South Australian CAMHS Review - 2023

Executive Summary

A review of Child and Adolescent Mental Health Services (CAMHS) was requested by the Office of the Chief Psychiatrist (OCP) in partnership with the Women's and Children's Health Network (WCHN). The purpose of the review is to inform the development of future service and workforce requirements for CAMHS in South Australia (SA), and to inform strategic directions and contemporary models of care. The review was expected to benchmark best care in SA for infants, children and adolescents for the next 5 to 10 years, to inform the development of future service and workforce requirements and to inform strategic planning.

A review team of seven members included: carer and consumer consultants; a leading Aboriginal academic; and mental health clinicians including a senior nurse, a paediatrician, a clinical and academic psychologist, and a child psychiatrist. The team was drawn from South Australia, Queensland and Victoria.

While the team had a limited time period to conduct the review, the scope of the review was very broad with twelve (12) specific terms of reference in addition to the question of strategic direction. These terms of reference covered Inpatient and Community Mental Health services, the role of CAMHS as it related to the Emergency Departments and Paediatrics, as well as wider stakeholders including National Disability Insurance Scheme (NDIS), Department for Child Protection (DCP), Department for Education, Primary Health Networks (PHNs) and General Practitioners (GPs). The review was to make special reference to Aboriginal and Torres Strait Islander people, people from Culturally and Linguistically Diverse backgrounds, those in residential care, children under Guardianship and those in secure custody. Other priority groups included LGBTQIA+ and neurodiverse children and adolescents. Workforce support and enhancement was another area of focus for the reviewers along with the considerations for the commissioning of the new Women's and Children's Hospital.

The reviews spent many months meeting regularly in preparation for a week-long visit to SA in late June 2023. The review team read over 140 documents related to past reviews of health services in SA, planning and strategy documents, and performance and quality data for the services. The review team were provided with written feedback from 83 staff members who responded to an online survey. The reviewers then consulted directly with CAMHS staff, consumer carer advocates, and other key stakeholders during face-to-face site visits and online forums.

The review team focused on four questions to staff and stakeholders; (1) what was CAMHS doing well?, (2) what are the service gaps?, (3) how could things be improved? and (4) what should be reduced in CAMHS?

During the many and varied consultations with the CAMHS staff the reviewers were very impressed with the level of passion, dedication and clinical innovation that SA CAMHS staff brought to their work. This was despite many challenges including staff burnout from the

impact of the COVID-19 pandemic, lack of resources and an increased demand for their tier 3 service.
The review team made ninety-four (94) specific recommendations across ten (10) areas relating to the terms of reference:

A. CAMHS outpatient model of care (15 recommendations)
B. CAMHS inpatient (Mallee ward) model of care (9 recommendations)
C. Interface between Mallee ward, Paediatric Emergency Department (PED) and CAMHS (5 recommendations)
D. Partnerships with Key Stakeholder (11 recommendations)
E. Early intervention (5 recommendations)
F. Workforce support and enhancement (16 recommendations)
G. Consumers with neurodiversity and disabilities (5 recommendations)
H. Aboriginal and Torres Strait Islander people (13 recommendations)
I. Other priority populations including LGBTQIA+, out-of-home care and CALD peoples (7 recommendations)
J. Research, Training, and data collection (8 recommendations)

Seven headline recommendations were made for the strategic future of SA CAMHS. Different stakeholders, including CAMHS, have singular and joint responsibility for achieving these changes. Headline recommendations focused on CAMHS providing an integrated continuum of mental health care for their consumers and their families; becoming a high-quality tier 3 mental health service; achieving sufficient staffing levels and enhancing staff morale; tracking the rising demand in mental health demand while shaping realistic expectations about what CAMHS should, and can, do.

There is much to be proud of in CAMHS and in SA. With a clearer conceptual framework, enhanced resourcing, clearer communication and strategic use of partnerships, it will be well placed to provide the leadership around the formal and informal system of mental health services for the young people of South Australia.

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Acknowledgment

The authors of this report acknowledge South Australian Aboriginal people as the traditional custodians of country across South Australia, and recognise and respect their deep connections to land, sea, sky, community and country. We pay our respect to their Elders past, present and emerging.

Throughout this document the word Aboriginal is inclusive of Torres Strait Islander children, young people, and their families.

The authors would also like to gracefully acknowledge the collective voices of those with a lived experience of mental illness. We respect and appreciate the thoughtful insights shared by consumers, their carers and their families.

We thank those who generously contributed their wisdom and experiences with the review team.

Consumers, their carers and their families are the experts in their journeys towards mental health recovery. Recovery can only happen in a respectful relationship between consumers, their carers and clinicians.

Review team

- 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)

Background

This review was requested by the Office of the Chief Psychiatrist (OCP) in partnership with the Women's and Children's Health Network (WCHN). The purpose of the review is to inform the development of future service and workforce requirements for Child and Adolescent Mental Health Services (CAMHS) in South Australia, and to inform strategic directions and therefore contemporary Models of Care.

Recommendations from this report will also be considered by 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.

Context

The CAMHS in South Australia (SA) is governed by WCHN, provides tertiary level mental health assessment and treatment for infants, children and young people (as well as for parents in the perinatal period) with severe and complex mental health difficulties that require the support of a multidisciplinary team. CAMHS provides mental health services across metropolitan, regional and rural South Australia. While teams are located at various sites around South Australia and may have defined catchment areas, it is important to understand that, as a whole entity, CAMHS is a state-wide service and the only child and adolescent mental health service in the state with a remit for assessing and treating severe and complex mental health challenges.

According to the Model of Care, CAMHS core role within this service context is to provide specialist mental health assessment and therapeutic services, utilising a biopsychosocial, developmental, and family oriented framework. CAMHS values, respects, and undertakes its work within the cultural context of its consumers and families. CAMHS also recognises the

greater likelihood of mental health challenges and complexities in relation to engagement with services for Aboriginal and Torres Strait Islander children, young people and families, and for culturally and linguistically diverse (CALD) children, young people and families. Related challenges in engagement also occur for those children and young people, their carers and residential care staff under the Guardianship of the Chief Executive of the Department for Child Protection. Therefore, CAMHS prioritises access for these groups.

Following a review of CAMHS services in South Australia in 2014, a new service and Model of Care was developed in 2016-17. Services include:

- Inpatient Psychiatric Care - Mallee ward in the Women's and Children's Hospital for children and young people up to age 18 (12 bed unit);
- Inpatient and Community Care - Helen Mayo House, Perinatal Infant Mental Health Services;
- CAMHS Connect Referral and Intake Service;
- Emergency and Crisis Response - Emergency Mental Health Service (EMHS), Rapid Assessment Consultation Evaluation Review Team (RACER);
- State-wide Community-based Services - Anangu Pitjantjatjara Yankunytjatjara (APY) Lands, Northern and Southern Country (located across multiple sites), Northern, Central (located across Eastern and Western sites) and Southern Metropolitan teams;
- Senior Aboriginal Clinicians and Wellbeing Support staff working across multiple CAMHS services;
- Consultation Liaison Services - including specific support services for Eating Disorders, Gender Diversity, Neuropsychology and Developmental Disabilities Guardianship Service, CALD Teams;
- Lived Experience and Peer Workers;
- Forensic Services.

Prior to the long-term effects of the COVID-19 pandemic on mental health, CAMHS in South Australia had experienced a significant increase in demand for services. A range of new initiatives and changes have been put in place to support crisis response, inpatient services, forensic services and the service is evolving to provide more support for children and adolescents with neurodevelopmental disability. However, the resourcing required hasn't kept pace with the demand, with the South Australian Mental Health Services Plan 2020-2025 noting the increased resourcing required.

A review of preliminary academic data also indicates that the estimated demand of CAMHS Services across all sectors may continue to increase. Additionally, current research evidence is now highlighting the increasing need for mental health care for children experiencing physical, emotional or sexual harm or neglect. This is indicating an emerging public health crisis for infants, children and young people in the child protection system or at risk vulnerable socioeconomic groups and a need to break the intergenerational cycle of harm,

trauma and mental health impact. Outcomes in relation to a safe and supportive transition to discharge or transfer from CAMHS tertiary level services to less intensive primary or secondary health care providers have also been impacted by the significant increase in demand for community-based mental health support across the state.

CAMHS has sought to address some of the increase in demand for services and complexity of presentations by continuing to develop innovative services that enhance and improve access to tertiary level child and adolescent mental health expertise across the state. The additional COVID-19 Response Funding has also afforded an opportunity for CAMHS to review and assess the intake and referral processes, to strengthen screening and preliminary assessments for consumers on waiting lists, in addition to developing and implementing a new acute service to respond to urgent and high-risk presentations. The South Australian Government is also committed to establishing 10 extra mental health beds in the new Women's and Children's Hospital (nWCH), as well as urgently employing at least 5 additional child psychiatrists, 10 child psychologists and specialty nurses. However, it is likely that transitional measures will be needed to accommodate increasing need and demand for inpatient beds as the nWCH will likely not be commissioned prior to 2030.

Additional drivers that were considered to inform the review included: increased patient demand and increased complexity; COVID-19 quarantining and its effect on the mental wellbeing of young people; increased Eating Disorder presentations; increased Autism Spectrum Disorder (ASD) presentations to both WCHN and CAMHS; increased presentations of patients to the Emergency Department (ED); changes arising from past reviews; staff burnout; loss of staff to jobs outside of CAMHS; primary and secondary health sectors becoming risk averse with consequent directing of adolescents with moderate to low risk to the ED; and the collapse of tier 2 services especially with regard to children and the pressure on CAMHS to fill this gap.

The construct of tiers of care in mental health was initially developed in the United Kingdom (UK) and has been influential in framing mental health service provision in Australia *(Newman and Birleson, 2012)*. Tiers attempt to differentiate the elements of a health care system such that resource density and intensity are matched to the needs of the consumer. For example, maternal child health nurses could be expected to see the vast bulk of new infants and parents where low intensity interventions can be expected to help the majority. However, a number of more serious presentations will require paediatrician involvement. An even smaller number of infants and parents will require a multi-disciplinary team assisting with a severe issue. These correspond to a tier 1, 2 and 3 level. Table 1 illustrates this concept *(Newman and Birleson, 2012)*. While the number of tiers and their specificity was recently updated in a Victorian context *(Health, 2021)*, for simplicity and congruence with most other jurisdictions, the three-tier model will be used in this document.

