60. At CYMHS we have developed and rolled out a single session program to train staff on working with families and support networks. It has taken us 20 years to develop, resource and roll out this program and I consider it to be the most effective program that I have been involved with as it focuses on incorporating the family into the individual's treatment.

61. Specifically in the psychosis space, we also have a family intervention model which assists to develop family and carer engagement. This model is Open Dialogue, which was initially developed in Finland and has been rolled out in many countries and we have adapted it to Australia. The model also is a way to promote recovery orientated practice in general including increased choice and empowerment of people and their families.

(a) Why do they work well?

63. The single session program provides an in house training experience on how to work with families, which all new staff are required to complete. Working with families is a practical skill and is not usually taught at undergraduate level.. The single session program also allows our staff to learn these skills in a supportive context and reinforce CYMHS' philosophy that both the young person and their family all need to be involved in the treatment and that treatment starts early and focuses on helping the family with their concerns. This is a different philosophy to what is commonly taught at university, namely a focus on finding out what is wrong with the person and diagnosing them.

(b) What have been the challenges in establishing them?

64. There are significant challenges in establishing these models. Both clinicians and the community often feel more comfortable locating problems within individuals. In helping with mental distress the default position is to see young people on their own with some sort of talking therapy or drug. I believe especially in younger people it is unrealistic to expect them to overcome these challenges in isolation from their family or social network. Treatment needs to start with the family as the primary focus-it doesn't mean they can't have sessions by themselves as well or use some psychiatric medication to assist in relief of distressing mental symptoms

65. Establishing these models of care is time consuming but also needs to be supported by mechanisms which allow those models to work in practice.

(c) What factors have been helpful in initiating and embedding these models?

66. In order to embed those models into CYMHS, I have found it helpful to ensure there is a deeply ingrained philosophy regarding what helps people. In my experience, if clinicians are overly focused on identifying what is wrong with someone or assessing the risk around them, they will not have the right priorities for these service models to be successfully initiated. A service philosophy that is focused on outcomes, involving families and being directed by clients is crucial.

Alcohol and Drug use

What does a best practice service response and consumer experience entail for young people with co-occurring mental illness and problematic alcohol and other drug use?

67. Integration of services is the key aspect to ensuring that a best practice service response is provided in such circumstances.

68. Headspace YEP has an outreach program which is available 7 days a week. Based on the feedback from this service, around 80-90% of those young people are using illicit drugs. The absolute best practice response in those circumstances is to have a specific drug and alcohol specialist worker integrated into the mental health team.

69. In 2019 Headspace YEP was receiving funding from the South East Melbourne Primary Health Network (**SEMPHN**) to have a specialist drug and alcohol resource within our mental health team. This person had the specific knowledge, skill set and abilities to access resources such as detox facilities. I consider this to be the best practice model which could be implemented across Victoria's mental health system to assist young people with co-occurring mental health issues and problematic alcohol and drug use.

70. If that were not possible, the second best approach would be to have a co-location arrangement where a drug and alcohol specialist is available in the same building or close by to the mental health service.

71. Once young people are required to attend two different places for their mental health and drug and alcohol support, additional issues begin to arise such as a lack of continuity of care and difficulties in ensuring the individual's family are involved. This reduces the effectiveness of their treatment.

A significant number of stakeholders have called for greater 'integrated care' for people with co-occurring mental illness and problematic alcohol and other drug use:

(a) How do you define 'integrated care' and what are the ways this can be achieved in services for young people?

72. Integrated care is the inclusion of additional specialist supports within the mental health workforce. For example, for many young people experiencing psychosis are also addicted to alcohol or drugs. They will experience the best outcomes when mental health services are integrated with a drug and alcohol specialist.

73. Conversely, sometimes rehabilitation or detox facilities may be hesitant to provide support to an individual who also has mental health issues. Where a drug and alcohol specialist is integrated into the mental health team, they have the specialised support to

navigate those issues with the rehabilitation and detox facilities, to ensure the individual can receive the required support.

