Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF ALESSANDRA RADOVINI

I, Associate Professor Alessandra Radovini, Consultant Psychiatrist, of, 50 Flemington St, Travancore, Vic 3032, say as follows:

Professional background

1 My name is Associate Professor Alessandra Radovini MBBS DPM RANZCP Cert Child Psych.

2 I am a child and adolescent psychiatrist. Currently, I am the Director of Mindful, Centre for Training & Research in Developmental Health (**Mindful**) in the Department of Psychiatry at the University of Melbourne. I am also currently a consultant psychiatrist at Orygen Youth Health (**Orygen**).

3 My previous roles have included the following:

(a) I was a Senior Advisor for Youth Mental Health in the Mental Health Branch, in the Department of Health and Human Services (**DHHS**) for a period of 12 months in 2017. This was a secondment to contribute to initiatives in out of home care and youth justice areas for young people.

(b) Between 2012-2016, I was the Clinical Director of headspace, the National Foundation for Youth Mental Health. headspace is a commonwealth government initiative designed to provide early access to mental health services for young people aged between 12-25. This is done through headspace centres, eheadspace and school support programs.

(c) Between 2009-2011, I was the inaugural Chief Child Psychiatrist in the Office of the Chief Psychiatrist with the Victorian Department of Health (now DHHS). This position was created as part of the Victorian Mental Health Reform Strategy to focus on the needs of children, young people and their families.

Please note that the information presented in this witness statement responds to matters requested by the Royal Commission.

(d) Between 2007-2014, I was the Victorian Director of Advanced Training in Child and Adolescent Psychiatry for The Royal Australian and New Zealand College of Psychiatrists.

(e) Between 2001-2007, I was the Clinical Director of the Child and Adolescent Mental Health Services (**CAMHS**) in Bendigo.

(f) Between 2000-2009, I was a Consultant Psychiatrist at Orygen working in the Intensive Mobile Youth Outreach Service (**IMYOS**).

4 Mindful is the Victorian state-wide child and adolescent mental health teaching and training unit which hosts postgraduate and professional development courses and workshops for clinicians working in Child and Adolescent/ Youth Mental Health Service (CAMHS/CYMHS) and professionals in other sectors such as education, welfare and private practice. My role is to provide leadership across all of Mindful's teaching, training, research, engagement and administrative activities.

5 I additionally contribute to teaching and learning across multiple levels including direct teaching, supervision of psychiatry trainees, development of training materials, subjects and course development and coordination. I also have an advisory role in the planning and development of new courses and training workshops.

6 I participate in a board range of engagement activities at the local, state and national government levels. For example, I consult with DHHS, the Department of Education and Training (**DET**) and present at conferences in relation to issues around child and adolescent psychiatry.

7 I also provide leadership as one of the consortium partners in the Take 2 Program (the Victorian Specialist Therapeutic Service for Children in State Care) together with Berry Street Victoria, Latrobe University and the Victorian Aboriginal Childcare Agency.

8 I am giving evidence in my personal capacity.

9 I attach my curriculum vitae as exhibit **AR-1** to this statement.

QUESTIONS FOR PANEL MEMBERS

Question 1: 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?

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

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

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

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

10 In my opinion, an ideal community-based mental health service would include a continuum of service delivery for adolescents and young people with mild, moderate, severe mental illness and those who are in crisis or are inpatients. The governing principle should be 'the right help, at the right time delivered in the right way'. Currently, we have fragmented services where young people do not flow seamlessly from one service to another depending on their needs and the severity of their mental health at a point in time. Part of the current fragmentation, in my view, is based on resource limitations, and funding coming from different levels of government who have different key performance indicators, different criteria for eligibility and sometimes are limited by catchment restrictions.

11 Firstly, service offerings for young people and adolescents should be integrated, accessible and responsive and should be in a form that is acceptable to them in their age group and be also acceptable to their families. Interventions should be evidence based or using the best available practice wisdom. Secondly, mental health treatment alone is insufficient in caring for adolescents and young people. Mental health care, needs to be integrated with other important sectors such as health, education, child protection, youth justice, youth housing and other more generic services in order to provide holistic care for young people.

12 For adolescents and young people who are at risk of developing mental health issues, or are experiencing mild to moderate difficulties, services that are easily accessible (such as in schools) are ideally placed to offer assistance in a non-stigmatising environment. School staff are often the first to recognise that a young person is facing difficulties and are able to offer early intervention. I discuss the CASEA (CAMHS and Schools Early Action) Program in Primary Schools and the Doctors in Secondary Schools (**DiSS**) Programs at paragraphs 17 below as examples of services within schools that can offer early intervention (including, psychoeducation, emotional regulation, stress management and parenting interventions).

13 For adolescents and young people experiencing mild and moderate illness, what is required is easy access at low, or no, costs to services, delivering mental health interventions that are both generic (including psychoeducation stress management, problem solving skills and parenting support) and specific mental health interventions (such as psychotherapies and psychopharmacology). These services should allow for easy entry and easy exit into services as needed. This should include options for online assistance that increase choice and options for how young people seek care.

14 For adolescents and young people living with severe mental illness, ongoing holistic care (including the integration of psychotherapies and psychopharmacology) that is not time limited is required. This system should include an outreach capacity. There is a well-developed IMYOS model in Victorian CAMHS/CYMHS that provides mobile intervention to high risk and difficult to engage young people. There are also less developed models of Youth Crisis Assessment Teams (YAT). Both these models could be extended to provide more outreach and in-home interventions. These would need adapting for the geographical challenges of rural services Easy access to bed-based services when an adolescent and young person requires extra support is necessary, however, they must also remain well connected to educational and vocational services together with other holistic services such as housing supports. This is also a challenge for rural services as currently all adolescent in-patient units are in Melbourne. Some rural services use paediatric beds in local hospitals for short stay interventions, but this needs better funding and the development of such shared models of care. I consider that for adolescents and young people living with severe mental illness that other factors also need to be inbuilt such as the integration of an alcohol and other drug (**AOD**) capability, as well as understanding of neurodevelopmental disorders such as intellectual disability or the

autism spectrum disorders as these are often co-occurring, require more expert knowledge and skills, and lead to poorer outcomes if missed or not adequately treated.

15 In terms of families and carers, this is central to supporting adolescents and young people. In providing treatment to adolescents and young people, family sensitive practice and the involvement of families as developmentally appropriate is highly important. The involvement of parents /carers might include:

(a) provision of information or psycho education;

(b) assisting parents reflect upon the adolescent's socioemotional developmental needs, family interactions and their own parenting;

(c) assisting parents managing the interface between their adolescent and broader community systems; and

(d) assisting parents where issues such as unresolved trauma, mental illness are affecting their parenting capacity.

Being able to engage and develop partnerships with parents that are collaborative and support both the adolescent and parents is required.

Question 2: What are best-practice examples of community-based mental health care for adolescents and young people? Why do they work well?

16 In my view, headspace centres and eheadspace are examples of best practice in community-based mental health care for adolescents and young people living with mild to moderate mental illness. These centres are accessible and are no, or low, cost services. They are also acceptable to young people. By that I mean young people are willing to attend these centres because headspace is known and trusted as a service specifically for young people. I have observed that this has enabled earlier intervention in relation to young people accessing the service. headspace centres are often easily accessible as they are in shopping centres, in main streets or are easily located for young people and their families. This ease of access is also key in the uptake of these services by young people. Some headspace centres also are well-connected and supported by state tertiary mental health services for young people who may have more severe, complex or enduring mental illness and a need for a greater range of treatment options. This has included co-location of headspace services with tertiary mental health services.