Levels of Care	**Tier 1 Primary care**	**Tier 2 Specialists with mental health training**	**Tier 3 Specialist Multidiscipline**	**Tier 4 Super-specialist** *(often included as element of tier 3)*
Providers *(Note that the tier is a function of staff training and the presence of the multi-disciplinary team. The agency per se does not indicate the tier.)*	e.g. GPs, CHCs *(depending on provider)*, *Aboriginal Health Care service*	e.g. psychologist, paediatrician, psychiatrist, *headspace, school l mental health,*	e.g. CAMHS team	e.g. Mental Health inpatient unit or specialist clinic
Roles	Prevention, identification and referral, early intervention, collaborative care; for mild or early onset *challenges*	Prevention, early intervention, assessment and treatment, collaborative care, education; for moderately severe *challenges*	Assessment and treatment, consultation, collaborative care, education; for severe and complex *challenges*	Stabilisation, intensive intervention, consultation, rehabilitation; for *mental health challenges* with severe impairment or high risk
Estimated number with mental health *challenges*	8–9% with mild disorders	3–4% with moderately severe *mental health challenges*	2.5% with severe & complex *mental health challenges*	0.07% need inpatient care

CAMHS = specialist mental health services for children and adolescents; CHCs = Community Health Centres; GPs = general practitioners.

(Newman and Birleson, 2012)

Table 1: The Australian Mental Health Population Planning Model for 0-to-18-year olds

Note: Annotations onto the original are in italics

Figure 1 below illustrates the tiers concept. The base of the pyramid has greater coverage of the population and is able to provide treatment for lower intensity mental health challenges. The higher up the pyramid has lower coverage and can be expected to provide more intensive input for those with more severe mental health challenges. The degree to which the different tiers are organised around multidisciplinary mental health teams is an important differentiating factor in cost and accessibility. It is critical to note that services are in tiers and not consumers. The intensity of a mental health challenge for a consumer can be expected to vary over their journey and services from different tiers will be required at different times. Smooth movement between tiers as required by consumers is the ideal.

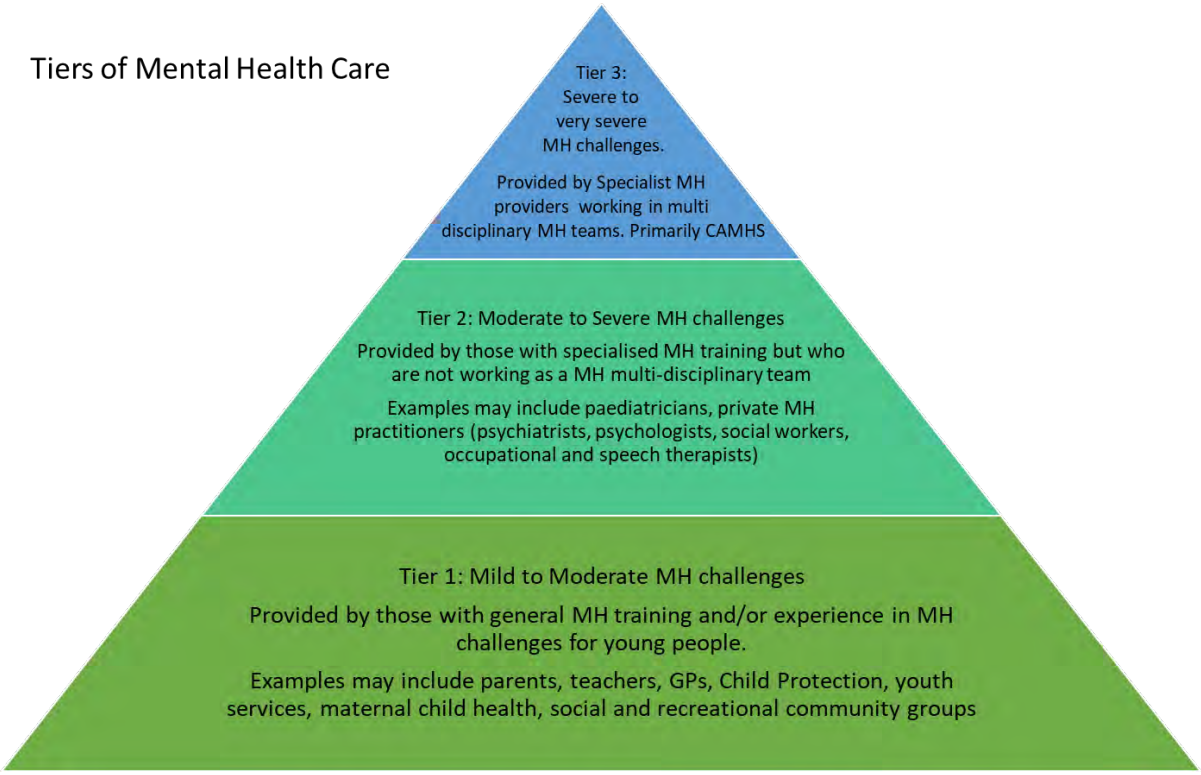

Figure 1: Tiers of mental health care

There is an impression that the health care system has shifted in line with Figure 2. Post the COVID-19 pandemic, there has been a relative collapse of tier 2 services. While there are also some large increases in SA in the number of professionals with specialist mental health training (e.g. Education), but who do not work in a multidisciplinary team, many of the tier 2 services were perceived to have become more risk averse. This may have affected their preparedness to work at a tier 2 moderate to severe mental health challenge level.

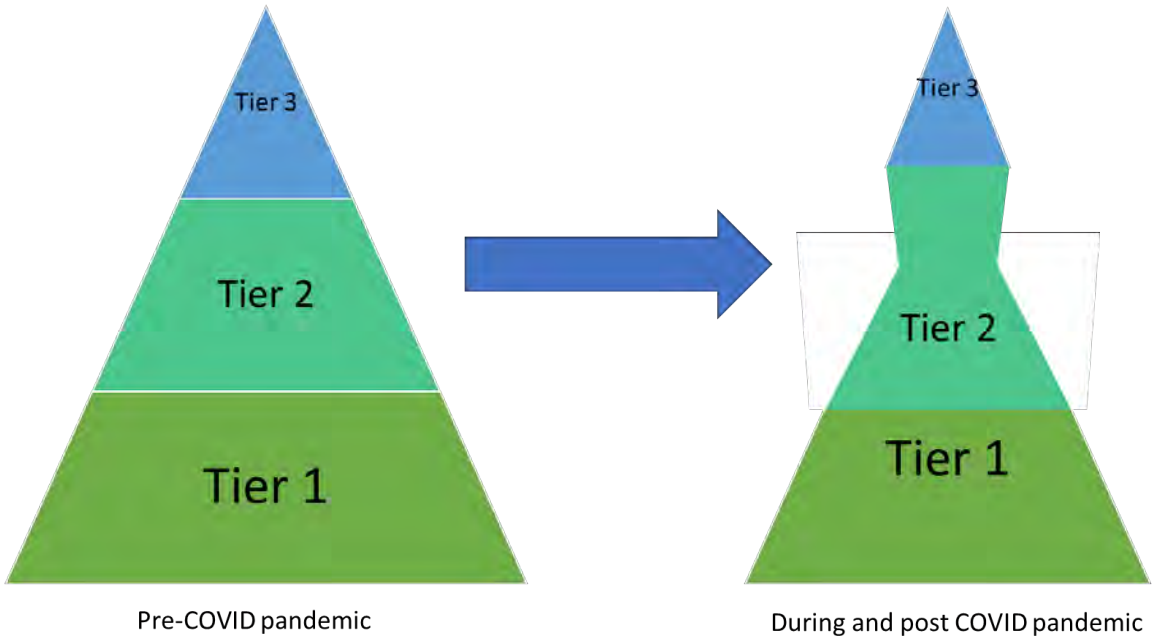

Figure 2: Representation of the shrinking of Tier 2 services

Method

The approach to the strategic review was determined in consultation with the WCHN and CAMHS Executive Leadership Teams in association with the OCP and included the following elements;

1. Review of documents: The reviewers were provided with past reviews, planning and strategy documents, inspection reports, performance and quality data for the services. Objective Connect, a secure external file sharing application, was used to share close to 150 documents with the Review Team.

2. Interviews: The reviewers consulted directly with CAMHS staff and key stakeholders during site visits or virtual forums conducting a combination of face-to-face meetings and interviews, with some video conferencing via Microsoft Teams. The precise work plan was determined through negotiation with the OCP, CAMHS and the WCHN Executive.

3. Staff Survey: CAMHS staff were encouraged to complete a staff survey to provide feedback about their experience of working in CAMHS and their views on how services could be delivered into the future. Written feedback was also accepted via email to camhsresources@sa.gov.au.

4. Dr John Brayley (Chief Psychiatrist SA), along with the CAMHS Executive leadership team, met with union representatives to inform them of the review and provide them with the DRAFT Terms of Reference for feedback. Communication plan: the key objectives within this plan was to inform CAMHS staff, WCHN staff and relevant

stakeholders about the strategic review of CAMHS services and to encourage CAMHS staff and show them how to provide feedback about the review.

5. A WCHN intranet page was established to provide a central accessible source of information about the review for CAMHS and WCHN staff.

The review team, in the limited time available, were not expected to address in detail every term of reference. Rather, through focussing on the strengths and challenges of CAMHS from multiple perspectives, it was anticipated that themes and recommendations pertaining to the terms of reference would also emerge. The terms of reference are located below (Table 2).

(1) To ensure that current and future services for the next five to ten years are aligned with best practice in CAMHS service delivery nationally or internationally, and which also responds to emerging issues related to Child and Adolescent Mental Health (TR1).
(2) To identify priority areas for CAMHS mental health service delivery across the state (rural and remote as well as metropolitan South Australia) in line with National and State planning priorities, and service delivery priorities in other jurisdictions (TR2).
(3) To make specific reference to the following areas (TR3):

a. Current and future service delivery models for inpatient care for children and young people with mental health concerns in South Australia over the next 5-10 years that should also be considered during the development of the new Women's and Children's Hospital (TR3a).

b. Any transition requirements that need to be considered prior to the commissioning of the nWCH (TR3b).

c. Inpatient and community-based service delivery models for the care of children and young people who have neurodevelopmental disabilities with co-morbid difficulties affecting emotions and behaviour (TR3c).

d. Service delivery responses to Emergency mental health presentations to emergency departments and in particular the management of suicidal young people (TR3d).

e. Clearly define the role of CAMHS as a tertiary mental health service as part of a Consumer-centric care pathway between primary, secondary, and tertiary mental health support including CAMHS CONNECT function and effectiveness (TR3e).

f. The relationships of CAMHS with key partners including the NDIA, Department of Child Protection, Department of Education, General Practitioners other agencies as well as industrial and community partners (TR3f).

g. Prevention and early intervention models of care for all age groups (TR3g).

h. Provision of a Child and Adolescent Mental Health Mobile & Assertive Outreach Services for adolescents including the access to such services for adolescents from hard-to-reach populations, with a particular focus on those from Aboriginal and Torres Strait Islander, Culturally and Linguistically Diverse (CALD) backgrounds, those in residential care, children and young people under the Guardianship of the Chief Executive and children and young people in secure custody. The optimum level of access to services for children of all ages, as well as emerging other priority groups or areas that should guide future CAMHS planning, including LGBTIQ+ youth (TR3h).

i. Strategies for building a highly skilled, robust, culturally informed, and sustainable long - term workforce for clinicians who specialise in Child and Adolescent Mental Health care (TR3i).

j. Involvement of lived experience in all levels of service planning and delivery (TR3j).

