Interim Response to the Review of the Child and Adolescent Mental Health Service (CAMHS) in South Australia

May 2024

Government of South Australia
SA Health

Contents

Background

A joint review commissioned in 2022 by the Office of the Chief Psychiatrist (OCP) and Women's and Children's Health Network (WCHN) has been completed by external reviewers.

The intention of this review was two-fold:

- Firstly, to assist CAMHS in leading state-wide service of excellence in the provision of child and adolescent mental health care across South Australia.
- Secondly, to inform the Chief Psychiatrist in undertaking the statutory roles of promoting continuous improvement in the organisation and delivery of mental health services, monitoring the standard of mental health care, and advising the Minister on matters relating to mental health.

As such, the review was designed to inform the development of future service and workforce requirements by CAMHS in South Australia and to inform strategic directions and therefore contemporary Models of Care.

The review team consisted of members from South Australia, Queensland and Victoria from a range of backgrounds.

- Bec Hunt (Carer and Consumer Consultant)
- Emma Hart (Nurse)
- Jacinta Coleman (Paediatrician)
- Laura Duncan (Consumer Consultant)
- Michael Gordon (Child Psychiatrist)
- Michael Larkin (Aboriginal Health Academic)
- Peter Brann (Clinical Psychologist and Academic).

The feedback provided during the extensive consultations along with written submissions from CAMHS staff, consumers and carers, and various stakeholders including the Commissioner for Children, The Commissioner for Aboriginal Children and Young People, Department for Child Protection, Department for Health and Wellbeing and various Non-Government and Government Health Services, were considered. Seven headline comments focusing on CAMHS providing an integrated continuum of mental health care for consumers and their families and becoming a high-quality tier 3 mental health service are included to support the strategic future for CAMHS over the next 5-10 years.

The Final report includes 94 recommendations across ten areas relating to the review's terms of reference.

Response

The report was provided to WCHN and the Mental Health Strategy and Planning in the Department for Health and Wellbeing (DHW) to assist with the coordination of an interim response to the recommendations on behalf of the Minister for Health and Wellbeing. Further consultation with government agencies will be required, in addition to consideration of current budget and resourcing ability.

Prior to the release of this report, the Government committed to improving the delivery of care to women, babies, children and young people in our community at WCHN.

The progressive appointment of additional child psychiatrists and psychologists over the next few years will enable improved access to services, clinical governance, and capacity across public services.

In addition to this, more nurses to boost mental health care for children have been recruited.

The report presented recommendations in two sections: Section one is seven (7) 'headline' overarching themes followed by Section two which provides 94 specific recommendations pertaining to individual terms of reference as presented. For the 'headline' overarching themes to be achieved, the 94 recommendations will need to be actioned.

The seven (7) 'headline' recommendations were identified as the most critical recommendations, these related to:

1. CAMHS providing an integrated continuum of mental health care for consumers and their families.
2. For CAMHS to be a high-quality tier 3 response and mental health service (for severe and complex mental health conditions requiring multi-disciplinary support)
3. Supporting, growing and training the CAMHS workforce and involving the workforce in change management
4. Responding to an increase in demand for mental health services by children and adolescents particularly in the areas of eating disorders, those presenting with very serious self-harm and autism.
5. Increasing budget, staffing and infrastructure
6. Stakeholder support including from tier 1 and 2 services
7. Acknowledging some recommendations can be actioned in the short term while others are longer term.

A response to the 94 Section Two recommendations is outlined in the table below.

As different stakeholders have singular and joint responsibility for achieving these changes, all recommendations have been grouped into three sections:

- 57 recommendations are to be led by CAMHS.
- 13 recommendations are to be led by WCHN.
- 24 recommendations are to be led by DHW.

All 94 recommendations have been considered in consultation with the WCHN, the Mental Health Strategy and Planning team and the Chief Psychiatrist, with forty five (45) recommendations endorsed as accepted. Forty nine (49) recommendations have been supported in principle subject to further investigation as further consideration is required in the context of strategic planning that is already underway.

Further consultation will be required with the Department of Premier and Cabinet (Office for Autism), the Department for Education and the Department for Human Services where there is a joint responsibility to provide care and support to children and young people.

Feedback received from Department for Education (DfE) regarding recommendations impacting their service has been included. The department asks that it is noted that the review makes reference to the Department for Education having 100 additional psychologists. It should be noted that the government committed to 100 FTE learning and wellbeing specialists with 55 FTE of this for specific multi-disciplinary mental health practitioners in up to 65 secondary schools. There are not 100 additional psychologists in schools.

As key service providers in the APY Lands, The Department of Human Services (DHS) recommends its inclusion in the development and implementation of various recommendations in partnership with CAMHS.

As the report outlines a 5-10 -year implementation plan, there is a likely need for future budget considerations however some of the recommendations can be considered within the current budget.

Recommendations to be led by CAMHS.

Number	Recommendation (with report reference code)	Response	Comment
1.	(A2) It is recommended that CAMHS describe and publish a service manual as to what it defines as CAMHS core business. This manual would articulate the values, strategies, the clinical models and principles that underlie this tier 3 service provision. This manual would be available within CAMHS and for external stakeholders.	Accepted	The existing CAMHS Model of Care and service-specific Operational Guidelines will be utilised to support the development of this document.
2.	(A4) It is recommended that an adolescent day program is established in partnership with the Department for Education (DfE). The day program would accept referrals from Mallee ward and CAMHS outpatient clinics and provide an additional service as step-up and step-down options in the continuum of mental health care. This day program would provide evidence-based treatments for adolescents living with mental health challenges and involving other stakeholders such as schools and NGOs. It is acknowledged that an adolescent day program should be a state-wide service and over time would need to evolve to provide a service across the whole state. It is understood that a previous incarnation of an adolescent SA day program had a number of challenges. Ideally the day program would follow a hub and spoke model to be aligned with the existing community CAMHS clinics	Supported in principle subject to further investigation	Consideration should be given to combining recommendations A4, A5, A11 and B5 to establish a service that is multi-functional. Further consultation with the Department for Education is required. Further consideration is required to understand the resourcing requirements and feasibility of this recommendation.
3.	(A5) It is recommended that CAMHS develop an Intensive Community Care Service (ICCS) for the treatment of adolescents who have failed to progress in their treatment either as an inpatient or from outpatient services (Keiller et al., 2023). An ICCS would target high risk and difficult to engage adolescents (Assan et al., 2008). The ICCS could be based on several models including multisystemic community treatment, intensive case management, and the Victorian intensive mobile outreach service. Consideration should be	Supported in principle subject to further investigation	Consideration should be given to combining recommendations A4, A5, A11and B5 to establish a service that is multi-functional. Further consideration is required to understand the resourcing requirements and feasibility of this recommendation.

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	given to the ICCS as a hub and spoke model aligned with the existing community CAMHS clinics.		
4.	(A6) It is recommended that CAMHS establishes a community-based group program including but not limited to early intervention, parent/family support, psychoeducation of consumers and carers, targeted but time limited interventions for specific psychological conditions and distress arising in children and adolescents.	Supported in principle subject to further investigation	Consideration should be given to combining recommendations A6, A15 and E2 to establish a service that is multi-functional. Further consideration is required to understand the resourcing requirements and feasibility of this recommendation.
5.	(A7) It is recommended that CAMHS develop family therapy expertise held by several clinicians for both training of CAMHS staff and as a specialised service. This family therapy service would provide family therapy directly, secondary consultation and teaching across SA. It is recommended that the family therapy service would provide treatment that partners with community and inpatient CAMHS clinicians for assessment and treatment via a dual clinician model.	Accepted	CAMHS has trained Family Therapists in its workforce. Further training and development of the workforce will be delivered in line with the CAMHS Learning and Development Framework.
6.	(A10) CAMHS Connect triages consumers for the CAMHS community clinics. However, it was reported that there is an additional and separate referral track into the CAMHS clinics by GPs and paediatricians writing directly to the CAMHS clinic child psychiatrist. The review team was unclear how this referral track complemented the overall outpatient intake	Accepted	This recommendation will be addressed during the ongoing refinement of referral and intake processes to best meet the needs of our consumers and their families.

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	system and what governance, and patient recording structures were in place. A separate concern the CAMHS clinicians reported was that as a result of the CAMHS Connect allocation they did not have any discretion to link the patient and their presenting mental health challenge with the best clinician/specialty in their outpatient clinic who could address that. It is recommended that the referral process from CAMHS Connect into the CAMHS outpatient clinics be reviewed.		The South Australian and Commonwealth Governments entered into a Bilateral Agreement on Mental Health and Suicide Prevention (the Agreement) in February 2022. The integration of the National Phone and Digital Intake Service (Head to Health) with existing state intake processes is a key initiative. CAMHS is a member of the SA Mental Health Phone Intake and Assessment Project Steering Committee. The outcomes of this work may influence the role of CAMHS CONNECT and should be considered when reviewing this recommendation.
7.	(A11) It is recommended that CAMHS explores the establishment of a hospital outreach post-suicide engagement service for children and adolescents who present with suicidal behaviour or significant suicide intent. This could be an expansion of the current RACER service in WCHN Emergency Department in Adelaide. Mental Health Policy, Planning & Safety at SA Health already allocates funding for self-harm follow-up for WCHN aligned with adult after care services. An Australian model for hospital outreach post-suicide engagement is HOPE. HOPE teams have been established at Victorian hospitals for the urgent and intensive outpatient follow-up of people who present to the Emergency Departments or ward following an attempted suicide or	Accepted	Consideration should be given to combining recommendations A4, A5, A11 and B5 to establish a service that is multi-functional. New funding has been provided by DHW to develop non-government supports for children presenting in distress. Work has commenced on implementation.