The co-location of multiple service providers at headspace centres means that irrespective of a young person's mental health or health concerns, they will be able to access the correct level of service without having to access multiple services. This 'single point of entry' minimises the risk of young people falling through the gaps and makes the pathway to care easier to navigate and less confusing for young people and families. In providing access to a mental health clinician on-line or by phone, eheadspace increases the choice for young people and is especially important for those who historically, 'can't, don't or won't' access in person services. By this I mean young people who are isolated (especially geographically) and those subgroups such as Indigenous, refugee, CALD, LGBTIQA+ who are underrepresented in in-person services or who are reluctant to seek help for various reasons such as of stigma.

17 I also consider that with some improvements, access to services in a school setting such as the CASEA Program (as identified at paragraph 12 above) is also a successful model, as is the DiSS program. The CASEA Program was rolled out in Victoria about 10 years ago. It began as a pilot program funded by the Mental Health Branch of DHHS and is an example of having mental health clinicians in primary school settings. School staff are in a position where they often can identify students at risk, or those experiencing mental health problems in the school environment, often presenting as behavioural or emotional dysregulation. Under this model, the mental health clinicians based in schools are able to assess a student, provide support to school staff and deliver interventions to the student in the school environment without referring the student to outside services. The benefits of this is that there is assurance that the child will access services because it is not contingent on a service accepting or declining a referral and solves some practical issues such as a parent being unable to take a child to appointments. Similarly, the DiSS program (funded by DET) which commenced in 2018, has local GPs working in the school setting who are able to identify at an early stage, young people with a range of health and mental health problems. In my view, these programs could be rolled out more broadly across schools in Victoria. This would provide additional mental health capability and capacity in schools to the current Student Support Officers and pastoral care professionals. It would also facilitate more nuanced and appropriate referral pathways to CAMHS/CYMHS and offer better supports for students in schools

18 Finally, a better Continuum of Services Delivery would be achieved if headspace centres and/or primary care providers and tertiary mental health service were integrated or co-

located where possible. This would allow for a more accessible stepped care approach offered to adolescents and young people if their mild or moderate needs increase. I am aware, for example, that Alfred Health's CYMHS and Orygen are lead agencies having a number of headspace centres and have tried different ways of doing this. This has allowed for some overarching organisation and coordination for a young persons' mental health at the mild, moderate and severe levels in the catchment areas of these services. Having said this, the entire system for adolescents and young people is underfunded and compounded by a maldistribution of resources not only across the state but also in different parts of metropolitan Melbourne. This significant unmet need has the effect that young people 'fall between the cracks' between primary and tertiary care, or more recently between generic and specialist care - this is referred to as the 'missing middle'.

19 This service delivery gap (the 'missing middle') for young people with moderate to severe and complex mental health issues results because headspace centres in the main, are not equipped to manage severe mental health issues and do not have the capacity, or expertise, of tertiary mental health services. Conversely, tertiary mental health services may take the view that a young person's mental health problems are not severe enough to be eligible for their services. There are also many young people who do not have easy access to a headspace centre in their local area. Further, there may be a fragmentation in relation to catchment areas. For example, I worked in Community Health Centres in the Sunbury and Romsey areas in 2019, as part of a new initiative 'Enrich' to provide care for the 'missing middle' young people. There are no federally funded headspace centres in those areas, which have two tertiary mental health services in their respective catchment areas (Sunbury is Orygen and Romsey is Bendigo Health). This causes practical problems around accessing, identifying and matching up services in those areas. Further, making referrals in these areas can be quite confusing and time consuming.

20 The 'Enrich' program is an example of some Primary Health Networks (**PHNs**) are attempting to fund the 'missing middle' gap for young people with complex needs. I am aware that one PHN, in partnership with Orygen, has funded psychiatrists and Senior Mental Health Clinicians to work in community health centres which allows young people with more complex needs to be treated within those community health centres. Ideally, we would also have an easier way to step up a person's care and to make referrals, if a young person's mental health deteriorates and increases from moderate to more severe.

I consider this to be a creative response to a service gap which has had success. The partnership trial between the PHN and Orygen was due to be completed at the end of 2019 but was extended. This model came about because Orygen and a number of community health services submitted this solution to a PHN and noted that this model would not only provide service delivery, but would be a more economically efficient solution. I would suggest this model could be rolled out even further. The use of telehealth for both primary and secondary consultations would further support clinicians in rural and regional areas.

Question 3: Should services for children, adolescents and youth be streamed by age, and why?

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

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

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

21 This is a complex question of how best to design services and what criteria to use, 'age' being just one consideration. Most importantly services need to be able to consider the developmental needs, not just the chronological age, of the child across the 0-25 age range of CAMHS/CYMHS. Currently, some services may see a 5 year old, a 15 year old and a 20 year old within the same team whilst in other services, teams are divided according to age (for example, 0-12, 13-25). It goes without saying that this age range encompasses enormous developmental differences, but there are also enormous differences in children of the same chronological age. As such, a more nuanced approach is required than strict age-based streaming. Currently, the decision of how to organise teams is based on the size of the services, the training of staff, and sometimes the need to quarantine resources across the age range. Further, these age cohorts have implications for staff training and recruitment, the scope of practice, the range of interventions offered and the physical layout of services. In relation to staff that work in the 0-25 age range, my impression is that some staff have a preference for an age group and they specialise in that age group. This limits staff's capability to be able to best treat other age groups at the service. Additionally, in my experience, risky behaviours of adolescents and young people (for example self-harm) and the volume coming to a

services can mean that they are prioritised before the needs of younger children in terms of resources.

22 Further, age-based streaming does not necessarily take into account neurodevelopmental difficulties that some children, adolescents and young people may face who have mental health issues, such as learning disorders, ASD and intellectual disabilities. The ages of these clients may not represent their developmental needs. Young people with disabilities, trauma backgrounds or with severe or chronic illness often function at a level well below their chronological age.

23 Another complication of age-based streaming is the differences in age cut-offs between mental health (where the cut-off is up to 25 years old), child protection and the youth justice system (where the cut-off is up to 21 years old) and secondary education (where the cut off is 18 years old). Some uniformity, where possible, across areas that impact adolescent and young people would assist in coordinating mental health service delivery and other issues that these young people may face.

24 I can see advantages in age-based streaming in terms of a distribution of resources and in staff developing expertise in working with that cohort. However, overall, I consider age-based streaming can create barriers and disruption to continuity of care if rigid age boundaries are in place (for example under 12, 12-18 and over 18). Historically transitions in care have often been difficult. These rigid age ranges become very problematic for regional and rural services that tend to be smaller in their service offerings and have greater difficulty recruiting staff.

25 Other models have streamed clients according to disorder groups (for example, neurodevelopmental disorders, anxiety, mood, psychosis etc) or according to perceived length of treatment required (for example, short-term versus longer term intervention). However, streaming based diagnostic categories or on the length of treatment implies the ability to accurately decide and assess treatment needs at the outset, which is not always possible.