Table 2: The CAMHS Review team's terms of reference

What were the Reviewers' Intentions?

The reviewers met staff from many different inpatient and community CAMHS teams, including those staff managing Aboriginal and Torres Strait Islander and CALD communities. The reviewers had the opportunity to interact with external stakeholders such as Child Protective Services, Department for Education, and General Practitioners (GPs). These interactions provided a rich source of information and insight, and the reviewers are so grateful to staff and stakeholders for their willingness to participate and be open and honest in their responses.

The reviewers attempted to coalesce the information provided by the participants into sections that we hope will pave the way for further consideration and development of the recommendations.

The reviewers initial intent was to provide a forum where staff could feel safe to reflect on current practices and put forward ideas for improvements. The reviewers were keen to acknowledge the best practices that were already in place in many areas of SA CAMHS. The reviewer's intention was to provide direction and focus for further development and clarification of services within SA CAMHS in a culture of improvement, cooperation and collaboration. Most importantly, the reviewers sought to join with the SA Government, WCHN and SA CAMHS in working towards better outcomes for young people, carers, staff and the community, now and into the future.

Review Limitations

The review team was impressed and delighted by the generosity of all involved. The reviewers attempted to deal with all the material provided verbally and written with care and respect. This review was allowed to touch on many areas with a broad set of terms of reference. However, it is important to note that there was limited time available (approximately 60 hours per reviewer) to achieve planning, interviews, discussions, and draft feedback for August. With one week of interviews in South Australia, the review team have had to become very focussed. The reviewers acknowledge that with the time limitations of the review, not all areas have been addressed in totality.

There are three immediate consequences that readers need to be aware of when reading this report:

First, the review was generally unable to do independent verification or systematic cross referencing of claims made about the functioning of the mental health system. Written materials were graciously provided but the report will not systematically speak to everything that was provided.

Second, systematic literature reviews on Models of Care, Evidence based practice, Engagement practices, and visits to consumers, carers, referrers, partners and staff in the country and APY Lands were not possible. Meetings with those from the country relied on video links.

Third, due to time, and to a number or pre-existing reviews involving CAMHS, themes, issues and recommendations will be stated as succinctly and clearly as possible.

Themes from the staff survey

Responses to the CAMHS staff survey were received from 83 individuals. Their characteristics are shown below.

Where do you spend most of your time working within CAMHS?

ANSWER CHOICES	RESPONSES	
Metropolitan Community Team	44.58%	37
Country Community Team	18.07%	15
Statewide Services	14.46%	12
Hospital based services	6.02%	5
Inpatient Services	0.00%	0
Executive Support team (Administration, Project, Safety Quality and Risk, Finance)	4.82%	4
Prefer not to say	4.82%	4
Other (please specify) Responses	7.23%	6
TOTAL		83

What is your primary role within CAMHS?

ANSWER CHOICES	RESPONSES	
Aboriginal Social and Emotional Wellbeing Worker/Clinician/Senior	3.61%	3
Administrative Officer	6.02%	5
Mental Health Nurse	12.05%	10
Occupational Therapist	8.43%	7
Psychiatrist (including Registrars,Medical Unit Heads)	6.02%	5
Psychologist	10.84%	9
Social Worker	28.92%	24
Speech Pathologist	3.61%	3
Service Manager, Clinical Coordinator or Nurse Unit Manager	3.61%	3
CAMHS Co-Director or Manager (Community Operations or Statewide Services)	0.00%	0
Lived Experience or Peer Support Worker	0.00%	0
Prefer not to say	16.87%	14
TOTAL		83

What is the level of the role in which you spend the most time working in CAMHS?

ANSWER CHOICES	RESPONSES	
Level 1 (ASO, AHP, RN)	2.41%	2
Level 2 (ASO, AHP, RN)	31.33%	26
Level 3 (ASO, AHP, RN)	39.76%	33
Level 4 (ASO, AHP, RN)	3.61%	3
Level 5 (ASO, AHP, RN)	3.61%	3
Level 6 (ASO and above)	1.20%	1
WHA	0.00%	0
Medical Consultant	6.02%	5
Registrar	0.00%	0
Prefer not to say	12.05%	10
TOTAL		83

How long have you worked within CAMHS?

ANSWER CHOICES	RESPONSES	
less than a year	10.84%	9
1-5 years	25.30%	21
5-10 years	13.25%	11
10 years or over	40.96%	34
prefer not to say	9.64%	8
TOTAL		83

1. Strengths and Sources of Pride

1.1 CAMHS Staff

The key strength identified was the commitment and caring nature of the CAMHS workforce. A number of adjectives and terms were used to describe CAMHS staff including dedicated, passionate, empathetic, genuine desire to make a difference, skilled, knowledgeable, resilient, warm and friendly, creative thinkers, adaptable, and flexible, and displaying kindness. There was a recognition of the countless hours of unpaid overtime, using own funds to brighten up therapeutic spaces, while maintaining management of large caseloads in an under-resourced and complex care environment. CAMHS staff were seen as highly qualified and supportive of each other through sharing knowledge and skills and making the

best of limited resources. CAMHS people are its greatest strength. This recognition of character extended across the entire CAMHS workforce including administrative staff, clinicians, coordinators, seniors, and management.

> *"Friendly, warm clinicians who genuinely care about consumer and family wellbeing. Strong team culture that values connection and kindness."*

1.2 Diversity of Services, Programs, and Therapeutic Approaches

The diversity of programs and services available to consumers were also frequently mentioned as a strength, such as; acute and community services, emergency mental health services, psychiatry and allied mental health, CALD community services, RACER clinic, Mallee ward, Aboriginal community services, WCHN CREATE values, specialist eating disorder service, specialist gender dysphoria service, adolescent sexual assault prevention program, forensic in reach to Kurlana Tapa and Youth Court, Helen Mayo House and the Bridge Project. Therapeutic approaches included; safe and comprehensive triage, risk assessment, safety planning, escalation protocols, case management, case conferences, assertive follow up, counselling, advocating for consumers, family and dyadic approaches, working with Children of Parent with a Mental Illness (COPMI), trauma informed care, Mindfulness-Based Cognitive Therapy, Dialectic behaviour therapy (MBCT), Cognitive Behavioural Therapy (CBT), Acceptance and Commitment therapy (ACT), Marte Meo therapy, Theraplay, and Parallel parent child narrative (PPCN).

1.3 Collaboration and Partnerships

Working collaboratively across the system was recognised as a strength, with the following interagency partnerships highlighted; Department for Child Protection, Department of Human Services, Department for Education, community-based organisations, and the operation of the Interagency Therapeutic Needs Panel. Partnerships with lived experience consumers and connections to community were also highlighted as a strength of CAMHS in influencing service planning, along with being open and responsive to consumer and carer feedback.

1.4 Positive Outcomes for Consumers and Families

The greatest source of pride for CAMHS staff was seeing positive outcomes for consumers and families from the depth and quality of assessment and therapeutic work. This achievement of outcomes was illustrated through staff commitment to managing complex cases through multi-disciplinary teams and multi-agency collaboration, to help young people, carers and their families make sense of "who they are '' and "what they need". There was no team or service singled out to be the most important or significant in achieving positive outcomes for consumers, rather there was a mutual and shared respect for the importance and achievements of all services across CAMHS.

> *"All of the services CAMHS currently provides are vital and integral components. There is no one team that is more or "most'' important - acute, community and subspecialist teams are all essential elements of any state-wide child and adolescent mental health service."*

2. Weaknesses and Gaps

The common weaknesses or areas for improvement identified fell under the themes of staff recruitment, retention and capabilities, CAMHS model of care, and administrative documentation systems. The key themes for service gaps were also connected to the CAMHS model of care, specifically group and family therapy, assertive outreach and prevention, and services for early years and disability. More generally, there was frustration expressed with staffing levels being insufficient to meet need and with long wait lists to access a number of services. This concern was more pronounced for country areas.

2.1 Staff Recruitment, Retention, and Capabilities

The issues raised associated with staff recruitment and retention included; staff burnout due to increasing caseloads (no caps), lack of diversity in case load (all high end, high complexity), limited pathways for career progression, short term contracts, salary structures significantly lower than other departments, states, and private settings, and a lack of financial incentives to work in country regions. The issue of staff capabilities is multi-layered and was raised as a weakness of the system and model of care in which clinicians operated, not as a deficit of individual workers. There was a perception there was too high an expectation placed on entry level clinicians leading to potential unsafe practice, and that while CAMHS is a tertiary service there are a large number of clinicians who do not have adequate training and expertise to provide therapy and treatment for mental health disorders. The limitations of staff capacity to provide the appropriate level of tertiary care was linked to inadequate access to training, professional development, and quality supervision, and the ‘generalist’ nature of the model of care, leading to a lack of clear boundaries across disciplines and staff feeling they need to be “everything to everyone”.

2.2 Model of Care

Firstly, the model of care was seen as too restrictive to incorporate broader needs of consumers connected to the social and cultural determinants of health, devaluing case management and systemic coordination, particularly in the work of community teams. A need for greater flexibility was expressed to allow for more community engagement and relationship building, being more proactive in identifying and providing services to children in need before reaching crisis point. This was highlighted specifically in the context of CAMHS work on the APY Lands, stating the importance of not enforcing metro-centric models which have not been co-designed with the local community. It was argued that the current model could be improved by more formally recognising CALD and Aboriginal Wellbeing Workers as specific disciplines, acknowledging the invaluable role of cultural expertise and appropriate engagement in achieving positive outcomes for consumers. It was raised that all CAMHS teams (acute, community, and sub-specialist) should have allocated time, resources and scope for relationship building, education and early intervention.

Secondly the model of care was seen to underutilise the full range of clinician skills within the multidisciplinary team, with allied health professionals all employed as generic “CAMHS Clinicians”. This was seen to contribute to de-skilling and reduce job satisfaction. This was particularly highlighted for Psychology. It was felt there is a stronger focus on risk aversion and processing consumers through the system, opposed to providing meaningful therapy.

Generic mental health clinician roles in CAMHS have not been seen to improve consumer outcomes.