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	serious plan. The HOPE team acts as the first phase in aftercare of a suicidal child or adolescent who presents to hospital. This SA review recommendation is in keeping with the Royal Commission into Victoria's Mental Health System (Health, 2021) recommendation 3 which was to fund four area mental health services to offer hospital outreach to complement usual care.		
8.	(A12) It is recommended that there is an investment and use of digital healthcare service delivery. The use of virtual care for mental health support is something that young people are willing to engage with and would be well utilised. CAMHS has been trialling e-health initiatives and this should be continued.	Accepted	As a state-wide, community-based mental health service, CAMHS continues to invest in digital healthcare services delivery across South Australia with over 36% of contacts using telehealth in the 22-23 FY. The CAMHS Model of Practice and Telehealth Guidelines support clinical best practice. A training module has been developed and will be available for staff in iLearn in 2024.
9.	(A13) It is recommended that the role of the Complex Case Review Panel is reviewed to see if it is meeting the needs of the referrers. The internal referrers feedback reflected that the recommendations from the panel did not meet the needs of the referrers. It would be useful to review the ideal mix of staff in the review team, the nature of the questions posed and audit how best to feed back to referrers. The lead clinicians may need to be expanded to include outside experts and staff with dedicated EFT for the panel.	Accepted	CAMHS will continue to work with all stakeholders to strengthen the systems that support the care for this highly vulnerable at-risk group. This recommendation should be viewed in conjunction with recommendations A13, A14, I4, I5 and I6

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10.	(A14) It is further recommended that the role of the Complex Case Review Panel is reviewed to consider situations where that risk sits over multiple agencies. These risks are unable to be moderated or reduced by the one CAMHS or WCHN service alone. Consideration should be given to the exploration of a multiagency escalation review process with key stakeholders (e.g., DCP, DfE, SAAS, SAPOL, NDIS lead etc) that provide a final decision where acute and chronic issues cannot be managed by one service alone.	Accepted	A review of the function and scope of the Complex Care Review Committee (CCRC) panel commenced in January 2024. This recommendation should be viewed in conjunction with recommendations A13, A14, I4, I5 and I6. DHS recommends its inclusion in developing and implementing this recommendation.
11.	(B1) It is recommended that CAMHS develop explicit admission criteria for Mallee Ward.	Accepted	The existing CAMHS Mallee Ward Operational Guidelines and Model of Care will be reviewed to ensure that there are explicit admission criteria that are easily identifiable to the reader.
12.	(B2) It is recommended that CAMHS develops a one-page flow diagram to explain admission criteria to be shared with internal and external stakeholders.	Accepted	Link with B1.

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13.	(B3) It is recommended that CAMHS review the admission process into Mallee ward. The clinical decision to admit a patient to Mallee is best decided by the outpatient clinician who has seen the patient supported by their team psychiatrist. If they have only been seen in the Emergency Department, then the decision is to be made by the psychiatrist covering the Emergency Departments. If a patient is refused admission to Mallee by clinicians who have not assessed the patient this creates a significant clinical and governance risk for the consumer, CAMHS and WCHN.	Accepted	Link with B1.
14.	(B5) The time of heightened risk for suicide is in the days and weeks following discharge from hospital. It is recommended that Mallee Ward explores the options of a step-down option from within Mallee or incorporated within the role of the mobile assertive outreach teams (see Recommendations A4, A5 and A11).	Supported in principle subject to further investigation	Consideration should be given to combining recommendations A4, A5, A11 and B5 to establish a multi-functional service. Further consideration is required to understand the roles and resourcing requirements and feasibility of this recommendation in conjunction with available budgets.
15.	(B6) It is recommended that Mallee Ward as the only inpatient unit in SA is benchmarked on comparative data (seclusion, restraint, length of stay, occupancy) with equivalent hospitals in other states of Australia. This data is openly available (Health, 2023). If the data repeatedly exceeds benchmarking, then an escalation and review process to understand the source of the variance is undertaken, and a written remediation process is provided to management.	Accepted	WCHN no longer utilises Health Round Table (HRT), however, CAMHS is exploring the possibility of benchmarking directly with similar services across Australia.

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16.	(B8) It is recommended that Mallee develop clinical pathways for longer planned and negotiated admissions for refractory outpatient consumers and continue to build community support to ensure these consumers avoid admissions wherever possible.	Accepted	Link with B1.
17.	(C1) It is recommended that there is engagement at executive level between the WCHN Emergency Department and CAMHS to address issues as soon as they arise. The intention is to improve the relationship between WCHN Emergency Department and CAMHS on an overarching level and as needed on a case-by-case basis.	Accepted	Work continues to strengthen the clinical governance and working relationships between the executive leadership team/s.
18.	(C2) It is recommended to reassign the Emergency Department Mental Health nurses to be solely responsible for Emergency Department presentations of mental health presentations.	Accepted	This recommendation is being implemented as part of the service realignment that will include a redistribution of roles and responsibilities for CAMHS teams based at the Women's and Children's Hospital.
19.	(C3) It is recommended that a multidisciplinary CAMHS team is provided for WCHN Emergency Department including psychologists, nurses, social workers, occupational therapists, psychiatric registrars, Aboriginal and other cultural supports and a consultant psychiatrist, dedicated to the Emergency Department.	Supported in principle subject to further investigation	Link with C2.
20.	(C5) It is recommended that CAMHS develop comprehensive service plans for each individual consumer who has ≥ 2 presentations to the Emergency Department in 2 days, or 4 presentations in one month. These comprehensive service plans are summary clinical documents that detail patient demographic details, important patient contacts, a formulation, relevant, diagnoses, medications, triggers, and	Accepted	The WCH LLG (Local Liaison Group) involving CAMHS, SAAS, SAPOL, Paediatric Emergency Department (PED) and the Dept for Child Protection (DCP) will consider how best to communicate these plans with service users.

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	suggested strategies for managing the patient related to clinician approaches, appropriate use of prn medications, the role of carers and admission to hospital. The comprehensive service plan is developed with the consumer, their carers and treating team. The plan is provided to the consumer and/or their carers to assist them when presenting to services, particularly the Emergency Department. The plan is designed to provide a quick summary of the consumer and their challenges and provide guidance to the clinician who may not be familiar with the consumer. These plans would be held in a place accessible to those likely to see the consumer.		
21.	(D10) It is recommended that CAMHS explore from a clinical and operational perspective the feasibility of joint assessments with tier 2 services including headspace and school mental health clinicians.	Accepted	CAMHS is commencing work with the Primary Health Network (PHN) - commissioned services including headspace, with a particular focus on HYEPP (early psychosis program), to work in partnership with these services to deliver joint assessments and care.
22.	(F1) It is recommended that CAMHS review classifications for their clinicians. There is a current anomaly where a CAMHS clinician will be supporting and advising a school counsellor, but the identically qualified school counsellor is on a higher classification	Supported in principle subject to further investigation	For consideration with DfE and DHW as part of the development of the state-wide mental health workforce plan. DfE acknowledges and supports the recommendation for CAMHS to review classifications for their clinicians, however notes that school counsellors are not mental health clinicians. School counsellors or student wellbeing leaders as they are referred in education are teaching staff classifications and

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			therefore do not provide a basis for comparative classifications of CAMHS staff. It is noted that school counsellors or student wellbeing leaders are distinct from school mental health practitioners. The latter are classified according to their scope of practice.
23.	(F2) It is recommended CAMHS develop a strategy for direct entry for mental health workforce, with a career structure at point of starting with CAMHS.	Accepted	CAMHS has already commenced implementing strategies to ensure entry-level positions are available for Nurses and Allied Health staff in some CAMHS services. Under consideration as part of the development of the CAMHS mental health workforce plan.
24.	(F3) If a CAMHS position that has been advertised, shortlisted and interviewed for a particular mental health discipline (e.g., psychology) cannot be filled, it is recommended that the CAMHS position is then flexibly opened up for suitably trained clinicians from other disciplines (e.g. social work, nursing) to apply. Positions should not be left vacant while there is sufficient demand for assessment and treatment. It is possible to maintain multi-disciplinary teams without reserving discipline specific roles. For example, CAMHS can define the core disciplines for the team; highlight the missing discipline when a vacancy occurs; recruit to that in the first instance; if unsuccessful, recruit the best candidate for the remaining core professions; develop interest from the missing profession; repeat the process and target the missing discipline at the next vacancy; repeat the	Supported in principle subject to further investigation	For consideration as part of the development of the CAMHS mental health workforce plan. Further work is required to understand roles and possible resourcing implications amongst available budgets.

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	process. Other CAMHS/CYMHS, such as EH CYMHS in Victoria have implemented this.		
25.	(F4) It is recommended CAMHS consider the use of psychology students, nursing students, occupational therapy students and/or social work students within clinics with appropriate supervision.	Accepted	Under consideration as part of the development of a CAMHS mental health workforce plan.
26.	(F5) It is recommended that CAMHS create opportunities for shared staffing across Mallee Ward, Emergency Department, EMHS, CAMHS Connect and the Community CAMHS teams.	Accepted	Under consideration as part of the development of a CAMHS mental health workforce plan.
27.	(F6) It is recommended CAMHS transition staff on short term contracts to permanent positions and reduces the use of short-term contracts.	Supported in principle subject to further investigation	Under consideration as part of the development of a CAMHS mental health workforce plan.
28.	(F7) It is recommended that permanent positions are offered if a CAMHS clinician is in a temporary contract for over 12 months.	Supported in principle subject to further investigation	Under consideration as part of the development of a CAMHS mental health workforce plan.
29.	(F8) It is recommended that CAMHS develop an interdisciplinary training plan that aligns with the CAMHS Model of Care.	Accepted	CAMHS has endorsed a framework for professional, evidence-based training. An interdisciplinary training plan is under consideration.

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30.	(F9) It is recommended that individual CAMHS clinics develop expertise in areas as defined by the needs arising in the individual clinic catchment area.	Accepted	Link to F8.
31.	(F11) It is recommended that consideration is given to a policy of deliberate recruiting new graduates into CAMHS Connect junior positions with a promised pathway into a patient facing role in the wider CAMHS service.	Accepted	Under consideration as part of the development of a CAMHS mental health workforce plan.
32.	(F14) For CAMHS to establish a lived experience and carer workforce/peer workers to be embedded within the MDT. This workforce would engage with, advocate for and directly assist consumers and their families across inpatient and outpatient care. The peer/carer workforce would assist in navigating patients and their families across the various mental health systems (CAMHS, Emergency Department, NDIS, private practitioners, headspace, etc).	Supported in principle subject to further investigation	Subject to further consultation and budget considerations. Priority will be given to Lived Experience roles within any new services developed by CAMHS.
33.	(F15) CAMHS to employ Consumer Consultants to work with CAMHS clinicians at the systemic oversight level, to be involved in overarching policy work and attend meetings in CAMHS including staff interviews, clinical governance meetings and operational meetings.	Supported in principle subject to further investigation	While CAMHS is committed to including the voice of Lived Experience in all levels of governance, this recommendation will require further consultation and consideration.