26 There are some services that do not use age-based streaming. For example, some CYMHS do not use age-based streaming in all their services. However, this may be based on their resourcing constraints. For example, there are two clinicians in the Swan Hill and Castlemaine area for the entire population so there is no age streaming for children,

adolescents and young people. Regional and rural services also are not able to often offer age-based streaming because they have insufficient resources. So, in considering streaming models, what may work in metropolitan Melbourne may not have equal workability in other Victorian regions.

Question 4: How can Victoria better identify and support adolescents and young adults who need extra support for their mental health?

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

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

27 My experience is that if you can establish and enable access to mental health care in services that feel welcoming and appropriate for young people, young people are more willing to attend those services because there is less stigma. However, stigma continues to exist around mental health care for children, adolescents and young people and needs to be addressed. Community awareness campaigns are necessary to decrease stigma and to give adolescents and young people clear information about where to go if they have mental health concerns. This may be a specific service for young people like headspace or locating services in places such as schools, or online. These options address the issues of access and acceptability and give choice.

28 The next principle is that of integration both vertically (across prevention, early intervention and mild, moderate and severe mental health needs) and horizontally (across sectors such as education, welfare, justice and housing). I consider that this principle of integration and holistic care to be essential, however, it is the execution of these ideas that must be properly resourced and implemented. As indicated in paragraph 10 above, currently the system is a fragmentation of services that all have different eligibility criteria, different funding arrangements, different accountability measures and different key performance indicators that leads to siloes of care being developed. Establishing a 'no wrong door policy', clear bidirectional referral pathways, education, training and recruitment of professionals in each sector to understand young people's mental health and other needs is also essential. In order to provide integrated and holistic care, what is

required is not only principles and policies of co-operation and collaboration but for the sector to be supported and ultimately funded do properly do this and for organisations and all levels of government to be held accountable.

29 There are particular populations of young people who have an increased risk of developing mental health problems such as young people in Out of Home Care and those in the justice system. Whilst having the greatest needs and often facing layers of disadvantage, these young people receive less mental health care than other groups of young people. Similar to the approach in schools, there needs to be greater overall awareness of staff who work in these 'out of home' and justice systems to ensure they can identify mental health issues at an early stage and assist young people in accessing pathways for mental health support. There also needs to be appropriate resourcing to facilitate this whilst young people are in State-care or the justice system and to offer linkages to ongoing care within the community. So far this has only been done in a piecemeal fashion.

Question 5: What are the professional mindsets, capabilities and skills that are needed for working specifically with young people in mental health?

(a) How do they compare with the professional mindsets, capabilities and skills that are needed for working with adults?

(b) What prevents existing workforces from providing optimal care, treatment and support to young people, and what steps can be taken to overcome these factors?

(c) What capabilities and skills are needed within the workforce to better engage with parents and carers of young people as partners in their care, treatment and support?

(d) What are the implications of the required professional mindsets, capabilities and skills you have identified above for the composition, training and deployment of:

(i) clinical workforces?

(ii) non-clinical workforces?

(iii) workforces in other service settings who may identify presenting mental health needs in young people (e.g. education staff)?

30 The mental health clinicians that work with young people must, in my view, firstly have an interest in working with adolescents and young people and be able to work with their families and the systems around them. The workforce must have a thorough understanding of adolescent development and the challenges and tasks of adolescence, an understanding of childhood disorders that continue into adolescence (for example, neurodevelopmental disorders), an understanding of disorders that emerge in adolescence, an understanding of the impact of psychosocial stresses and childhood trauma and knowledge and skills about appropriate evidence based interventions for young people. The skills required include the ability to engage, collaborate, be transparent, work holistically and avoid coercion in treatment (i.e. the idea that you work collaboratively with a young person– a "done with" not a "done to" approach). It is also essential to be flexible and adaptable when working with adolescents and young people (for example, being able to offer office-based and outreach support, being able to work with different developmental ages and the ability to be able to adjust approaches around language, communication and the use of visual augmentation and the like). I also consider that it is essential for the workforce to have

education and training around the importance of supporting parents and carers and how to work together with families. Finally, staff must also have an understanding and an ability to work collaboratively across service sectors that involve young people such as education, child protection and youth justice.

31 The skills and capabilities identified in the paragraph above, would largely be considered as good care in adult mental health services. However, working with adults tends to be more 'disorder' based, focussed on the individual, be more language-based and conducted within an office environment. There is greater variability across the complexities of adolescent development and stages of cognitive, emotional and language development that needs to be considered than when working with adult clients. A twelve year old is very different from a 20 year old developmentally. My experience suggests that mental health workers from the adult sector, tend to find engagement with young people and their families very different to working with adults because of the above.

32 Currently, in my view, the workforce is not able to provide optimal care and treatment to young people based on under resourcing in the sector. There is insufficient staffing levels to meet the mental health needs of the community, including children and young people, which means current staff have extremely high caseloads and are put under substantial pressure (particularly where there are waiting lists and waiting times for new clients). A culture of 'do more with less' has permeated the sector based on this under resourcing which can result in difficulty recruiting and retaining staff in tertiary mental health services (particularly in rural areas further compounding the problem). There is also a need to adequately support clinical staff who work in high stress areas (for example, in-patient units) and staff who can work with complex and high-risk clients. As such, things can go wrong when working with young people in tertiary settings who are very unwell and there can be cultures of blame if adverse events occur. The volume, the complexity, the risk, and the perceived lack of support tends to discourage staff from working in this tertiary mental health space. This is particularly so if staff can work in private health or other organisations who do not treat clients with severe mental health issues, pay more, and where there may a reduced workload. Further, in my view, there is not enough investment in staff training and ongoing supervision and mentorship to embed training into practice, particularly for junior or less experienced staff. This is again based on under resourcing.

33 Fundamentally, it is my view that young people who are supported by family will do better than young people who have no such supports. Working with families and carers is

therefore essential in working with adolescents and young people. To achieve this, firstly, the workforce must have awareness and education about the evidence that working with parents and carers results in good outcomes being achieved for young people. There additionally needs to be staff training to develop skills in working collaboratively with parents, families and carers and providing support to these adults in their parenting role. In addition, there needs to be a greater awareness of the psychosocial stresses in families and on parents (for example, the impact of marital discord, unemployment and unstable housing). Consideration needs to be given to the needs of parents whose parenting role is impacted on by mental illness, drug and alcohol problems, physical ill health or disability. There also needs to be additional awareness around the issues of family violence and child abuse and appropriate responses. These are complexities that need to be recognised when staff work with families and carers.

34 In working with families, the workforce also needs to have a better understanding of concepts such as consent, capacity, privacy and confidentiality and how these apply to young people and their family. For more junior staff, this comes from supervision and mentorship by more experienced staff in order to provide optimal care. From my experience, sometimes a young person may refuse engagement with their family because they are trying to express their independence as part of their developmental stage, rather than there being any serious family issues. A more junior staff member may see this as a young person refusing consent for engagement with their family and take it at face value. Additionally, a more experienced staff member may also be able to identify where there are some very serious and legitimate reasons why family engagement may be counterproductive (for example, family violence issues). Formerly, there were staff in services whose role and training was specifically around working with families, for example, family therapists. However, as funding has gotten stretched, these specialist positions are now rare. My view is that these family specialist roles should be re-introduced and funded within services. Additionally, family peer workers who provide support to families and who can offer a carer perspective to an organisation have been very welcomed in making services more family sensitive.