> *“The allied health disciplines are all seen as "generalists" with each discipline's skillset not being utilised and disciplines being left managing areas of the work that they aren't necessarily trained in. It would be great if each discipline's strengths and training is utilised e.g. psychiatry for diagnosing, medication and medication review; psychology for diagnosing, treatment of mental health disorders and cognitive assessments; social work for family therapy, counselling, supporting with discharge planning and referral to other services, OT for input around sensory issues, etc.”*

Thirdly there were issues raised with the centralised triage system allocating consumers based upon available appointment slots, rather than matching the needs/complexity of consumers to the skills/experience of clinicians. This was seen as prioritising operational processes over the therapeutic care needs of consumers. From an efficiency perspective it was noted that community teams lost FTE to support the operation of CAMHS Connect however they were still required to do ‘duty’ every day. A refinement of referral processes was suggested to limit time spent on additional assessments for consumers who do not meet the tertiary mental health criteria, and an evaluation of the outputs of centralising triage in comparison to previous approaches.

2.3 Administrative Documentation Systems

There was significant frustration with duplication of reporting across paper based and electronic file systems, with some fault attributed to “ CBIS being an outdated resource”. (NB CBIS is one of the Community Based Information System used by SA Health mental health service.) The significant time clinicians spent on administrative duties took time away from working with consumers, hindered therapeutic outcomes and increased the waitlist times for consumers. Administrative positions were also rarely backfilled which further contributed to the workload of clinicians.

2.4 Group Therapy

The majority of clinician work was described as being undertaken 1:1, with little opportunity to undertake group work. Increasing delivery of group programs was seen to be of significant benefit for a large cohort of CAMHS consumers. Benefits related to increased access to care, with a number of specialist services having long wait times, and a reduction in recent years of the number of external referral options for group therapy. Group work also opens opportunities for interagency collaboration, and teaching skills in groups was thought to be more time and cost effective. Examples of group work included; Cos-p, skills based groups, Borderline Personality Disorder, Mentalization-based treatment (MBT), Dialectic Behaviour Therapy (DBT), social skills, parent/carers groups, cultural groups, men’s/women’s groups, family therapy, gender diversity, anxiety, and literacy and numeracy support.

2.5 Assertive Outreach and Prevention

The shift to focussing more heavily on the tertiary end of care was seen as a driver behind the reduction in CAMHS capacity for assertive outreach and prevention. It was felt CAMHS needed to focus further on prevention rather than constant crisis intervention, with more

capacity for mobile and home visiting services. This need was highlighted in particular for Aboriginal and CALD young people and children under the guardianship of the Chief Executive (CE), who faced increased barriers in navigating the system, and increased likelihood to not have accessed therapeutic support prior to a crisis presentation at the ED. Assertive outreach was also documented as an important support for targeting young people who were; hard to engage, had high complexity, emerging personality disorders, limited transport, and who were isolated or struggled to leave home. CAMHS could better partner with schools and childcare centres to identify children most at risk and offer a proactive and preventative service.

> *"Unfortunately, within the current resources available, there is minimal scope for capacity and relationship building, education for other services/parts of the system, early intervention approaches and shared care with primary health care services (which I would see are all key components of a gold standard tertiary mental health service). The reason for this is purely because of insufficient resources meaning almost all clinical time needs to be dedicated to clinical service provision to only the most unwell and in need. This becomes a "false economy" over time because not having the scope or resources to do that other work ultimately results in more young people and families transitioning into needing our services anyway."*

2.6 Early Years

Infant mental health and early years targeted services were seen as a significant gap, with limited training options, despite the provision of age-appropriate mental health services for infants being a core component of CAMHS model of care. The need was raised for a dedicated early years clinic (0–school age) and for recruitment of more early years clinicians to work with moderate level consumers who will become tomorrow's high-risk adolescents presenting to acute services. There was also a degree of uncertainty and mixed messaging if CAMHS Community Teams should be providing care for 0 – 5 years age range.

> *"We need specialised positions for young children in all community teams. Without them we will never service this age group, or interrupt the long term trajectory for these children with severe mental health difficulties. If you want less suicides, kids in juvenile justice, you must intervene early in life."*

2.7 Disability

Services for consumers with dual disability and mental health needs were seen as a gap, in particular ASD assessments, which were compounded by long wait-lists in the public system, and affordability issues for those seeking private options. Upskilling of staff is required to work more confidently with concurrent disability and mental health presentations. A suggested improvement for this space was for CAMHS to provide an enhanced multi-disciplinary developmental disability subspecialist service, with the scope to organise planned admissions, and provide diagnostic assessment for ASD. Alternatively, capacity could be increased within Community Teams to undertake this function. Currently consumers are being placed in the Mallee ward inpatient unit, which increases restrictive practices within the unit, and impacts both these consumers and others in need of acute care. This service gap was described as having arisen in part from when the CAMHS Model

of Care was endorsed, the National Disability Insurance Scheme (NDIS) was still in its early stages and the role of CAMHS in this space was not clearly defined.

3. New Programs and Women's and Children's Hospital

3.1 Perinatal Mothers, Infants and Families

The key themes were greater investment in early years/Perinatal services, a stronger focus on prevention and partnerships, and more options for family/group base therapy. Increasing investment in early years suggestions included; reinstating the infant reunification service and increasing infrastructure for child-parent psychotherapy (observation screens, video equipment). For prevention and partnerships better liaison with Child and Family Health Services (CaFHS) and Children's Centres was raised, as was the need to have outreach positions embedded within these services. Increasing provision of family therapy was noted as an important support for the management of stressors on families. Staff training was also consistently documented, specifically; PPCN, Adult Explorations of Attachment Interview (AEAI), Parallel Parent and Child Therapy (PPACT), child-parent psychotherapy, working with mothers with Borderline Personality Disorder, and awareness of referral options.

3.2 Children up to the Age of Twelve and their Families/Carers

Increasing CAMHS capacity to deliver group based and family therapy was the dominant theme for improvement, followed by strengthening interagency partnerships. Once again increased investment in Early Years services also emerged as a common theme. Group work and family therapy was seen as a crucial need for children with complex trauma impacting on schooling and family wellbeing. The specific therapeutic groups were consistent with those listed under service gaps. The interagency partnership improvements were also similar as previously raised however there was a heavier focus specifically on schools and the Department for Education, with the need for better liaison, mental health practitioners and programs based within education, increasing mental health literacy, primary prevention programs, and an age-appropriate life skills framework. Other improvements listed were animal and virtual reality therapy, programs dealing with tech addiction and increasingly younger access to pornography.

3.3 Adolescents 12 to 18 Years and their Families/Carers

For this age group there was a more diverse range of suggested improvements, however improving capacity to deliver group therapy was the strongest theme. The specific groups raised have all been previously mentioned under the service gaps section. DBT and BPD groups were the most commonly raised. Other suggested improvements included; an eating disorder day program, a dedicated youth drug and alcohol service, LGBTQIA+ specific assessments and services, and increased specialised gender support located in Community Teams.

3.4 New Women's and Children's Hospital

The majority of factors raised for the development of the nWCH related to the physical infrastructure. Suggested considerations included; adequate clinical spaces for CAMHS staff and consumers, appropriate assessment and interview spaces in the Paediatric Emergency Department (PED) for consumers who are highly distressed or displaying aggressive

behaviours, dedicated Eating Disorder Inpatient Unit co-run with Paediatrics, reviewing bed allocation across units to ensure beds aren't sitting empty, neurodevelopmental inpatient unit, increased capacity acute-mother baby unit, low stimulus quiet spaces (adjustable lighting) for diversional activities, outdoor courtyard access, private sound proof rooms for mental health consultations/family meetings (not in front of young person), individual office spaces with appropriate confidentiality (e.g. for consumer phone calls), no hot desking, standalone mental health outpatient space for subspecialist teams, sensory and play therapy rooms, safety features for every room (duress alarms and double exits), adequate infrastructure for telehealth (physical space, equipment, internet connection), specific spaces for CALD community and Aboriginal community, and having mental health facilities separated from the emergency department. There was an importance placed on co-locating all CAMHS hospital-based services in one place, opposed to being "scattered over various buildings and platforms", and to consider the projected future need for mental health services and an expanded workforce when planning the floor space, equipment and facilities.

4. Service Reduction / Funding Redirection

4.1 Disability Services

The overwhelming largest response was disability services, with uncertainty of CAMHS role in this space. A large number of consumers are presenting with a primary concern of ASD or Attention Deficit Hyperactivity Disorder (ADHD), with mental health being secondary. Staff felt pressure to service these consumers even though there are gaps in staff capabilities, and a viewpoint that this consumer group would be better served through the NDIS and other disability services. It was felt a number of consumers with a disability were accessing CAMHS primarily due to barriers in accessing the NDIS.

4.2 No Funding Redirection

The second most common response was that there were no services CAMHS could afford to reduce, and that there was an overall need for greater funding to adequately service increasing consumer numbers and complexity of care.

5. Maximising Improvements and Strategic Review Outcomes

The response themes from these two questions were highly consistent and covered a number of issues already raised under previous headings, in relation to staff employment conditions (permanent contracts, pay parity, training access), and the CAMHS model of care (services, therapies, partnerships). In maximising improvements, the key messages were the need for additional funding and increased staffing levels. There was also a strong feeling that before CAMHS adds any new programs or initiatives, it should first consolidate existing good work, and address issues within its current services and programs. Furthermore, any new development should be implemented with a 'whole of government' approach.

5.1 Organisational Leadership

The desired outcomes from the strategic review centred on the need for CAMHS leadership to work together with staff and consumers to take action and implement changes to improve job satisfaction and consumer care. The overarching theme was the need for a clear

definition of what is CAMHS ‘Core Business’, and for that information to be clearly communicated and promoted to all staff, partner agencies, consumers and the broader community.

> *“Need to identify what is CAMHS core business and develop partnerships with other agencies providing mental health care to ensure that all patient groups are adequately serviced (and serviced with the most appropriate intervention).”*

Further specific issues raised to be addressed by the review included; inconsistency of age ranges across services and regions, further review of CAMHS governance, model of care, and central metropolitan structure, building research partnerships, a 24/7 phone service, leaderships roles between Managers, Senior Clinicians, Clinic Coordinators and Medical Unit Heads, inclusion/exclusion criteria for Community Teams who “see everyone no other agency will see”, expanding services for Early Years, Aboriginal communities and CALD communities, and ongoing development of lived experience roles. The survey responses, being either strengths, gaps, or improvements, have all been provided in the context of seeking action coming out of the strategic review. This action is in the form of recognition, quality improvement, system strengthening, and exemplifying CAMHS vision of offering the best mental health care for consumers and families.

Themes from the meetings

The review team spent a week in face-to-face meetings. Additional meetings were conducted online. These meetings were attended by CAMHS staff, consumers, carers and external agencies and relevant stakeholders (see Appendix for a list of arranged meetings by attendees and agencies). All meetings had four prompt questions:

1. From your experience, what is helpful about what CAMHS does?; What are the helpful services or aspects of CAMHS?; What do you think people should be proud of and happy about?
2. From your experience, what are the service gaps in CAMHS?
3. How could things be improved in CAMHS?
4. If something in CAMHS is expanded, but resources are limited, what do you think should be reduced? This was described as the magic pudding question; Service capacity is not endless, and magical thinking may not solve resource issues. What should there be less of?