DIGITAL TECHNOLOGY

What are the enablers and challenges of expanding digital mental health services for young people?

74. The presence of digital mental health services for young people is essential to destigmatising and normalising mental health treatment. However, Victoria's mental health system fails to provide clear and accessible digital mental health services. There have been some inroads made through headspace National, Kids Helpline and Reachout where young people (more males than females) and family members often use these online portals for initial helpseeking and support. Demand for these services are high and there is no way currently to link up these services with local mental health services.

75. Wayfinding. Similarly, young people and families (as well as GPs) report that they find it hard to find services when they are in need of help and often under considerable stress. Information on services available and how to access these need to be readily accessible through routine internet searches to enable greater access.

76. Stigma. The Time to Change campaign in the UK (The British Journal of Psychiatry (2013) 202, s95–s101. doi: 10.1192/bjp.bp.112.113746) was an example of marketing being applied whereby the general public were targeted with sophisticated messaging aimed at destigmatizing mental illness in the community. A similar campaign whether state or national would be highly advantageous in overcoming stigma and enabling greater access.

77. This issue is reflected in Victoria's mental health system's online presence. With current technology you are able to search for anything online, from restaurants to public transport, and you will receive clear and accurate information on companies who provide those goods or services, the specific goods or services provided and details as to how to access those goods or services.

78. However, if you search the internet for anything related to Victoria's mental health system it is difficult to understand what services are available from different organisations. Even the CYMHS website does not provide sufficient information on what we do or how we can be of assistance. The headspace Early Psychosis program is accessible only through the headspace portal. Our young people report that the headspace platform while well suited to those with more prevalent less serious disorders does not resonate with the experiences of young people with more severe

conditions. There is a need to attend to develop digital platforms for those with more serious conditions such as emerging psychosis.

79. Marketing and communication. There is a dearth of online stories and materials that present a recovery orientated positive image to young people of recovery from serious disorders. Our headspace program has developed 2 digital stories based on experiences of young people that offer a hope and inspiration that recovery is possible. These have been successful because there were developed in partnership with the 2 young people who told their authentic stories through animation.

80. There are some specialist children, adolescent and youth mental health services, such as Orygen, who have dedicated significant time and resources to their digital presence and as a result have a fantastic website with great information for individuals and their families and carers. This is not just information but there are opportunities for online support and treatment.

81. To improve this issue for other specialist youth services dedicated funding and infrastructure is required. Such digital websites and services could be set up and specialised to target the individual requirements of each 'catchment area' and guide individuals to the most appropriate mental health service in that area to provide them with treatment and assistance.

In your view, when and how can digital approaches help to improve young people's ability to:

(a) find and use information that helps them to understand their mental health needs?

(b) access information on mental health services?

(c) make decisions about what service, treatment, care and support is right for them?

82. It is now even more common for young people to access and find information they are seeking on the internet, rather than making telephone calls or approaching services in person.

83. In order to continue the work which has already begun, to destigmatise mental health issues, we need to ensure that young people are able to find information regarding their mental health in the same way they are able to access information on any other topic they would search for. The lack of online resources, in the format that young people are accustomed to interacting with, may contribute to an ongoing misunderstanding that seeking treatment for mental health is something 'different' or 'shameful' from seeking treatment for other medical issues.

In your view, when and how can digital technologies help to improve:

(a) young people's ability to easily access mental health services in a timely manner?

(b) care pathways, treatment and supports?

(c) the quality of services being provided?

(d) measurement and feedback loops?

84. The national headspace platform has been especially successful in marketing services to young people so that it is often a first port of call. As well young people and families learn about services available through perinatal and maternal and child health services, kindergartens and childcare centres, school wellbeing services and tertiary student support systems. Marketing services to these service providers would be especially helpful in increasing access to services.