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34.	(F16) Streamline onboarding of peer workers for inpatient and outpatient work, assist them with achieving a certificate 4 in mental health peer support.	Supported in principle subject to further investigation	For consideration as part of the development of an interdisciplinary training plan (link to F8).
35.	(G2) It is recommended that given its finite resources that CAMHS limits assessment and treatment for consumers that have neurodiversity or disability to where there is an additional, prominent mental health condition requiring tier 3 treatment (such as eating disorder, psychosis, major depression).	Supported in principle subject to further investigation	For consideration during the revision of the CAMHS Model of Care.
36.	(G5) It is recommended that CAMHS develop a multidisciplinary developmental disorders clinic for the assessment of complex consumers that may have autism or ADHD. This assessment-only clinic would be staffed by a child psychiatrist, neuropsychologist, speech pathologist, occupational therapist and paediatrician. The role of the clinic would be to support both the Mallee ward and the Community CAMHS teams to assess consumers with complex presentations that may be complicated by trauma, developmental delays, learning issues, cultural issues or where English is not the consumer's first language. This developmental clinic would have a primary and secondary consultation capacity and be able to provide support both in person and via telehealth.	Supported in principle subject to further investigation	Further investigation is required to understand the multiple roles and, resourcing requirements and feasibility of this recommendation in conjunction with available budgets. (Link to G2)

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37.	(H1) The Aboriginal workforce should be increased to meet the level of community need across all services areas; APY Lands, Southern and Northern Country, Metropolitan Community Teams, and other service areas in Acute and State-wide Services.	Supported in principle subject to further investigation	Priority will be given to Aboriginal-specific roles within any new services developed by CAMHS. This recommendation will be considered as strategies to achieve quality outcomes in the provision of culturally safe CAMHS care are continually examined.
38.	(H2) It is recommended that continued investment in the CAMHS Aboriginal Learning & Development Framework aligned with WCHN Aboriginal Cultural Learning Plan 2021-2026 occurs to support the ongoing learning and development needs of the Aboriginal workforce, including support for undertaking tertiary level qualifications.	Accepted	CAMHS and WCHN continues to improve collaboration and strengthen relationships with Aboriginal Community Controlled Health Organisations.
39.	(H3) It is recommended that all decisions impacting on Aboriginal consumers and communities must have Aboriginal leadership and appropriate consultation with stakeholders.	Accepted	A Senior Aboriginal Leadership Team already exists within CAMHS. CAMHS is committed to ensuring that Aboriginal Staff and Consumer voice is included at all levels of governance.
40.	(H4) It is recommended that Aboriginal Mental Health and Wellbeing workers are placed in the WCHN to support acute care services.	Supported in principle subject to further investigation	Link with H1.

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41.	(H5) Due to a greater number of Aboriginal young people presenting in crisis, and access barriers for Aboriginal families to services such as headspace, it is recommended there needs to be a greater scope for Aboriginal Mental Health and Wellbeing Workers to provide assertive outreach to mild to moderate consumers, working collaboratively with interagency partners.	Accepted	Link with H1. CAMHS currently employs Aboriginal Social, Emotional Wellbeing Workers in its community teams, who provide ongoing cultural support to consumers. Further investigation into how these roles can provide assertive outreach will be explored.
42.	(H7) It is recommended that Aboriginal consumers be engaged to contribute to service planning and evaluation. This will help to ensure that the service structure is a culturally safe environment as determined by consumers and the CAMHS Senior Aboriginal Leadership Team.	Accepted	The development of an Aboriginal Advisory Groups at a local level to provide input for CAMHS Aboriginal services and CAMHS overall is identified as a key action within the CAMHS Consumer Carer and Community Engagement Action Plan.
43.	(H8) It is recommended in response to community need and requirements for Aboriginal leadership on strategic and operational matters, that a management structure be adopted for CAMHS Aboriginal services that separates strategic and operational business. The Principal Aboriginal Mental Health Lead role should be focused on operations, undertaking management responsibilities such as cultural and clinical supervision for all Aboriginal staff within CAMHS, cultural supervision for non- Aboriginal staff who work with Aboriginal consumers, multi-disciplinary team review and debriefing, and membership on CAMHS operational committees. A new Senior Management position should be created to focus primarily on strategic business such as strengthening whole of government approaches, interagency partnerships, membership on WCHN Senior Aboriginal Leadership Group,	Supported in principle subject to further investigation	WCHN and CAMHS are working to ensure that Aboriginal Leadership on strategic and operational matters across the community division is effective and efficient. This recommendation will be considered as strategies to achieve quality outcomes in the provision of culturally safe CAMHS care are continually examined.

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	implementation of the WCHN reconciliation action plan, WCHN Aboriginal Cultural Learning Plan, development of new Women's and Children's Hospital, and cultural oversight of the entire CAMHS organisation including all areas within Acute & State-wide Services, and Community Services.		
44.	(H9) It is recommended that CAMHS recognise the existing achievements of the APY Lands Team and ensure the good work is built upon through adequately resourcing the implementation of the WCHN APY Lands Integrated Model of Care.	Accepted	CAMHS is shifting into phase two of the implementation of the Women's and Children's Health Network Integrated Model of Care for the Anangu Pitjantjatjara Yankunytjatjara Lands (APY Lands). As part of this work, CAMHS is continuing to identify appropriate models, strategies, partnerships and resources to best meet the needs of the communities. DHS recommends its inclusion in developing and implementing this recommendation.

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45.	(H10) It is recommended that continued investment in building and strengthening of relationships to ensure the local community leaders are involved in ongoing program planning, recruitment of Malpas and clinicians, and to ensure cultural appropriateness of services and models of care.	Accepted	Malpa roles continue to be advertised to support culturally appropriate service provision across gender and geographic locations. CAMHS is also working with local partners to ascertain if there are alternative ways of employing Anangu to provide Malpa support. DHS recommends its inclusion in developing and implementing this recommendation.
46.	(H11) It is recommended that there be continued investment in building and strengthening inter-agency partnerships with other services operating on the APY Lands in areas such as health, education and community programs.	Accepted	The WCHN Integrated Model of Care (IMoC) team in the APY lands have had a sustained focus on building and maintaining relationships with key stakeholders such as Nganampa Health Service, NPY Women's Council the Pitjantjatjara Yankunytjatjara Education Committee, DfE and others. This includes shared premises, shared program delivery, coordination, liaison and cross referral for effective care. DHS recommends its inclusion in developing and implementing this recommendation.

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47.	(H12) It is recommended that there be further investment into training for Anangu people as Malpas and clinicians.	Accepted	CAMHS has continued to refine its onboarding framework for the APY Lands team, co-designed and refined as Malpas are employed within the service. DHS recommends its inclusion in developing and implementing this recommendation.
48.	(H13) It is recommended there is flexibility allowed to use a FIFO integrated model of care, recognising recruitment challenges, while still maintaining a commitment to 'on APY Lands' based positions and workforce development	Accepted	WCHN currently provide a fly-in-fly-out (FIFO) model of care to ensure that we continue to provide a high standard of service delivery to the APY Lands communities and have flexibility in hiring to recruit new staff who wish to live on Lands or those to operate in a FIFO capacity. DHS recommends its inclusion in developing and implementing this recommendation.
49.	(I1) It is recommended that CAMHS increase CALD consumer/family-facing positions.	Supported in principle subject to further investigation	This recommendation will be considered as strategies to achieve quality outcomes in the provision of culturally safe CAMHS care are continually examined.

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50.	(I2) It is recommended that CAMHS develop CALD/trauma training for their clinicians and external stakeholders across all disciplines. This could be incorporated into Recommendation A8.	Supported in principle subject to further investigation	This recommendation will be considered as strategies to achieve quality outcomes in the provision of culturally safe CAMHS care are continually examined.
51.	(I3) It is recommended that CAMHS consider liaising with interstate services such as Foundation House in Victoria who advocate and support the rights of refugees and asylum seekers.	Accepted	For consideration in consultation with STTARS (Survivors of Torture and Trauma Assistance and Rehabilitation Service) in South Australia and the CAMHS Culturally and linguistically diverse (CALD) Working Group.
52.	(J1) It is recommended that a permanent position is created for a skilled officer for health data collection.	Supported in principle subject to further investigation	A temporary Data Report Developer position was created by CAMHS in mid-2022. The transition to a permanent health data collection position is under exploration.
53.	(J2) It is recommended that CAMHS benchmark their data against national framework data and Health Roundtable data.	Accepted	WCHN no longer utilises Health Round Table, however, CAMHS is exploring the possibility of benchmarking directly with similar services across Australia. Mental Health quality and safety indicators are measured and reported currently with a modern self-service dashboard that provides a breakdown of data related to National KPIs, as well as data for

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			each CAMHS team to enable comparisons between services.
54.	(J3) It is recommended that the data analyst in conjunction with the senior CAMHS staff conduct gap analysis to address current and future clinical demand.	Supported in principle subject to further investigation	A temporary Data Report Developer position was created by CAMHS in mid-2022. The transition to a permanent health data collection position is under exploration.
55.	(J5) It is recommended that CAMHS form a team of interested staff to develop a dedicated strategy for clinical research at both a quality improvement level and publication level in line with the WCHN research recommendations. Experience has shown that only protected time or EFT will enable clinical research.	Supported in principle subject to further investigation	The requisite foundational work to establish a CAMHS Research Framework in line with the WCHN Research Strategy 2023-2027 is under exploration.
56.	(J7) It is recommended that a new role for CAMHS consultation with stakeholders is developed. This Community Consultation Senior Clinician's primary role would be to liaise with CAMHS core stakeholders (including but not limited to Child Protection, Education, Paediatrician and GPs). The Community Consultation Senior Clinician would arrange and coordinate teaching opportunities delivered by CAMHS clinicians, and would also build links with senior stakeholders, and provide education about what is the core business of CAMHS.	Supported in principle subject to further investigation	This recommendation will be considered as part of quality improvement strategies to achieve coordinated care for CAMHS consumers. DHS recommends its inclusion in developing and implementing this recommendation.
57.	(J8) It is recommended that processes are developed to evaluate any new programs introduced in CAMHS to assess the clinical benefit, consumer and carer feedback and impact they have on overall service delivery using hard and soft outcome measures. Hard outcome measures could include such measures as changes to Health of the Nation Outcome	Accepted	This recommendation will be considered as part of quality improvement strategies to achieve coordinated care for CAMHS consumers.