Attendees were told that we would follow their conversation, but the questions would help us establish commonality in themes in the limited time available.

What is helpful about what CAMHS does?

Staff are hardworking, committed, values driven and highly skilled.

This was a constant description across most meetings whether with internal or external attendees. Staff want to be at CAMHS, they care deeply about the severe challenges faced by consumers and carers. They impressed the review team as being passionate about their

work and were looking for reasons to stay with CAMHS (in the face of many push and pull factors encouraging departure). There were numerous examples of innovation and discussions of possible further innovations.

Team related strengths included:

- Rapid Assessment Clinic; DBT, Gold Card Principle, (N= 4 sessions);
- Helen Mayo House (MBU/perinatal inpatient service, N=6), Bridge Program to support waiting list. Assertive Hospital in the home;
- Women's and Children's Foundation; money for the gender service;
- Forensic service extended to Saturday and Sunday.

Strengths of CAMHS overall included:

- Clinical Governance processes between teams;
- CAMHS multidisciplinary view of patients. CAMHS has increased its capacity to provide multi-disciplinary reviews across all of its teams over recent years;
- Senior worker oversight of cases and case review;
- Tiers of escalation process including case conference, case review, complex care (2 x per week, internal and external stakeholders);
- Complex care review committee;
- Supervision, 1:1 predominantly, monthly but can shift in frequency depending on individual needs;
- Clinician's values based on commitment to children and families held at the centre of care;
- Framework for working with Aboriginal people. Aboriginal social workers embedded in the CAMHS teams. The Aboriginal leadership team has a clear strategic framework. Strategic approach to improving the access and quality of care for Aboriginal and Torres Strait Islander people;
- Work closely with Aboriginal community. Explaining the reasoning behind the four month wait list time helps to keep community members enthusiastic and hopeful;
- The size and gender spread of the Aboriginal workforce in the Forensic service. Every Aboriginal person is offered contact with the Aboriginal workforce;

- Multi-agency meetings are occurring on the APY Lands;
- APY Lands Model of care document created with extensive consultation. The model of care incorporates broader work of WCHN on the APY Lands. Focus on working with Anangu people to run the business Anangu way. Developed by Aboriginal people who all respect Aboriginal Lore;
- Workers travelling to APY Lands have built credibility with the community and have cultural respect;
- Focus on therapeutic engagement;
- Inpatient peer workers (in unfunded positions, currently financed by Activity Based Funding);
- Collaboration between CAMHS and internal stakeholders;
- Support for mothers with BPD;
- Leadership walkarounds (from WCHN and CAMHS);
- What the staff do with limited resources;
- Core competencies for staff. There is now a systematic approach to identifying core competencies for staff and a process for comparing that with applications for training;
- *"Multidisciplinary Team care is done very well. We share knowledge and work well across teams;"*
- *"Since COVID we have transitioned to online meetings really well, it has actually helped to break down silos;"*

Strengths of CAMHS relationships with external providers included:

- Interagency therapeutic needs panel with the Department for Child Protection, Department for Education;
- The advocacy for young people and their families;
- Collaborative work;
- Wrap around to young person and their families;

- Towards Wellness Plan has improved relationships with Adelaide Primary Health Network (PHN) and WCHN.

What are the service gaps in CAMHS?

Attendees at meetings perceived that there were numerous gaps within CAMHS and within specific teams. These included:

- Adolescent outreach doesn't exist;
- Early years interventions missing;
- Primary prevention missing out. Circle of security and Incredible years programs are no longer provided by CAMHS;
- Mallee ward is a brief stay only. Length of Stay is 4 days on average;
- Youth positions taken away from CAMHS to create Youth Mental Health response in SA; This stopped outreach options;
- Child and adolescent gender service is small. Can't transition to adult gender service. Gender service 15 month waiting period. Marked distress being on gender waiting list;
- Inconsistencies in approach to diagnosis of ASD & ADHD in CAMHS community teams;
- Inconsistency in assessment and management of ASD across the CAMHS community teams. Variety of views on whether ASD is CAMHS, paediatrics or NDIS. There were inconsistent views on which consumers with ASD and with acute mental health issues were within CAMHS remit;
- High levels of ASD in forensic patients with insufficient resources;
- CAMHS service available 9 am to 5 pm. No weekend service;
- Access with APY Lands. Filling vacancies with staff who can live, or do live the APY Lands is the desired goal compared with the current approach of fly in fly out (FIFO). However the difficulty in recruiting to live on the APY Lands means unfilled positions;
- 8 – 12 week wait for community teams;

- Other than Helen Mayo House and Mallee ward, there are no peer workers in metro-community or rural. The lived experience workforce does not appear to be permanently funded;

- CAMHS Connect allocate to CAMHS community without any consideration about best fit of clinician/discipline;

- No middle between community and acute CAMHS services (ward, ED);

- Inpatient and outpatient services but no day program for children or adolescents;

- CAMHS is fundamentally under-resourced. Some country teams can not operate;

- CAMHS RACER response to ED is limited to WCHN. Country teams have to respond to local hospital ED presentations with none of the metro resources;

- Role of ED Mental Health Team too broad.

- There were relatively few CAMHS staff from priority populations. In some areas there were no Aboriginal staff or only one gender. The size and gender spread of the Aboriginal workforce in the Forensic service was a noted strength. However, across all of CAMHS, there needs to be a gender split to ensure culturally appropriate care;

- It was reported that there were only two CALD clinicians for the whole service;

- The excessive administration requirements are not improving consumer care, they are actually detracting due to the time required for all the manual processes and duplication of paper files. “The amount of admin and paperwork is ridiculous when trying to find time to actually undertake clinical work.” “We are triple handling the same information”;

- Need to determine what is CAMHS ‘core business’;

- Not enough Aboriginal staff to meet communities’ needs. It was reported that at least a team of 4 staff in the south and 4 in the north were required. The teams should not be one gender only, in order to be culturally safe;

- No Aboriginal mental health workers in the hospital;

- Need to increase the Aboriginal workforce, prioritise recruitment and mentoring, develop career pathways (including clinical and management qualifications), and ensure culturally safe spaces are available. It was reported that there were more teams than Aboriginal staff;

- Needs to be greater recognition of cultural understanding and engagement as a competency and skill amongst the Aboriginal and the multicultural workforce. Need to ensure that culturally safe approaches to engagement with those requiring a tier 3 service are supported;

- Current data reporting systems do not adequately capture the significant cultural workload of Aboriginal staff

- The need for more youth workers in the country;

As well as focussing on gaps with CAMHS, attendees also described numerous gaps in the mental health care system and the broader health and wellbeing sectors. These included:

- Overwhelming reliance on ED “for fixing” 17 to 18 years old; services don’t align, not an integrated model. It is of interest that a number of gaps described by participants appeared to the reviewers to be more about gaps in the overall health and wellbeing system, rather than a gap of CAMHS per se;

- Management of social admissions that occur as a consequence of lack of alternative approaches;

- Little opportunity for CAMHS to refer or access adult service until the young person is just about to turn 18 years old. Even then, there is inconsistency in the lower age limit for youth mental health (and correspondingly, inconsistency in the upper age limit for CAMHS), and criteria for referral. Most CAMHS consumers requiring adult services cannot get into adult auspiced youth mental health services;

- Access to adult gender services could be 18 months;

- Inconsistency between child and youth; 16/18 years. Acute care to 18 years;

- Inconsistency over whether ASD is an acute mental health disorder in its own right, or whether the role of CAMHS is to work with any comorbid mental health disorders;

- An inconsistent and under-developed interface between paediatrics, child psychiatry, NDIS and Child Protection for the management of neurodiverse children and teenagers;

- Community access vs Acute care (ED, admission). Community was reported to be underdone to support those with neurodiversity;

- A lack of clarity about what Tier 3 services treat. This applies to referrers, stakeholders and CAMHS. There was expressed confusion over who is in scope at what point in their journey;

- Where are the tier 2 services? There are shortages of paediatricians and so neurodiverse consumers who would have been seen there are now sent to CAMHS;

- CAMHS can't compete on recruitment. For example, the NDIS private sector, Education, PHN funded services offer higher wages and less severe consumer groups. This also compounds the difficulty recruiting specific professions (i.e. psychology, speech, occupational therapy and nursing);

- Discharging from CAMHS to tier 2. Where are these services?;

- A void in services for mild to moderate young people as CAMHS focuses only on higher level needs – *"CAMHS not reaching down and Headspace not reaching up";*

- Staff are being lost to Education Allied Health positions. Less complex work and paid higher wages;

- CAMHS comes from a clinical model, there needs to be more consideration of cultural factors. Western clinical thinking doesn't always align with Aboriginal spirituality.

How could things be improved in CAMHS?

Attendees had a number of suggestions for improvements in CAMHS. These included:

- Need to transition successful pilot projects to being offered broadly across CAMHS;

- Offer groups collaboratively with partners (e.g. headspace);

- Deliver an outreach, hospital in the home, approach. This would reduce the use of hospital based care and intervene earlier in the settings where people live, study and play;

- Need to expand the Lived Experience Workforce;

- Lived experience representatives for the Aboriginal community could also include recognition of the lived experience of extended family and Elders where culturally appropriate;

- Better integrate Non-Government Organisations (NGOs) and Lived Experience Workforce into discharge services and processes;

- Using data on the expected numbers of infants, children and young people in the community that could be expected to need CAMHS to compare with the actual age breakdowns in CAMHS;

- Develop a psychology student clinic, to increase the workforce in that discipline;

- Work to reduce staff burnout. Retaining staff was also mentioned with regard to the use of short term contracts with their consequent insecurity. This, as well as different pay rates, and less severe consumers being seen are part of the attraction leading to an exodus of staff to education, private practice and NDIS funded roles;

- Increase the availability of CAMHS outside business hours;

- Co-locating PHN, Headspace and CAMHS, and a wish from some attendees to have a shared intake process;

- Increase use of telehealth for country areas;

- Develop audio resources in language for CALD communities. More investment to engage the community;

- Improve messaging around CAMHS role, and explain the what, how and why around therapies provided;

- More text based mobile phone support for young people;

- Use more Apps where young people can input data themselves;

- Need a more balanced workload like it used to be, with some mild to moderate consumers. *"We want more variety in our work, always dealing with crisis is leading to burn-out";*

- Training in family and narrative therapy;

- Aboriginal people need to be central to all decisions made around Aboriginal business. This could include assessment and therapeutic models, decolonising operating and data procedures, and translating culturally safe practices into tier 3 practices;

- When Aboriginal consumers are involved with CAMHS, it should be the default position that the Aboriginal workforce is involved, either directly with the consumer, family and community, or indirectly through consultation with the non-Aboriginal workforce;

- Assessment reports need to ensure the context behind presentations are described routinely;
- The 9-5 working hours are too rigid and CAMHS lacks flexibility for a work/life balance;
- More training in dyadic therapy;
- More permanent contracts for staff;
- Data and KPI's need to be partitioned by consumer's Indigenous status, so that different inputs and outcomes can be monitored and addressed. This data must be visible to all programs to guide continuous quality improvement
- The collection, feedback and interpretation of data should be informed by consumers and carers. This is particularly relevant where data can be misread without an informed cultural lens;
- Need data of what services CAMHS provided to out of home care children, and what are the health outcomes. Need a longitudinal minimum data set.