35 Finally, in my view, there needs to be appropriately trained staff in sufficient numbers that are clinical, non-clinical and from other sectors to provide holistic care and treatment to adolescents and young people. There needs to be clear pathways of care from clinical services to non-clinical services and vice versa and skill development and time allocation

to support collaborative work from all staff, irrespective of their roles. This collaborative approach is currently not happening universally.

COMMUNITY MODEL OF CARE

Barriers to the delivery of effective community-based care for adolescents and young people

36 I consider the key barriers to the delivery of effective community-based care is the lack of awareness of mental health problems around adolescents and young people and the continued stigma our society has around mental illness. I further consider that access to appropriate services that are acceptable and accessible and that offer a continuum of service delivery to also be key barriers. Finally, cost may be a barrier for adolescents and young people receiving appropriate care in the community.

37 As discussed above in paragraphs 16 and 18, the co-location of holistic services in a low stigma environment that are accessible and appropriate for young people is key in having them engage with a service. Additionally, in dealing with adolescents and young people, different platforms of care must be developed and rolled out. For example, digital and online solutions are key for this age group as indicated by the success of eheadspace (headspace's online offering). However, online and digital solutions must be able to refer young people to in person services to avoid a young person getting a siloed/ in adequate approach in their care.

Identifying infants and children who are at risk of developing mental illness

38 For infants at risk of developing mental illness, I consider that maternal and child health nurses are key in identifying this risk given the near universal uptake of this service. This could be augmented with in-home visit programs for at risk populations. Assisting first time parents and at-risk populations, for example, teenage parents or premature or unwell babies, is important. There needs to be an understanding of 'red flags' around 'normal' infant development and early referral for further investigation when these flags are raised.

39 For children at risk of developing mental illness and vulnerable families, there needs to be greater awareness about social and family issues, such as family violence and other family welfare issues, which impact on a child's wellbeing. Additionally, there needs to be a greater awareness that academic underachievement and behavioural issues may be

'red flags' for identifying a child at risk of possible mental health issues. Programs such as CASEA and the *Tuning into Teen- Whole School Approach* are designed as prevention, early identification and intervention of at risk children/ teens. The Whole School Approach (WSA) combines a 3-pronged program simultaneously targeting 1. teachers [*Tuning into Students]*, 2. students [*Tuning in to Teens for Teens]* and 3. parents being offered a modified version of the parenting intervention]*Tuning into Teens- brief version]*.

Identifying children who are experiencing or living with mental illness

40 For children experiencing, or living with, mental health issues, there needs to be more support inbuilt into schools, both in the classroom environment and outside the classroom. There needs to be the capacity to adapt curriculums, have more flexible learning environments and support children to have better and positive peer interactions and engagement in activities and hobbies. Support for parents and carers in the home is also essential. Specific in-school program such as CASEA, Tuning into Teens Whole School Approach and DiSS, provide additional mental health support to school communities.

41 Finally, training, support/supervision and pathways to specialist mental health care need improving to enable GPs, paediatricians, and other allied health professionals working in private to better identify and assist 'at risk' infants and children or infants.

Services and types of care in the community-based mental health system for infants, children and their families and carers

Similar principles as outlined above apply to services for younger children and their families. Community-based mental health services must deliver care and services that are evidence-based, flexible and adaptable so they can be offered, as required, to children and their families. Home outreach and the capacity to provide direct support and work with parents is even more essential when treating infants and children who are more susceptible to the impact of psychosocial stresses in the home and who are unable to advocate for themselves. Younger children are more likely to present with emotional and behavioural dysregulation as non-specific signs of their distress, or responses to adverse events in the home as well as these being signs of mental health disorders. This needs careful and sensitive evaluation. There is considerable evidence-based practice related

to working with parents that should be available within CAMHS and there is a range of evidence-based parenting programs that should be universally provided through CAMHS. One example is the Victorian model 'Tuning into Kids' based at Mindful. The mental health workforce should be trained to deliver these parenting interventions. Evidence-based Parenting Programs such as *Tuning into Kids Teens* train clinicians to work with parents in a non-stigmatising way to better understand and manage their child's emotional and behavioural distress. There is clear evidence for the efficacy of these programs but again these have not been funded and universally rolled out for maximum effect instead it has been left to individual organisations to fund this training in a piecemeal way. This again results in pockets of expertise only.

42 The ability to work across sectors is essential when working with infants and children in terms of the different services that they may need (including physical health services). Mental health services need to work closely with GPs, family support services, child protection, adult mental health and disability services to provide holistic care for younger children and their families.

ALCOHOL AND DRUG USE

Best practice responses for young people with co-occurring mental illness and problematic AOD use

43 AOD use is highly prevalent in young people with mental illness. It is important to understand and accept that many young people recreationally use drugs and alcohol in our society but for some young people with mental illness this becomes problematic and impacts on their mental state and recovery. It is important that there be the capacity to diagnose problematic AOD use, as a co-morbid mental health issue and be able to attend to both. This is not always the case and exacerbated by the fact that mental health and AOD services may not be concurrently delivered in the same services in Victoria. My understanding is that AOD and mental health services are separated because of the history of both sectors. In adult models of treatment for problematic AOD use, the focus is on a person wanting to change and being self-motivated to change. This is different for young people who may not have the ability or maturity to access AOD treatment because they may not yet recognise their AOD use as problematic or negatively impacting their mental health. Young people require an integrated service for AOD and mental health treatment either with dual trained clinicians or co-located clinicians that can work together

with the young person and families and also offer support to families. Integrated care to a young person with a dual diagnosis of mental health and AOD issues is essential.

Integrated care for young people living with co-occurring mental illness and problematic AOD use

44 I refer to my responses in paragraphs 27-28 in defining integrated care. I further note that an essential way to achieve integrated care is through multidisciplinary teams offering holistic care and treatment to young people with co-occurring mental health and problematic AOD use. This means all clinicians being part of the one service and there being integration in treatment, case management, team meetings and clinical reviews in order to achieve the best treatment results. This is particularly so when there may be pharmacological treatments that need to be provided for AOD issues (such as opiate substitution therapy) and issues around withdrawal, as well as mental health and other physical health needs. In my view, a young person with a mental illness cannot and should not be expected to go to another service to receive treatment for an AOD issue. This is fragmented care and is therefore poor care. In addition, this increases stress for families trying to negotiate different services. Mental health services are complex to navigate, and I do not consider that it should be the responsibility of a young person or their family to navigate what services they require or what part of a service they require. I make an example that a person is not expected to work out what level or part of a cardiology service they require for a heart problem. In my view, a young person simply needs to attend a service virtually or in-person and be able to say, 'there is something wrong'. A process should then be undertaken around them to decide what level of care they need and how and when those treatments will be offered.

New roles, training and development to enable integrated practice for the mental health and AOD workforces

45 It is essential to have dual trained clinicians (this would be the ideal) or co-located clinicians trained in mental health and AOD problems for young people in integrated services. Mental health workers, in particular, need to better identify and manage problematic AOD use and AOD workers conversely need to understand that mental health problems may present initially as AOD problems and be able to identify this and respond appropriately. Generally, these problems are intrinsically linked and cannot be

pulled apart such that a young person can be separately treated. Training, supervision and dual expertise is the key.