85. Digital technologies could be used in multiple ways to improve and assist in all of these areas. Digital pathways for self-referral would be potentially much more user friendly for young people to seek help. Digital mechanisms could also be used to support treatment through education, resources, homework activities, contact at home and after hours. We are already seeing a massive uptake of use of technology to see and help families via telehealth in the COVID19 crisis and this has been very well received by families. They can also be empowering by helping clients access their own files pathology and other information. Digital platforms can also be used to track real time measures of client progress and satisfaction with treatment, enabling the services to tailor the treatment to outcomes.

COMPULSORY TREATMENT

The Victorian mental health services annual report 2018-19 states that 'the average duration of a period of compulsory treatment, which has been stable at 23–25 days, has risen substantially to 30.6 days' among children and young people.

From your perspective, why is the duration of compulsory treatment among children and young people increasing statewide?

86. The increased length of compulsory treatments is particularly worrying for children, adolescents and youth as the only reason a person should be placed in hospital against their will is because they are incapable of making safe decisions, not because clinicians are fearful.

87. However, in my experience many clinicians have a level of fear of being blamed for a patient's suicide or other serious negative outcome. This stems from the way that suicide investigations are undertaken within Victoria. These investigations are focused

on root cause analysis and attributing blame in the situation. There is also a fear of criminal sanctions as a result of these investigations.

88. Historically investigations with such a focus were primarily undertaken within the adult section of the mental health system. As clinicians in the child and youth section of the system would work alongside families and use a common sense approach, such a culture avoided permeating child services. The culture of blame and fear from the adult section is now slowly creeping into the child and youth section of the mental health system. I believe that more clinicians are acting in a fearful and risk adverse way which would be more likely to involve the additional use of compulsory treatment and for longer periods of time.

89. This increased culture of fear and risk aversion actually inadvertantly increases the risk to individuals with mental health issues. It has been documented that the riskiest time for a patient with mental health issues is the first week of being discharged from inpatient care. We should be reducing the number of incidents of compulsory treatment in order to improve outcomes for patients.

90. This culture of fear is also evidenced in the way that Victoria's mental health system still uses risk assessment forms to assess the risk level of a patient. The process followed in Australia and is contrary to the UK National Institute for Health and Care Excellence Guidelines (**NICE Guidelines**). It is the only procedure within Australian's mental health system which is contrary to the NICE guidelines.

91. The changes which have been made to the *Mental Health Act 2014* (Vic) may have also played a role in the increased levels of compulsory treatment. Previously a number of adolescents would be placed into adolescent units under a 'parental authority', however now often the only option is for the clinician to order compulsory treatment.

What could be done to reduce the use of compulsory treatment? Please consider policy, practice and funding levers.

92. I consider the major change to reduce the use of compulsory treatment would be to change the culture of fear for clinicians within Victoria's mental health system. If the mental health system could reduce the level of fear that clinicians are experiencing, they would be free to practice in a more confident way which is focused on assisting patients to achieve the best treatments and outcomes in a manner that is collaborative.

Governance

What aspects of governance arrangements need to change or remain the same, to empower community based mental health services to deliver improved outcomes for consumers, families and carers?

93. I think the main aspect of governance which needs to be changed is how funding is managed. As I discussed below at paragraphs 99 – 109, I consider it to be a benefit that mental health services can access the two kinds of government funding. I simply think that each mental health service needs to manage each kind of funding together.

94. Overall, I think managing the two kinds of government funding would make mental health services more accountable to larger sections of the population.

At a service level, what are the merits and limitations of integrating the governance arrangements of mental health services and acute health services?

95. I support the integration of mental health services with acute health services as it leads to better outcomes for individuals.

Commissioning

Commissioning encompasses a large number of activities. From planning and purchasing services, to monitoring and holding providers to account for the delivery of agreed outcomes. Services may be commissioned for a whole population (e.g. geographically defined), a subpopulation (e.g. people with diabetes in a given region) or an individual (e.g. the coordination of a range of services for one person).

How can commissioning approaches support new care models?

96. I consider that commissioning services for the population, subpopulation or individuals is a good approach. However, in planning and delivering such services, the adoption of non-competitive tendering would lead to better results. This is because competitive tendering does not foster a sense of collegiality between mental health services if they are constantly required to compete for funding.