Number	Recommendation (with report reference code)	Response	Comment
	Scales for Children and Adolescents (HoNOSCA), readmission rate, presentations to Emergency Department, while soft measures could include patient satisfaction questionnaires.		

Recommendations to be led by WCHN.

Number	Recommendation (includes report reference code)	Response	Comment
58.	(A3) It is recommended that the WCHN expand the existing Women's and Children's Hospital Child and Adolescent Virtual Urgent Care Service (CAVUCS) to include the provision of mental health services Monday to Sunday 9 am to 9 pm. The Women's and Children's CAVUCS was developed together with a project team from the Northern suburbs of Melbourne (Sher et al., 2022). In discussions with the lead developer and author of the Victorian CAVUCS, for the expansion of the service to provide mental health support across all of SA this would need dedicated FTE, appropriately trained staff, effective supervision models to support and develop staff, and provision of contingencies for leave cover.	Supported in principle subject to further investigation	This recommendation will be considered as strategies to achieve quality outcomes in the provision of culturally safe CAMHS care are continually examined. Existing service does not currently include Mental Health Clinicians. A 12-month trial of embedding Mental Health Clinicians into CAVUCS began in May 2024. This will inform resourcing requirements and feasibility of this recommendation in conjunction with available budgets.

Number	Recommendation (includes report reference code)	Response	Comment
59.	(A8) It is recommended that CAMHS establishes a specialised service for the training in trauma informed care to CAMHS clinicians and external stakeholders. This clinical and training service could be considered in partnership with HARTTS. This trauma service would have expertise in cultural and linguistic challenges found in the assessment and treatment of trauma arising in refugees and asylum seekers. The trauma informed service would provide a secondary consultation service. Evidence-based models could include Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) and Dialectic Behaviour Therapy.	Supported in principle subject to further investigation	This recommendation will be considered as strategies to achieve quality outcomes in the provision of culturally safe CAMHS care are continually examined.

Number	Recommendation (includes report reference code)	Response	Comment
60.	(A15) Since the COVID pandemic, there has been a significant rise in the number of adolescents presenting with eating disorders both in SA and across the world (McNicholas et al., 2021; Campbell et al., 2022). As inpatients those people with eating disorders are managed by the paediatric unit on the adolescent medical ward with the focus on medical stability with minimal mental health support available. It was reported that patients will have one mental health assessment by the liaison psychiatrist or psychologist, and they are usually not seen again during that admission with an average length of stay of 14 days. Meal support is largely done by the medical nursing staff with a recent investment in a mental health meal support specialist. Mallee ward does not accept eating disorder patients unless they have acute mental health issues and nasogastric feeding is not done on the Mallee ward. Best practice is to treat young people at home with outpatient mental health, medical and dietetic support and for the family to be engaged in Family based treatment. Adolescent Eating Disorder. Day Programmes are an alternative to inpatient treatment and provide an effective step up/step down model (Baudinet and Simic, 2021). In conjunction with Adolescent medicine and WCHN, it is recommended that CAMHS review eating disorder patient management with the development of a multidisciplinary team to provide mental health assessments and distress management on the medical ward. Consideration should be given to a step up/step down model of care for the deteriorating patient with an eating disorder to avoid hospital admission. This would help empower parents to continue meal support at home and avoid exposure to other eating disorder patients in an inpatient setting. Recruitment of a lived experience workforce and carer representatives would assist the MDT to provide liaison support between the different levels of care and assist the young person and parents/carers with engagement with the service (see recommendations F12 – 16).	Supported in principle subject to further investigation	CAMHS works in partnership with the Department of General Medicine (WCHN) and Flinders Medical Centre, along with the State-wide Eating Disorder Service (SEDS) to provide a State-wide Paediatric Eating Disorder Service (SPEDS). The inpatient model of care for consumers with eating disorders is being explored in the context of the new Women's and Children's Hospital. Consideration should be given to combining recommendations A6, A15 and E2 to establish a service that is multi-functional.

Number	Recommendation (includes report reference code)	Response	Comment
61.	(F13) CAMHS to develop a Consumer and Carer Lived Experience Workforce with a dedicated leadership and organisational structure that reflects the needs and challenges for consumers and carers.	Supported in principle subject to further investigation	CAMHS is committed to including the voice of Lived Experience in all levels of governance. Priority will be given to Lived Experience roles within any new services developed by CAMHS.
62.	(D6) It is recommended that CAMHS in conjunction with WCHN and NGOs, develop a patient navigator workforce. Patient navigators are non-clinicians, employed by the hospital or CAMHS who can book, cancel appointments, can assist the consumer and their carers to navigate through the challenges of obtaining National Disability Insurance Scheme (NDIS) support, and negotiating with tier 2 services. An alternative model is in Queensland where there is a nurse navigator who works within specialist areas including eating disorders and the gender clinic that helps families with admission and discharge processes as well as navigating paediatric and mental health services. The navigator workforce could be rolled out incrementally beginning with the high-risk consumers who present frequently to the Emergency Departments or for admission.	Supported in principle subject to further investigation	This recommendation will be considered as strategies to achieve quality outcomes in the provision of culturally safe CAMHS care are continually examined. This recommendation will require further consultation and consideration of available budgets.
63.	(D7) It is recommended that CAMHS partner with mental health clinicians in schools to develop protocols for referral from schools to CAMHS; supervision of school clinicians; secondary consultation; and to develop shared care arrangements for young people with mental health challenges.	Supported in principle subject to further investigation	WCHN has had a sustained focus on building and maintaining relationships with key stakeholders. DfE School Mental Health Service has a clinical governance framework and practitioners are provided supervision within the department. Shared care arrangements between DfE adn CAMHS also needs further clarification. CAMHS and the DfE have a shared working group to collaborate on these matters and to monitor the strengths and arising

Number	Recommendation (includes report reference code)	Response	Comment
			challenges in partnership work as they occur. DHS recommends its inclusion in developing and implementing this recommendation.
64.	(D8) It is recommended that there is an increase in partnering with interested and motivated General Practitioners for the process of embedding shared care arrangements for appropriate consumers. It is recommended that there is a template and process developed for this shared care arrangement.	Accepted	CAMHS initiated a GP ADHD Shared Care Program in partnership with GPEX-GP Partners in 2023 with over 122 GPs participating in the program to date. The learning from this program will be utilised to inform planning for other Shared Care Pathways in the future.
65.	(D9) It is recommended that for those children and adolescents in rural areas, CAMHS explore providing virtual clinical consultation to General Practitioners, provided by senior CAMHS clinicians modelled on the CAMHS ECHO (Extension for Community Health Care Outcomes) access to care service delivery approach (Rooney et al., 2021; Sockalingam et al., 2018). Project ECHO is a Queensland adaptation of the New Mexico ECHO model, with a hub-and-spoke knowledge sharing network for collaborative medical education and patient care designed for rural and under-serviced communities (Queensland, 2017). Project ECHO provides live learning through facilitated case discussions on paediatric health including mental health, gender health care, refugee health and child protection.	Accepted	Link to D8. A future shared care pathway to include the ECHO program will be explored.
66.	(D11) It is recommended that opportunities to work closely with the Department of Child Protection as a key stakeholder are explored. Research suggests that children with exposure to emotional, physical, and sexual abuse are at increased risk of significant mental health disorders, externalising behaviours, and drug and alcohol addiction (Cecil et al., 2017). Quarterly stakeholder meetings with protective services, SAPOL, education department and CAMHS	Accepted	WCHN has had a sustained focus on building and maintaining relationships with key stakeholders and will continue to work with all stakeholders to strengthen the systems that support the care for this highly vulnerable at-risk group.

Number	Recommendation (includes report reference code)	Response	Comment
	would enable earlier identification of children at risk with increased community support put in place to monitor their progress; whilst strengthening the relationships between protective services and clinical services.		Link to A13, A14, I4, I5 and I6. DHS recommends its inclusion in developing and implementing this recommendation.
67.	(E2) It is recommended that CAMHS in conjunction with CAFHS, NGOs and other services engage in parent support. These partnerships would look to reintroduce evidenced-based early interventions such as Circle of Security parenting, The Incredible Years, and mentalisation therapy for parents.	Accepted	CAMHS is currently co-located with the Child and Family Health Service (CaFHS) in some country locations and is exploring opportunities for collaboration across our services. Consideration should be given to combining recommendations A6, A15 and E2 to establish a service that is multi-functional.
68.	(I4) It is recommended that each CAMHS community clinic has regular (fortnightly/monthly basis) consultation meetings (ideally face to face) with local senior Department of Child Protection workers to discuss mutual consumers of concern.	Supported in principle subject to further investigation	CAMHS will continue to work with all stakeholders to strengthen the systems that support the care for this highly vulnerable at-risk group. Further consultation to be undertaken with the Department of Child Protection. This recommendation should be viewed in conjunction with recommendations A13, A14, I4, I5 and I6. DHS recommends its inclusion in developing and implementing this recommendation.

Number	Recommendation (includes report reference code)	Response	Comment
69.	(I5) It is recommended that there are links developed for escalation of consumers of concern from CAMHS to child protection allowing for discussions at a high level for the best outcome of the child in mind.	Accepted	CAMHS will continue to work with all stakeholders to strengthen the systems that support the care for this highly vulnerable at-risk group. This recommendation should be viewed in conjunction with recommendations A13, A14, I4, I5 and I6. DHS recommends its inclusion in developing and implementing this recommendation.
70.	(J6) It is recommended establishing a formal network between CAMHS and academic leaders to facilitate the growth of applied research expertise in service settings including CAMHS, Emergency Departments and in the adolescent medical ward.	Supported in principle subject to further investigation	The requisite foundational work to establish a CAMHS Research Framework that is in line with the recent publication of the WCHN Research Strategy 2023–2027 is under exploration.

Recommendations to be led by DHW.

Number	Recommendation (includes report reference code)	Response	Comment
71.	(A1) It is recommended that the Department of Health and Wellbeing, in consultation with CAMHS and WCHN, establish a standardised age range for entry and exit into CAMHS services across all of SA. This would provide a clear age transition from adolescent to youth services, but with some clinical discretion based on the developmental presentation of the young person (at school, intellectual disability etc), negotiated on a case-by-case basis.	Supported in principle subject to further investigation	The endorsed Youth Mental Health Services for South Australia MOC (Model of Care) (2022) outlines an integrated highly personalised service approach to maximise the wellbeing of young people in our community. A standardised age range for entry and exit into CAMHS services will be considered as part of the final model.