FAMILIES AND CARERS

Family and carer engagement in delivering effective care to adolescents and young people

46 Family and carer engagement is critical in the delivery of effective care. I refer to paragraphs 15 and 32-33 above where I discuss the importance of family and carer involvement. As indicated above, the outcomes for adolescents and young people with family/carer supports is much better than young people who do not have these family supports. Other supportive adults (for example, teachers, coaches and mentors) can also play and important role for young people.

47 I explore the enablers and challenges for successful family and carer engagement in paragraphs 41. Other issues that may pose as challenges to successful family/carer engagement include parental mental illness, poverty, family violence and parent unemployment.

DIGITAL TECHNOLOGY

Factors that encourage or discourage young people to access or use digital technology for mental health services

48 Digital technology is essential in engaging and providing services to adolescents and young people. In my experience, this cohort will generally google and research mental health issues and services before they access them. My view is that adolescents and young people also find accessing services through digital means less anxiety provoking than in-person services which means they are more likely to access a digital service if that option is available. Virtual tours of services may help young people understand what is on offer and where they may progress in their treatment to allay anxiety. Digital options are also free or low cost which is very important when appealing to young people.

49 Some factors that concern me in relation to digital solutions is the fact that young people who need access to additional services may not get the adequate level of support they require and ultimately may ‘drop out’ from service delivery. There need to be good

pathways available - from digital options to in-person care. Not all mental health problems are suitable for solely online treatments. This is particularly the case for young people with more severe mental health issues. Further, some mental health problems for adolescents and young people can be associated with motivational, concentration and cognitive difficulties which would impact on young people being able to benefit from online solutions.

The benefits of digital technology

50 As indicated, digital approaches are essential for young people, particularly those who may be geographically isolated, marginalised or those who refuse to attend physical, in-person service options. As such, there needs to be good, reliable and quality digital sources of information about mental health problems, treatments and services available. Unfortunately, there are many websites and other digital solutions (apps and the like) that contain countertherapeutic information about services, mental health problems and treatments that can hinder appropriate help seeking.

51 Trusted organisations such as headspace and Beyond Blue have created reliable online and digital sources of information that are specifically designed for young people in ways that are appealing to them. For example, headspace have created infographics where key information is put on one page in a format that is engaging to young people. Those infographics also have the ability to reach hundreds of thousands of people over the internet (for example, an Instagram post) in a way that requires little expense. This is very powerful in my view. headspace centres also offer virtual tours of the service, treatment options and virtually can introduce staff. The work also done by headspace is in relation to eheadspace mental health support service has also been very significant and successful. At one point, there was about 30 clinicians (I was a psychiatrist working on eheadspace at this time) responding to young people using eheadspace and we were unable to keep up with the demand from 'chats' coming through from young people. One of the key features I consider in eheadspace was that young people could make contact and discuss issues anonymously in the first instance (the only details that were requested were their age and postcode). However, if a young person required additional services or required a warm referral, we would then obtain further details as necessary. At the time, eheadspace was a victim of its own success as it could not cope with the demand for its services, however, I have not worked for headspace since 2016 so am unable to provide more recent information on this except to say additional resources were required at the

time in relation to their e-services. Orygen has also been conducting research into digital options for young people in the formal delivery of mental health care.

The capacity of digital technology to improve timely access to mental health services, quality of services, care pathways, treatments and supports

52 Digital technologies can be used to gather information about young people's mental health easily and in a timely manner. My impression is that many young people are more inclined to answer an online questionnaire about their mental health than respond to direct questions as it can be less threatening and less anxiety provoking which can assist in providing appropriate care pathways, treatments and supports. As indicated, the quality and reliability of the information available online is essential, as is ensuring that young people are getting the appropriate level of support they require. Referrals and pathways to telepsychiatry or in-person services will still be required in many instances so whilst digital technologies are essential when working with young people, they cannot be the complete answer.

53 Quality of services, outcome measures and feedback loops can be readily completed online in my view, including complaints mechanisms. I consider that for young people, they would be more inclined to offer this type of feedback or make complaints via a digital means, particularly if this can be done anonymously. However, some young people will need assistance in understanding what is being asked of them either because of educational limitations, cognitive impairments or because their mental health symptoms may be too severe. Online questionnaires can still be completed in these circumstances, with assistance from clinicians, family or others.

Preparing the workforce for integrated digital capabilities

54 Some members of the workforce may require assistance and training in relation to the operation of digital options. In practice, younger clinicians seem to me to have less difficulties in embracing and using digital technology as they have often themselves grown up in a digital era. Currently, training regarding digital treatment options is poorly funded, not inbuilt or prioritised for a workforce who are often time-poor with high caseloads. It is often left to individual clinicians to explore this themselves. Additional funding is required and time devoted to this level of training so that clinicians are more aware of good quality

digital options that can assist a young person, giving them greater choice and/or augmenting their in-person care.

The take up of digital mental health at a service level and the challenges in implementing digital services/technology

There has to be support for digital services at an organisational level to make educating the workforce a priority. I consider it would be beneficial if clinicians in the mental health sector were given clear information about the benefits of offering digital services to engage young people, particularly when the consumer voice of young people is providing feedback that online and digital services are essential in the way they seek out information and services. The best way to do this is to provide clinicians with the research and evidence base about the utility and uptake of digital services for young people, provide updated information on online options and train clinicians in their use so that they can then support young people. In addition, organisations need to invest in training and IT support for these options. More recently, COVID-19 has suddenly forced many organisations and clinicians to have to explore online services delivery from which there will be many learnings and I think a greater willingness by the workforce to use these.

FORENSIC MENTAL HEALTH

Key changes in the past 10-15 years for children and young people engaged with, or, at risk of engaging with, the youth justice system

55 Young people involved in the youth justice system are the most vulnerable young people and they tend to get the least access to mental health services. About 30-50% of young people in youth justice have diagnosable mental health problems and may also have other issues such as neurodevelopmental disorders (intellectual disabilities, learning difficulties, speech and language difficulties) and problematic AOD use. These issues are drivers, at least partly, for the offending behaviour. They may also contribute to the question of whether a young person is judged to have capacity in regard to their offending behaviour because of these potential impairments. Despite these multiple issues, we find that young people within the youth justice system sometimes do not have access to mental health treatment as well as opportunities for engagement in appropriate educational and vocational options. In addition, there is only one dual trained child and adolescent and forensic psychiatrist for Victoria and Tasmania.

56 In my experience, forensic youth mental health is not currently being serviced well and historically has been very inconsistent in Victoria. My impression is that there has been a tendency in the past for mental health services to avoid service delivery to young people involved in the youth justice system. Eligibility criteria may often not extend to youth offenders as youth justice clients may be deemed overly complex, or too risky or violent to be cared for within Mental Health Services (particularly adolescent inpatient units). This lack of care is further compounded when young people are released from a Youth Justice Centre and there are barriers to accessing care and being linked to local mental health services. There have been some recent changes with Orygen receiving funding for some dedicated youth forensic beds allowing a refurbishment of part of the Orygen in-patient unit specifically to meet the needs of unwell youth justice clients. In addition, Orygen has developed a Forensic Youth Mental Health Service to in reach into youth custodial settings. This service is increasingly exposing the level of unmet need that currently exist. When young people are in custody, this potentially presents an opportunity sometimes for the first time, to have mental health problems identified, assessed and treated if adequate service provision exists.