If there is no magic pudding, what should be reduced in CAMHS?

While all attendees hoped for an increase in resources commensurate with the size of the mental health needs of the young of South Australia, they were able to discuss the options for reducing or altering services in order to accommodate new, or expanded initiatives. Suggestions included:

- Either get Youth Mental Health resources back, or make a clear consistent cut off age;
- Social admissions to the inpatient unit should only occur where there is a clear severe and complex mental health challenge and not where the prime issue is lack of an alternative;
- Curtail people with no mental health expertise making decisions about admissions to psychiatric inpatient units;
- Reduce our inconsistency, in criteria, decision making, and our public face.

Recommendations

The recommendations listed below are provided acknowledging that the clinical, administration and operational staff are already providing, in many areas, exemplary care to a very vulnerable group of young people and their carers. The review team would like to

acknowledge the impressive CAMHS workforce and how very dedicated and committed they are to helping those young people most in need.

The recommendations are presented in two sections. First, those that are the most critical, are likely to have the greatest impact, and which may be the most challenging are immediately below. Second, specific recommendations pertaining to individual terms of reference are presented. These are presented as suggestions for consideration. The review team is well aware of both the request to prioritise the recommendations and the large number of requests from previous reviews.

Improving the mental health of young people in South Australia is a challenge facing all levels of Government, the private and the not for profit sector. Any recommendations suggested specifically for CAMHS are not intended to diminish this challenge for all those stakeholders.

1. *The overarching recommendation is for South Australian Child and Adolescent Mental Health Service (CAMHS) to provide an integrated continuum of mental health care for consumers and their families.*

2. *The recommendation is for the South Australian Child and Adolescent Mental Health Service (CAMHS) to be a high quality tier 3 mental health service.*

   Infants, children, adolescents, mothers and parents in the perinatal period who require tier 3 mental health services experience severe and complex mental health conditions, and require a multi-disciplinary mental health team. While CAMHS will prioritise these consumers, they will also develop flexible and responsive relationships with tier 2 and tier 1 providers enabling smooth step-up and step-down pathways. These relationships are likely to utilise shared care, consultation, education, system development, development of partnerships, active and respectful engagement with communities, and person-family-centred approaches.

   The young people of SA will benefit from the genuine partnership and collaboration between services, where those services are clear, flexible, committed to achieving a continuum of care, and transparent about their capacity. The service delivery from CAMHS and the broader partnerships to develop system capacity will be culturally appropriate, developmentally respectful, actively engaged with the other tiers in the mental health care system, and deliberately consumer and family centred. Strategies for developing necessary additional services will be actively progressed by the network of SA tier 1, 2 and 3 partners.

3. *There has been significant staff burnout within CAMHS arising from the effect of the COVID-19 pandemic which had reduced the capacity of tier 2 to provide services while the number of vulnerable young people needing treatment had substantially increased. There is currently insufficient staffing to provide service delivery. Supporting, growing, and training the CAMHS workforce is critical and underpins any mental health service delivery moving forward. Involving the CAMHS workforce in the change management is essential to retaining the staff and bolstering morale.*

4. *There has been a marked increase in demand for child and adolescent mental health services since the COVID-19 pandemic in Australia and across the world (McGorry et al., 2023). The increase in demand reported by CAMHS to the review team mirrors the significant increase in demand for CAMHS services highlighted in the literature (McGorry et al., 2023). It has been reported that there is an over 50% increase in urgent and regular CAMHS referrals (McNicholas et al., 2021) associated with increases in child and adolescent mental health Emergency Department presentations (Ashworth et al., 2022). The increase in demand for mental health services by children and adolescents extends across all mental health conditions but particularly in the areas of eating disorders (Campbell et al., 2022), those presenting with very serious self-harm (Corrigan et al., 2022), and autism (Ashworth et al., 2022).*

5. *The ongoing demand for child and adolescent mental health services in what is an overextended CAMHS service requires urgent attention. It is not possible to provide appropriate and timely care to this vulnerable population with increased demand for mental health services without an increase in budget, staffing and infrastructure. It is not appropriate to convert existing positions to cover any of the recommendations. Any attempt to simply redistribute existing services (without an increase in resources) will lead to a diminishment in mental health service delivery.*

6. *CAMHS requires significant stakeholder support. Most of the complaints from the community focus on CAMHS as providing the sole answer for the identified service gap. Following the exponential increase in demand for mental health services during and after the COVID-19 pandemic, tier 2 and 1 services have not been able to meet the needs of consumers whose acuity and complexity would otherwise sit in tier 1 and 2. There has been an unrealistic expectation that CAMHS should meet this shortfall in services. CAMHS alone is not staffed or funded to address all these gaps. Many of the mental health service gaps can only be addressed as an all of government response and are outside of the remit or sole control of CAMHS.*

7. *There are a number of recommendations included in this report which have been benchmarked against best practice across Australia. While many of the recommendations can be actioned in the short-term, the reviewers were mindful that the terms of reference sought recommendations for CAMHS into the next 5 - 10 years and some of the recommendations would require longer timelines to action.*

In providing this report, a balance was sought to find practical suggestions for consideration that were not too broad to be unhelpful, but equally not so prescriptive and detailed that would prevent them from being adapted to the South Australian context. The numbers and letters that appear in brackets after each of the subheadings relate to the Terms of Reference set out for the review team, see Table 2.

Suggestions for Consideration

A. CAMHS outpatient model of care (TR1, TR2, TR3h, TR3e)

CAMHS provides several services within its mental health service including community CAMHS teams, Mallee ward adolescent inpatient unit, specialised clinics and the Rapid Assessment Clinic. The review team identified that there were several missing pieces that would enhance and strengthen the existing services providing clinicians, the consumers and their families with additional care options and supports. It was noted that the perinatal service has many additional treatment options and already approximates a continuum of care. However, for those over the age of 1 year, it is recommended that there are additional complementary services developed through CAMHS in partnership with WCHN which would enhance existing CAMHS services. This would allow CAMHS to provide a continuum of care across a range of therapeutic and assessment modalities.

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).

B. CAMHS inpatient (Mallee) model of care (TR1; TR3a, TR3b, TR3c, TR3e)

The Mallee ward was criticised by several stakeholders related to difficulty accessing beds for adolescents.

The key performance indicators for Australian adolescent inpatient units are length of stay, post-discharge contact rate, readmission rates, seclusion rates, and frequency of restraint. Mallee ward had during and emerging from the COVID period, an occupancy of 50% in the 12-bed ward with an average length of stay of 3.3 days. Comparable trimmed mean length of stay in Victorian Hospitals is between 4.2 and 10.3 days (Health, 2023). The Mallee ward length of stay was remarkably shortened during the COVID period; 2020/2021 financial year mean was 3.65 days, 2021/2022 mean 3.79 days and 2022/2023 mean was 3.3 days. It was reported that the Mallee ward length of stay in part relates to ceasing overnight and day leave from the ward.

Across Australia, the current statement of priorities, is to reduce, and where possible, eliminate seclusion. At Mallee ward there were 13 seclusion episodes in March 2023, 9 seclusion episodes in April 2023 and 7 seclusion episodes in May 2023. The Mallee ward seclusion rates per 1,000 bed days as provided by the Department for Health and Wellbeing were April 2023 28.2 (target 9.5), 13.4 for May 2023 (target 9.5), 3.2 for June 2023 (target 9.5) and July 9.1 (target 5). Additional information regarding Mallee ward restrictive practice can be found in the Appendix, table 3a. At Monash Health, in July 2023 the seclusion rate benchmark is ≤ 5 /1,000 bed days.

Mallee ward restraints per 1,000 bed days were May 2023 13.4 (target 5%), June 2023 6.4 (target 5%), and July 2023 7.3 (target 9%).

From March 2022 to March 2023 the Mallee ward readmission rate fluctuated between 4% and 32%. While 32% is high, readmission rates can be difficult to interpret in an adolescent population as many patients have readmission as part of their management plan if they are not coping in the community. It would be meaningful to know which patients were unexpected and unplanned readmissions.

Post-discharge contact is one of the most significant psychiatric outcome measures. Inpatients are particularly at risk of suicidal behaviour immediately following discharge. Post-discharge contacts are the responsibility for both the discharging unit and outpatient teams. Mallee ward seven-day post discharge contact rates are reported in the appendix, table 3b. The benchmark for post-discharge contact of ≥ 88% was not met for most of the months reported.

An inpatient admission to Mallee ward is decided by virtue of risk to self or others arising from a psychiatric condition, or need for inpatient assessment or treatment that cannot be provided in the outpatient setting.

Psycho-social admissions are defined as admissions that are not being adequately managed by the supports in the community but do not meet threshold for either mental health or paediatric inpatient care. At present, social admissions are being directed to the paediatric services, with little mental health support for acute behavioural disturbance. It would seem NDIS services are not providing adequate respite care for acute behavioural disturbance and other psycho-social admissions which should be in their remit.

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.

C. Interface between Mallee ward, Emergency Department and CAMHS (TR3d)

It was reported that there were longstanding tensions between the WCHN PED, the CAMHS mental health nurses who staff the PED, and Mallee ward. The CAMHS psychiatric nurses who see consumers in the PED also respond to code blacks, SA crisis phone calls, as well as covering the mental health assessment of acute toxicology/ingestion on the ward. There were historical and anomalous reasons cited for the current role of CAMHS nurses in the PED. There were significant management issues arising about the clinical appropriateness of having social admissions on either Mallee ward or the Adolescent medical ward.

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.

D. Partnerships with Key Stakeholders (TR3f)

There are many challenges in working with tier 1 and 2 mental health services. While the demand for mental health services has increased dramatically in the last 3 years, there has been a marked reduction in the capacity of the tier 2 service providers to see young people with mental health needs over the COVID period. This has led to an increase in demand for services for CAMHS in tier 3 and presentations to the ED. While there are 13 headspace clinics in SA (5 in Adelaide and 8 in country SA), the comparable states of Australia such as Western Australia and the Northern Territory have 21 and 4 headspace clinics respectively (headspace, 2023). The locations of the South Australian centres are listed in the Appendix. Further, it was reported to the reviewers that the NGOs that run the headspace clinics begin to taper and cease services in the months and year leading up to retendering for their contracts with the Federal Government. As a separate development, the SA government has made provision for 100 school psychologists to work in schools; it has been unclear how this school-based workforce will integrate with CAMHS.