Number	Recommendation (includes report reference code)	Response	Comment
72.	(A9) It is known that there is a significant association between substance abuse and mental health conditions (Conway et al., 2016). It is recommended that CAMHS and WCHN work in partnership with the South Australian drug and alcohol service (DASSA) to establish a secondary consultation drug and alcohol service for those under 18-year- olds to support and advise clinicians, stakeholders, adolescents, and parents about the management of substance abuse and substance abuse disorders.	Supported in principle subject to further investigation	Further investigation is required to understand the multiple roles, benefits, resourcing requirements and feasibility of this recommendation in conjunction with available budgets. Any implementation plan will need to be developed as a partnership between WCHN, CAMHS, DASSA and the Department for Health and Wellbeing and the remaining regional LHNs.
73.	(B4) All SA Services (WCHN, CAMHS, Department of Child Protection (DCP), DfE, Department of Paediatric Medicine (DPM) and NDIS services have a role and responsibility for social admissions. It is recommended that a high- level governance meeting be formed that includes these stakeholders with a Terms of Reference (TOR) for addressing social admissions that holds the child and family at the centre of care.	Supported in principle subject to further investigation	DHS recommends its inclusion in developing and implementing this recommendation.
74.	(B7) A high percentage of consumers who are admitted to an inpatient unit suffer childhood sexual abuse (Sansonnet-Hayden et al., 1987). It is recommended that Mallee review the feasibility of gender segregation and additional gender-sensitive practices on their inpatient service. This recommendation would be a consideration in any future hospital rebuild.	Accepted	This OCP Standard Sexual Safety in Mental Health Services describes expectations regarding the creation and maintenance of sexually safe environments for the delivery of mental health services in South Australia. WCHN will continue to work to ensure compliance with this Standard as part of their statutory obligations under the Health Care Act 2008.

Number	Recommendation (includes report reference code)	Response	Comment
75.	(B9) It is recommended that National Key Performance Indicators (including seven-day post discharge) be available on a monthly basis and be utilised by Mallee Ward to improve the quality of care.	Accepted	Mental Health quality and safety indicators are measured and reported regularly.
76.	(C4) It is recommended that note writing is streamlined into one software program. There is an expectation by staff in the Emergency Department and CAVUCS for CAMHS clinicians to enter patient reports in the EMR, making access to patient reports difficult. It would be useful to explore the barriers of CBIS to non CAMHS hospital staff and the need for pertinent information to be cross linked with Electronic Medical Records (EMR).	Supported in principle subject to further investigation	Work is currently being undertaken by DHW and the LHN's to examine a single client management software system to be utilised across all community Mental Health Services.
77.	(D1) It is recommended that the Department of Health and Wellbeing in consultation with WCHN and CAMHS advocate for the expansion of Tier 2 services in SA.	Supported in principle subject to further investigation	Further investigation is required to understand the multiple roles, benefits, resourcing requirements and feasibility of this recommendation in conjunction with available budgets. To be explored as part of the commitment to the Commonwealth/State Bilateral Agreement (Mental Health and Suicide Prevention).

Number	Recommendation (includes report reference code)	Response	Comment
78.	(D2) It is recommended that the Department of Health and Wellbeing in consultation with WCHN and CAMHS to partner with PHNs for the provision of headspace clinics, with specific consideration to the Alfred CYMHS model in Melbourne.	Supported in principle subject to further investigation	To be explored as part of the commitment to the Commonwealth/State Bilateral Agreement (Mental Health and Suicide Prevention).
79.	(D3) It is recommended that there is a single-entry point for mental health services across CAMHS, headspace, HARTTS, CAFHS, with CAMHS as the lead agency.	Supported in principle subject to further investigation	To be explored as part of the commitment to the Commonwealth/State Bilateral Agreement (Mental Health and Suicide Prevention).
80.	(D4) It is recommended the Department of Health and Wellbeing support CAMHS to achieve colocation of service between CAMHS and tier 2 for service delivery (face-to-face and virtual) for assessment and treatment. Development of formal partnerships of step-up and step-down referral pathways, shared infrastructure and co-location between area mental health services, mirrors recommendation 20 of the Royal Commission into Victoria's Mental Health System (Health, 2021).	Supported in principle subject to further investigation	To be explored as part of the commitment to the Commonwealth/State Bilateral Agreement (Mental Health and Suicide Prevention).
81.	(D5) It is recommended that the Department of Health and Wellbeing undertake service mapping as a real-time survey of all the tier 1, 2 and 3 services. As these services are providing psychiatric care and assessment it is important to understand what their capacity, availability and waiting times to be seen are for consumers. It is recommended that this service is updated regularly and is available to services across SA.	Supported in principle subject to further investigation	To be explored as part of the commitment to the Commonwealth/State Bilateral Agreement (Mental Health and Suicide Prevention).

Number	Recommendation (includes report reference code)	Response	Comment
82.	(E1) It is recommended that there is ring-fenced funding and clinician time for service provision for those children under 12 years of age in line with the National Mental Health Service Planning Framework.	Supported in principle subject to further investigation	Link to D2. Funding has been provided via the Kids 'Head to Health program under the Commonwealth/State Bilateral Agreement. CAMHS is a key partner and will use this opportunity to further develop services for this age group.
83.	(E3) A number of staff reported that CAMHS previously was involved with Child Protection in the Infant Therapeutic Reunification Service. It was reported that this was a cost- effective service which provided meaningful intervention for mothers and their infants. It is recommended that this intervention is explored particularly as it could support vulnerable consumers from Aboriginal and CALD backgrounds. CAMHS and DCP should determine the best governance and commissioning arrangements for this.	Supported in principle subject to further investigation	WCHN has had a sustained focus on building and maintaining relationships with key stakeholders and will continue to strengthen the systems that support the care for this highly vulnerable at-risk group.
84.	(E4) It is recommended that stronger links be developed with important stakeholders including SAPOL, Child Protection, Department of Human Services and Aboriginal services to identify women at highest risk for removal of their child related to high-risk behaviour and drug and alcohol use. This could be achieved through quarterly stakeholder meetings.	Accepted	WCHN has had a sustained focus on building and maintaining relationships with key stakeholders.
85.	(E5) It was reported that more support is required for infant mental health and better mental health supports for young mothers with high-risk behaviour, drug and alcohol use, CALD and Aboriginal and Torres Strait Islander women in the pre- and perinatal period. Currently this is mainly provided in the private sector with little access for those from vulnerable groups in SA society. It is recommended that staff specifically trained in Infant Mental Health, and culturally sensitive practice be employed in the WCHN	Supported in principle subject to further investigation	WCHN has had a sustained focus on building and maintaining relationships with key stakeholders. Further investigation is required to understand the multiple roles, benefits and resourcing requirements and feasibility of this recommendation in conjunction with available budgets.

Number	Recommendation (includes report reference code)	Response	Comment
	maternity service to help identify women at risk for post-natal depression.		
86.	(F10) It is recommended that for hospital-based staff, the Department of Health and Wellbeing explore a system to streamline patient note writing into one software program only.	Supported in principle subject to further investigation	Link to C4. Work is currently being undertaken by DHW and the LHN's to examine a single client management software system to be utilised across all community Mental Health Services.
87.	(F12) The Department of Health and Wellbeing in collaboration with CAMHS and other key stakeholders to develop a lived experience and carer engagement framework. An existing framework has been described by the Victorian Department of Health which encompasses vision, values, and what is a meaningful engagement and the tools for this engagement (Services, 2019).	Accepted	The existing Consumer, Carer and Community Engagement Strategic Framework 2021-2025 outlines the responsibilities of SA Health to strengthen and improve the practice of consumer, carer and community engagement.
88.	(G1) It is recommended that the Department of Health and Wellbeing, DfE, Department of Human Services and Department of Child Protection work with WCHN, CAMHS and the Division of Paediatric Medicine, to co-design a state-wide plan for the multisystem organisational approach to the management of consumers with neurodiversity and disability.	Supported in principle subject to further investigation	A range of informal partnerships to undertake collaborative care and share resources are in place. This will be considered with reference to the State Autism Strategy and in consultation with relevant Government agencies.

Number	Recommendation (includes report reference code)	Response	Comment
89.	(G3) People with symptoms of neurodiversity or disability, who do not have a comorbid mental health challenge, sit outside the remit of CAMHS as a tier 3 service. These people still require assessment to assess if they have Autism Spectrum Disorder or Attention Deficit Hyperactivity Disorder (ADHD). The missing middle here is a service to diagnose developmental disorders including ADHD and autism. The Victorian Royal Commission into Mental Health addressed this with the recommended development of a community hub, Recommendation 19 (Health, 2021). The Victorian Royal Commission into Mental Health described six levels of mental health services with level 5 corresponding to CAMHS and level 3 corresponding to tier 2. Level 4 is a new level of service delivery sitting between tier 2 and tier 3 (figure 3 in the Appendix). Community hubs, which sit at level 4, are available for the diagnosis, parental support and brief treatment of patients 0 – 11 years who display significant emotional or behavioural disturbance (Health, 2021). It is recommended that community hubs are developed as a collaboration of community health and paediatrics but supported by CAMHS.	Supported in principle subject to further investigation	For consideration as part of regional mental health planning with DHW and PHNs. Further investigation is required to understand the multiple roles, benefits and resourcing requirements and feasibility of this recommendation in conjunction with available budgets.

Number	Recommendation (includes report reference code)	Response	Comment
90.	(G4) People with neurodiversity and disability, who do not have a comorbid mental health challenge, sit outside the remit of CAMHS as a tier 3 service. However, as noted, a small number of these people can be extremely challenging in their behaviours to their families and themselves, and in the absence of an alternative solution present to Emergency Departments seeking a mental health intervention. It is recommended that a new developmental, residential unit with well-trained staff is developed as an alternative to Mallee Ward. Development of this unit should be led by the Department of Health and Wellbeing (DHW) DfE, Department of Human Services (DHW) and Department of Child Protection (DCP), WCHN, and the division of Paediatric Medicine. This would be a short-stay unit for family to be admitted; ideally one parent and their child. This unit would have 4 – 5 beds that would come under the remit of a partnership model. Parents of those children with neurodiversity or other disabilities would be offered crisis and planned admissions to this developmentally informed unit. Some of the features of this developmental unit could include sensory rooms and staff well-trained in the de-escalation of challenging behaviours. As this unit would not be focussed on the treatment of any comorbid mental health conditions, it is not suggested that CAMHS should take the lead.	Supported in principle subject to further investigation	WCHN has had a sustained focus on building and maintaining relationships with key stakeholders. For consideration as part of regional mental health planning with DHW and PHNs. Further investigation is required to understand the multiple roles, benefits and resourcing requirements and feasibility of this recommendation in conjunction with available budgets.
91.	(H6) It is recommended that dedicated investment and focus on strengthening intersectoral partnerships across Aboriginal Community Controlled and State Government organisations and agencies occurs, to enhance service planning and coordination.	Supported in principle subject to further investigation	A range of informal partnerships to undertake collaborative care and share resources, information, and premises are in place across South Australia. Formal partnerships such as service agreements and MOAAs are developed where CAMHS requires longer-term arrangements, or where there is contracted shared resources.