57 Further, there appears to me to be a level of anxiety from the mental health workforce, which often reflects a lack of training about youth offenders who may suffer mental health problems. They are sometimes seen as overly complex or dangerous by the mental health sector and not suitable to be treated within community mental health services. In my view, young people who commit an offence and have a mental health issue, are also heavily stigmatised by the community and by some components of the mental health sector.

Good practice models and key changes to forensic mental health services for young people with mental illness

58 Orygen Forensic Youth Mental Health Service was established in February 2019 with some limited funding by the Department of Justice and Corrections following the transfer of youth justice from DHHS in about 2018. This was established to provide an in-reach service into custodial settings. Orygen has also established some limited beds as part of their inpatient unit that are available for young people from a custodial setting that have a serious mental illness requiring in-patient treatment. This has removed the barrier to accessing in-patient care. However, this service does not link young people into community-based mental health services post their release. I am not able to comment in

greater detail about Orygen's forensic health initiative other than it was seen as a first step to improving care for youth justice clients and it was expected that it would need expanding.

59 In my view, we need to identify and provide young people who may have mental health problems with early interventions that may prevent criminal offending in the form of, for example, multi-systemic therapies and parenting interventions. Young people who may have conduct problems as an adolescent or as a younger child, who may appear emotionally dysregulated or who may have some learning difficulties are at greater risk of engaging in offending behaviour and require targeted interventions.

60 Key changes and reforms for youth justice clients would be to provide them appropriate services within the youth justice system that would offer them a pathway for continued care post release. These services must include mental health and AOD treatment services. One suggestion is to link these young people (and particularly young people in remand) into community-based services when they are in custody, so that following their release, they could continue with that service and be followed-up. Additionally, in my view, there needs to be further research about service delivery improvement for young people involved in the youth justice system and issues around neurodevelopment. This research would be substantially aided by data that could link issues in relation to justice with health. Finally, in terms of the workforce, we need to bolster expertise in the youth justice setting and have more roles that are dually trained in relation to adolescent mental health and offending behaviour.

RESEARCH

Research capacity, capability and opportunities

61 I am a clinician, so it is very important that there is research conducted about issues around mental health and young people which will provide the evidence-base of how we teach and train our workforce in the public health sector. Currently, in my view, child and adolescent psychiatry is in crisis. There are very few academic child and adolescent psychiatrists in Victoria. For example, the key position of Director of the Centre for Developmental Psychiatry & Psychology at Monash University has been vacant for years. The reason for this, in my view, is because we have no pathways to academia even if a trainee were interested in pursuing an academic career. Funding is required, specifically

for research positions, so that trainee child and adolescent psychiatrists can undertake research as part of their training which becomes a first step towards an academic career. Whilst adult psychiatry has limitations in research positions this is still better than in child and adolescent psychiatry. This is possibly related to 'critical mass' and lack of availability of research mentors hence the unfilled Monash Professorial position has an even greater impact. Ultimately, this means that there is very little academic research being conducted in child and adolescent psychiatry in Victoria currently and there are no clear pathways into academia for those psychiatrists who would wish to do so. In practice this means that only a few psychiatrist will undertake a PhD, in their own time whilst they are working in a mental health service. To pursue a PhD in these circumstances requires substantial support from a person's organisation. Orygen has been successful in supporting their staff with ongoing research and in applying for funding grants to support academic research.

62 The Mental Health Branch of DHHS has funded clinical academics for some time. I am one of these academics, my position is specifically a training role as Director of Mindful. However, the funding for these positions has stayed static for many years and has been subject to repeated review and year to year funding rounds which is unsatisfactory for workforce stability and planning. In child and adolescent psychiatry this is compounded as most of the current clinical academic positions are for adult psychiatry. I would recommend that it is essential that there be specific academic pathways, that are properly funded for child, adolescent and youth psychiatrists to enable more local research to develop evidence based practice in the Australian context

The importance of translational research and the benefit of research for patient outcomes

63 In my view, translational research is very important, however, such research in child and adolescent psychiatry (even from other jurisdictions in Australia) is very limited which means we are often looking at international research findings. It can be difficult, costly and ineffective to apply overseas models or research because of different cultural settings, service provisions, workforce or other specific factors that are not applicable in a Victorian context. Ultimately, all the work we do as child and adolescent psychiatrists must be linked to evidence or establishing evidence in order apply it to the 'real world' and to combine research and best practice. An example of very successful Victorian research has been the 'Tuning into Kids', suite of parenting interventions. This evidence-

based intervention has come out of research conducted at Mindful. We developed a model for dissemination and implementation to support a broad workforce who work with children, adolescents and their parents in clinical and non-clinical settings. Unfortunately, this has been a much slower process because of very limited funding available for this kind of prevention and early intervention research focussed on looking at parenting.

Enablers for integrated service delivery and research environments

64 As indicated in paragraph 62 above, in my view, funding of research positions for child and adolescent psychiatrists and research pathways for psychiatry registrars must be seen as integral for there to be continued best practice. Research must not be treated as an 'add-on' or an after-thought but be considered as essential and funded accordingly. Organisations must also support staff in undertaking research given it ultimately underpins empirically-based best practice in treatment and outcomes. There must be a clear loop of clinical work that drives research, which then informs training that better address the clinical dilemmas. In my view, there must be a shift away from research and clinical work being seen as separate.

WORKFORCE

Professional behaviours and practices that underpin multi-disciplinary, recovery-oriented consumer and family-centred care in relation to relation to adolescent and youth mental health

65 I refer to my comments in response to question 5 above in discussing the workforce.

66 In my view, multi-disciplinary teams are essential in providing care for adolescents and their families. This means that the right people with the right skills are able to provide treatment, care and support at the right times in collaboration with young people and families. For adolescents and young people, a tailored holistic approach in regards to broader overall wellbeing and a specific understanding of young people's care needs, must be the focus for our workforce. The workforce must also have skills in good collaboration, consultation, communication and cooperation in working with the young person, their families and carers and the broader systems that support them.

67 In relation to consumer-focused care, collaborative and transparent practice led by the needs and priorities of young people is essential to enable and support them with informed decision-making.

68 I have discussed the importance of family-centred care above. I refer to these paragraphs in noting how essential family-centred care is.

69 Recovery-oriented practice requires a strength-based approach that offers holistic care which includes supporting an adolescent or young person in relation to matters such as relationships, education, hobbies, sporting activities, work as well as health and mental health needs. Together with a broader system of supports, the mental health workforce is ideally placed to help young people identify and prioritise goals in the short and long term and develop skills that will assist them to grow and improve their functioning and wellbeing and successfully make the transition from childhood to young adulthood.

Attached to this statement and marked 'SR-1' is a copy of my CV.

sign here ►

print name Alessandra Radovini

date 10.06.2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT SR-1

This is the attachment marked 'SR-1' referred to in the witness statement of Alessandra Radovini dated 10 June 2020.

CURRICULUM VITAE

Associate Professor Alessandra Radovini

PERSONAL DETAILS

Work address: **Mindful** – Centre for Training and Research in Developmental Health

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Orygen Youth Health
35 Poplar Rd
Parkville VIC 3052

ACADEMIC QUALIFICATIONS

2002	Certificate of Child & Adolescent Psychiatry, Royal Australian & New Zealand College of Psychiatrists
1992	Fellow of the Royal Australian & New Zealand College of Psychiatrists
1992	Diploma of Psychological Medicine, The University of Melbourne
1983	Bachelor of Medicine, Bachelor of Surgery, The University of Melbourne

EMPLOYMENT AND LEADERSHIP

1. Current Positions

1.1 Director: Mindful – Centre for Training and Research in Developmental Health [2007-current]

- **Associate Professor, Department of Psychiatry, The University of Melbourne [UoM]**

Since 2007 I have successfully led what is a unique partnership between the Victorian Department of Health, The University of Melbourne, Monash University, the Royal Australian and New Zealand College of Psychiatrists [RANZCP] and the Victorian Tertiary Mental Health Sector.