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.

E. Early intervention (TR3g)

Apart from the CAMHS perinatal service, it was reported that there was a significant gap in the provision of services from the early years up to 12 years of age, something that was missing across all service providers. The PHNs have limited training in the under 12 space with most of the clinicians being adult trained. Headspace does not provide for any service for those under 12 years of age. Private psychology and psychiatry is not affordable for many families and requires a large gap payment.

Infants of young mothers with high-risk behaviour, drug and alcohol use, and/or Aboriginal and Torres Strait Islander background are at highest risk of removal from their parents.

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.

F. Workforce support and enhancement (TR3i, TR3j)

The CAMHS workforce interviewed reported that "it is a buyer's market" for clinicians. The NDIS, tier 2 including private practice and schools were seeking to employ CAMHS clinicians and it was reported offering more money than CAMHS and to see consumers with lower risks to self and others. Retaining the current workforce, expanding the skill base of the current workforce, involving the CAMHS clinicians in the change management process and developing early-in-career clinicians to be part of the wider CAMHS workforce were critical tasks moving forward.

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.

A contemporary mental health service requires a lived experience consumer and carer workforce to strengthen the expertise and sensitivity of the CAMHS services and support the value of the consumer and carer voice. This would include:

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.

G. Consumers with neurodiversity and disabilities (TR3c)

Neurodiversity is an umbrella term that includes, amongst other diagnoses, ASD and ADHD. ASD and ADHD can be diagnosed by mental health clinicians including private psychologists, speech pathologists, child psychiatrists, as well as paediatricians. It is reported to the review team that there is a community expectation that CAMHS provides ASD and ADHD assessments. Currently, CAMHS is inconsistently offering assessments for ASD and ADHD. CAMHS has neither the capacity, staff, resources nor the remit to assess all people seeking diagnoses of ASD or ADHD in SA.

The significant challenge of managing consumers with neurodiversity who suffer with externalising behavioural challenges is not unique to CAMHS, the WCHN Emergency Department, Mallee ward or South Australia. Consumers with neurodiversity as they age become physically stronger and experience the significant growth and hormone changes of puberty. These changes can become extremely challenging for their carers resulting in (at times) significant property damage, carer assaults, risks to the consumer and carer burnout. Where the wider system (community CAMHS teams, private practitioners, schools, GPs has been unable to provide adequate support and safety to the young person and their families, then it is understandable that the only recourse is for the family to look to emergency services and the ED for support and interventions. It was reported that 34% of consumer presentations to ED involved ASD with 21% involving Intellectual Disability. Presentation to the ED is a last resort but there is nowhere else, particularly in the after-hours, for these parents and carers to go. Unfortunately, EDs are not equipped to address or deal with neurodiverse people with significant behavioural challenges including aggression. It was reported that there has been a resistance to manage consumers with ASD in the Mallee ward where ASD in the absence of another defined mental health condition is the predominant presenting symptom.

Consumers with neurodiversity have high rates of comorbid psychiatric conditions (Lai et al., 2019). Where a patient has comorbid ASD and other significant mental health conditions (such as an eating disorder, major depression) they pose a very significant clinical treatment challenge. The risk of suicide or attempted suicide in people with ASD increases significantly when there is a comorbid psychiatric condition (Kõlves et al., 2021). Patients with complex needs require a collaborative, interagency model of care where the consumer is owned by all the services and evidence-based treatments are emphasised and implemented. The challenge is to find creative solutions in a patient-centred, curious and compassionate approach rather than the strategy of boundary setting. A key to this approach would involve respectful communication between all people and agencies.

It was reported that the disability services that existed prior to the rollout of NDIS were superior at managing complex consumers living with disabilities. These disability services were disbanded since NDIS came into existence. The NDIS offers a number of services to assist with the management of more complex consumers with neurodiversity; but accessing NDIS is a challenge. Patients and their carers need to regularly provide extensive paperwork to both receive NDIS and to rollover existing packages. The NDIS is provided by private clinicians and companies who can decline service. The NDIS is expensive and is better suited to treat people at the milder, less challenging end of the behavioural continuum. During the COVID-19 pandemic there was a significant reduction in services provided face to face via the NDIS.

The review team came to the view that any person who lives with ASD or ADHD who continues to re-present to the ED has been failed by the wider system. CAMHS alone however, will be unable to resolve this situation, without an all of government approach.

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.

H. Aboriginal and Torres Strait Islander people (TR3g, TR3h)

Aboriginal and Torres Strait Islander culture and self-determination are significant protective factors in managing psychological distress. These protective factors include: maintaining connection to Country, spirituality, ancestry and kinship networks, strong community governance and cultural continuity (Zubrick et al., 2014). Despite the strengths of culture and resilience of Aboriginal communities, young Aboriginal people can face additional challenges in transitioning into adulthood, such as the effects of intergenerational trauma, racism and prejudice, and disadvantage across the social determinants of health (AIHW, 2018). Aboriginal people are less likely to access mainstream primary mental health care services, and more likely to use emergency mental health services during times of crisis. In recognising these access barriers, Aboriginal culture must be a core consideration in consumer's clinical care (CALHNMHD, 2021). CAMHS Aboriginal workforce and consumers must be appropriately engaged as the guiding voice in both strategic planning and the delivery of services.

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.

I. Other populations (LGBTQIA+, out of home care, CALD) (TR3g, TR3h)

CALD refers to people from cultural and linguistic backgrounds who were born overseas and speak languages other than English. The CALD population is a number of heterogeneous groups including permanent residents, temporary migrants, refugees, asylum seekers from a wide variety of countries and ethnic backgrounds. People from CALD communities have higher rates of mental health challenges arising from a myriad of intersection vulnerabilities including but not limited to trauma and conflict in their country of origin, social disadvantage, poor health literacy, language and communication challenges, treacherous migration journeys, and physical health issues. Those people who are refugees and asylum seekers are the more vulnerable sub-groups in the CALD population (Khatri and Assefa, 2022). Mental health challenges for CALD people include very high rates of Post-Traumatic Stress Disorder, somatisation, anxiety and depression (Khatri and Assefa, 2022). It has been reported that refugees and asylum seekers have relatively poor access to health care services (Khatri and Assefa, 2022). It is anticipated that the current Australian Immigration Minister will increase the current quota of refugee and humanitarian quotas. It is highly likely that there will be an increase in the CALD communities in South Australia in the coming years. Currently CAMHS has two clinicians to provide for the children and adolescents who present with mental health needs.

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.

CAMHS has a very important role in partnering with Child Protection to see those children whose mental health challenges require a tier 3 service. CAMHS is uniquely skilled at providing formulation and systemic understanding of behavioural symptoms, mental health presentation and the challenges of the young people seen by Child Protection. CAMHS has a very important role in providing input into Child Protection care team meetings. However, CAMHS is not equipped to provide long-term psychotherapy to children in out of home care. Equally, CAMHS is not resourced to screen all children who are in out of home care for mental health challenges.

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.

It is acknowledged that children and adolescents who are gender diverse have higher rates of mental health challenges and suicidal thinking and behaviours than the general population. The presentation to the review team by the CAMHS Gender Service was very impressive. The obvious gap in the service delivery appears to be the lack of a receiving service for adolescents with gender dysphoria when they transition to youth services at 18 years old.

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.

J. Research, Training, and data collection (TR1, TR2)

The collection of data to benchmark SA with the rest of Australia was a theme which had come up in many of the reviewer's discussions. The other significant feedback from the CAMHS staff was that overall, there is limited research in CAMHS.

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.

The review team is very grateful for the opportunity to be welcomed into the CAMHS teams and be trusted to make - hopefully - useful recommendations. We all sincerely wish the best for CAMHS as it enters the next chapter of its future in helping a very vulnerable cohort of infants, children and adolescents.

Finally, we wish to thank Sharon Phillips from CAMHS, and Jill Agius from Mental Health, Strategy and Planning working on behalf of OCP for their invaluable support, tireless energy and enthusiasm in bringing this review to completion.

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Appendix :

Mallee ward Restrictive Practices	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Physical restraint events	12	8	7	3	4	2
Seclusion events	13	9	7	2	5	1
Total number of SLS reports	13	10	7	3	6	2
Mallee ward OBDs	153	158	217	265	223	210
Physical restraint RATE (per 1000 OBDs)	**78.4**	**50.6**	**32.3**	**11.3**	**17.9**	**9.5**
Seclusion RATE (per 1000 ODBs)	**85.0**	**57.0**	**32.3**	**7.5**	**22.4**	**4.8**

Table 3a. Mallee ward Restrictive Practice March 2023 to August 2023 (data source: Office of the Chief Psychiatrist Safety and Quality Team. Note: the rate of restrictive practices per 1000 bed days may differ from rates identified within other reports due to differing calculations of occupied bed days

% Clients Seen by CMHS 7 Days Discharge INCLUDING INPATIENT UNIT S' FOLLOWUP CONTACTS - MH KPI ID 003

Source: ISAAC (separations), CBIS/CCCME (copy from copy from here

			rptper												rptper		
		1/07/2022 - 30/6/2023											1/07/2023 - 30/6/2024				
	Hosp	Ward	07 - Jul	08 - Aug	09 - Sep	10 - Oct	11 - Nov	12 - Dec	01 - Jan	02 - Feb	03 - Mar	04 - Apr	05 - May	06 - Jun	07 - Jul	YTD	YTD Prev
Measure	WCH	Boylan															
Consumer		Mallee															
involved		Mallee [Sunrise]	97%	89%	69%	80%	78%	83%	88%	76%	82%	55%	69%	52%	63%	63%	97%
Measure	WCH	Boylan															
Consumer		Mallee															
OR		Mallee [Sunrise]	97%	91%	75%	85%	78%	88%	90%	78%	82%	63%	71%	52%	63%	63%	97%
Carer																	
involved																	

Table 3b. Mallee ward seven day post-discharge contacts

Primary Health Network	headspace service	Service type
Adelaide	Adelaide	Centre and EPYS Hub
	Edinburgh North	Centre
	Marion	Centre
	Onkaparinga	Centre
	Port Adelaide	Centre
Country SA	Berri	Centre
	Mount Barker	Centre
	Mount Gambier	Centre
	Murray Bridge	Centre
	Port Augusta	Centre
	Port Lincoln	Centre
	Victor Harbor	Satellite from Murray Bridge
	Whyalla	Centre

Table 4: Primary Health Network and headspace locations in South Australia (headspace, 2023)