Number	Recommendation (includes report reference code)	Response	Comment
92.	(I6) It is recommended that a senior service liaison care team between Child Protection Director and CAMHS Director be established to foster an escalation point for contentious individual consumers and for a review of systems issues as they arise in real-time. This a clinical escalation point between Clinical Directors in relation to clinical matters that can't at lower levels.	Accepted	CAMHS and DCP already have high-level meetings to discuss consumers of concern. Consideration will be given to the effectiveness and efficiency of this meeting. This recommendation should be viewed in conjunction with recommendations A13, A14, I4, I5 and I6.
93.	(J4) It is recommended that all National Key Performance Indicators be available on a timely basis and be utilised by CAMHS to improve the quality of care. This will include such items as outcome measures, seven-day post-discharge and additional measures of consumer and family safety and satisfaction. Most measures should be available on a minimum monthly basis. Responsibility for production of the measures may sit with bodies outside CAMHS. The CAMHS Executive with the support of WCHN and the OCP will prioritise advocacy for a satisfactory resolution.	Accepted	Mental Health quality and safety indicators are measured and reported regularly.
94.	(I7) It was recommended that the Department of Health and Wellbeing consider developing a gender youth service. This would consist of representatives from CAMHS, Adult Mental Health, endocrinology, surgery and lived experience workers.	Supported in principle subject to further investigation	This recommendation will be considered as part of the development of the State-wide Gender Diversity Model of Care.

Appendix One – List of Recommendations

A. CAMHS Outpatient Model of Care

A1. It is recommended that the Department for Health and Wellbeing, in consultation with CAMHS and WCHN, establish a standardised age range for entry and exit into CAMHS services across all of SA. This would provide a clear age transition from adolescent to youth services, but with some clinical discretion based on the developmental presentation of the young person (at school, intellectual disability etc.), negotiated on a case-by-case basis.

A2. It is recommended that CAMHS describe and publish a service manual as to what it defines as CAMHS core business. This manual would articulate the values, strategies, the clinical models and principles that underlie this tier 3 service provision. This manual would be available within CAMHS and for external stakeholders.

A3. It is recommended that the WCHN expand the existing Women's and Children's Hospital Child and Adolescent Virtual Urgent Care Service (CAVUCS) to include the provision of mental health services Monday to Sunday 9 am to 9 pm. The Women's and Children's CAVUCS was developed together with a project team from the Northern suburbs of Melbourne (Sher et al., 2022). In discussions with the lead developer and author of the Victorian CAVUCS, for the expansion of the service to provide mental health support across all of SA this would need dedicated FTE, appropriately trained staff, effective supervision models to support and develop staff, and provision of contingencies for leave cover.

A4. It is recommended that an adolescent day program is established in partnership with the Department for Education. The day program would accept referrals from Mallee ward and CAMHS outpatient clinics and provide an additional service as step-up and step-down options in the continuum of mental health care. This day program would provide evidence-based treatments for adolescents living with mental health challenges and involving other stakeholders such as schools and NGOs. It is acknowledged that an adolescent day program should be a state-wide service and over time would need to evolve to provide a service across the whole state. It is understood that a previous incarnation of an adolescent SA day program had a number of challenges. Ideally the day program would follow a hub and spoke model to be aligned with the existing community CAMHS clinics.

A5. It is recommended that CAMHS develop an Intensive Community Care Service (ICCS) for the treatment of adolescents who have failed to progress in their treatment either as an inpatient or from outpatient services (Keiller et al., 2023). An ICCS would target high risk and difficult to engage adolescents (Assan et al., 2008). The ICCS could be based on several models including multisystemic community treatment, intensive case management, and the Victorian intensive mobile outreach service. Consideration should be given to the ICCS as a hub and spoke model aligned with the existing community CAMHS clinics.

A6. It is recommended that CAMHS establishes a community-based group program including but not limited to early intervention, parent/family support, psychoeducation of consumers and carers, targeted but time limited interventions for specific psychological conditions and distress arising in children and adolescents.

A7. It is recommended that CAMHS develop family therapy expertise held by several clinicians for both training of CAMHS staff and as a specialised service. This family therapy service would provide family therapy directly, secondary consultation and teaching across SA. It is recommended that the family therapy service would provide treatment that partners with community and inpatient CAMHS clinicians for assessment and treatment via a dual clinician model.

A8. It is recommended that CAMHS establishes a specialised service for the training in trauma informed care to CAMHS clinicians and external stakeholders. This clinical and training service could be considered in partnership with Health and Recovery Trauma Safety Services (HARTTS). This trauma service would have expertise in cultural and linguistic challenges found in the assessment and treatment of trauma arising in refugees and asylum seekers. The trauma informed service would provide a secondary consultation service. Evidence based models could include Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) and Dialectic Behaviour Therapy.

A9. It is known that there is a significant association between substance abuse and mental health conditions (Conway et al., 2016). It is recommended that CAMHS and WCHN work in partnership with the South Australian Drug and Alcohol Service (DASSA) to establish a secondary consultation drug and alcohol service for those under 18-year-olds to support and advise clinicians, stakeholders, adolescents, and parents about the management of substance abuse and substance abuse disorders.

A10. CAMHS Connect triages consumers for the CAMHS community clinics. However, it was reported that there is an additional and separate referral track into the CAMHS clinics by GPs and paediatricians writing directly to the CAMHS clinic child psychiatrist. The review team was unclear how this referral track complemented the overall outpatient intake system and what governance, and patient recording structures were in place. A separate concern the CAMHS clinicians reported was that as a result of the CAMHS Connect allocation they did not have any discretion to link the patient and their presenting mental health challenge with the best clinician/specialty in their outpatient clinic who could address that. It is recommended that the referral process from CAMHS Connect into the CAMHS outpatient clinics be reviewed.

A11. It is recommended that CAMHS explores the establishment of a hospital outreach post-suicide engagement service for children and adolescents who present with suicidal behaviour or significant suicide intent. This could be an expansion of the current RACER service in WCH Emergency Department in Adelaide. Mental Health Policy, Planning and Safety at SA Health already allocates funding for self-harm follow-up for WCHN aligned with adult after care services. An Australian model for hospital outreach post-suicide engagement is HOPE. HOPE teams have been established at Victorian hospitals for the urgent and intensive outpatient follow-up of people who present to the Emergency Departments or ward following an attempted suicide or serious plan. The HOPE team acts as the first phase in aftercare of a suicidal child or adolescent who presents to hospital. This SA review recommendation is in keeping with the Royal Commission into Victoria's Mental Health System (Health, 2021) recommendation 3 which was to fund four area mental health services to offer hospital outreach to complement usual care.

A12. It is recommended that there is an investment and use of digital healthcare service delivery. The use of virtual care for mental health support is something that young people are willing to engage with and would be well utilised. CAMHS has been trialling e-health initiatives and this should be continued.

A13. It is recommended that the role of the Complex Case Review Panel is reviewed to see if it is meeting the needs of the referrers. The internal referrers feedback reflected that the recommendations from the panel did not meet the needs of the referrers. It would be useful to review the ideal mix of staff in the review team, the nature of the questions posed and audit how best to feed back to referrers. The lead clinicians may need to be expanded to include outside experts and staff with dedicated EFT for the panel.

A14. It is further recommended that the role of the Complex Case Review Panel is reviewed to consider situations where that risk sits over multiple agencies, These risks are unable to

be moderated or reduced by the one CAMHS or WCHN service alone. Consideration should be given to the exploration of a multiagency escalation review process with key stakeholders (e.g. Department for Child Protection, Department for Education, SA Ambulance Service, SA Police, NDIS lead etc.) that provide a final decision where acute and chronic issues cannot be managed by one service alone.

A15. Since the COVID-19 pandemic, there has been a significant rise in the number of adolescents presenting with eating disorders both in SA and across the world (McNicholas et al., 2021; Campbell et al., 2022). As inpatients those people with eating disorders are managed by the paediatric unit on the adolescent medical ward with the focus on medical stability with minimal mental health support available. It was reported that patients will have one mental health assessment by the liaison psychiatrist or psychologist, and they are usually not seen again during that admission with an average length of stay of 14 days. Meal support is largely done by the medical nursing staff with a recent investment in a mental health meal support specialist. Mallee ward does not accept eating disorder patients unless they have acute mental health issues and nasogastric feeding is not done on the Mallee ward.

Best practice is to treat young people at home with outpatient mental health, medical and dietetic support and for the family to be engaged in Family based treatment. Adolescent Eating Disorder Day Programmes are an alternative to inpatient treatment and provide an effective step up/step down model (Baudinet and Simic, 2021).

In conjunction with Adolescent medicine and WCHN, it is recommended that CAMHS review eating disorder patient management with the development of a multidisciplinary team to provide mental health assessments and distress management on the medical ward. Consideration should be given to a step up/step down model of care for the deteriorating patient with an eating disorder to avoid hospital admission. This would help empower parents to continue meal support at home and avoid exposure to other eating disorder patients in an inpatient setting. Recruitment of a lived experience workforce and carer representatives would assist the multidisciplinary team (MDT) to provide liaison support between the different levels of care and assist the young person and parents/carers with engagement with the service (see recommendations F12 – 16).

CAMHS Inpatient Model of Care (Mallee Ward)

B1. All SA Services (WCHN, CAMHS, Department for Child Protection, Department for Education, Department of Paediatric Medicine (DPM) and NDIS) have a role and responsibility for social admissions. It is recommended that a high-level governance meeting be formed that includes these stakeholders with a Terms of Reference for addressing social admissions that holds the child and family at the centre of care.