It has been my vision for Mindful to strengthen the centre's leading role in the integration of research, teaching & training and service delivery to better equip the broader mental health workforce with skills and knowledge in Child and Youth Mental Health.

As Director of Mindful I provide leadership across all of Mindful's teaching, training, research, engagement and administrative activities.

1.2 Consultant Child and Adolescent Psychiatrist for the Neurodevelopmental Stream, Orygen Youth Health [2019-current]
Provide Psychiatric input as park of the Multidiciplinary Neurpdevelopmental Team doing assessments , secondary consultation and training to build capacity at Orygen to better meet the needs of young people with ASD [and other Neurodevelopmental Difficulties] and comorbid psychiatric illness and support their families

Psychiatrist to the *Enrich* program [2019 only], an innovative partnership between Orygen and several Community Health Centres in the periurban areas of Northern Melbourne to provide mental health services in the community for young people with complex needs.

1.3 Consultant Psychiatrist for Homeward Bound [2019-curent].
This is a global leadership initiative for women with STEMM [Science, Technology Engineerring Mathematics, Medicine] backgrounds. I am part of the Wellbeing Stream and was the Senior Clinican for the fourth cohort [HB 4] in 2019; the year long program for 99 women from 38 countries culminating in a voyage to Antarctica in Nov/Dec.
I remain involved in participant selection, program development and delivery and advisor regarding mental health wellbeing.

2. Previous Positions

2.1 Senior Advisor- Youth Mental Health – Dept of Health & Human Services Victoria [DHHS], [0.4 secondment from UoM] [Feb 2017- Feb 2018]

Key Responsibilities

Provide Child & Adolescent Mental Health expertise and leadership and liaise with stakeholders in relation to current projects within the Mental Health Branch

Out of Home Care- OoHC
ISS - Intensive Support Service - 'Keys'- new initiative in South Division of DHHS for YP in OOHC
Partnership between Mental Health and Child Protection, OoHC, NGO provider - Anglicare

Youth Justice

1. New Initiative -Designated Youth Justice Mental Health Beds. Provide input re Capital works and Model of Service Delivery

2. Redesign of In-reach MH services to Youth Justice clients in Custodial care

Partnership between Dept of Justice & Regulation, DHHS- Mental Health
Develop a model of care, particularly looking at the Continuum of Service Delivery between increasing levels of Intensity from In-reach service to bed based care and links with Youth MH providers when young person [YP] is no longer in Custody

3. Community Forensic Youth Mental Health Service

Develop model of care for community based forensic youth mental health service, early intervention for YP with mental illness at risk of serious offending – sitting with DJR and linked to item 2 above.

State wide Child in-patient units at Austin and Monash Health
Develop model of service delivery and operating rules [referral pathways, admission criteria,

distinction between the 2 units]

Office of the Chief Psychiatrist [OCP] –Mental Health Branch
assist with Child, Adolescent & Youth client-based queries coming to OCP.

2.2 Clinical Director (inaugural), headspace, National Youth Mental Health Foundation [0.4-0.6EFT] [Dec 2011 – June 2016]

headspace is an Australian Commonwealth Government funded national program whose aim is to create an integrated early intervention and prevention service to engage and support young people [12-25yo] with health and/or mental health problems. This is through the delivery of services in Centres across Australia [90 by 2015], via online and telephone services and through suicide post- vention support to secondary schools.

headspace centres provide mental health care, primary care, drug and alcohol programs and vocational assistance to young people. In addition, **e-headspace** is the first National online and telephone counselling service staffed by 65+ trained mental health clinicians. The **headspace** School Support Program provides post-vention to secondary schools across Australia who have experienced the death of a student as a result of suicide.

In 2013 headspace established an Early Psychosis Program [x9 hubs] on the **headspace centre** primary care platform to enable easy access to care.

Key Responsibilities

- Provision of leadership across all **headspace** activities as part of the Extended Executive Team
- Provision of leadership in Clinical Governance across all **headspace** Clinical Programs
- Provision of advice to the CEO and the **headspace** Board of Directors in relation to all Clinical matters
- Development of the protocols and establish Telepsychiatry for **headspace**
- Direct oversight and Clinical accountability for **eheadspace** and **headspace** School Support national programs
- Establishment of **headspace** Early Psychosis Program

2.3 Inaugural Chief Child Psychiatrist [0.4EFT] with the Victorian Department of Health, April 2009 – Dec 2011

The Chief Child Psychiatrist position was created by the Minister for Mental Health as part of the Victorian Mental Health Reform Strategy 2009-2019, "*Because Mental Health Matters,"* as it was recognised that there needed to be an additional focus on the specific needs of children, young people and their families as a key part of service reform.

Key Responsibilities

- Provide high-level authoritative policy advice to the Minister, Secretary and Executive Director and represent the Mental Health Branch on child, adolescent and youth mental health issues

  This included
  - ***Author*** Ministerial Briefings on current issues arising, as requested by the Minister's Office

- ***Advisor*** to the Mental Health Act [MHA] Review Expert Advisory Group into the draft MHA as to how it would address the specific needs of young people <18yo
- ***Advisor*** regarding the reform and restructure of Victorian Child and Adolescent Mental Health Services [for 0-25yo], as a member of the Child and Youth Partnership Subcommittee of the Mental Health Reform Strategy.
- ***Member***, Quality Assurance Committee [QAC], Office of the Chief Psychiatrist, DoH
- ***Chair***, Office of the Chief Psychiatrist Clinical Review Panel

- Assist the Chief Psychiatrist in matters relating to the care and welfare of children, adolescents and young people receiving treatment/care for a mental illness including:
  - ensuring the fulfilment of statutory responsibilities under the Mental Health Act
  - providing Clinical Child & Adolescent Psychiatric expertise in relation to individual clients and / or for Child & Adolescent/Youth Mental Health Services (CAMHS/CYMHS)
- Strengthen links and providing leadership to CAMHS/CYMHS in the areas of "Best Practice" frameworks, training and education
- Provide input within the DoH, Mental Health Branch child and youth policy, service system and workforce development. The latter particularly linked to my role as Director of Mindful.
- Strengthen linkages and assisting in the development of a more co-ordinated response to the care of vulnerable children and young people with complex needs within the Mental Health Branch and other DHS divisions, [Child Protection and Youth Justice] building on the IMYOS research.

2.4 2000 - 2009 Consultant Child and Adolescent Psychiatrist [0.5 EFT], Intensive Mobile Youth Outreach Service [IMYOS], Orygen Youth Health.
IMYOS was a Department of Health- initiative (commencing in 1998) focused on developing and providing outreach services for high-risk, difficult-to-engage adolescents aged 12-18 years [at risk of suicide, self-harm, accidental death/injury, violence]. The adolescents accessing IMYOS services have complex needs, high risk and challenging behaviours and historically have failed treatments via office-based services.