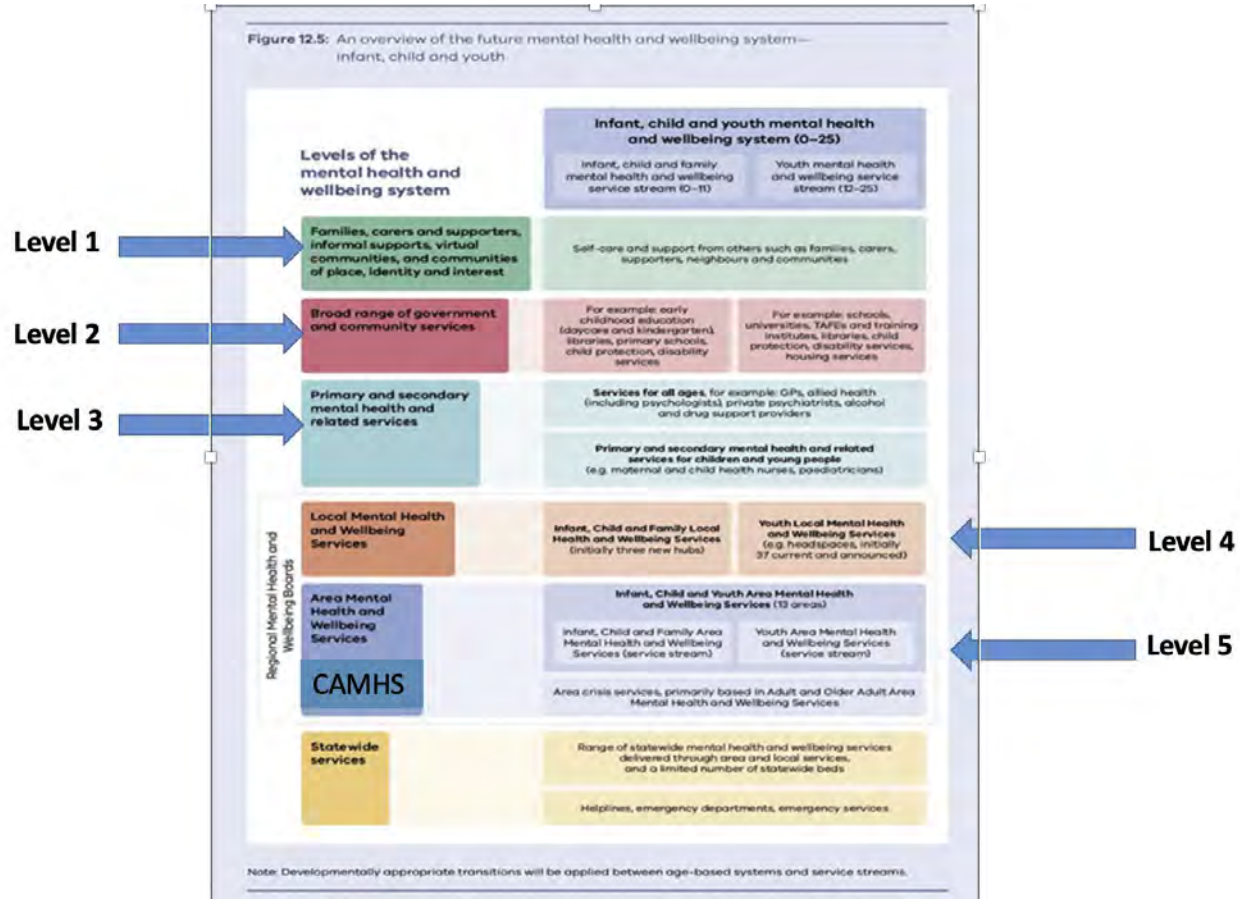

Figure 3. Levels of service intervention as described by the Victorian Royal Commission into Mental Health. (Health, 2023)

Note: The invaluable role of parents, communities and informal supports as tier 1 agents is a long overdue addition to conceptualising the mental health care system. Level 2 and part of level 1 correspond to tier 1. Level 4 and part of level 3 correspond to tier 2. Levels 5 and 6 correspond to tier 3.

Adie Gibbons	Ali Wells-Fechner	Alicia O'Neill
Alison Flanagan	Amy Wallace	Andjela Mechis
Anna Chesson	Anne Gannoni	Anne Marie Taplin
April Lawrie	Ashlea McIntosh	Ashleigh Ditcham
Ashum Owen	Asif Mir	Belinda Torr
Ben Jackson	Ben Wells	Benjamin D'Souza
Bernadette Mulholland	Billy Elrick	Breanna Hincks
Bree Scharber	Brigitte Houldsworth	Brooke Oliver
Callum Deakin	Camilla Morgan	Carmela Sergi
Carolyn Doherty	Caterina Carbone	Catherine Turnbull
Celia Karpfen	Chad Collins	Charlene Du
Cheryl Lowe	Chloe Trapp	Chris Ciancio
Chris Yelland	Christina Helbes	Christine Lock
Christine McCracken	Clare Smith	Claudia Cao
Colleen Barker	Daniel Centofanti	Daniel Tumminello
Danniella Caradonna	Daphne Sim	David Baulderstone
Davinder Gill	Dayna Cocks	Deb Keter
Deena Cakebread	Dhowhaa Ahmed	Dianne Van Giesen
Duncan Skene	Ella Gibson	Ellen Murray
Ellen Van Giesen	Elsa Jureidini	Emily Gibson
Emily Lowe –	Emily Roxburgh	Gabby McCormack
Genevieve Brandenburg	Georgie Swift	Ginny Slattery
Greg Keil	Hala Abokamil	Helen Connolly
Helen Parry	Helen White	Isabelle Taylor
Jackie Ah Kit	Jackie McCormack	Jacob Keeler
James Wanganeen	Jane Smith	Janiene Deverix
Jenny Curran	Jenny Edwards	Jeremy Weenik

Jessica Evans	Jodie-Ann Hochuli	Joel O'Rielly
John Widger	Jon Jureidini	Jordan Sumner
Judy O'Sullivan	Julia Sharpe	Kaitlyn Tilley
Karina Starkey	Kat Evans	Kate Obst
Kath Lines	Kathy Crossing	Katie Johnson
Katrina Waechter	Kayla Hann	Keegan Wallace
Kelly Pitt	Kelly Wells	Kelly-Anne Allen
Kendall Lounder	Kenneth Hooper	Kerry McKeough
Kim Whitehead	Koghinie Mohan	Kristy Collins
Kym Smith	Lani Maier	Lauren Schilds
Leanne Cooper	Leanne Galpin	Leanne Norman
Lee Marling	Lesley Saunders	Lexi Ashforth
Lily Griffin	Lindy Partrey	Lisa Doyle
Lisa Verona	Lisa Wilton	Liz Prowse
Lorraine Bateman	Louise Chamberlain	Luana Passalacqua
Luka Dimanic	Lyn Jones	Lynly Mader
Lynn Croft	Lynne Whitcher	Maddi Greenslade
Maddie Close	Mahalah O'Malley	Mai Duong
Maria Scicchitano	Marie Capelle	Mariya Zubaryeva
Mark Pertini	Marnie Campbell	Marnie O'Meara
Matt Costello	Matthew McCurry	Matthew Smith
Meg Prior	Megan Nichos	Megan O'Connell
Melissa Gayler	Michael Hare	Michaela Baulderstone
Michelle Tonkin-Smith	Milena Bishop	Mohammed Usman
Monique Anninos	Nadia McEvoy	Natalie Hood
Natasha Sparrow	Nicole Walters	Nikki Speer
Nina Anastasia	Ornella Baldin	Palma Edmonds

Paul Dignam	Paul Hosking	Peter Benn
Peyman Bakhtiarian	Prue McEvoy	Rachel Djorem
Rachel Law	Rebecca Hill	Rebecca Tricker
Rita Zaccardo	Robin Davey	Robin Davey Jnr
Ros Powrie	Rosie Ratcliff	Ruth Thomson
Sally Milsom	Sam Khune	Samantha Pearson
Samaria Prohaska	Sandra Volvricht	Sarah Anstey
Sarah Lawrence	Sarah Paine	Sarah Rowe
Sarah Roy	Sarah Tirrell	Scarlett Kraehe
Scekar Valadian	Shannon Nichols	Sharon Phillips
Sharon Wright	Shilo Agnew	Simon Hein
Stacey Roy	Stephanie Jenkin	Susannah Frost
Tahlia Schultz	Tamira Pascoe	Tania Day
Tanner O'Reilly	Tanya Little	Tanya McGregor
Tanya Russo	Tea Boromisa	Tegan McLean
Tia Cherry	Tim Crowley	Tom Sheppard
Tracey Dryden-Mead	Zac Hurrell	Zakiyyaf Muuammad

Table 5: List of Attendees

Adelaide and Country SA Primary Health Networks (PHNs)
Anangu Pitjantjatjara Yankunytjatjara (APY) Lands Team
CAMHS Central Western Team
CAMHS Connect Referral and Intake Service Team
CAMHS Consultation Liaison team
CAMHS Culturally and Linguistically Diverse (CALD) team
CAMHS Developmental Disabilities team
CAMHS Eating Disorders team
CAMHS Executive Support Staff
CAMHS Gender team
CAMHS Guardianship team
CAMHS Mallee ward
CAMHS Northern Country Community Team
CAMHS Northern Metropolitan Team
CAMHS Principal Leads
CAMHS Psychiatry Team
CAMHS Senior Aboriginal Leadership Team (SALT)
CAMHS Southern Country Team
CAMHS Southern Metro Community Team
Carer representatives from CAMHS Consumer Advisory Group and Parents for Parents South Australia
Cedar Health
Central Eastern Metro Community Team
Chief Child Protection Officer SA Health
CAMHS Senior Leadership Team
Child and Adolescent Virtual Urgent Care Service (CAVUCS)

Child and Family Health Service (CaFHS)
Child Protection Services WCH
Commissioner for Aboriginal Children and Young People
Commissioner for Children and Young People
Department for Education Student Support Services/WCHN Hospital schools
Department for Child Protection (DCP)
Director, Mental Health Policy, Planning and Safety
Emergency Mental Health Service (EMHS)
Forensic/Adolescent Sexual Assault Prevention Program (ASAPP) Team and key staff
GP Liaison representative from South Australian Local Health Networks (LHN)
Guardian for Children and Young People
Office of the Chief Psychiatrist
Paediatric Emergency Department (PED)
Perinatal Infant Mental Health teams (inclusive of Helen Mayo House)
Rapid Assessment Consultation Liaison Review Team (RACER)
Union representatives from the Australian Nursing Midwifery Foundation, South Australian Salaried Medical Officer's Association, Public Services Association, Health Services Union
WCHN Aboriginal Health Division
WCHN Adolescent Ward
WCHN Disability and Complex Care Team
WCHN Health Education Interface (HEI)
WCHN My Youth Health Team
WCHN Paediatricians and key staff
WCHN Youth Advisory Group (YAG)
Women's and Children Health Network (WCHN) Executive Leadership

Table 6: List of Meetings by Agencies