B2. The time of heightened risk for suicide is in the days and weeks following discharge from hospital. It is recommended that Mallee ward explores the options of a step-down option from within Mallee or incorporated within the role of the mobile assertive outreach teams (see Recommendations A4, A5 and A11).

B3. It is recommended that Mallee ward as the only inpatient unit in SA is benchmarked on comparative data (seclusion, restraint, length of stay, occupancy) with equivalent hospitals in other states of Australia. This data is openly available (Health, 2023). If the data repeatedly exceeds benchmarking, then an escalation and review process to understand the source of the variance is undertaken, and a written remediation process is provided to management.

B4. A high percentage of consumers who are admitted to an inpatient unit suffer childhood sexual abuse (Sansonnet-Hayden et al., 1987). It is recommended that Mallee review the

feasibility of gender segregation and additional gender sensitive practices on their inpatient service. This recommendation would be a consideration in any future hospital rebuild.

B5. It is recommended that Mallee ward develop clinical pathways for longer planned and negotiated admissions for refractory outpatient consumers and continue to build community support to ensure these consumers avoid admissions wherever possible.

B6. It is recommended that National Key Performance Indicators (including seven-day post discharge) be available on a monthly basis, and be utilised by Mallee ward to improve the quality of care.

Interface between Mallee Ward, Emergency Department and CAMHS

C1. It is recommended that there is engagement at executive level between the WCHN Emergency Department and CAMHS to address issues as soon as they arise. The intention is to improve the relationship between WCHN Emergency Department and CAMHS on an overarching level and as needed on a case-by-case basis.

C2. It is recommended to reassign the Emergency Department Mental Health nurses to be solely responsible for Emergency Department presentations of mental health presentations.

C3. It is recommended that a multidisciplinary CAMHS team is provided for WCHN Emergency Department including psychologists, nurses, social workers, occupational therapists, psychiatric registrars, Aboriginal and other cultural supports and a consultant psychiatrist, dedicated to the Emergency Department.

C4. It is recommended that note writing is streamlined into one software program. There is an expectation by staff in the Emergency Department and CAVUCS for CAMHS clinicians to enter patient reports in the Electronic Medical Records (EMR), making access to patient reports difficult. It would be useful to explore the barriers of CBIS to non CAMHS hospital staff and the need for pertinent information to be cross linked with EMR.

C5. It is recommended that CAMHS develop comprehensive service plans for each individual consumer who has ≥ 2 presentations to the Emergency Department in 2 days, or 4 presentations in one month. These comprehensive service plans are summary clinical documents that detail patient demographic details, important patient contacts, a formulation, relevant, diagnoses, medications, triggers, and suggested strategies for managing the patient related to clinician approaches, appropriate use of pro re nata (prn) medications, the role of carers and admission to hospital. The comprehensive service plan is developed with the consumer, their carers and treating team. The plan is provided to the consumer and/or their carers to assist them when presenting to services, particularly the Emergency Department. The plan is designed to provide a quick summary of the consumer and their challenges and provide guidance to the clinician who may not be familiar with the consumer. These plans would be held in a place accessible to those likely to see the consumer.

Partnerships with Key Stakeholders

D1. It is recommended that the Department for Health and Wellbeing in consultation with WCHN and CAMHS advocate for the expansion of Tier 2 services in SA.

D2. It is recommended that the Department for Health and Wellbeing in consultation with WCHN and CAMHS to partner with PHNs for the provision of headspace clinics, with specific consideration to the Alfred Child and Youth Mental Health Service (CYMHS) model in Melbourne.

D3. It is recommended that there is a single-entry point for mental health services across CAMHS, headspace, HARTTS, CaFHS, with CAMHS as the lead agency.

D4. It is recommended the Department for Health and Wellbeing support CAMHS to achieve colocation of service between CAMHS and tier 2 for service delivery (face to face and virtual) for assessment and treatment. Development of formal partnerships of step-up and step-down referral pathways, shared infrastructure and co-location between area mental health services, mirrors recommendation 20 of the Royal Commission into Victoria's Mental Health System (Health, 2021).

D5. It is recommended that the Department for Health and Wellbeing undertake service mapping as a real-time survey of all the tier 1, 2 and 3 services. As these services are providing psychiatric care and assessment it is important to understand what their capacity, availability and waiting times to be seen are for consumers. It is recommended that this service is updated regularly and is available to services across SA.

D6. It is recommended that CAMHS in conjunction with WCHN and NGOs, develop a patient navigator workforce. Patient navigators are non-clinicians, employed by the hospital or CAMHS who can book, cancel appointments, can assist the consumer and their carers to navigate through the challenges of obtaining NDIS support, and negotiating with tier 2 services. An alternative model is in Queensland where there is a nurse navigator who works within specialist areas including eating disorders and the gender clinic that helps families with admission and discharge processes as well as navigating paediatric and mental health services. The navigator workforce could be rolled out incrementally beginning with the high-risk consumers who present frequently to the Emergency Departments or for admission.

D7. It is recommended that CAMHS partner with mental health clinicians in schools to: develop protocols for: referral from schools to CAMHS; supervision of school clinicians; secondary consultation; and to develop shared care arrangements for young people with mental health challenges.

D8. It is recommended that there is an increase in partnering with interested and motivated General Practitioners for the process of embedding shared care arrangements for appropriate consumers. It is recommended that there is a template and process developed for this shared care arrangement.

D9. It is recommended that for those children and adolescents in rural areas, CAMHS explore providing virtual clinical consultation to General Practitioners, provided by senior CAMHS clinicians modelled on the CAMHS Extension for Community Health Care Outcomes (ECHO) access to care service delivery approach (Rooney et al., 2021; Sockalingam et al., 2018). Project ECHO is a Queensland adaptation of the New Mexico ECHO model, with a hub-and-spoke knowledge sharing network for collaborative medical education and patient care designed for rural and under-serviced communities (Queensland, 2017). Project ECHO provides live learning through facilitated case discussions on paediatric health including mental health, gender health care, refugee health and child protection.

D10. It is recommended that CAMHS explore from a clinical and operational perspective the feasibility of joint assessments with tier 2 services including headspace and school mental health clinicians.

D11. It is recommended that opportunities to work closely with the Department for Child Protection as a key stakeholder are explored. Research suggests that children with exposure to emotional, physical, and sexual abuse are at increased risk of significant mental health disorders, externalising behaviours, and drug and alcohol addiction (Cecil et al.,

2017). Quarterly stakeholder meetings with protective services, SAPOL, education department and CAMHS would enable earlier identification of children at risk with increased community support put in place to monitor their progress; whilst strengthening the relationships between protective services and clinical services.

Early Intervention

E1. It is recommended that there is ring-fenced funding and clinician time for service provision for those children under 12 years of age in line with the National Mental Health Service Planning Framework.

E2. It is recommended that CAMHS in conjunction with CaFHS, NGOs and other services engage in parent support. These partnerships would look to reintroduce evidenced based early interventions such as Circle of Security parenting, The Incredible Years, and mentalisation therapy for parents.

E3. A number of staff reported that CAMHS previously was involved with Child Protection in the Infant Therapeutic Reunification Service. It was reported that this was a cost-effective service which provided meaningful intervention for mothers and their infants. It is recommended that this intervention is explored particularly as it could support consumers from Aboriginal and CALD backgrounds. CAMHS and DCP should determine the best governance and commissioning arrangements for this.

E4. It is recommended that stronger links be developed with important stakeholders including SAPOL, Department for Child Protection, Department of Human Services and Aboriginal services to identify women at highest risk for removal of their child related to high-risk behaviour and drug and alcohol use. This could be achieved through quarterly stakeholder meetings.

E5. It was reported that more support is required for infant mental health and better mental health supports for young mothers with high-risk behaviour, drug and alcohol use, CALD and Aboriginal and Torres Strait Islander women in the pre and perinatal period. Currently this is mainly provided in the private sector with little access for those from these groups in SA society. It is recommended that staff specifically trained in Infant Mental Health, and culturally sensitive practice be employed in the WCHN maternity service to help identify women at risk for post-natal depression.

Workforce support and enhancement

F1. It is recommended that CAMHS review classifications for their clinicians. There is a current anomaly where a CAMHS clinician will be supporting and advising a school counsellor, but the identically qualified school counsellor is on a higher classification.

F2. It is recommended CAMHS develop a strategy for direct entry for mental health workforce, with a career structure at point of starting with CAMHS.

F3. If a CAMHS position that has been advertised, shortlisted and interviewed for a particular mental health discipline (e.g. psychology) cannot be filled, it is recommended that the CAMHS position is then flexibly opened up for suitably trained clinicians from other disciplines (e.g. social work, nursing) to apply. Positions should not be left vacant while there is sufficient demand for assessment and treatment. It is possible to maintain multi-disciplinary teams without reserving discipline specific roles. For example, CAMHS can define the core disciplines for the team; highlight the missing discipline when a vacancy occurs; recruit to that in the first instance; if unsuccessful, recruit the best candidate for the remaining core professions; develop interest from the missing profession; repeat the process

and target the missing discipline at the next vacancy; repeat the process. Other CAMHS/CYMHS, such as EH CYMHS in Victoria have implemented this.

F4. It is recommended CAMHS consider the use of psychology students, nursing students, occupational therapy students and/or social work students within clinics with appropriate supervision.

F5. It is recommended that CAMHS create opportunities for shared staffing across Mallee ward, Emergency Mental Health Service, CAMHS Connect and the Community CAMHS teams.

F6. It is recommended CAMHS transition staff on short term contracts to permanent positions and reduces the use of short-term contracts.

F7. It is recommended that permanent positions are offered if a CAMHS clinician is in a temporary contract for over 12 months.

F8. It is recommended that CAMHS develop an interdisciplinary training plan that aligns with the CAMHS Model of Care.

F9. It is recommended that individual CAMHS clinics develop expertise in areas as defined by the needs arising in the individual clinic catchment area.

F10. It is recommended that for hospital-based staff, the Department for Health and Wellbeing explore a system to streamline patient note writing into one software program only.

F11. It is recommended that consideration is given to a policy of deliberate recruiting new graduates into CAMHS Connect junior positions with a promised pathway into a patient facing role in the wider CAMHS service.

F12. The Department for Health and Wellbeing in collaboration with CAMHS and other key stakeholders to develop a lived experience and carer engagement framework. An existing framework has been described by the Victorian Department of Health which encompasses vision, values, and what is a meaningful engagement and the tools for this engagement (Services, 2019).