2.5 2001 – Mar 2007 Inaugural Clinical Director [0.5EFT] of Bendigo Health CAMHS
Bendigo Health CAMHS is responsible for service delivery across a wide geographical area (approximately 36,000 sq. kms) from Gisborne to Swan Hill operating over 5 sites

2.6 Other Positions
Mid 2000- Jan 2001 Senior Registrar [0.5], Alfred Hospital CAMHS, Melbourne
(I completed the RANZCP Child & Adolescent Psychiatry Training on return from Ireland.]

Mid 1998- mid 2000 Consultant Psychiatrist, Lucena Clinic, Rathmines, Dublin, Ireland
Child & Adolescent Mental Health Services for South Dublin
In consultation with the Victorian RANZCP Child & Adolescent Psychiatry Training Scheme, I commenced training in Child Psychiatry in 1999, under the auspices of the Royal College of Psychiatrist, Child Psychiatry Training Scheme in Dublin, Ireland.

1997-mid 1998 Consultant Psychiatrist [0.5], EPPIC program (Early Psychosis Prevention & Intervention Centre), Orygen Youth Health

1993-1997 Consultant Psychiatrist [0.5], Consultation-Liaison Psychiatry, Austin & Repatriation Medical Centre, Melbourne

1996-1998 Consultant Psychiatrist, Queen Elizabeth Centre for Mothers & Babies, Parkville,
1993 - mid-1998 Private Practice [0.5] in General Adult Psychiatry and Psychotherapy
1987-1992 Victorian Post graduate Psychiatry Training Program
1984-1986 Internship and residency: Based at St Vincent's Hospital, Melbourne

PUBLICATIONS

Publications
Peer-reviewed journal publications

1. Schley, C., Yuen, K., Fletcher, K. & **Radovini**, A. - Does Engagement with an Intensive Outreach Service Predict Better Treatment Outcomes in "High-Risk" Youth?. Early Intervention in Psychiatry, 6(2): 2012, pp. 176-184
2. Schley, C., **Radovini**, A., Halperin, S. & Fletcher, K. - Intensive Outreach in Youth Mental Health: Description of a Service Model for Young People who are Difficult to Engage and "High-Risk". Children & Youth Services Review, 33(a): 2011, pp. 1506-1514
3. Ryall, V., **Radovini,** A., Crothers, L., Schley, C., Fletcher, K., Nudds, S., Groufsky, C. - Intensive Youth Outreach in Mental Health: An Integrated Framework for Understanding and Intervention. Social Work in Mental Health, 7(1-3): 2009, pp. 153-175
4. Schley, C., Ryall, V., Crothers, L., **Radovini**, A., Fletcher, K., Marriage, K., Nudds, S., Groufsky, C. & Yuen, H.P - Early Intervention with Difficult to Engage, 'High-Risk' Youth: Evaluating an Intensive Outreach Approach in Youth Mental Health. Early Intervention in Psychiatry, 2(3): 2008, pp. 195-200
5. Schley, C., **Radovini,** A. - Engaging the Unengageable: Assertive Outreach with High-Risk Youth. Australian and New Zealand Journal of Psychiatry, 41(Supplement 2): 2007, pp. A305

Book Chapters and Reports

6. Gasparini, E., Judd, F. & **Radovini**, A. - Mental Health in Adolescence, in The Women's Health Book: A Complete Guide to Health & Wellbeing for Women of All Ages, Heinemann Australia, North Sydney: pp 153-172 (2014)
7. **Radovini**, A. - Adolescents and Children, in Electroconvulsive Therapy: A Guide. (2nd ed.), ed. J.W.G. Tiller, R.W. Lyndon, Health Education Australia, Fitzroy, Vic.: pp 53-59 (2013)
8. **Radovini,** A. - Child and Adolescent Psychiatry, in A Primer of Clinical Psychiatry (2nd ed.), ed. D. Castle, D. Bassett, J. King, & A. Gleason, Elsevier, Sydney: pp. 298-312 (2013)
9. Bull, K. & **Radovini**, A. - A Guide to Identification, Diagnosis and Treatment of Autism Spectrum Disorder, Victorian Mental Health Services, Melbourne; Mental Health Drugs and Regions Division, Department of Health (2013) [Report]
10. Kimber, D. & **Radovini,** A. - CAMHS and Paediatricians Working Together, Mental Health, Drugs and Regions Division, Department of Health, Melbourne: 54 pp. (2011) [Report]
11. Smith, A. & **Radovini**, A.- Preliminary Report for Child Mental Health Bed- based Services Project, Mental Health Branch, Department of Health and Human Services, [2017]

Electronic Publications
headspace has lead the way in the use of electronic media to raise community awareness of Youth Mental Health problems and promote help seeking. I have played a major role in **developing the content and ensuring that the correct message** is achieved when information has been promoted electronically via 'infographics' and video.

Infographics- enable information to be posted via social media which is then able to reach tens of thousands of young people. I have provided Clinical expertise to infographics produced in 2012/2013 on *bullying, body image, homophobia, suicide, depression*

For the first 'posting' on Social Media

Suicide- Shared 4296 on Facebook reaching an audience of 447,000
Bullying- Shared 1076 times on Facebook reaching an audience of 212,000
Depression- Reached audience on Facebook of 151,00
Homophobia- Reached audience on Facebook of 132,000

headspace has now posted each of these infographic on multiple occasions with an even great cumulative reach.

[https://www.pinterest.com/headspaceaus/infographics/]

Videos- I have provide Clinical expertise to the following videos produced in 2013 whose specific links are listed below and can be found on youtube as well as the **headspace** website [http://www.headspace.org.au/about-headspace/news-videos/videos/mental-health-info.]

Each of these has now been seen by thousands of viewers. [youtube count]

Self Harm –
http://www.youtube.com/watch?v=OY5akjDzm18&list=UUORFEF05t9rFXq5TFW4vGDw
Alcohol-
http://www.youtube.com/watch?v=wWbx1F3TRpw&feature=c4overview&list=UUORFEF05t9rFXq5TFW4vGDw
Relationships -
http://www.youtube.com/watch?v=BMW0UPlPErE&list=UUORFEF05t9rFXq5TFW4vGDw
Self esteem-
http://www.youtube.com/watch?v=uQKY4_HwTqI&feature=c4-overview&list=UUORFEF05t9rFXq5TFW4vGDw
Mental health -
http://www.youtube.com/watch?v=BMW0UPlPErE&list=UUORFEF05t9rFXq5TFW4vGDw
Anger - http://www.youtube.com/watch?v=F82ALeWEJPs&feature=c4-overview&list=UUORFEF05t9rFXq5TFW4vGDw

In 2016 I contributed to the **headspace** GP Online Training Project and recorded the following videos which can be found at the links below

Recognising Bipolar Disorder in the Clinic: https://www.youtube.com/watch?v=zjnyTD5lHek
Taking a clinical history when trauma is suspected:
https://www.youtube.com/watch?v=Unpk6dvVVa8
Safety Planning With a Young Person that Won't Engage:
https://www.youtube.com/watch?v=YELRWnxhoc0

MEMBERSHIP OF PROFESSIONAL ORGANISATIONS

- Royal Australian & New Zealand College of Psychiatrists [RANZCP]
- International Association for Youth Mental Health [IAYMH]
- International Early Psychosis Association [IEPA]
- Australian Lesbian Medical Association [ALMA]
- International Women's Development Agency [IWDA]