97. A better model would be to link the commissioning of those services to a degree of accountability. For example, if a service could show that people were improving once they had made contact with the service it would be granted the right to offer those commissioned services.

98. While it may be possible to link funding to the outcome of commissioned activities, it is inherently difficult to measure outcomes within the mental health system. Therefore, it may be more appropriate to link some level of bonuses rather than substantial funding.

What funding arrangements (mental health or otherwise) currently work well, and for what patient types or populations?

99. I consider that the 'missing middle' is a result of block and activity funding not being linked any meaningful way. The 'missing middle' represents the gap between the individuals who are provided with services funded by activity based funding, for mild to moderate issues, and those individuals who are provided with services funded by block funding for more complicated issues. It is the lack of integration between that funding which allows people to fall out of the system.

Integration of block and activity funded services

100. I do not necessarily consider that additional funding will fix all of the issues within Victoria's mental health system. However, enabling mental health services to dedicate additional time and resources to people, which requires funding, would make the most significant difference within Victoria's mental health system, not simply providing additional funding.

101. It is important that time is afforded to each individual. There is a concept of 'slow psychiatry' which involves not rushing to diagnose an individual, but instead taking the time to listen to that person and their situation before working with them to provide solutions to their distress. That process takes both skill and time. It also requires a lot of workforce training to ensure that that staff are well skilled and more experienced clinicians have time to train and mentor them. Additional funding would allow services to dedicate additional resources to such processes and, as a result provide, additional time to clinicians to spend with people.

102. Currently mental health services receive funding in one of two ways:

(a) activity based funding, which works well for mild to moderate problems and involves a service being provided with funding for certain activities being provided to an individual; or

(b) block funding, which is the state system, which allows a service to provide support to people who have more complicated or challenging problems.

103. Only being funded in one way presents risks that the service is not as efficient or effective as it could be. For example I am aware that services in the UK receive payment by results, which is similar to activity based funding. This results in services constantly needing to classify the 'severity' of individuals' mental health issues. While it is easy to diagnose and classify general illnesses, this becomes a significant challenge in the mental health space which requires a more flexible approach to classification and diagnosis.

104. I am also aware that a number of people in the mental health system prefer activity based funding, in order to avoid or prevent catchment zones from being used, however

I do not believe that such a system would work practically as it would require significant infrastructure and there are a significant number of impediments to such a system being implemented.

105. On the other hand, it is inefficient to have all services block funded as there is a level of efficiency which is promoted by activity based funding. Headspace has seen 3,200 individuals in the last 12 months, and some of that efficiency can be attributed to the funding being provided as a result of activities being undertaken.

106. However, across Australia the treatment provided by activity funded services often has no links to the services provided by block funded services. The lack of integration increases the incentive for services to 'handball' people to another service and results in the 'missing middle'.

Outcome based funding

107. No service in Australia currently reports on its outcomes and this should change to a greater emphasis on the reporting outcomes. The role of the Department of Health and Human Services and the Chief Psychiatrist could be to hold services accountable for recovery based practice, measuring outcomes and the quality of care provided by services.

108. Currently, there is also a very old fashioned system whereby the psychiatrist/clinician rates the outcome, rather than the patient rating the outcome. A system that allowed for the collection and measurement of patient outcomes as measured by patients themselves would lead to greater accountability for services.

109. There is also a question as to whether patient outcomes should also impact on funding. It is possible that there could be a bonus or monetary incentive for patient outcomes but there is an important need to balance wide access into the system and the need to provide effective outcomes.

110. There is a risk that the flow on from such outcome based funding may be that the system becomes overly 'incentivised'. There are moderate measures that can be taken, rather than strictly attaching funding to outcomes, Consideration could be given to whether a service is efficient, if patients are getting better and if there is ongoing continuity of care. To assess those things consideration could be given to reinstating the Chief Psychiatrist audits. They provided a level of accountability, and if this was matched with a more trusting and open approach that would be an ideal mechanism to allow services to understand their efficiency and effectiveness including in comparison to comparable services.