F13. CAMHS to develop a Consumer and Carer Lived Experience Workforce with a dedicated leadership and organisational structure that reflects the needs and challenges for consumers and carers.

F14. For CAMHS to establish a lived experience and carer workforce/peer workers to be embedded within the MDT. This workforce would engage with, advocate for and directly assist consumers and their families across inpatient and outpatient care. The peer/carer workforce would assist in navigating patients and their families across the various mental health systems (CAMHS, Emergency Department, NDIS, private practitioners, headspace, etc.).

F15. CAMHS to employ Consumer Consultants to work with CAMHS clinicians at the systemic oversight level, to be involved in overarching policy work and attend meetings in CAMHS including staff interviews, clinical governance meetings and operational meetings.

F16. Streamline onboarding of peer workers for inpatient and outpatient work, assist them with achieving a certificate 4 in mental health peer support.

Consumers with Neurodiversity and Disabilities

G1. It is recommended that the Department for Health and Wellbeing, Department for Education, Department of Human Services and Department for Child Protection work with WCHN, CAMHS and the Division of Paediatric Medicine, to co-design a state-wide plan for the multisystem organisational approach to the management of consumers with neurodiversity and disability.

G2. It is recommended that given its finite resources that CAMHS limits assessment and treatment for consumers that have neurodiversity or disability to where there is an additional, prominent mental health condition requiring tier 3 treatment (such as eating disorder, psychosis, major depression).

G3. People with symptoms of neurodiversity or disability, who do not have a comorbid mental health challenge, sit outside the remit of CAMHS as a tier 3 service. These people still require assessment to assess if they have ASD or ADHD. The missing middle here is a service to diagnose developmental disorders including ADHD and ASD. The Victorian Royal Commission into Mental Health addressed this with the recommended development of a community hub, Recommendation 19 (Health, 2021). The Victorian Royal Commission into Mental Health described six levels of mental health services with level 5 corresponding to CAMHS and level 3 corresponding to tier 2. Level 4 is a new level of service delivery sitting between tier 2 and tier 3 (figure 3 in the Appendix). Community hubs, which sit at level 4, are available for the diagnosis, parental support and brief treatment of patients 0 – 11 years who display significant emotional or behavioural disturbance (Health, 2021). It is recommended that community hubs are developed as a collaboration of community health and paediatrics, but supported by CAMHS.

G4. People with neurodiversity and disability, who do not have a comorbid mental health challenge, sit outside the remit of CAMHS as a tier 3 service. However, as noted, a small number of these people can be extremely challenging in their behaviours to their families and themselves, and in the absence of an alternative solution present to Emergency Departments seeking a mental health intervention. It is recommended that a new developmental, residential unit with well-trained staff is developed as an alternative to Mallee ward. Development of this unit should be led by the Department for Health and Wellbeing, Department for Education, Department of Human Services, and Department for Child Protection, WCHN, and the Division of Paediatric Medicine. This would be a short-stay unit for family to be admitted; ideally one parent and their child. This unit would have 4 – 5 beds that would come under the remit of a partnership model. Parents of those children with neurodiversity or other disabilities would be offered crisis and planned admissions to this developmentally informed unit. Some of the features of this developmental unit could include sensory rooms and staff well-trained in the de-escalation of challenging behaviours. As this unit would not be focussed on the treatment of any comorbid mental health conditions, it is not suggested that CAMHS should take the lead.

G5. It is recommended that CAMHS develop a multidisciplinary developmental disorders clinic for the assessment of complex consumers that may have ASD or ADHD. This assessment-only clinic would be staffed by a child psychiatrist, neuropsychologist, speech pathologist, occupational therapist and paediatrician. The role of the clinic would be to support both the Mallee ward and the Community CAMHS teams to assess consumers with complex presentations that may be complicated by trauma, developmental delays, learning issues, cultural issues or where English is not the consumer's first language. This developmental clinic would have a primary and secondary consultation capacity and be able to provide support both in person and via telehealth.

Aboriginal and Torres Strait Islander People

H1. The Aboriginal workforce should be increased to meet the level of community need across all services areas; APY Lands, Southern and Northern Country, Metropolitan Community Teams, and other service areas in Acute and State-wide Services.

H2. It is recommended that continued investment in the CAMHS Aboriginal Learning & Development Framework aligned with WCHN Aboriginal Cultural Learning Plan 2021-2026 occurs to support the ongoing learning and development needs of the Aboriginal workforce, including support for undertaking tertiary level qualifications in the full range of CAMHS roles.

H3. It is recommended that all decisions impacting on Aboriginal consumers and communities must have Aboriginal leadership and appropriate consultation with stakeholders.

H4. It is recommended that Aboriginal Mental Health and Wellbeing workers are placed in WCHN to support acute care services.

H5. Due to a greater number of Aboriginal young people presenting in crisis, and access barriers for Aboriginal families to services such as headspace, it is recommended there needs to be a greater scope for Aboriginal Mental Health and Wellbeing Workers to provide assertive outreach to mild to moderate consumers, working collaboratively with interagency partners.

H6. It is recommended that dedicated investment and focus on strengthening intersectoral partnerships across Aboriginal Community Controlled and State Government organisations and agencies occurs, to enhance service planning and coordination.

H7. It is recommended that Aboriginal consumers, carers and Elders be engaged to contribute to service planning and evaluation. This will help to ensure that the service structure is a culturally safe environment as determined by consumers and the CAMHS Senior Aboriginal Leadership Team.

H8. It is recommended in response to community need and requirements for Aboriginal leadership on strategic and operational matters, that a management structure be adopted for CAMHS Aboriginal services that separates strategic and operational business. The Principal Aboriginal Mental Health Lead role should be focused on operations, undertaking management responsibilities such as cultural and clinical supervision for all Aboriginal staff within CAMHS, cultural supervision for non-Aboriginal staff who work with Aboriginal consumers, multi-disciplinary team review and debriefing, and membership on CAMHS operational committees. A new Senior Management position should be created to focus primarily on strategic business such as strengthening whole of government approaches, interagency partnerships, membership on WCHN Senior Aboriginal Leadership Group, implementation of the WCHN reconciliation action plan, WCHN Aboriginal Cultural Learning Plan, development of nWCH, and cultural oversight of the entire CAMHS organisation including all areas within Acute & State-wide Services, and Community Services.

With regard to the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands Program, the following suggestions for consideration are offered.

H9. It is recommended that CAMHS recognise the existing achievements of the APY Lands team and ensure the good work is built upon through adequately resourcing the implementation of the WCHN APY Lands Integrated Model of Care.

H10. It is recommended that continued investment in building and strengthening of relationships to ensure the local community leaders are involved in ongoing program planning, recruitment of Malpas and clinicians, and to ensure cultural appropriateness of services and models of care.

H11. It is recommended that there be continued investment in building and strengthening inter-agency partnerships with other services operating on the APY Lands in areas such as health, education and community programs.

H12. It is recommended that there be further investment into training for Anangu people as Malpas and clinicians.

H13. It is recommended there is flexibility allowed to use a FIFO integrated model of care, recognising recruitment challenges, while still maintaining a commitment to 'on APY Lands' based positions and workforce development.

Other populations (LGBTQIA+, out of home care, CALD)

I1. It is recommended that CAMHS increase CALD consumer/family facing positions.

I2. It is recommended that CAMHS develop CALD/trauma training for their clinicians and external stakeholders across all disciplines. This could be incorporated into Recommendation A8.

I3. It is recommended that CAMHS consider liaising with interstate services such as Foundation House in Victoria who advocate and support the rights of refugees and asylum seekers.

I4. It is recommended that each CAMHS community clinic has regular (fortnightly/monthly basis) consultation meetings (ideally face to face) with local senior Department for Child Protection workers to discuss mutual consumers of concern.

I5. It is recommended that there are links developed for escalation of consumers of concern from CAMHS to child protection allowing for discussions at a high level for the best outcome of the child in mind.

I6. It is recommended that a senior service liaison care team between Child Protection Director and CAMHS Director be established to foster an escalation point for contentious individual consumers and for a review of systems issues as they arise in real time. This a clinical escalation point between Clinical Directors in relation to clinical matters that can't at lower levels.

I7. It was recommended that the Department for Health and Wellbeing and WCHN consider developing a gender youth service This would consist of representatives from CAMHS, Adult Mental Health, endocrinology, surgery and lived experience workers.

Research, Training, and data collection

J1. It is recommended that a permanent position is created for a skilled officer for health data collection, analysis and feedback.

J2. It is recommended that CAMHS benchmark their data against national framework data and Health Roundtable data.

J3. It is recommended that the data analyst, in conjunction with senior CAMHS staff, including those with priority population expertise, ensure that data is culturally contextualised. Data should then inform CAMHS operations and strategic developments. This will include gap analysis to address current and future clinical demand.

J4. It is recommended that all National Key Performance Indicators be available on a timely basis, and be utilised by CAMHS to improve the quality of care. This will include such items as outcome measures, seven-day post discharge and additional measures of consumer and family safety and satisfaction. Most measures should be available on a minimum monthly basis. Responsibility for production of the measures may sit with bodies outside CAMHS. The CAMHS Executive with the support of WCHN and the OCP will prioritise advocacy for a satisfactory resolution.

J5. It is recommended that CAMHS form a team of interested staff to develop a dedicated strategy for clinical research at both a quality improvement level and publication level in line with the WCHN research recommendations. Experience has shown that only protected time or EFT will enable clinical research.

J6. It is recommended establishing a formal network between CAMHS and academic leaders to facilitate the growth of applied research expertise in service settings including CAMHS, Emergency Departments and in the adolescent medical ward.

J7. It is recommended that a new role for CAMHS consultation with stakeholders is developed. This Community Consultation Senior Clinician's primary role would be to liaise with CAMHS core stakeholders (including but not limited to Child Protection, Education, Paediatrician and GPs). The Community Consultation Senior Clinician would arrange and coordinate teaching opportunities delivered by CAMHS clinicians, and would also build links with senior stakeholders, and provide education about what is the core business of CAMHS.

J8. It is recommended that processes are developed to evaluate any new programs introduced in CAMHS to assess the clinical benefit, consumer and carer feedback and impact they have on overall service delivery using hard and soft outcome measures. Hard outcome measures could include such measures as changes to Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA), readmission rate, presentations to Emergency Department, while soft measures could include patient satisfaction questionnaires.

For more information

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