Forensic mental health

Drawing on your experience treating vulnerable children and young people either engaged with, or at risk of becoming engaged with, the justice system what, if any, are the key changes in the needs of this cohort over the past 10-15 years?

What have been your experiences of rolling out the Community Forensic Youth Mental Health Service at Alfred Health?

(a) What is the current service model?

(b) How do you engage with Youth Justice and other agencies?

(c) What has been the demand for the service?

(d) What, if any, have been your reflections on the effectiveness of the service?

(e) How many young people has the service supported since it has been in operation?

(f) What changes, if any, would you recommend to this service?

111. The Community Forensic Youth Mental Health Service (**CFYMHS**) at Alfred Health provides mental health support to youth who are experiencing mental illness and who are at risk of offending or have offended. It is a consultation service that provides forensic expertise to CYMHS services with complex clients presenting with forensic issues. It does not currently provide case management and treatment, although treatment recommendations are provided to assist referring services to manage their clients.

112. The CFYMHS program is based on young people presenting with problem behaviours, including interpersonal aggression and violence, threats, stalking, sexualised behaviour, arson, animal cruelty and other complex behaviour disturbance.

113. Female youth are more likely to enter the mental health system because there is a tendency towards self-harm and suicide, which is usually identified and treated within the mental health system. Young males, however, tend to act out with violence and aggression and as a result they usually do not get treatment within the mental health system. Instead they are dealt with solely by the justice system.

114. As a result the majority of individuals connecting with the CFYMHS service are male youth who have traumatic pasts and are acting in an aggressive manner.

115. The Community Forensic Youth Mental Health Service at the Alfred (Youth Forensic Specialist Service) has been in operation for over one year. In that period they have assessed a diverse range of young people, including a disproportionate number with diagnoses of Autistic Spectrum Disorder, or suspicions of autistic features. It has

become evident that this subgroup poses unique challenges for area mental health services to manage.

116. The current service model involves providing a dedicated mental health worker for the eastern and western regions of Melbourne. We currently have:

(a) 1.4 equivalent full time staff for the eastern region; and

(b) 2.4 equivalent full time staff for the western region.

117. These clinicians undertake primary assessments of youth who are currently within the justice system. YFSS are currently limited to primary assessments in the Southern metropolitan region and secondary consultations with the Eastern metropolitan region and Eastern rural Victoria. It has become clear that primary consultations are often necessary and more helpful to the referral services. It would be desirable to have sufficient resources to provide primary consultations to all of metropolitan Melbourne and rural Victoria.

118. Currently referrals to YFSS are limited to CYMHS in the different regions, but we have recognised the need to expand the referral services to include DHHS, Youth Justice, VFTAC and possibly privately practitioners including GPs, paediatricians and private psychiatrists.

119. YFSS have assessed seventy-five cases in the first year with approximately twenty primary consultations and fifty-five secondary consultations. YFSS would have conducted more primary consultations if we were permitted in the regions outside southern metropolitan Melbourne. We have lately offered primary consultations in these outside regions on a discretional basis in the response to the recognition that primary consultations are more useful.

120. Whilst Orygen provide forensic mental health services in custody, YFSS have provided services to Youth Justice in the community. This has also included young people who have been difficult to engage in the community and/or young people who have been incarcerated during the period when they were difficult to engage.

121. No further treatment or follow up service is able to currently be provided. Forensic work generally requires specific expertise that generic mental health services struggle to manage. A treatment arm to the forensic youth services is critical and would match equivalent Forensicare adult services.

122. We would like to expand the service to not just provide primary assessments, but to also assist with case management and provide initial support to youth who are progressing through the juvenile justice system and courts. I think that such an

expansion would strengthen the program, particularly as separating assessment and treatment of individuals with mental health issues can be difficult.

123. The CFYMHS program was implemented to address the lack of forensic mental health services available for youth within Victoria. Forensicare provides support to all adults with mental health issues and there was no comparable support for youth experiencing similar mental health and juvenile justice issues.

124. The biggest impediment to the CFYMHS program currently is a lack of resources and staff members. To expand the service to incorporate additional and further services would require a team of 7 – 8 full time employees who will then be able to provide ongoing treatment and case management.

Please describe your observations of:

(a) any good practice models of forensic mental health services for young people in contact with the justice system;

(b) any key changes and/or reforms do you consider would effectively support young people to better manage or resolve co-occurring mental illness and engagement with the justice system?

125. I consider Victoria is behind in this area. The state which has the most comprehensive and effective program is Queensland with the their child and youth forensic program

126. Forensic Child and Youth Mental Health Service (Forensic CYMHS). This large team is comprised of two main arms – 1) the Brisbane Youth Detention in-service or MHATODS – Mental Health Alcohol and Other Drugs Service, and 2) the community outreach service CYFOS – Child and Youth Forensic Outreach Service. While Queensland is a less populated state than Victoria, the Child and Youth Forensic Outreach Service operates over the majority of the state, encompassing locations as far north as Toowoomba.

127. The Child and Youth Forensic Outreach Service has grown over the last 10 years and I believe they now have the full time equivalent of 30 employees.

128. This service supports individuals up to the age of 18 and provides various services including:

(a) conducting evidentiary assessments including fitness to plead

(b) providing support to individuals in youth detention; and

(c) providing support to ensure individuals and their families can access the mental health service.

129. The Child and Youth Forensic Outreach Service is a very comprehensive support to the youth justice system in Queensland and I believe that with additional funding and time CFYMHS could provide a similar service in Victoria.

Workforce

In relation to adolescent and youth mental health, can you describe the capabilities and practices that underpin:

(a) multi-disciplinary care (that ensures the right people with the right skills provide treatment, care and support at the right times)?

130. Much of the difficulty in developing these workforce capacities comes back down to the philosophy of both the training received by clinicians and the workplaces in which they are situated. A philosophy that is focused on finding the exact problem with a person from an expert perspective and then providing the expert perspective indicated treatment and avoiding any risk will struggle to achieve any of these points. A service philosophy that is focused on outcomes, involving families and being directed by the needs and goals of clients is crucial

(b) consumer-focused care (that meets the individual and holistic needs of consumers)?

131. A vibrant and resourced peer workforce (both consumer and carer) is also helpful in anchoring the service to the experience of clients and their families and privileging the views of service users

(c) family-centred care (that works with people in their relational context)?

(d) recovery-oriented practice (that supports people to build and maintain a meaningful and satisfying life and personal identity)?

What prevents existing workforces from providing optimal care, treatment and support to young people, and what steps can be taken to overcome these factors (please consider factors such as workforce shortages, training, workplace supports)?

132. It is the underlying philosophies and culture of psychiatry which prevent the existing workforce from providing optimal care, treatment and support to young people.

133. Examples of these philosophies include:

(a) treating the individual without the involvement or support of their family and social network;

(b) focusing on identifying what is wrong with the individual; and

(c) treating the individual without considering all aspects of their life.

134. If these kinds of perspectives can be altered within the mental health workforce it would lead to positive outcomes for young people with mental illness.

135. Changing these kinds of philosophies will be considered radical by some within the mental health system, with some clinicians even disagreeing on a therapeutic level. However I believe that it is crucial to change these philosophies, and the overall culture of the workforce, before real change can be made to Victoria's mental health system.

136. The approach which is currently undertaken involves an individual attending a meeting with a clinician, absent from their family and social network, where various problem focused questions are asked, they are diagnosed with a particular mental health issues and more often than not medication is then prescribed. Open dialogue is a model which is able to address some of these concerns. In an open dialogue session you would have the individual and their family in attendance and you would listen to the experiences and perspectives all the people in the room, regardless of how different they may be to the experience and perspective of the individual. Once you have taken the time to understand those perspectives you can then work out a treatment approach in a collaborative way that will result in the individual feeling supported and involved in their treatment plan.

137. It should be noted that the approach taken by Headspace YEP is not radical, original or even particularly different. Similar approaches are used in other countries such as Finland, UK and the USA. Despite this, as far as I am aware, Headspace YEP is the only mental health service in Australia which adopts an open dialogue approach.

138. The aim of the open dialogue model is to give people as much responsibility and empowerment in their own life as they are able to handle. While some clinicians may think it is a radical approach, it is not discounting that an individual is ill, it is simply the process of listening and understanding before making a decision. Discussing an individual's issues and their options for treatment empowers the individual.

Housing for young people who have an onset of severe mental illness

Based on your experience at Alfred Child and Youth Mental Health Service and Headspace, to what extent do young people with an onset of a severe mental illness experience housing insecurity of homelessness and what are the characteristics of this cohort?

For young people who have an onset of a severe mental illness and are at risk of housing insecurity or homelessness:

(a) What are the characteristics of effective models of housing and support that would assist this cohort?

139. Up to 60% of young people with a severe mental illness are also experiencing homelessness or housing insecurity. The key to supporting these young people is implementing an early intervention model.

(b) Are there models, approaches, or programs in other jurisdictions (either in Australia or internationally) that Victoria could learn from to better support his cohort?

140. Victoria has a great program which could be provided with more funding to better support this cohort of young people, being the Education First Youth Foyers.

141. These Foyers are all tied to a TAFE institute and provide young people with supervised accommodation while they undertake an education program through the relevant TAFE.

142. There are currently three Foyers in Glen Waverley, Broadmeadows and Shepparton. I think it would be beneficial to roll out additional Foyers in the south of Victoria, particular around Frankston and the Peninsula regions. However, to provide this level of additional support requires significant investment, including capital investment.

143. Programs such as Foyers are important as they are early intervention models, rather than attempting to treat young people once the issues have already become entrenched.

144. For later intervention, I think the most ideal model is again integration. An example of an integrated approach may be having a housing worker being integrated into the relevant mental health team. At Headspace YEP we have previously had a housing worker from the Brotherhood of St Laurence work within our mental health team three days per week. The feedback from our staff was overwhelmingly positive and requests were made for the arrangement to be extended to five days per week.

(c) What is working well and what could be improved in Victoria's current approach to the supply of mental health accommodation options for this cohort?

145. There is a shortage of supportive accommodation for young people with mental health issues.

146. The most common issue we have identified is that most refuges will not tolerate drug use and this is problematic because many young people experiencing mental health issues want to keep using drugs. Two groups of homeless young people with mental illness that are particularly difficult to find suitable accommodation for are those also with active drug problems and those with a significant forensic history. Ideally dedicated programs could help these young people who are currently ending up on the street or in rooming houses.

147. There are good models of care, for example in Moorabbin there is supportive accommodation for young people with mental health issues. I have received feedback from my staff members that the interview process to be admitted to that accommodation is grueling to ensure that the young person will fit in and spaces are at a premium.

148. I think the major improvement to Victoria's current approach should be to fund existing and additional programs which are specifically targeted at this cohort of young people with severe mental health issues who are experiencing homelessness or housing insecurity.

What are your observations of the emerging changes in demand for mental health services as a consequence of COVID-19?

Social Context

149. Family life has changed and this has caused a lot of stress and pressure on family relationships. From stress and uncertainty to reduction in social connection, households are together in ways that they have never been before. Otherwise healthy relationships are burdened, and there is a lot of grief and loss about the changes to life and relationships.

150. Young people are particularly at risk as their education, independence, connection with peers and the social world outside of the family are impacted. Adolescence is a time when these things become emphasised, and are particularly important to the health and wellbeing of young people. Also pre-COVID-19, young people already had much uncertainty about their future with climate fears and other social concerns. They now have to contend with these along with a future likely to have major economic consequences from the pandemic.

Impact on Child and Youth Services

151. We have had an increase in intake calls for clients who would not require a Tier 3 multidisciplinary service but are unable to afford private practitioner gaps due to job losses with parents.

152. We have had an increase in the number of calls due to COVID-19 related anxiety. Many young people on the margins, i.e. tenuously attending school or with limited social supports, are really struggling to cope.

153. There appears to be an increase in family violence including adolescent violence in the home.

154. Our usual referrers are closed, for example schools, or offering less comprehensive monitoring, i.e. child protection, so there are less eyes on vulnerable children.

155. Our Mental Health Intellectual Disability – Youth (**MHIDI-Y**) team has been more of a crisis response, as many families with young people with an intellectual disability are struggling due to the decrease in respite options, structured routine and school closure.

156. We have seen a massive increase in presentation of young people with serious eating problems. It is impossible to say whether this is linked to the COVID-19 crisis. However, we can speculate that the occurrence of eating problems and other crises of adolescence, are likely to increase in this context given the points above. We also know that eating problems often manifest due to fears of the future, a sense of loss of control in life, underdeveloped coping mechanisms to deal with life, and struggles to cope with independence and the increased demands of emotional and social maturity.

What are your observations of the emerging changes in mental health service delivery as a consequence of COVID-19?

157. Obviously, mental health service delivery has had to adapt quickly in this time and adopt technology that enables virtual meetings and telehealth. This has its limitations, in terms of relational attunement and therapeutic processes. It also has advantages, allowing people to be together (virtually) from different places. For families, this has probably allowed some improved flexibility and opportunity for participation, and in some ways it has brought treatment into their world, with families being seen in their own environment.

158. We continue to see families face to face with appropriate screening and social distancing - this is particularly important for families with complex problems where there are high risks and where it is important to maximise engagement and get off to a good start.

159. Young people with attachment difficulties can sometimes experience telehealth as invalidating as the service prioritises "risky" and "serious" presentations face to face.

160. With milder individual presentations, for example in our Headspace Primary service, telehealth has been implemented relatively seamlessly especially for existing clients where engagement has been established. Some young people are finding the Telehealth more engaging and having shorter but more frequent contact which they are reporting as helpful. There have been some efficiencies for both staff and families with Telehealth with reduced travel and convenience.

161. What is certain is Telehealth is only as good as the strength and reliability of the internet connection and when aligned with preferences of families.

162. Although face to face delivery has had to reduce in this context, for young people with eating disorders this has not been as possible due to the physical health care needs

that effective treatment includes. The COVID crisis has probably helped us to take a better account of this in the mental health setting and develop our practices in this regard. With the risks and restrictions on hospital based medical care, the physical health care of young people with eating disorders has shifted more into community mental health care context, which is appropriate and has helped treatment to become more integrated.

163. We have not been able to sustain some areas of orientation and practice development with staff through telehealth especially in respect to family based interventions.

Could these changes emerge into longer term opportunities for new approaches to service delivery, for the benefit of you people, their families and carers?

164. I am certain we will continue to use Telehealth more into the future. It will increase the choice in the way families can engage with us.

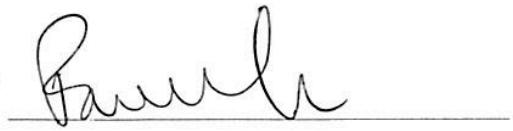
165. A major benefit is providing more choice and options for families. Our youth advisory group and group programs at headspace have reported improved attendance and engagement through Telehealth. Almost certainly for "milder/moderate" problems and individually focused treatment Telehealth can be a definite option. For existing clients who already have strong engagement it can also be an option.

166. For some complex situations it can also be of benefit for some hard to reach young people and families. For new and more complex presentations and much family work it seems more effective working face to face.

167. Some meetings as well have been more efficient and effective via telehealth.

168. The shift of focus from medical care to mental health care for the treatment of eating disorders results in better outcomes. However if such changes are to be sustained then the mental health system needs to be equipped more to provide more in-home care and intensive family based treatment with clinicians trained in meal support and meal time interventions

169. There is also a need to have increased out-of-hospital nutritional interventions, either in home or ambulatory systems that allow for nasogastric or bolus feeding to support treating teams and families to keep young people at home and out of hospital.

sign here ▶ 

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